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 Avg # of Individuals Serv Per Mth: Total Community Services & Supports

Calculation Method: N **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-01 OC 01

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the total monthly average number of individuals served through many of the agency's community services and supports programs. The different types of individuals 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., 1.4.2., 1.4.4., 1.5.1., and 1.6.4. Output measure 1 from strategy 1.4.2 and explanatory measure 2 from strategy 1.4.1 are also included.

BL 2014 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Data for these services are based on annual unduplicated individual 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., 1.4.2., 1.4.4., 1.5.1., and 1.6.4, output measure 1 of strategy 1.4.2 and explanatory measure 2 of strategy 1.4.1.

BL 2014 Data Source

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

BL 2014 Methodology

This measure reports the sum of the average number of individuals 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, and Texas Home Living); non-Medicaid Title XX programs; In-Home and Family Support Services; PACE; promoting independence services; and the average number of individuals with intellectual and developmental disabilities receiving community, residential, and In-Home services.

BL 2014 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.	2	Avg # Persons on Interest Lists/Mth: Total Community Serv & Supports

Calculation Method: N **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-01 OC 02

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the sum of the average monthly number of individuals 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, Community Services, In-Home and Family Support Services and 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., and 1.4.4.

BL 2014 Data Limitations

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

BL 2014 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 2014 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., and 1.4.4.

BL 2014 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.	3	% LTC Individuals with ID Served in Community Settings

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference:**

Key Measure: N **New Measure: Y** **Percent Measure: Y**

BL 2014 Definition

This measure is the calculation of the number of individuals with intellectual disabilities (ID) served in a Medicaid-funded waiver service (HCS, CLASS, DB/MD, and TxHmL) divided by the total number of individuals with ID served in Medicaid-funded programs at DADS (waivers and Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) – public and private), expressed as a percent.

BL 2014 Data Limitations

This measure excludes persons receiving safety net services provided by LAs due to the fact that not all of these persons are Medicaid-eligible and therefore could not receive ICF/IID services. Because it takes several months to close out 100% of the claims for a month of service, the # of individuals ultimately served in each program as well as cost/individual per month must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the # of individuals "approved-to-pay" to-date and/or the # of individuals 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 # of claims processing months after the month of service, can be considered a certain % complete based upon historical patterns.

BL 2014 Data Source

This measure is derived by summing payment/enrollment data for component programs that comprise this measure. See measures under strategies 1.3.2., 1.3.3., 1.3.4., 1.3.6, 1.7.1. and 1.8.1.

BL 2014 Methodology

This measure is derived by dividing the total monthly average number of individuals with ID served in Medicaid waiver-based community settings per month (the sum of the number of individuals served in strategies 1.3.2, 1.3.3, 1.3.4, and 1.3.6)., by the total monthly average number of individuals with IDD served in DADS long-term services and supports (the number of individuals with IDD served in Medicaid waivers, plus the number of individuals served in strategies 1.7.1 and 1.8.1) , multiplied by 100.

BL 2014 Purpose

This measure quantifies the extent to which the agency's ID Long-term Services and Supports individuals are being served through the agency's Medicaid waiver-based 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. 4 Avg # Individuals with ID Deinsti/Diverted Institutional Settings Mth

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference:**

Key Measure: N **New Measure: Y** **Percent Measure: N**

BL 2014 Definition

This measure sums two numbers. 1) The average number of individuals with intellectual disabilities (ID) per month who are successfully moved from an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), including public and private ICFs/IID, into community services (a Medicaid-funded waiver service including HCS, CLASS, DB/MD, and TxHmL) and 2) the average number of individuals with IDD per month who are diverted from institutional care (public or private ICF/IID) into community services (Medicaid-funded waiver services only – HCS, CLASS, DB/MD, and TxHmL).

BL 2014 Data Limitations

This measure excludes persons receiving safety net services provided by LAs due to the fact that not all of these persons are Medicaid-eligible and therefore could not receive ICF/IID services. Because it takes several months to close out 100% of the claims for a month of service, the # of individuals ultimately served in each program as well as cost/individual per month must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the # of individuals "approved-to-pay" to-date and/or the # of individuals 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 # of claims processing months after the month of service, can be considered a certain % complete based upon historical patterns.

BL 2014 Data Source

This measure is derived by summing payment/enrollment data for component programs that comprise this measure. See measures under strategies 1.3.2., 1.3.3., 1.3.4., and 1.3.6.

BL 2014 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 individuals (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2014 Purpose

This measure quantifies the extent to which the agency's ID Long-term Services and Supports individuals are being served through the agency's Medicaid waiver-based 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	Percent LTC Ombudsman Complaints Resolved or Partially Resolved

Calculation Method: C **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-01 OC 05

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

The percent of LTC Ombudsman Program complaints resolved or partially resolved is defined as the percent of complaints received by the Long-Term Care (LTC) Ombudsman Program and resolved either totally or partially to the satisfaction of the complainant. A complaint is defined as a concern brought to, or initiated by, the certified ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare, or rights of a resident. A resident is an individual living in a nursing home or assisted living facility.

BL 2014 Data Limitations

All complaints received by the LTC Ombudsman Program are documented in the statewide-operated database. Only complaints reported as closed and with a disposition status are included in the calculation.

BL 2014 Data Source

Data is reported by local LTC Ombudsman Programs in the format specified by the Department of Aging and Disability Services (DADS).

BL 2014 Methodology

The percentage is calculated by dividing the number of complaint dispositions of "resolved" and "partially resolved" by the total number of complaints closed with a disposition status. The seven disposition categories are: 1. resolved, 2. partially resolved, 3. no action needed, 4. referred to another agency, 5. withdrawn, 6. not resolved, and 7. regulatory or legislative action needed.

BL 2014 Purpose

This outcome measure analyzes LTC Ombudsman Program effectiveness in responding to complaints made by or on behalf of residents of nursing homes and assisted living facilities. The measure allows decision-makers and state agency staff to identify trends of the program. State agency staff may also identify opportunities for training and technical assistance to the local LTC Ombudsman Programs.

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 # Individuals Serve/Mth: Medicaid Non-waiver Commity Serv & Suppts

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 01-02 OC 01

Key Measure: Y **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the monthly average unduplicated number of individuals 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 2014 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals 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 individuals approved-to-pay to-date and/or the number of individuals 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

BL 2014 Data Source

Two types of data are used to calculate this measure. The number of individuals 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 individuals 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 2014 Methodology

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

BL 2014 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 individuals 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/Individual: Medicaid Non-waiver Commity Svc & Supports

Calculation Method: N **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-02 OC 02

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual 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 individuals "approved- to- pay" to-date and/or the number of individuals 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 2014 Data Source

Month-of-service to-date data that reports, by type-of-service, the number of individuals 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 2014 Methodology

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 individuals for all months of the reporting period; the result is then divided by the number of months.

BL 2014 Purpose

This measure quantifies the unit cost for providing eligible individuals 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	Average Number of Individuals Served Per Month: Waivers

Calculation Method: C **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 01-03 OC 01

Key Measure: Y **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the total monthly average number of Community Services and Supports Medicaid waiver individuals 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; and Texas Home Living Waiver –1.3.6.

BL 2014 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals 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 individuals approved-to-pay to-date and/or the number of individuals 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

BL 2014 Data Source

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

BL 2014 Methodology

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

BL 2014 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/Individual Served: Commity Services & Support Waivers (Total)

Calculation Method: N **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-03 OC 02

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the total monthly average cost of serving Community Care Medicaid waiver individuals. 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; Texas Home Living Waiver –1.3.6.

BL 2014 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual 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 individuals approved-to-pay to-date and/or the number of individuals 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 2014 Data Source

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

BL 2014 Methodology

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

BL 2014 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.	3	Number of Persons Receiving Svcs at End of the Fiscal Year: Waivers

Calculation Method: C **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-03 OC 03

Key Measure: Y **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the total number of Community Services and Supports Medicaid waiver individuals being served at the end of the fiscal year. 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; and Texas Home Living Waiver –1.3.6.

BL 2014 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals 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 individuals approved-to-pay to-date and/or the number of individuals 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

BL 2014 Data Source

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

BL 2014 Methodology

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

BL 2014 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 # Individuals Served Per Mth: Total Non-Medicaid Commity Serv/Supp

Calculation Method: N **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-04 OC 01

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received one or more of the following non-Medicaid Community Services and Supports: adult foster care, individual 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 individuals with disabilities, residential care, respite care and In-home Family Support. Also included are community services consisting of assessment and service coordination, vocational and training services, respite, specialize therapies and In-home and Family Support.

BL 2014 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 strategy 1.4.4, output 2 under strategy 1.4.2 and explanatory measure 2 under strategy 1.4.1.

BL 2014 Data Source

Specific data sources are detailed under each of the measures that comprise this "roll-up" measure. See output measure 1 under strategy 1.4.4, output measure 2 under strategy 1.4.2, and explanatory measure 2 under strategy 1.4.1.

BL 2014 Methodology

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

BL 2014 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 individuals 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/Individual Served: Total Non-Medicaid Commity Serv/Supp

Calculation Method: N **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-04 OC 02

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

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

BL 2014 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 individual 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 and 4, and efficiency measures 1 and 2 of strategy 2, of this objective.

BL 2014 Data Source

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

BL 2014 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 individuals for the months of the reporting period; this is then divided by the number of months in the reporting period.

BL 2014 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 **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 01-04 OC 03

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the sum of the average monthly number of individuals 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 Community Services. The count only includes those individuals on the list who are in "open" status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.) The count includes individuals 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. and 1.4.4., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this "total" measure.

BL 2014 Data Limitations

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

BL 2014 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. and 1.4.4., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this "total" measure.

BL 2014 Methodology

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

BL 2014 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 **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 01-06 OC 01

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This measure reports the number of individuals served in nursing facilities expressed as a percent of the state's population at risk of needing nursing facility services. Individuals served in nursing facilities is defined as the sum of: the average number of individuals receiving Medicaid-funded nursing facility services per month (strategy 1.6.1, output measure 1), and the average number of individuals 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 individuals with income at or below 220% of the poverty level that need assistance with daily living.

BL 2014 Data Limitations

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

BL 2014 Data Source

Specific data sources for the number of individuals 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 2014 Methodology

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

BL 2014 Purpose

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

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

Goal No.	1	Long-term 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 **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 539 082-R-S70-1 01-06 OC 02

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 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 individuals in Texas. The number of individuals utilizing Medicaid nursing facility beds is defined as the average number of individuals per month served in nursing facilities (defined in outcome measure 1).

BL 2014 Data Limitations

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

BL 2014 Data Source

Specific data sources for the number of individuals 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 2014 Methodology

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

BL 2014 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 State Supported Living Centers
Outcome No. 1 Avg # Days SSLC Residents Recom for Comunty Placemt Wait for Placement

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 01-08 OC 01

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 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 individual, 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 individual's needs and the location preferences of the individual and family or guardian.

BL 2014 Data Limitations

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

BL 2014 Data Source

The recommendation for placement in the community is from each individual'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 SSLCs enter the annual review recommendations into the department's CARE system.

BL 2014 Methodology

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

BL 2014 Purpose

Ideally, campus residents recommended for community placement would be placed within 180 days. (Movement within 180 days of an individuals recommendation for community placement is a requirement of the Promoting Independence Plan.) A shorter average wait indicates success in developing community placements for campus residents who can benefit from community placement.

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

Goal No.	1	Long-term Services and Supports
Objective No.	8	State Supported Living Centers
Outcome No.	2	Number of Individuals with IID Who Moved from Campus to Community

Calculation Method: C **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 01-08 OC 02

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This outcome is based on individuals with intellectual and developmental disabilities 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 ICF/IID funding for new capacity. Movement from campus (i.e. state ID facilities which are large self-contained areas where individuals live and receive 24-hour supervised care) to community tends to be from one type of residential setting to another residential setting.

BL 2014 Data Limitations

None

BL 2014 Data Source

Movement of individuals 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 from which indicates actual date of community placement. These forms are located in records available from the State Supported Living Centers. 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 ID facility.

BL 2014 Methodology

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

BL 2014 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	8	State Supported Living Centers
Outcome No.	3	% Consumers Expressed Satisfaction w Ombudsman's Resolution of Issue

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 01-08 OC 03

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This measure reports the percentage of residents, families and advocates expressing satisfaction with the resolution from the Ombudsman.

BL 2014 Data Limitations

Data for this measure is available and updated on the 15th of each month.

BL 2014 Data Source

The number of residents, families and advocates who filed a concern, Consumer Rights and Services (CRS) Ombudsman Reports, with the Ombudsman.

BL 2014 Methodology

The percentage of consumers who expressed satisfaction is based on final evaluation of the case.

BL 2014 Purpose

This measure is a satisfaction indicator of the reform effort to provide more oversight and protection for the residents of the living centers.

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 **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 01

Key Measure: Y **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This measure reports the number of facilities (nursing facilities, Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), 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/IID 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/IID facility, or a licensing inspection. Licensing inspections conducted in conjunction with a standard or an annual survey are counted as one activity.

BL 2014 Data Limitations

Does not apply.

BL 2014 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 2014 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 2014 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 **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 02

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This measure reports the percentage of facilities (nursing facilities, Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), 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 2014 Data Limitations

Does not apply.

BL 2014 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 2014 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 2014 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 with More Than Six On-site Monitoring Visits Per Year

Calculation Method: N **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 03

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This measure reports the percentage of nursing facilities that have more than six 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 2014 Data Limitations

Does not apply.

BL 2014 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 2014 Methodology

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

BL 2014 Purpose

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

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

Goal No.	2	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 **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 04

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 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 261.001.

BL 2014 Data Limitations

Does not apply.

BL 2014 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 2014 Methodology

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

BL 2014 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 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. 5 Rate (1000) Substantiated Complaint Allegations Abuse/Neglect: ICF/IID

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 05

Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This measure reports the rate of substantiated complaint allegations of abuse and/or neglect in ICFs/IID 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 2014 Data Limitations

Does not apply.

BL 2014 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/IID” in the future. The data for the number of residents in ICF/IID 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 2014 Methodology

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

BL 2014 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in ICF/IID 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 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 **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 06

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 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 2014 Data Limitations

Does not apply.

BL 2014 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 2014 Methodology

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

BL 2014 Purpose

This measure shows the effect of the agency's program to ensure that nursing facility administrators are in compliance with legal requirements. It is a tool for assessing the program's 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 **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 07

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 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 2014 Data Limitations

Does not apply.

BL 2014 Data Source

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

BL 2014 Methodology

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

BL 2014 Purpose

This measure shows the effect of the agency's program to ensure Medication Aides and Nurse Aides are in compliance with legal requirements. It is a tool for evaluating the 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. 8 % Complaints and Referrals Resulting in Disciplinary Action: NFA

Calculation Method: N **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 08

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 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 2014 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 in the past when the NFAAC was temporarily abolished.

BL 2014 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 2014 Methodology

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

BL 2014 Purpose

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

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

Goal No. 2 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 **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 09

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 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 2014 Data Limitations

Does not apply.

BL 2014 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 2014 Methodology

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

BL 2014 Purpose

This measure shows the effect of the agency's program to ensure medication aides and nurse aides are in compliance with legal requirements. It is a tool for evaluating the program's 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 **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 082-R-S70-1 02-01 OC 10

Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 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 2014 Data Limitations

Does not apply.

BL 2014 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 2014 Methodology

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

BL 2014 Purpose

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