Health and Human Services System Strategic Plan 2009–13

Volume II: Appendices

Health and Human Services Commission

Department of Aging and Disability Services

Department of Assistive and Rehabilitative Services

Department of Family and Protective Services

Department of State Health Services

Additional copies are available from:
Texas Health and Human Services Commission
Planning and Project Management
P.O. Box 13247
Austin, Texas 78711-3247
512/487-3326

An electronic copy is available at:

http://www.hhs.state.tx.us\StrategicPlans\HHS09-13\StrategicPlan_FY2009-2013.pdf

Upon request, the document may be made available in large print and in Braille. Please contact the Division for Blind Services at the Department of Assistive and Rehabilitative Services at 512/377-0665.

Texas Health and Human Services System Strategic Plan for 2009-13

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Appendix A

Description of Planning Process

As noted in Chapter IV, this health and human services (HHS) Strategic Plan includes both the Coordinated Strategic Plan (CSP) and the individual HHS agency Strategic Plans. This section describes the planning process used for both the CSP and the agency plans.

The 2009-13 HHS Strategic Plan is the third plan developed since the enactment of House Bill 2292, 78th Texas Legislature, Regular Session, 2003 and the consolidation of HHS agencies. Similar to the previous planning cycle, the HHSC planning staff was assigned to work and coordinate with the four other HHS agencies and HHSC. Leadership in each of the other agencies appointed a liaison to act as a single point of contact for planning activities and responsibilities within each of the agencies. Liaisons were also responsible for obtaining necessary departmental information and coordinating the planning efforts within the individual agencies.

Stakeholder input, statutorily mandated for the CSP, requires that the HHS System biennially conduct a series of public hearings in diverse locations throughout the state to give citizens of the state an opportunity to comment on the state's provision of health and human services. To address this mandate, hearings were held in six locations between April 15 and May 14, 2008: Mesquite, Plainview, Harlingen, El Paso, Baytown, and Corpus Christi. The hearing in Plainview satisfied the statutory requirement for a rural hearing location. The plan draft was also posted on the HHS website to enable public review and comment.

Agency Councils played a key role in the development of each agency's Strategic Plan. Agency Councils may have provided input into an early strategic plan draft, either through review and comment on a detailed outline of the plan or on a draft of the plan. Agency Councils also received public and stakeholder input on drafts of the Strategic Plan. Council Members also participated in the six statewide public hearings and offered insightful comments on the multitude of issues and concerns raised by the public.

The following timeline indicates the activities and timeframes for the development of the 2009-13 HHS Strategic Plan.

Plan Development Schedule

September 2007: Leadership Direction

- Obtain Executive Commissioner perspective and guidance on the strategic plans and strategic planning process.
- Brief HHS agency and HHSC executives on the process, and secure appointment of planning liaisons at each agency.

October—December 2007: Data Gathering, Research, and Analysis

- HHS agency staff, coordinating with HHSC planners, work to identify challenges and opportunities, issues, internal and external factors, impacts of recent legislation, and other topics for inclusion in the strategic plans.

January—February 2008: Issue Identification and Narrative Drafting

- Executive review at HHSC and other HHS agencies of topics for possible inclusion in strategic plans.
- Seek initial Agency Council input on strategic plans.
- Agency staff and HHSC planners work in coordination to prepare initial draft of strategic plans.
- Initial draft of strategic plans.

March—April 2008: Stakeholder Input

- Public input may be received at meetings of agency councils.
- Begin public hearings on draft strategic plans, as required by Texas Government Code Section 531.036.

May—June 2008: Plan Revision, Review, and Approval

- Conclude public hearings.
- Revising draft strategic plans as appropriate based on comments received.
- Conduct final review and obtain approvals to submit strategic plans.

July 2008: Plan Submission

- Print and transmit final strategic plans to GOBPP and LBB.

Appendix B

Current Health and Human Services System Agency Organizational Charts

The following hyperlinks connect with the organizational chart for each respective agency.

Health and Human Services Commission

Department of Aging and Disability Services

Department of Assistive and Rehabilitative Services

Department of Family and Protective Services

Department of State Health Services

Appendix C

Five-Year Projections for Outcomes

Table C.1.
HHSC Five-Year Projections for Outcomes

Code	Goal/Outcome Measure	2009	2010	2011	2012	2013
Goal 1: HHS Enterprise Oversight and Policy						
Objective 1 – Enterprise Oversight and Policy						
1-1-1	% Persons Receiving Long-term Care Served in Community-Based Settings	71.36%	71.21%	71.59%	72.84%	73.15%
1-1-2	Average Medicaid/CHIP Child Receiving Services	2,555,747	2,609,580	2,666,377	2,746,290	2,829,095
Goal 2: Medicaid						
Objective 1 – Medicaid Health Services						
2-1-1	Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month	2,943,527	3,021,181	3,105,401	3,221,537	3,345,017
2-1-2	Average Medicaid Acute Care (Includes STAR+PLUS) Cost Per Recipient Month	256.99	268.52	280.32	291.92	303.99
2-1-3	% Eligible Clients Receiving Acute Care Services	95.30%	95.30%	95.30%	95.30%	95.30%
2-1-4	% of 100% Poverty Population Covered by Acute Care Services	72.84%	73.38%	74.01%	75.36%	76.80%
2-1-5	Average Medicaid Acute Care Child Recipient Months per Month	2,040,538	2,090,260	2,143,850	2,220,521	2,300,052
Objective 2 – Other Medicaid Services						
No measures						
Objective 3 – Special Medicaid Services for Children						
2-3-1	% of THSteps Eligible Pop. Screened	50.00%	51.00%	51.00%	52.00%	52.00%

	FFS Medicaid-Medical					
2-3-2	Percent of THSteps Eligible Population Served-Dental	51.00%	52.00%	52.00%	53.00%	53.00%
Objective 4 – Medicaid Support						
2-4-1	Percent of Medicaid Eligible Population Served	75.00%	75.00%	75.00%	75.00%	75.00%
2-4-2	Emergency Room Visits Per 1,000 Avg Member Months/Year	413.7	413.7	413.7	413.7	413.7
Goal 3 - CHIP Services						
Objective 1 – CHIP Services						
3-1-1	Percent of CHIP-eligible Children Enrolled	82.91%	72.92%	72.51%	81.82%	81.45%
3-1-2	Average CHIP Programs Recipient Months Per Month (Includes all CHIP Programs)	543,086	483,358	485,706	555,689	559,677
3-1-3	Average CHIP Programs Benefit Cost without Prescription Benefit (Includes all CHIP Programs)	$152.09	$111.03	$116.58	$173.82	$181.75
3-1-4	Average CHIP Programs Benefit Cost with Prescription Benefit (Includes all CHIP Programs)	$174.48	$137.48	$144.23	$199.26	$208.33
Goal 4 - Encourage Self-Sufficiency						
Objective 1 – Assistance Services						
4-1-1	Percent of Total Children in Poverty Receiving TANF and State Two Parent Cash Assistance	6.80%	6.73%	6.66%	6.60%	6.50%
4-1-2	Number of Adults Exhausting TANF and the State Two Parent Cash Assistance Time-limited Benefits	1,140	960	720	720	720
4-1-3	% TANF and State Two Parent Cash	12.25%	11.70%	11.20%	11.20%	11.20%

	Assistance Caretakers Leaving Due to Increased Employment Earnings					
Objective 2 – Other Family Support Services						
4-2-1	Percent Adult Victims Requesting Shelter Denied Due to Lack of Space	23.00%	24.80%	26.80%	28.60%	31.60%
Goal 7 - Office of Inspector General						
Objective 1 – Client and Provider Accountability						
7-1-1	Medicaid Subrogation Receipts as a Ratio of Subrogation Administrative Expenses	95.00%	95.00%	95.00%	92.00%	92.00%
7-1-3	Net Dollars Recovered by OIG Divided by OIG Expenditures (Return On Investment)	$13.40	$13.40	$13.40	$14.50	$14.50

Table C.2.
DADS Five-Year Projections for Outcomes

Code	Goal/Outcome Measure	2009	2010	2011	2012	2013
Goal 1: Long-term Services and Supports						
Objective 1-1: Intake, Access and Eligibility						
1-1-1	Percent of nursing homes with a certified Ombudsman	100.00%	100.00%	100.00%	100.00%	100.00%
1-1-2	Average number of clients served per month: Total Community Services and Supports	228,849	227,758	233,124	238,366	243,731
1-1-3	Average number of persons on interest lists per month: Total Community Services and Supports	144,396	189,671	222,693	255,715	288,737
1-1-4	Percent of long-term care clients served in community settings	71.94%	71.78%	72.15%	72.51%	72.85%
1-1-5	Average number of clients deinstitutionalized or diverted from institutional settings per month	55,965	52,166	52,685	52,685	52,685
1-1-6	Percent LTC Ombudsman Program Complaints Resolved or Partially Resolved	80.00%	75.00%	75.00%	75.00%	75.00%
Objective 1-2: Community Services and Supports—Entitlement						
1-2-1	Average number of clients served per month: Medicaid non-waiver Community Services and Supports	113,410	117,882	122,731	127,579	132,427
1-2-2	Average monthly cost per client served: Medicaid Non-waiver Community Services and Supports	$697.99	$698.89	$699.90	$699.90	$699.90

Objective 1-3: Community Services and Supports—Waivers						
1-3-1	Average number of clients served per month: Community Services and Supports Waivers (Total)	49,683	45,417	45,527	45,637	45,747
1-3-2	Average cost per client served: Community Services and Supports Waivers (Total)	$2,131.52	$2,144.24	$2,142.45	$2,142.45	$2,142.45
Objective 1-4: Community Services and Supports – Non-Medicaid						
1-4-1	Average number of clients served per month: Total Non-Medicaid Community Services and Supports	59,474	57,710	57,709	57,709	57,709
1-4-2	Average monthly cost per client served: Total Non-Medicaid Community Services and Supports	$271.12	$272.92	$272.92	$272.92	$272.92
1-4-3	Average number of persons on interest list per month: Total Non-Medicaid Community Services and Supports	33,466	39,677	40,097	40,517	40,937
Objective 1-6: Nursing Facility and Hospice Payments						
1-6-1	Percent of at-risk population served in nursing facilities	9.56%	9.39%	9.24%	9.09%	8.88%
1-6-2	Medicaid nursing facility bed utilization per 10,000 aged and disabled persons in Texas	128.93	126.46	124.22	121.28	118.50
Objective 1-8: MR State School Services						
1-8-1	Average number of days mental retardation (MR) campus residents recommended for community placement wait for placement	150	150	150	150	150
1-8-2	Number of consumers with mental	216	216	216	216	216

	retardation (MR) who moved from campus to community					
Goal 2: Regulation, Certification, and Outreach						
Objective 2-1: Regulation, Certification and Outreach						
2-1-1	Percent of facilities complying with standards at time of inspection for licensure and/or Medicare/Medicaid certification	66.42%	64.16%	64.16%	64.16%	64.16%
2-1-2	Percent of facilities correcting adverse findings by time of first follow-up visit after inspection	86.85%	86.85%	86.85%	86.85%	86.85%
2-1-3	Percent of Nursing Facilities/Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) with more than six on-site monitoring visits per year	32.00%	35.00%	35.00%	35.00%	35.00%
2-1-4	Rate (per 1000 residents) of substantiated complaint allegations of abuse/neglect: Nursing Facilities	0.2327	0.2327	0.2327	0.2327	0.2327
2-1-5	Rate (per 1000 residents) of substantiated complaint allegations of abuse/neglect: Intermediate Care Facilities for Persons with Mental Retardation	0.48	0.48	0.48	0.48	0.48
2-1-6	Percent of Nursing Facility Administrators with no recent violations	98.61%	98.41%	98.23%	98.23%	98.23%
2-1-7	Percent of Nurse Aides and Medication Aides with no recent violations	99.89%	99.88%	99.87%	99.87%	99.87%
2-1-8	Percent of complaints and referrals resulting in disciplinary action: Nursing Facility Administrators	38.60%	40.60%	42.60%	42.60%	42.60%
2-1-9	Percent of complaints and referrals resulting in disciplinary action: Nurse	86.76%	88.76%	90.00%	90.00%	90.00%

	Aides and Medication Aides					
2-1-10	Percent of Home and Community Support Services Agencies complying with standards at time of inspection	90.00%	90.00%	90.00%	90.00%	90.00%
2-1-11	Percent of residents whose care has been improved through evidence-based practices	8.15%	9.00%	9.00%	9.00%	9.00%

Table C.3.
DARS Five-Year Projections for Outcomes

Code	Goal/Outcome Measure	2009	2010	2011	2012	2013
Goal 1: Children with Disabilities						
Objective 1-1: ECI Awareness and Services						
1-1-1	% of Population under Age Three Served	3.55%	3.74%	3.93%	4.12%	4.34%
1-1-2	% Growth in Number of Children Enrolled	6.40%	6.40%	6.00%	6.00%	6.00%
Objective 1-2: Services for Blind Children						
1-2-1	% of Children Successfully Completing Services	79.00%	79.00%	79.00%	79.00%	79.00%
Goal 2: Persons with Disabilities						
Objective 2-1: Rehabilitation Services—Blind						
2-1-1	Average Earnings per BET Consumer Employed	$92,000	$94,000	$94,000	$94,000	$94,000
2-1-2	% of VR Consumers Exiting Program & Remaining Employed	85.00%	85.00%	85.00%	85.00%	85.00%
2-1-3	% of VR Consumers Who Achieve Employment Outcomes	72.00%	72.00%	72.00%	72.00%	72.00%
Objective 2-2: Deaf and Hard of Hearing Services						
2-2-1	% of Certified Interpreters with No Recent Ethics Violations	100.00%	100.00%	100.00%	100.00%	100.00%
Objective 2-3: General Disabilities Services						
2-3-1	% of VR Consumers Who Achieve Employment Outcomes	55.80%	55.80%	55.80%	55.80%	55.80%
2-3-2	% of Consumers Who Have Significant Disabilities	85.00%	85.00%	85.00%	85.00%	85.00%

2-3-3	% of VR Consumers Exiting Program & Remaining Employed	70.00%	70.00%	70.00%	70.00%	70.00%
Goal 3: Disability Determination						
Objective 3-1: Accuracy of Determination						
3-1-1	% of Case Decisions That Are Accurate	90.60%	90.60%	90.60%	90.60%	90.60%
3-1-2	Number of Case Processing Days Below Target	35.00	35.00	35.00	35.00	35.00

Table C.4.
DFPS Five-Year Projections for Outcomes

Code	Goal/Outcome Measure	2009	2010	2011	2012	2013
Goal 1: Provide Access to DFPS Services by Managing a 24-hour Call Center						
Objective 1-1: Provide 24-hour Access to Services Offered by DFPS Programs						
1-1-1	Avg Hold Time: SWI (English)	11.8	12.0	12.3	12.6	12.8
Goal 2: Protect Children Through an Integrated Service Delivery System						
Objective 2-1: Reduce Child Abuse/Neglect and Mitigate Its Effect						
2-1-1	% CPS Priority 1 Reports Initiated Within 24 hrs	100%	100%	100%	100%	100%
2-1-2	Incidence of Child Abuse	11.5	11.6	11.6	11.6	11.6
2-1-3	% At-Risk Children Served	95.5%	95.5%	95.5%	95.5%	95.5%
2-1-4	% Absence Repeat Maltreatment 6 Mths (CPS)	96.0%	96.0%	96.0%	96.0%	96.0%
2-1-5	% With Two or Fewer Placements	76.8%	76.8%	76.8%	76.8%	76.8%
2-1-6	% Absence of Children Re-entering 12 Months	96.7%	96.7%	96.7%	96.7%	96.7%
2-1-7	% Children Safe in Substitute Care	99.6%	99.6%	99.6%	99.6%	99.6%
2-1-8	% Legal in 12 Months	58.0%	58.0%	58.0%	58.0%	58.0%
2-1-9	% Permanent in 18 Months	88.8%	88.8%	88.8%	88.8%	88.8%
2-1-10	% Conserved to Majority	9.0%	9.0%	9.0%	9.0%	9.0%
2-1-11	Avg Time Out-of-Home Care	21.5	21.5	21.5	21.5	21.5
2-1-12	Median Stay in Foster Care	9.4	9.4	9.4	9.4	9.4
2-1-13	% Children Reunified 12 Months	52.0%	52.0%	52.0%	52.0%	52.0%
2-1-14	% Adoptions Consummated 24 Months	50.0%	50.0%	50.0%	50.0%	50.0%
2-1-15	Median Length of Stay of Adoptions	25.6	25.9	26.1	26.3	26.6

	Consummated					
2-1-16	CPS Caseworker Turnover Rate	26.9%	27.1%	27.4%	27.5%	27.6%
2-1-17	% CPS Workers Retained 6 Months	72.4%	70.6%	68.8%	67.9%	67.5%
Goal 3: Prevention and Early Intervention Programs						
Objective 3-1: Provide Contracted Prevention and Early Intervention Programs						
3-1-11	% STAR + at 90 Days	86.5%	86.5%	86.5%	86.5%	86.5%
3-1-12	% CYD Youth Not Referred to JPC	98.8%	98.8%	98.8%	98.8%	98.8%
Goal 4: Protect Elder/Disabled Adults Through a Comprehensive System						
Objective 4-1: Reduce Adult Maltreatment and Investigate MH and MR Reports						
4-1-1	Incidence of Adult Abuse	11.1	11.2	11.3	11.4	11.4
4-1-2	% Abused Adults Served	80.6%	80.7%	80.8%	80.8%	80.9%
4-1-3	Incidence of MHMR Abuse	4.9	5.3	5.7	6.1	6.6
4-1-4	% Repeat Maltreatment 6 Mths (APS)	7.3%	7.1%	7.0%	7.0%	6.9%
4-1-5	APS Caseworker Turnover Rate	16.9%	16.4%	16.0%	15.7%	15.5%
4-1-6	% APS Caseworkers Retained 6 Months	83.2%	82.9%	82.5%	82.4%	82.3%
Goal 5: Regulate Child Day Care and Residential Child Care						
Objective 5-1: Reduce Occurrences of Serious Risk in Child Care Facilities						
5-1-1	% Validated Occurrences	39.1%	45.4%	52.8%	58.4%	64.1%
5-1-2	% Facility with No Violation	35.0%	34.3%	33.5%	32.1%	31.4%
5-1-3	% Complaint Disciplinary Action	2.4%	2.6%	3.0%	3.3%	3.8%

Table C.5.
DSHS Five-Year Projections for Outcomes

Code	Goal/Outcome Measure	2009	2010	2011	2012	2013
Goal 1: Preparedness and Prevention Services						
Objective 1-2: Infectious Disease Control, Prevention and Treatment						
1-2-1	Vaccination Coverage Levels among Children Aged 19 to 35 Months	78.00%	78.00%	78.00%	79.00%	79.00%
1-2-2	Incidence Rate of TB Among Texas Residents	7.20	7.20	7.20	7.00	7.00
1-2-3	% of 1995 Epizootic Zone that is Free From Domestic Dog-Coyote Rabies	97.00%	97.00%	97.00%	97.00%	97.00%
1-2-4	% of 1996 Epizootic Zone that is Free From Texas Fox Rabies	59.00%	60.50%	60.50%	60.50%	60.50%
Objective 1-4: Laboratory Operations						
1-4-1	% High Volume Tests Completed within Established Turnaround Times	95.00%	95.00%	95.00%	95.00%	95.00%
Goal 2: Community Health Services						
Objective 2-1: Provide Primary Care and Nutrition Services						
2-1-1	Percentage of Eligible WIC Population Served	80.00%	80.00%	80.00%	80.00%	80.00%
2-1-2	# of Infant Deaths Per Thousand Live Births (Infant Mortality Rate)	5.30	5.40	5.50	5.50	5.40
2-1-3	Percentage of Low Birth Weight Births	8.00%	8.10%	8.10%	8.20%	8.20%
2-1-4	# Pregnant Females Age 13-19 Per Thousand (Adolescent Pregnancy Rate)	45.90	46.30	46.00	45.70	45.50
2-1-5	% of Eligible Indigent Patients Provided Access to PHC	8.80%	8.60%	8.50%	8.50%	8.40%

Objective 2-2: Provide Behavioral Health Services						
2-2-1	Prevalence of Tobacco Use among Middle & HS Youth Target Areas	19.00%	19.00%	19.00%	19.00%	19.00%
2-2-2	Statewide Prevalence of Tobacco Use among Middle and High School Youth	21.80%	21.80%	21.80%	21.80%	21.80%
2-2-3	Prevalence of Smoking among Adult Texans	19.00%	19.00%	19.00%	19.00%	19.00%
2-2-4	% Youth Enrolled in Substance Abuse Prevention Programs	75.00%	75.00%	75.00%	75.00%	75.00%
2-2-5	Percent of Adults Engaged in Substance Abuse Treatment for 90 Days	20.00%	20.00%	20.00%	20.00%	20.00%
2-2-6	Percent of Youth Completing Treatment Programs Who Report Abstinence	84.00%	84.00%	84.00%	84.00%	84.00%
2-2-7	Percent of Adults Completing Treatment Programs Who Report Abstinence	87.00%	87.00%	87.00%	87.00%	87.00%
2-2-8	Percent of Youth Completing Treatment w/ Reduction in Absenteeism	72.00%	72.00%	72.00%	72.00%	72.00%
2-2-9	State MH Hospital and Center Re-admission Rate	27.00%	27.00%	27.00%	27.00%	27.00%
2-2-10	% Community MH Adults Admitted to a Level of Care (Service Package)	80.00%	80.00%	80.00%	80.00%	80.00%
2-2-11	% Community MH Adults Stabilized or Improved	81.00%	81.00%	81.00%	81.00%	81.00%
2-2-12	% Community MH Children Admitted to a Level of Care (Service Package)	80.00%	80.00%	80.00%	80.00%	80.00%
2-2-13	% Community MH Children Stabilized or Improved	80.00%	80.00%	80.00%	80.00%	80.00%
2-2-14	Percent MH Children with a History of Arrest Who Avoid Rearrest	80.00%	80.00%	80.00%	80.00%	80.00%
2-2-	% Medicaid Receiving Crisis Services	11.00%	11.00%	11.00%	11.00%	11.00%

15	Followed by ER Visit					
2-2-16	% Receiving Crisis Services Followed by Psychiatric Hospitalization	13.00%	13.00%	13.00%	13.00%	13.00%
2-2-17	% Receiving Crisis Services Followed by Jail Booking	This is a new program/measure, a base line will be established and data will be captured in the future.	This is a new program/measure, a base line will be established and data will be captured in the future.	This is a new program/measure, a base line will be established and data will be captured in the future.	This is a new program/measure, a base line will be established and data will be captured in the future.	This is a new program/measure, a base line will be established and data will be captured in the future.
Goal 3: Hospital Facilities Management and Services						
Objective 3-1: Provide State Owned Hospital Services and Facility Operations						
3-1-1	% Cases of TB Treated at TCID as Inpatients - Patients Treated to Cure	50.00%	50.00%	50.00%	50.00%	50.00%
3-1-2	% of State Mental Health Facility Consumers Stabilized or Improved	99.00%	99.00%	99.00%	99.00%	99.00%
3-1-3	Patient Satisfaction with State Mental Health Facility Treatment	4.11	4.11	4.11	4.11	4.11
Goal 4: Consumer Protection Services						
Objective 4-1: Provide Licensing and Regulatory Compliance						
4-1-1	Percentage of Inspected Entities in Compliance with Statutes/Rules	85.00%	85.00%	85.00%	85.00%	85.00%
4-1-2	Avg # Inspections/Investigations/Surveys Per Compliance Field Staff	500.00	500.00	500.00	500.00	500.00
4-1-3	Percentage of Licenses Issued within Regulatory Timeframe	98.00%	97.00%	97.00%	96.00%	96.00%
4-1-4	Percent of Licensed/Certified Professionals with No Recent Violations	99.86%	99.86%	99.86%	99.86%	99.86%
4-1-5	% of Licensed/Certified AHCF Meeting St/Fed Regulations at Survey	92.00%	92.00%	92.00%	92.00%	92.00%
4-1-6	Percent of Facilities with No Recent Violations	94.00%	94.00%	94.00%	94.00%	94.00%

Appendix D

Performance Measure Definitions

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Outcome No.	1	% Persons Receiving Long-term Care Served in Community-based Settings

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 529 080-R-S70-1 01-01 OC 01

BL 2010 Definition

This is a measure of the percentage of persons receiving long-term care services in community-based settings.

BL 2010 Data Limitations

The number of persons served will be based on the program data that best represents the number of persons served in the program, usually based on performance measure data. The 'total' number of persons served will not always be the most representative data in programs such as CIDC, which provides a variety of inexpensive ancillary services to large numbers of clients. A small percentage of children in the Medically Dependent Children's program continue to receive services in nursing facilities; however, the percentage is so small that the program should be classified as community-based.

BL 2010 Data Source

The source of data will be reports on the number of persons served from the operating agencies providing long-term care services. Institutional services are provided by the Department of Aging and Disability Services and Department of State Health Services and are defined as services provided in state schools, state mental hospitals, nursing facilities/hospice and ICF-MR facilities. Community services are defined as the services in the Department of Aging and Disability Services' community care objectives: Community Care - Entitlement, Community Care - Waivers, Community Care - State, and Program of All-inclusive Care for the Elderly (PACE).

BL 2010 Methodology

1) Determine the number of the persons served in the programs classified as community-based services. 2) Determine the number of the persons served in institutional programs. 3) Divide the number of persons served in programs classified as community-based services (Step 1) by the sum of the persons served in community-based setting (Step 1) and the number of persons served in institutional programs (Step 2) 4) Multiply by 100.

BL 2010 Purpose

Historically, the State of Texas through actions by the Legislature has increased the resources devoted to serving persons with disabilities in community-based settings. In Executive Order GWB 99-2, the Governor of Texas affirmed the value of community-based supports for persons with disabilities as did the U.S. Supreme Court in the Olmstead v. Zimring case. HHSC is implementing a Promoting Independence Initiative to assure that the state moves deliberately and decisively toward a system of services and supports that fosters independence and provides meaningful opportunities for people with disabilities to live productive lives in their home communities, for those who choose to do so.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Outcome No.	2	Average Medicaid and CHIP Children Recipient Months Per Month

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

BL 2010 Definition

This is a measure of the monthly average number of children served in Medicaid and CHIP

BL 2010 Data Limitations

None.

BL 2010 Data Source

Medicaid data are obtained from the Premiums Payable System (PPS). CHIP data are obtained from the Administrative Services Contractor. The contractor produces monthly enrollment reports showing cumulative enrollment.

BL 2010 Methodology

Sum the total number of children and newborn perinatal clients from the CHIP enrollment report with the total number of TANF children, foster care STAR Health, newborns, and poverty-related children (ages 1-18) from the PPS and divide that number by the number of months in the reporting period. Children under age 19 in Medicaid as Pregnant Women or SSI clients are not included in this count.

BL 2010 Purpose

This measure reflects the total average monthly number of children receiving services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Outcome No.	1	Average Medicaid Acute Care (& STAR+PLUS) Recipient Months Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-01 OC 01

BL 2010 Definition

Medicaid Acute Care Recipient Months per Month (includes Star+Plus)is the average monthly number of recipient months (Managed Care and non-Managed Care combined) for Medicaid recipients classified in the nine risk groups (Aged and Medicare Related, Disabled and Blind, TANF Children, TANF Adults, Pregnant Women, Newborns, Expansion Children, Federal Mandate Children, and Medically Needy).

BL 2010 Data Limitations

The measure includes recipient months for acute care services. Star+Plus is included. Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

BL 2010 Data Source

Sources include the monthly RG-23 and RG-24 Premium Payable System Reports and Social Security Administration (SSA) eligibility files. Because data are reported on an incurred basis, recipient month figures are completed using completion ratios.

BL 2010 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. The quarterly average is the sum of the recipient months (Managed Care and non-Managed Care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (Managed Care and non-Managed Care combined) divided by the number of months summed.

BL 2010 Purpose

This measure determines the average number of recipient months per month for which a claim or premium is paid.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Outcome No.	2	Average Medicaid Acute Care (& STAR+PLUS) Cost Per Recipient Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-01 OC 02

BL 2010 Definition

Average Medicaid Acute Care Cost per Recipient Month (for Managed Care and non-Managed Care combined) is the amount paid to HMOs for each recipient month incurred plus the estimated cost of acute care services for the Primary Care Case Management (PCCM) and Fee-For-Service (FFS) models and reflects the cost of all covered Medicaid services in the nine risk groups (Aged and Medicare Related, Disabled and Blind, TANF Children, TANF Adults, Pregnant Women, Newborns, Expansion Children, Federal Mandate Children, and Medically Needy) to include drug expenditures for foster care children. The monthly premiums for HMOs are determined by negotiations.

BL 2010 Data Limitations

This measure involves the recipient months and costs for acute care services. It includes Star+Plus Acute Care, but not Star+Plus Long Term Care. Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

BL 2010 Data Source

Data sources for this measure are the monthly STMR750 statistical reports compiled by the health insuring agent and the RG-23 and RG-24 Premium Payable System reports, HMO rates, and SSA eligibility files. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-reimbursed Services.

BL 2010 Methodology

For a quarterly or annual weighted cost per recipient month, sum the Medicaid acute care dollars for the given time period. Sum the acute care recipient months for the same time period. The quarterly or annual weighted cost per recipient month is therefore equal to the total statewide dollar amounts for the time period divided by the total statewide recipient months for the time period. Recipient months are derived from the RG-23 and RG-24 Premium Payable System reports and Social Security Administration (SSA) eligibility files. For the more recent months of data, appropriate completion factors shall be applied in order to generate total incurrals. Cost estimates shall be based on statistical reports that depict claim cost and/or encounter information (the STMR750 reports furnished by the state contractor) and HMO rates. Dollars come from Star HMO, PCCM, Star+Plus, Medicaid Foster Care (in FY08 and FY09), and Fee-For-Service programs.

BL 2010 Purpose

This measure determines the average cost per recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Outcome No.	3	Percent of Eligible Clients Receiving Acute Care Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-01 OC 03

BL 2010 Definition

Percent of eligible clients receiving acute care services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

MSIS report. (In January of each year, the data is complete for the previous federal fiscal year.)

BL 2010 Methodology

This measure is the percentage of the eligibles who actually receive acute care services, also referred to as the utilization rate. It indicates the annual unduplicated number of eligibles who actually received services divided by the annual unduplicated number of eligibles.

BL 2010 Purpose

Measures the percent of eligible clients receiving acute care services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Outcome No.	4	Percent of 100% Poverty Population Covered by Acute Care Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-01 OC 04

BL 2010 Definition

This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

RG-23 (MA007-01) & RG-24 (MS008-01) reports from the Premiums Payable System for recipient months. Poverty figures are derived from census survey

BL 2010 Methodology

The percentage is derived from the average number of recipient months for individuals eligible for acute care services divided by the estimated number of persons at or below 100% of the FPIL. When calculating the end of year figure, the average number of months is the sum of the monthly recipient month counts divided by the number of months summed.

BL 2010 Purpose

This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Outcome No.	5	Average Medicaid Acute Care Child Recipient Months Per Month

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-01 OC 05

BL 2010 Definition

Medicaid Acute Care Recipient Months per Month is the average monthly number of recipient months (Managed Care and non-Managed Care combined) for Medicaid recipients classified in the nine risk groups (Aged and Medicare Related, Disabled and Blind, TANF Children, TANF Adults, Pregnant Women, Newborns, Expansion Children, Federal Mandate Children, and Medically Needy). For historical purposes, CHIP Phase I and Spillover are included.

BL 2010 Data Limitations

The measure includes recipient months for acute care services. The measure does not include Disabled and Blind STAR+PLUS in capitated HMOs.

BL 2010 Data Source

Sources include the monthly RG-23 and RG-24 Premium Payable System Reports and Social Security Administration (SSA) eligibility files. Because data are

BL 2010 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted
for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations,
retroactive decisions, and post and prior eligibility periods. The quarterly average is the sum of the recipient months (Managed Care and non-Managed Care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (Managed Care

BL 2010 Purpose

This measure determines the average number of recipient months per month for which a claim or premium is paid.

BL 2011 Definition

Medicaid Acute Care Recipient Months per Month is the average monthly number of recipient months (Managed Care and non-Managed Care combined) for Medicaid recipients classified in the nine risk groups (Aged and Medicare Related, Disabled and Blind, TANF Children, TANF Adults, Pregnant Women, Newborns, Expansion Children, Federal Mandate Children, and Medically Needy). For historical purposes, CHIP Phase I and Spillover are included.

BL 2011 Data Limitations

The measure includes recipient months for acute care services. The measure does not include Disabled and Blind STAR+PLUS in capitated HMOs.

BL 2011 Data Source

Sources include the monthly RG-23 and RG-24 Premium Payable System Reports and Social Security Administration (SSA) eligibility files. Because data are

BL 2011 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted
for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations,
retroactive decisions, and post and prior eligibility periods. The quarterly average is the sum of the recipient months (Managed Care and non-Managed Care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (Managed Care

BL 2011 Purpose

This measure determines the average number of recipient months per month for which a claim or premium is paid.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Outcome No.	1	Percent of THSteps (EPSDT) Eligible Pop. Screened FFS Medicaid-Medical

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-03 OC 01

BL 2010 Definition

This measure reports the percentage of Texas Health Steps (THSteps) Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) clients receiving medical check-ups in Fee For Service Medicaid, as calculated using the CMS-416 methodology.

BL 2010 Data Limitations

There are several limitations. The data reported only reflects the percentage of medical check-ups reported and completely processed as of the reporting timeframe. The THSteps (EPSDT) providers have 95 days in which to submit a claim after the date of service and if a claim is denied the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due, therefore, estimates or projections may be included based on available data.

BL 2010 Data Source

The data source, HISR303A, is generated by the Medicaid Claims Administrator. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

The calculation is the result of dividing the number of THSteps eligible children who received at least one initial or periodic medical check up by the number of children who should have received at least one medical check up. To calculate the denominator, the average period of eligibility (in decimal years) for each age group (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20) is multiplied by the recommended number of check-ups for the age group and then by the number of THSteps eligible children in the age group. The resulting numbers of children by age group who should have received a check up are summed. The numerator is an unduplicated count of THSteps eligible children who received one or more documented check-ups.

BL 2010 Purpose

The purpose of the measure is to monitor the THSteps (EPSDT) clients served for children receiving medical check-ups in Fee For Service Medicaid, as calculated using the CMS-416 methodology.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Outcome No.	2	Percent of THSteps (EPSDT) Eligible Population Served-Dental

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-03 OC 02

BL 2010 Definition

This measure reports the annual Texas Health Steps (THSteps)Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) dental client participation.

BL 2010 Data Limitations

None.

BL 2010 Data Source

HISR303A generated by the Medicaid Claims Administrator. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting

BL 2010 Methodology

The calculation is the result of dividing the number of THSteps eligible children who received at least one dental service by the number of THSteps children who should have received at least one dental service. The denominator is the sum of the eligibles in the age grous 1-20; the numerator is the sum of the number of eligibles in the age groups 1-20 who reveived at least one dental service. The ratio of the numberator to the denominator is the THSteps dental

BL 2010 Purpose

This measure reports the annual THSteps (EPSDT) dental client participation.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	4	Medicaid Support
Outcome No.	1	Percent of Medicaid Eligible Population Served

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-04 OC 01

BL 2010 Definition

This is a measure of the percentage of the population estimated to be eligible for Medicaid that enrolls in the program. Both acute care and long-term care Medicaid programs are included.

BL 2010 Data Limitations

No standard state-specific data source is available for developing statistically reliable estimates of this measure. No comparable historical data are available for Texas. No comparable data are available for the nation or the other states.

BL 2010 Data Source

Measure to be estimated using direct (statistical simulation/imputation) techniques based on data taken from various sources, including the Current Population Survey (CPS), the Survey of Income and Program Participation (SIPP), and the Texas State Data Center. Data Source for actual Medicaid enrollment information is the monthly Medicaid enrollment (Med-Id) file.

BL 2010 Methodology

Divide the number of persons enrolled in Medicaid on a monthly average basis, per fiscal year, by the estimated monthly average number of potential eligibles. Multiply the result by 100.

BL 2010 Purpose

As the single state agency designated to oversee and administer the state's Medicaid program, HHSC serves as the liaison to the federal government and is responsible for establishing agreements with other state agencies in carrying-out the technical operations and service delivery for the Medicaid program. This measure indicates the effectiveness of outreach efforts to eligible populations and is of increased importance with implementation of the Children's Health Insurance Program.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	4	Medicaid Support
Outcome No.	2	Emergency Room Visits Per 1,000 Avg Member Months/Year

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 02-04 OC 02

BL 2010 Definition

Measures emergency room visits per 1000 average member months per year. An emergency room (ER) visit is defined by a service billed on a UB-92, using the appropriate codes. The eligible population is defined as all Medicaid Managed Care enrollees who were enrolled in the plan during the reporting

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data sources are the Utilization Management (UM) reports.

BL 2010 Methodology

ER rates (ER visits per member months per year) are calculated using the formula - number of ER visits / (average monthly member months of eligible populations x 12 x 1000).

BL 2010 Purpose

Measures emergency room visits per 1000 average member months per year.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Outcome No.	1	Percent of CHIP-eligible Children Enrolled

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 03-01 OC 01

BL 2010 Definition

This is a measure of the percentage of children estimated to be eligible for the Children's Health Insurance Program (CHIP) that are enrolled in the program.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The source of data on the number of children eligible for the CHIP program is the March Current Population Survey (CPS) for Texas published during September-October of every year. Specifically, the identified population consists of children ages 0-18 that are not Medicaid-eligible but are from families with incomes of 200 percent of poverty or less. The data sources on the number of children enrolled in the program are the CHIP program statistical databases maintained in electronic format and compiled by HHSC on a continuous basis.

BL 2010 Methodology

1) Determine the number of children eligible from the latest available CPS. 2) Determine the number of children enrolled as of the end of the last month of the state fiscal year (i.e., the count of enrollees for the month of August). 3) Divide by the total number of children enrolled in the program by the total number of children eligible. 4) Multiply by 100.

BL 2010 Purpose

This is a measure of the effectiveness of the outreach efforts of the CHIP program. CHIP is a federal program administered by HHSC to provide health insurance to children who do not qualify for Medicaid. Federal law requires extensive outreach efforts by states to enroll eligible children.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Outcome No.	2	Average CHIP Programs Recipient Months Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 03-01 OC 02

BL 2010 Definition

The measure provides the average CHIP recipient months per month, including all CHIP-enrolled children (including CHIP Phase II children, Immigrant children, School Employee children and Perinates).

BL 2010 Data Limitations

None.

BL 2010 Data Source

Integrated Eligibility staff produces monthly CHIP II enrollment reports, which includes the number of all CHIP enrollees.

BL 2010 Methodology

Divide the cumulative number of CHIP recipient months (CHIP II, Legal Immigrant, School Employee dependents, and Perinates) from the enrollment report by the number of months in the period for which the measure is reported.

BL 2010 Purpose

To provide an overall average monthly CHIP caseload across all CHIP categories (CHIP II, Immigrants, School Employee dependents, and Perinates) regardless of the method of finance or eligibility.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Outcome No.	3	Average CHIP Programs Benefit Cost without Prescription Benefit

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 03-01 OC 03

BL 2010 Definition

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental providers on behalf of all CHIP-enrolled children (which includes CHIP Phase II, Immigrant children and School Employee children and Perinates). Benefit costs are understood to include amounts paid to health plans, the dental contractor, and HHSC to cover contractor administration.

BL 2010 Data Limitations

Prescription Drug Benefits are excluded from this monthly benefit calculation as they are reported separately.

BL 2010 Data Source

Integrated Eligibility staff furnishes a monthly report to HHSC containing the caseload for which each health and dental plan will incur costs during the following month. The numbers in that report are multiplied by the premium amount to be paid to the respective plans. For vaccine costs, HHSC receives a quarterly invoice from DSHS (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children.

BL 2010 Methodology

The amounts incurred by HHSC in relation to the health and dental carriers and to TDH (or successor agency) for benefit expenditures related to all CHIP-enrolled children (CHIP II, Immigrant, and School Employee and Perinates) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II, Immigrant, and School Employee and Perinates) during the reporting period. The result of this calculation is then divided by the number of months in the reporting period.

BL 2010 Purpose

This will provide an overall CHIP benefit cost per CHIP-enrolled child regardless of the eligibility category for CHIP.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Outcome No.	4	Average CHIP Programs Benefit Cost with Prescription Benefit

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 03-01 OC 04

BL 2010 Definition

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and including prescription drugs) and dental providers on behalf of all CHIP-enrolled children (which includes CHIP Phase II, Immigrant children, School Employee children and Perinates). Benefit costs are understood to include amounts paid to health plans, the dental contractor, and DSHS (or successor agency) to cover contractor

BL 2010 Data Limitations

None.

BL 2010 Data Source

Integrated Eligibility staff furnishes a monthly report to HHSC containing the caseload for which each health and dental plan will incur costs during the following month. The numbers in that report are multiplied by the premium amount to be paid to the respective plans. For vaccine costs, HHSC receives a quarterly invoice from DSHS (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children. The data sources for prescription drug costs are HHSC actuary reports.

BL 2010 Methodology

The amounts incurred by HHSC in relation to the health and dental carriers and to DSHS (or successor agency) for benefit expenditures related to all CHIP-enrolled children (CHIP II, Immigrant, School Employee, and Perinates) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II, Immigrant, School Employee, and Perinates) during the reporting period. The result of this calculation is then divided by the number of months in the reporting period.

BL 2010 Purpose

This will provide an overall CHIP benefit cost per CHIP-enrolled child regardless of the eligibility category for CHIP.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Outcome No.	1	Percent of Total Children in Poverty Receiving TANF & State Assistance

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 04-01 OC 01

BL 2010 Definition

This measure reports the number of children receiving TANF and the State Two-Parent Cash Assistance program benefits expressed as a percent of all children in Texas living in poverty.

BL 2010 Data Limitations

The estimated number of children in poverty is subject to change as a result of updates/revisions to the population estimates and projections.

BL 2010 Data Source

The number of children receiving TANF and State Two-Parent Cash Assistance is from ad hoc computer runs against the SAVERR Warrant history file (TP509260), which is downloaded from the agency mainframe to a local server computer. The number of children under age 18 in poverty is estimated using baseline family income information obtained from the last two March Current Population Surveys 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.

BL 2010 Methodology

Data are computed by dividing the monthly average number of children receiving TANF and State Two-Parent Cash Assistance by the total number of children in Texas under 18 years of age whose family's income is at or below 100 percent of poverty, and then multiplying this result by 100.

BL 2010 Purpose

This measure is an expression of the percent of need being met as it pertains to providing financial assistance through the TANF and State Two-Parent Cash Assistance programs to children who are living in poverty. It is an indicator of the impact the agency is having on reaching this target population (children in poverty).

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Outcome No.	2	Number of Adults Exhausting TANF & State Assistance Benefits

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 04-01 OC 02

BL 2010 Definition

This measure reports the unduplicated number of adult TANF and the state Two-Parent Cash Assistance clients who exhausted their eligibility for state or federal time-limited benefits during the fiscal year. TANF clients who exhausted their time limited benefits and continue to receive TANF and the state Two-Parent Cash Assistance because of personal or economic hardship are not included in the counts. State time limits are 12, 24, or 36 months, depending on education and work history. Federal time limits are 60 months.

BL 2010 Data Limitations

Migration from the agency's legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Ad hoc computer runs using SAVERR benefit and client strip files (TP509260, TP550100, TT005400, and TP687500). Data from TIERS will be used as it becomes available.

BL 2010 Methodology

Data on the reports represent the cumulative number who have exhausted their time limited benefits if they have 0 months remaining and are inactive. To determine the number exhausting time limited benefits for the applicable fiscal year, the cumulative number through the end of the prior fiscal year is subtracted from the cumulative number through the applicable fiscal year.

BL 2010 Purpose

This measure quantifies the adult population who may need but no longer are eligible for financial assistance through the TANF block grant and the state Two-Parent Cash Assistance because they have utilized the maximum number of service months for which they were eligible to receive benefits as stipulated in welfare reform legislation. This data is useful in projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Outcome No.	3	% TANF Caretakers Leaving Due to Increased Employment Earnings

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 04-01 OC 03

BL 2010 Definition

This measure reports the number of TANF and State Two-Parent Cash Assistance caretakers who are denied TANF and State Two-Parent Cash Assistance during the fiscal year because of increased employment earnings expressed as a percent of the total number of caretakers who leave the program during the same time period.

BL 2010 Data Limitations

Time-limited benefits and implementation of full family sanctions impact this measure. The measure is impacted by the level of activity of Local Workforce Development Boards and the state of the economy. Migration from the agency's legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Data are obtained from the automated report RP-28, "PA Denial and Reinvestigation Transaction Summary" generated from the SAVERR database.

BL 2010 Methodology

Data are computed by taking the total number of TANF and State Two-Parent Cash Assistance families who leave the TANF and State Two-Parent Cash Assistance programs per year because of increased employment earnings, including those denied for earnings and those transferred to transitional Medicaid because of earnings. This number is divided by the total number of TANF and State Two-Parent Cash Assistance families who leave the TANF and State Two-Parent Cash Assistance programs during the same time period, and then multiplied by 100 to obtain the reported percentage.

BL 2010 Purpose

This measure assesses the impact of the agency's efforts to effectively move clients from welfare to work.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Outcome No.	1	Percent Adult Victims Requesting Shelter Denied Due to Lack of Space

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 04-02 OC 01

BL 2010 Definition

This measure reports the number of adult victims of family violence who were denied shelter at the time of their request due to lack of space in the shelter they contacted, expressed as a percent of all adult victims of domestic violence who requested shelter. Adult victims denied shelter at an original site may find shelter (with assistance from the original site) at another location. A family member, friend, or another shelter may fill the need. Victims denied shelter may receive non-residential services.

BL 2010 Data Limitations

In rare instances, this count may be duplicated when a victim denied shelter at the original site seeks services in another location and is denied again due to lack of space. Data does not include walk-in clients or nonresidential clients who are seeking shelter.

BL 2010 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program. Contractors not able to participate in this system submit their data manually to the Family Violence Program where it is combined with the automated data for reporting.

BL 2010 Methodology

The number of adult victims denied shelter due to lack of space (numerator) is divided by the sum of the number of adult victims denied shelter due to lack of space and the total number of adults receiving residential services (denominator), multiplied by 100.

BL 2010 Purpose

This measure is an indicator of the need for shelter services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Outcome No.	1	Medicaid Subrogation Receipts as a Ratio of Subrogation Admin Expenses

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 529 080-R-S70-1 07-01 OC 01

BL 2010 Definition

Medicaid subrogation receipts include tort actions taken on behalf of the Medicaid program.

BL 2010 Data Limitations

HHSC is dependent on its contractor for the identification of leads and recovery of funds. Ratio excludes DHS (or successor agency) recoveries.

BL 2010 Data Source

The sources of data are the Medicaid claims administrator system, as well as reports prepared by the state's contractor (TMHP), and the Office of Inspector General at HHSC.

BL 2010 Methodology

To calculate the measure, total dollars recovered in tort actions during the reporting period are divided by HHSC tort administrative expenditures (estimated) for the period.

BL 2010 Purpose

This is a measure of the effectiveness of the state's efforts to identify and recover Medicaid dollars for services for which a third party is liable.

BL 2011 Definition

Medicaid subrogation receipts include tort actions taken on behalf of the Medicaid program.

BL 2011 Data Limitations

HHSC is dependent on its contractor for the identification of leads and recovery of funds. Ratio excludes DHS (or successor agency) recoveries.

BL 2011 Data Source

The sources of data are the Medicaid claims administrator system, as well as reports prepared by the state's contractor (TMHP), and the Office of Inspector General at HHSC.

BL 2011 Methodology

To calculate the measure, total dollars recovered in tort actions during the reporting period are divided by HHSC tort administrative expenditures (estimated) for the period.

BL 2011 Purpose

This is a measure of the effectiveness of the state's efforts to identify and recover Medicaid dollars for services for which a third party is liable.

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Agency Code: 529 Agency: **Health and Human Services Commission**

Goal No.	7	1	HHS Enterprise Oversight and Policy
Objective No.	1	1	Enterprise Oversight and Policy
Strategy No.	3	1	Enterprise Oversight and Policy
Measure Type		EF	
Measure No.		1	Average Cost Per Minority Health Initiative Developed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 529 080-R-S70-1 07-01 OC 02

BL 2010 Definition

This measure is defined as the total Minority Health budget divided by the number of initiatives developed. An initiative is defined as efforts by HHSC central and regional staff that affect minority and disadvantaged populations, improve health status, or preserve the public health throughout the state.

BL 2010 Data Limitations

None

BL 2010 Data Source

HHSC Operating Budget

BL 2010 Purpose

Measures the average cost per minority health initiative.

BL 2010 Methodology

This measure is defined as the total Minority Health budget divided by the number of initiatives developed.

Goal No.	7	1	HHS Enterprise Oversight and Policy
Objective No.	1	1	Enterprise Oversight and Policy
Strategy No.	3	1	Enterprise Oversight and Policy
Measure Type		EF	
Measure No.		3	Dollars Recovered Per Dollar Expended from All Funds

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 529 080-R-S70-1 01-01-01 EF 03

Fall/Annual: N

BL 2010 Definition

The return on investment of combined Federal and State dollars that fund the Office of Inspector General (OIG). "Recoveries" refers to payments received by HHSC to satisfy financial obligations due the state. Recoveries are handled by various programs in OIG.

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

The sources of data are the OIG case management system and the claims administrator system and databases. OIG staff collects data on recoveries on a monthly basis, entering the information in the appropriate system and/or database.

BL 2010 Methodology

For the given reporting period, the sum of OIG dollars recovered is reduced by the sum of all OIG expenditures in all funds. This quantity is then divided by the sum of all OIG expenditures in all funds. The result is then reported as a dollar figure.

BL 2010 Purpose

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	1	Enterprise Oversight and Policy
Measure Type	OP	
Measure No.	1	Number of Rates Determined Annually

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

The number of rates determined annually for Medicaid and non-Medicaid programs for both acute and long-term care services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

HHSC, Financial Services Division; Rate Analysis Department. Rates are based on data collected from service vendors.

BL 2010 Methodology

Methodologies specific to various programs.

BL 2010 Purpose

Rates are used to reimburse vendors for services provided.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	1	Enterprise Oversight and Policy
Measure Type	OP	
Measure No.	2	Number of Guardianship Assistance Grants

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the number of guardianship or guardianship alternative programs that receive Guardianship Assistance grants from the Guardianship Alliance for Texas (GAT).

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

The data source is accounting records of grants made.

BL 2010 Methodology

The measure is calculated as a count of programs for which GAT provides funding during the quarter. A grant made earlier in the fiscal year is assumed to be in effect during any reporting quarter that fiscal year.

BL 2010 Purpose

HHSC is statutorily charged with providing staff assistance to local guardianship projects. An increase in availability of such programs is important to protect the safety and rights of incapacitated individuals.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	1	Enterprise Oversight and Policy
Measure Type	OP	
Measure No.	3	Number of Minority Health Initiatives Implemented

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

Efforts by HHSC central and regional staff that affect minority and disadvantaged populations, improve health status, or preserve the public health throughout the state will be considered as initiatives.

BL 2010 Data Limitations

None

BL 2010 Data Source

These initiatives will be identified in periodic reports submitted by regional minority health coordinators.

BL 2010 Methodology

The count of initiatives is cumulative for the year.

BL 2010 Purpose

Measures the number of Minority Health Initiatives implemented.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EF	
Measure No.	1	Average Cost Per Eligibility Determination

Calculation Method: C **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of determining eligibility for TANF and State Two-parent cash assistance, food stamps, MEPD, Medicaid, and CHIP. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2010 Data Limitations

There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems.

BL 2010 Data Source

The cost is obtained from expense queries for eligibility determination departments using standard internal data collection protocols. The average monthly number of eligibility determinations is the same as 1-1-2-OP-1.

BL 2010 Methodology

The numerator is the sum of the expense for the departments included in the eligibility determination sub-strategy divided by the number of months in the reporting period. This number is then divided by data for 1-1-2-OP-1 for the reporting period.

BL 2010 Purpose

This measure is useful for comparing costs, over time, of the principal workload drivers for Eligibility Determination, the largest sub-strategy within the Integrated Eligibility and Enrollment Strategy.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EF	
Measure No.	2	Accuracy Rate of Benefits Issued: TANF

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the percentage of TANF benefits delivered correctly, as determined by the most recent TANF quality control (QC) results for the fiscal year. "Issued in error" is the difference between the dollar amount of benefits actually issued and the dollar amount of benefits that would have been issued had all relevant client information been reported in an accurate and timely fashion by the client and had all relevant client information been processed in accordance with applicable state and/or federal guidelines. (This definition includes over issuances only, and encompasses such things as a client reporting inaccurate information, a client not reporting changes on a timely basis, agency failure to correctly apply policy, and so on.)

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are based on the quality control eligibility review, which uses a statewide random sample of TANF benefits.

BL 2010 Methodology

The reported data are computed as follows: The numerator consists of the number of benefit dollars in the QC sample for the period, minus the number of dollars issued in error for the period, as determined through the QC review process. Only over issuances are included. The denominator consists of the number of benefit dollars in the QC sample for the period. Dividing the numerator by the denominator yields the accuracy rate for the period.

BL 2010 Purpose

This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of TANF benefits.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EF	
Measure No.	3	Accuracy Rate of Benefits Issued: Food Stamps

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EF 03

Fall/Annual: N

BL 2010 Definition

This measure reports the percentage of Food Stamp benefits delivered correctly, as determined by the most recent Food Stamp quality control results for the fiscal year, adjusted for the federal re-review regression percentage. "Issued in error" is the difference between the dollar amount of benefits actually issued and the dollar amount of benefits that would have been issued had all relevant client information been reported in an accurate and timely fashion by the client and had all relevant client information been processed in accordance with applicable state and/or federal guidelines. (This definition includes both over issuances and under issuances, and encompasses such things as a client reporting inaccurate information, a client not reporting changes on a timely basis, agency failure to correctly apply policy, and so on.)

BL 2010 Data Limitations

For the federal re-review process, FNS randomly selects approximately one-third of each state's annual sample and subjects each of the selected cases to an independent review to determine the accuracy of benefits issued. FNS uses its findings on this subset of cases to adjust the state's error rate through regression -- a term describing the statistical process of FNS projecting its findings from the subset of re-reviewed cases to estimate what would have been found had a federal re-review been conducted on all cases in the state's sample. For most states and in most years, the regression adjustment increases the state's error rate; in Texas, FNS' regression for federal fiscal year 2006 added 0.1%.

BL 2010 Data Source

Data are based on the quality control eligibility review and the Federal re-review process, which uses a statewide random sample of Food Stamp benefits. This sample complies with federally mandated precision tests.

BL 2010 Methodology

The reported data are computed as follows: The numerator consists of the number of benefit dollars in the QC sample for the period, minus the number of dollars issued in error for the period, as determined through the QC review process. The denominator consists of the number of benefit dollars in the QC sample for the period. Dividing the numerator by the denominator yields the accuracy rate for the period. The numerator includes both over issuances and under issuances, and it is the absolute value of the magnitude of the error that contributes to the numerator - for example, two cases, one with a $50 over issuance and one with a $50 under issuances, do not cancel each other out but instead contribute a total of $100 to the numerator. The numerator also includes ineligible cases, with the contribution to the numerator being equal to the amount of the benefit issued.

BL 2010 Purpose

This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of food stamp benefits.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EF	
Measure No.	4	Percent of Eligibility Decisions Completed on Time

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EF 04

Fall/Annual: N

BL 2010 Definition

This measure is the number of eligibility case decisions that were completed within established timeframes for MEPD, Texas Works (TW) programs for TANF and State Two-Parent Cash Assistance, food Stamps, and Medicaid for Families and Children, expressed as a percentage of all eligibility decisions completed in the same period.
Case decisions are defined as applications approved, denied, or applications open/closed.
TW programs include Title XIX Medical Programs for Families and Children, TANF and State Two-Parent Cash Assistance, and Food Stamps. MEPD includes all Title XIX Medicaid services provided to aged or disabled people residing in Texas including Supplemental Security Income (SSI), Medical Assistance Only (MAO), Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiaries (SLMB), other LTC ME qualified individuals, and Medicaid Waiver

BL 2010 Data Limitations

Data are combined from TIERS and SAVERR reports which may count/measure data differently.

BL 2010 Data Source

TW data are obtained from TIERS and SAVERR monthly timeliness reports produced by Enterprise Applications. MEPD data are obtained from the "Medicaid Eligibility Activity Report" (MEARs) that is prepared by the Office of Eligibility Services using data from the SAVERR system.

BL 2010 Methodology

The total number of applications processed on time (not delinquent) in the reporting period divided by the total number of applications processed in the same reporting period, multiplied by 100, determines the percent of eligibility decisions completed on time.

BL 2010 Purpose

This measure quantifies timeliness and is an indicator of productivity as it pertains to determining eligibility for Texas Works and MEPD benefits.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EX	
Measure No.	1	% Poverty Met by TANF, Food Stamps, and Medicaid Benefits

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the value of TANF, food stamps and Medicaid benefits that a family of three receives expressed as a percent of the poverty income guideline amount for a three person family.

BL 2010 Data Limitations

Projected poverty income guidelines are subject to change due to changes in the projected Consumer Price Index (CPI).

BL 2010 Data Source

The TANF payment standard is as published in the Texas Works Handbook; the USDA publishes regulations on food stamp allotments; the value of medical benefits is estimated by the U.S. Bureau of Labor Statistics' lower living standards, adjusted by the Consumer Price Index for Medical Care; and the current Federal Poverty Income Guidelines are issued annually by the U.S. Department of Health and Human Services and published in the Federal Register under

BL 2010 Methodology

Data are computed by adding together the maximum monthly TANF grant amount for a family of three, the monthly food stamp allotment for a family of three with no countable income, and the monthly value of Medicaid benefits for a TANF family of three; dividing this total by the federal poverty income guideline amount for a family of three, and then multiplying by 100.

BL 2010 Purpose

This measure quantifies the benefit levels provided through the TANF financial assistance, food stamp and Medicaid programs as compared to federally established poverty levels. Because the receipt of these benefits does not move clients out of poverty, the data reflected by this measure are an indication of

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EX	
Measure No.	2	Total Value of Food Stamps Distributed

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the total amount (dollar value) of food stamps issued to households that have been determined eligible for benefits.

BL 2010 Data Limitations

This measure does not include costs for administration of the program. Migration from the legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Data are obtained from the automated monthly report, RF-03E-4, Food Stamp EBT Issuance Household Profile and Food Stamp Case extract from TIERS.

BL 2010 Methodology

The value of food stamps distributed during the months of the reporting period is totaled.

BL 2010 Purpose

This measure conveys the total amount of food stamp benefits distributed. These benefits are 100 percent federally funded.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EX	
Measure No.	3	Percent of Potential Eligible Population Receiving Food Stamps

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: h** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EX 03

Fall/Annual: N

BL 2010 Definition

This measure reports the number of persons receiving food stamps expressed as a percent of the state's population potentially eligible to receive food stamps. The number of persons potentially eligible for food stamps is defined as persons living in households with income at or below 130 percent of the poverty level.

BL 2010 Data Limitations

The population potentially eligible for food stamps is subject to change as updates/revisions to the population estimates and projections become available. Migration from the legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Recipient data are from the automated monthly report, RF-03E- 4, "Food Stamp Issuance Household Profile" and Food Stamp Case extract from TIERS. The population of potential eligibles is estimated using baseline information obtained from the last two March Current Population Surveys 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.

BL 2010 Methodology

Data are computed by totaling the number of food stamp recipients over all months in the reporting period, and dividing by the number of months in the reporting period to determine the average monthly number of food stamp recipients. This result is divided by the number of persons potentially eligible for food stamps, and then multiplied by 100.

BL 2010 Purpose

This measure is an expression of the impact the agency is having on serving the population potentially eligible to receive food stamps. It is an indicator of the percent of need being met.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EX	
Measure No.	4	Percent Potential Eligible Population Receiving CPW Medicaid

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 EX 04

Fall/Annual: N

BL 2010 Definition

# of persons receiving services provided by the Children, Pregnant Women and Medically Needy (CPW Medicaid) programs expressed as % of state's population potentially eligible to receive these services. Potential eligibles include: NonTANF elig pregnant women >= age 19 with income at/below 158% of pov., NonTANF elig pregnant women < age 19 with income at/below 185% of pov. NonTANF elig infants < age 1 with family income at/below 185% of pov. NonTANF elig children 1 to 6 years are elig if family inc. is at/below 133% of pov. NonTANF elig children age 6 thru 18 are elig if family's income is at/below 100% of pov. Persons in the Medically Needy (MN) group are considered elig if medical bills reduce their family income < the MN income limit so that children < age 19 or pregnant women become Medicaid elig. Persons who would otherwise qualify for TANF but chose not to get TANF or have timed out of TANF may qualify for TANF level Medicaid coverage.

BL 2010 Data Limitations

The population potentially eligible for CPW Medicaid programs is subject to change as updates/revisions to the population estimates and projections become available. Legislation enacted by the Texas Legislature results in significant changes in the number of these individuals receiving Medicaid, making projections unreliable until the data series settle down. Migration from the legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Recipient data are from the automated monthly report RN-04-4, "Income Assistance Medical Programs Caseload/Recipient Profile" and/or the TIERS equivalent report, when it becomes available. The population of potential eligibles is estimated using baseline information obtained from the last two March Current Population Surveys 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.

BL 2010 Methodology

Data are computed by totaling the number of children, pregnant women and medically needy persons receiving medical care through CPW Medicaid programs over all months in the reporting period and dividing by the number of months in the reporting period to determine the average monthly number of CPW Medicaid recipients. This result is divided by the population potentially eligible for the CPW Medicaid programs, and then multiplied by 100.

BL 2010 Purpose

This measure is an expression of the impact the agency is having on serving the population potentially eligible for services available under the Children, Pregnant Women and Medically Needy (CPW Medicaid) programs. It is an indicator of the percent of need being met.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	EX	
Measure No.	5	Percent of Direct Delivery Staff with Less than One Year

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

Fall/Annual: N

BL 2010 Definition

This measure reports the percentage of supervisors, workers and clerks with less than one year tenure.

BL 2010 Data Limitations

Only tenure in the current position is counted. The count of eligibility determination staff may differ from actual full-time equivalents.

BL 2010 Data Source

Data are obtained from HRMS database queries.

BL 2010 Methodology

The number of supervisors, workers and clerks with less than one year of tenure at the end of the reporting period is divided by the total number of supervisors, workers, and clerks at the end of the reporting period. The result is expressed as a percentage.

BL 2010 Purpose

At least one year is required for staff to become proficient in eligibility determination tasks. The measure may explain timeliness, performance, staffing and cost anomalies.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	OP	
Measure No.	1	Average Monthly Number of Eligibility Determinations

Calculation Method: N **Key Measure: N** **New Measure: Y** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly number of eligibility determinations for TANF and State Two Parent Cash Assistance, food stamps, MEPD, Medicaid and CHIP. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2010 Data Limitations

There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems.

BL 2010 Data Source

Data sources include the MEARS report, data provided by the Administrative Services Contractor(s), current and legacy HHSC reports supplemented by data extracts and strip files.

BL 2010 Methodology

Data are computed by totaling, over all months in the reporting period, the number of eligibility determinations performed and dividing by the number of months in the reporting period.

BL 2010 Purpose

This measure is useful for comparing, over time, the principal workload drivers for Eligibility Determination, the largest sub-strategy within the Integrated Eligibility and Enrollment Strategy.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	OP	
Measure No.	2	Avg Number of Eligibility Determinations Per Staff Person Per Month

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

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly number of eligibility determinations for TANF and State Two Parent Cash Assistance, food stamps, MEPD, Medicaid, and CHIP per staff person. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2010 Data Limitations

There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems. The count of eligibility determination staff may differ from actual full-time equivalents.

BL 2010 Data Source

The numerator is the data for 1-1-2-OP-1. The number of staff is from a monthly query of HRMS.

BL 2010 Methodology

Data for the numerator are computed by totaling, over all months in the reporting period, the number of eligibility determinations performed and dividing by the number of months in the reporting period. Data for the denominator are computed by totaling, over all months in the reporting period, the number of eligibility determination staff and dividing by the number of months in the reporting period.

BL 2010 Purpose

This measure is useful for comparing eligibility staff workload over time.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	1	Enterprise Oversight and Policy
Strategy No.	2	Integrated Eligibility and Enrollment (IEE)
Measure Type	OP	
Measure No.	3	Average Number of Recipients Per Month: Food Stamps

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly number of Food Stamp recipients. Data include public assistance (PA) and non-public assistance (NPA) recipients. Public assistance recipients are members of households in which all members receive TANF or State Two-Parent Cash Assistance or SSI and TANF. Non-public assistance recipients are members of households in which no one or only some of the members receive TANF or State Two-Parent Cash Assistance.

BL 2010 Data Limitations

Recipients are counted in each month they receive a Food Stamp benefit, so this measure does not report an unduplicated count of recipients over time. Results will be impacted by outreach efforts during the reporting period.

BL 2010 Data Source

Data are obtained from the automated monthly report, RF-03E-4, Food Stamp EBT Issuance Household Profile and the Food Stamp Case extract from TIERS.

BL 2010 Methodology

Data are computed by totaling, over all months in the reporting period, the monthly number of Food Stamp recipients and dividing this total by the number of months in the reporting period.

BL 2010 Purpose

This measure shows the number of Texans impacted by the agency's performance in implementing the provisions of this strategy. It is an indicator of the agency's workload as it pertains to providing services to persons receiving Food Stamp benefits. It is useful for projecting caseloads and future funding needs. It is also information that legislators and the public frequently request.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	1	HHS Enterprise Oversight and Policy
Objective No.	2	HHS Consolidated System Support Services
Strategy No.	1	Consolidated System Support
Measure Type	EF	
Measure No.	1	Percent of Informal Dispute Resolutions Completed Within Timeframes

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 01-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) completed by HHSC that are completed within the required timeline of 30 calendar days from receipt of the IDR request to the date the final decision and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to deficiencies and/or violations cited against a nursing facility, assisted living facility or intermediate care facility for persons with mental retardation by the state survey agency.

BL 2010 Data Limitations

Extenuating circumstances that result in delays in IDR completion may need to be identified and such circumstances excluded from the 30 calendar day

BL 2010 Data Source

The percentage of IDR reviews conducted within the required timeline is determined via an HHSC maintained database, in coordination with state survey agency long-term care regulatory automated system.

BL 2010 Methodology

To calculate the measure, divide the number of IDRs completed within the required timeline by the total number of IDRs completed during the reporting period of the fiscal year.

BL 2010 Purpose

The IDR process, by legislation, should be completed within 30 calendar days of the IDR request. Texas Government Code, §531.058 establishes the 30 calendar day timeframe. Per the Texas Government Code, §311.014, if the due date falls on a Saturday, Sunday or legal holiday, the due date becomes the following business day. IDR due dates that meet this criteria will be recognized the next business day.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	1	Medicare and Supplemental Security Income Risk Groups
Measure Type	EF	
Measure No.	1	Average Aged and Medicare Related Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly cost paid per Aged and Medicare-Related recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) & STRR750 (Managed Care) statistical reports compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-

BL 2010 Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months to be incurred. The measure will include Managed Care & Non-Managed Care for the Aged and Medicare-Related group.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	1	Medicare and Supplemental Security Income Risk Groups
Measure Type	EF	
Measure No.	2	Average Disabled and Blind Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-01 EF 02

Fall/Annual: N

BL 2010 Definition

The average monthly expenditure per Disabled and Blind recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) & STRR750 (Managed Care) statistical reports compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-

BL 2010 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months to be incurred. The measure will include Managed Care & Non-Managed Care for the Disabled and Blind group.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	1	Medicare and Supplemental Security Income Risk Groups
Measure Type	OP	
Measure No.	1	Average Aged and Medicare Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Aged and Medicare-Related recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Managed Care and Fee-for-Service are included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	1	Medicare and Supplemental Security Income Risk Groups
Measure Type	OP	
Measure No.	2	Average Disabled and Blind Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Disabled and Blind recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Managed Care and Fee-for-ervice are included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	2	Temp Asst for Needy Families Adults & Children Risk Groups
Measure Type	EF	
Measure No.	1	Average TANF Adult Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly expenditure per TANF Adult recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) & STRR750 (Managed Care) statistical reports compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-

BL 2010 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months to be incurred. The measure will include Managed Care & Non-Managed Care for the TANF Adult group.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	2	Temp Asst for Needy Families Adults & Children Risk Groups
Measure Type	EF	
Measure No.	2	Average TANF Children Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-02 EF 02

Fall/Annual: N

BL 2010 Definition

The average monthly expenditure per TANF Children recipient month, excluding foster care managed care children.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) & STRR750 (Managed Care) statistical reports compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-

BL 2010 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months to be incurred. The measure will include Managed Care & Non-Managed Care for the TANF Children group.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	2	Temp Asst for Needy Families Adults & Children Risk Groups
Measure Type	EF	
Measure No.	3	Average Foster Care Children Cost Per Recipient Month

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-01-02 EF 03

Fall/Annual: N

BL 2010 Definition

Average monthly expenditure per Foster care children recipient months.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the statistical reports (STRR750) compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates.

BL 2010 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from HMO capitation rates. The measure includes Managed Care for the Foster Care Children served in the statewide Medical Passport program.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	2	Temp Asst for Needy Families Adults & Children Risk Groups
Measure Type	OP	
Measure No.	1	Average TANF Adult Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of TANF Adult recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Managed Care and Fee-for-Service are included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	2	Temp Asst for Needy Families Adults & Children Risk Groups
Measure Type	OP	
Measure No.	2	Average TANF Children Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of TANF Children recipient months, excluding foster care children in the statewide Foster Care Managed Care program. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Managed Care and Fee-for-Service are included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	2	Temp Asst for Needy Families Adults & Children Risk Groups
Measure Type	OP	
Measure No.	3	Average Foster Care Children Recipient Months Per Month

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Foster Care Children in statewide Managed Care (a subgroup of the TANF Children Risk Group) recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Managed care only is included; these children are Foster Care children served in the statewide Managed Care "Medical Passport" program.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	3	Pregnant Women Risk Group
Measure Type	EF	
Measure No.	1	Average Pregnant Women Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly expenditure per Pregnant Women recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) & STRR750 (Managed Care) statistical reports compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-

BL 2010 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months to be incurred. The measure will include Managed Care & Non-Managed Care for the Pregnant Women group.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	3	Pregnant Women Risk Group
Measure Type	OP	
Measure No.	1	Average Pregnant Women Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-03 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Pregnant Women recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Managed Care and Fee-for-Service are included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	4	Children & Medically Needy Risk Groups
Measure Type	EF	
Measure No.	1	Average Children Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-04 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly expenditure per Children recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) & STRR750 (Managed Care) statistical reports compiled by the Medicaid contractor, the RG-23 and RG-24 reports from the Premiums Payable System, and HMO capitation rates. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-

BL 2010 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months to be incurred. The measure will include Managed Care & Non-Managed Care for the Children group that includes Newborns, Federal Mandate Children, and Expansion Children.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	4	Children & Medically Needy Risk Groups
Measure Type	EF	
Measure No.	2	Average Medically Needy Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-04 EF 02

Fall/Annual: N

BL 2010 Definition

The average monthly expenditure per Medically Needy recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR750 (Non-Managed Care) statistical report compiled by the Medicaid contractor and the RG-23 and RG-24 reports from the Premiums Payable System. Medically Needy is Non-Managed Care only. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, EPSDT-CCP, Texas Health Steps, and Cost-reimbursed

BL 2010 Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims which include administration fees in the total by the number of projected recipient months to be incurred.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	4	Children & Medically Needy Risk Groups
Measure Type	OP	
Measure No.	1	Average Children Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-04 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Children recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. The Children group includes Newborns, Federal Mandate Children, and Expansion Children. Managed Care and Fee-for-Service are included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	4	Children & Medically Needy Risk Groups
Measure Type	OP	
Measure No.	2	Average Medically Needy Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-04 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Medically Needy recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Only Fee-for-Service is included.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	5	For Clients Dually Eligible for Medicare and Medicaid.
Measure Type	EF	
Measure No.	1	Average SMIB Premium Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-05 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly premium paid for Supplemental Medical Insurance Benefits (SMIB) Part B premium for Medicare eligible Medicaid clients. The SMIB Part B premium is set by the Social Security Administration and is effective for each calendar year.

BL 2010 Data Limitations

This measure includes Qualified Medicare Beneficiary Qualifying Individuals (QMB QI-1s). The MF-232-01 report, a source document for this measure, provides both SMIB and QMB QI-1 recipient months. No distinction is made between the two types in this report. SMIB and QMB QI-1s have the same

BL 2010 Data Source

Social Security Act and report MF232-01.

BL 2010 Methodology

The average is calculated by taking the total estimated dollar value of claims projected to be incurred for this type of client and dividing the total by the number of projected recipient months to be incurred. The SMIB Part B premium is set by the Social Security Administrations and is effective for each calendar year.

BL 2010 Purpose

HHSC pays the Social Security Administration a premium for coverage of physician and other related services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	5	For Clients Dually Eligible for Medicare and Medicaid.
Measure Type	EF	
Measure No.	2	Average Part A Premium Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 080-R-S70-1 02-01-05 EF 02

Fall/Annual: N

BL 2010 Definition

The average monthly premium paid for Medicare Part A coverage for Medicare eligible Medicaid clients. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year. Medicare Part A is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Social Security Act and report MF832-01.

BL 2010 Methodology

The average is calculated by taking the total estimated dollar value of claims projected to be incurred by clients and dividing this total by the number of projected recipient months to be incurred. The numerator will be the sum of full and reduced rate Part A dollars; the denominator will be the sum of full and reduced rate Part A recipient months. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

BL 2010 Purpose

HHSC pays the Social Security Administration a premium for coverage of inpatient hospital stays and other related services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	5	For Clients Dually Eligible for Medicare and Medicaid.
Measure Type	EF	
Measure No.	3	Avg Qualified Medicare Beneficiaries (QMBs) Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-05 EF 03

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly cost for the payment of Medicare deductible and coinsurance benefits for eligible Medicaid clients, Qualified Medicare Beneficiaries (QMBs).

BL 2010 Data Limitations

None.

BL 2010 Data Source

The monthly RG-23 and RG-24 reports from the Premiums Payable System and monthly billing vouchers submitted for payment by the Medicaid contractor.

BL 2010 Methodology

The calculation is made by taking the total yearly deductible and coinsurance payments paid and dividing this by the total monthly number of QMB recipient months for the year.

BL 2010 Purpose

This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	5	For Clients Dually Eligible for Medicare and Medicaid.
Measure Type	OP	
Measure No.	1	Average SMIB Recipient Months Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-05 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of recipient months of eligibility for which a premium payment is made for supplemental medical insurance benefits (SMIB) Part B coverage. Medicare Part B is medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.

BL 2010 Data Limitations

This measure includes Qualified Medicare Beneficiary Qualifying Individuals (QMB QI-1s). The MF-232-01 report, a source document for this measure, provides both SMIB and QMB QI-1 recipient months. No distinction is made between the two types in this report. SMIB and QMB QI-1s have the same

BL 2010 Data Source

Monthly MF-232-01 report, which provides the number of eligibles for each month on an incurred basis.

BL 2010 Methodology

The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year-to-date average is the sum of the monthly recipient months divided by the number of months summed.

BL 2010 Purpose

HHSC pays the Social Security Administration a premium for Medicare Part B coverage for Qualified Medicare Beneficiaries (QMB), which covers physician and other related services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	5	For Clients Dually Eligible for Medicare and Medicaid.
Measure Type	OP	
Measure No.	2	Average Part A Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-05 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of Medicare eligible recipients for which a Medicare Part A premium is paid. HHSC pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Monthly MF-832 report, which provides the number of eligibles for each month on an incurred basis.

BL 2010 Methodology

The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year-to-date average is the sum of the monthly recipient months divided by the number of months summed. Part A full rate and reduced rate recipient months are included. Combine as a sum in calculations then average.

BL 2010 Purpose

HHSC pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	5	For Clients Dually Eligible for Medicare and Medicaid.
Measure Type	OP	
Measure No.	3	Average QMBs Recipient Months Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-05 OP

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly number of Medicare eligible Medicaid clients who meet the criteria established by federal legislation.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The monthly RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months divided by the number of months summed.

BL 2010 Purpose

HHSC is required to pay Medicare premiums, deductibles, and coinsurance liabilities for QMBs whose income is at or below certain eligibility criteria. These clients are not eligible for other Title XIX services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	EF	
Measure No.	1	Avg Cost Per Aged & Medicare Recipient Month: STAR+PLUS Acute Care

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-01-06 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly cost paid per Aged and Medicare-Related recipient month.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

PREM report (currently with incurred data). The PREM partly consists of data from the monthly STMR750 and STRR750statistical reports compiled by the Medicaid contractor. Recipient Months are obtained from the Premiums Payable System. Dollars include administration fees for client services. Dollars exclude Fee-For-Service costs in Family Planning, Early, Periodic, Screening, Diagnosis and Treatment-Comprehensive Care Program, Texas Health Steps,

BL 2010 Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims which include administration fees in the total by the number of projected recipient months to be incurred.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	EF	
Measure No.	2	Avg Cost Per Aged & Medicare Recipient Month: STAR+PLUS Long Term Care

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-01-06 EF 02

Fall/Annual: N

BL 2010 Definition

The average monthly premium per Medicare-eligible recipient month in STAR+PLUS managed care. Recipient month is defined as one month's membership (member month) in STAR+PLUS for an individual who is in the Medicare-eligible category. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

BL 2010 Data Limitations

Cost data does not include acute care costs as these are not included in the premium and are primarily covered by Medicare.

BL 2010 Data Source

The source for expenditure data is the capitation rates set by the HHSC Actuarial Analysis Division. Recipient month data, used to calculate average monthly premium is from the Premium Payment System.

BL 2010 Methodology

The average monthly premium per Medicare-eligible recipient month is calculated by dividing the total premiums paid to the STAR+PLUS Health Maintenance Organization including administrative fees on behalf of Medicare-eligible members for the reporting period by the total number of recipient months projected to be incurred in the reporting period.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	EF	
Measure No.	3	Avg Cost Per Disabled and Blind Recipient Month: STAR+PLUS Acute Care

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-01-06 EF 03

Fall/Annual: N

BL 2010 Definition

Acute Care costs for Disabled and Blind population.

BL 2010 Data Limitations

The allocation of premium to long-term care vs. acute care is estimated. The Premium Payment System is based on premium payments and not actual costs.

BL 2010 Data Source

The PPS System, and the average capitated rate paid (allocated to acute care). In-patient hospital cost will be obtained from the STMR750 and STRR750 statistical reports compiled by the Medicaid Contractor. Recipient Months are obtained from the Premiums Payable System.

BL 2010 Methodology

Multiply the caseload for this category by the average capitated premium rate attributable to acute care.

BL 2010 Purpose

The average acute care cost will show caseload and caseload mix information.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	EF	
Measure No.	4	Avg Cost/ Disabled and Blind Recipient Month:STAR+PLUS Long Term Care

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-01-06 EF 04

Fall/Annual: N

BL 2010 Definition

The average monthly premium per non-Medicare recipient month in STAR+PLUS managed care. The non-Medicare category includes members who are aged, blind, or disabled who are not qualified for Medicare. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single

BL 2010 Data Limitations

Cost data includes most acute care services, except for prescription drugs and in-patient hospital costs, as well as Long-term Care (LTC) services.

BL 2010 Data Source

The source for expenditure data is the capitation rates set by the HHSC Actuarial Analysis Division. Recipient month data, used to calculate average monthly premium is from the Premium Payment System.

BL 2010 Methodology

The average monthly premium per non-Medicare recipient month is calculated by dividing the total premiums paid to the STAR+PLUS Health Maintenance Organization (HMOs) including administrative fees on behalf of non-Medicare members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	EX	
Measure No.	1	Avg # of Members Receiving Nonwaiver Community Care through STAR+PLUS

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-06 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of STAR+PLUS members, not enrolled in the 1915(c) component of STAR+PLUS, who received Medicaid Community Care services. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

BL 2010 Data Limitations

This measure does not describe the level, type or amount of community care received by members.

BL 2010 Data Source

Data to produce this measure will be derived from the ISP Registry in the Claims Management System (CMS).

BL 2010 Methodology

The sum of managed care members receiving non-waiver community-care services for all months of the reporting period, divided by the number of months in the reporting period, yields the reported performance.

BL 2010 Purpose

This measure shows the impact of managed care on Medicaid community care services caseloads for clients who are not enrolled in the 1915(c) waiver component of STAR+PLUS. This data is a useful tool for projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	EX	
Measure No.	2	Avg # of Members Receiving Waiver Services through STAR+PLUS

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-06 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of STAR+PLUS members, enrolled in the 1915(c) component of STAR+PLUS, who received Medicaid Community Care services. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

BL 2010 Data Limitations

This measure only includes STAR+PLUS members who are enrolled in the 1915(c) waiver component of STAR+PLUS. This measure does not describe the level, type or amount of community care received by members.

BL 2010 Data Source

Data to produce this measure will be derived from the ISP Registry in the Claims Management System (CMS).

BL 2010 Methodology

The sum of managed care members receiving 1915(c) waiver community-care services for all months of the reporting period, divided by the number of months in the reporting period, yields the reported performance.

BL 2010 Purpose

This measure shows the impact of managed care on community care caseloads for clients who are enrolled in the 1915(c) waiver component of STAR+PLUS. This data is a useful tool for projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	OP	
Measure No.	1	Avg Aged and Medicare-eligible Recipient Months Per Month: STAR+PLUS

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-06 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2010 Data Limitations

Incurred data will be used until there is more experience with actual paid data.

BL 2010 Data Source

The RG-23 and RG-24 reports from the Premiums Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. STAR+PLUS is a Managed Care Program.

BL 2010 Purpose

This measure reflects the amount paid for each recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	1	Medicaid Health Services
Strategy No.	6	STAR+PLUS (Integrated Managed Care)
Measure Type	OP	
Measure No.	2	Average Disabled and Blind Recipient Months Per Month: STAR+PLUS

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-01-06 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number non-Medicare client recipient months in STAR+PLUS. A recipient month is defined as one month's membership (member month) in STAR+PLUS for an individual who is in the non-Medicare category. The non-Medicare category includes members who are aged, blind or disabled who are not qualified for Medicare. The STAR+PLUS program integrates preventive, primary, acute care and long-term care into a single Health Maintenance Organization (HMO) managed care model.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data are obtained from HHSC's Premium's Payable System.

BL 2010 Methodology

Average recipient months per month is calculated by summing the non-Medicare STAR+PLUS recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional twenty four months to allow for corrections, redeterminations, and retroactive decisions.

BL 2010 Purpose

This measure reflects the average monthly number of recipient months for the named group.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	1	Cost Reimbursed Services
Measure Type	EF	
Measure No.	1	Average Emergency Services for Non-citizens Cost Per Recipient Month

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly costs of providing Medicaid to non-citizens residing in the United States, who are in need of medical services due to an emergency

BL 2010 Data Limitations

This measure involves Type 30 (TP 30) program recipient months and expenditures. TP 30 eligible persons are aliens residing in the United States who do not meet citizenship requirements for TANF or other medical programs. These persons are nonimmigrants, undocumented persons, and certain legal permanent

BL 2010 Data Source

The monthly RG-23 and RG-24 reports from the Premiums Payable System and monthly billing data submitted for payment by the Medicaid Contractor.

BL 2010 Methodology

The total TP 30 expenditures incurred are divided by the total number of TP 30 recipient months. Data is provided on an incurred basis. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2010 Purpose

Captures the average monthly cost of providing Medicaid to TP 30 non-citizens residing in the U.S., who are in need of medical services due to an emergency

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	1	Cost Reimbursed Services
Measure Type	EX	
Measure No.	1	Average Monthly # of Medicaid Clients Served in FQHCs

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly number of Medicaid clients served in Federally Qualified Health Centers (FQHCs).

BL 2010 Data Limitations

The measure seems relatively easy for gathering past data. Annual trends fluctuate greatly and would make future projections rather difficult.

BL 2010 Data Source

The Medicaid contractor obtains the monthly unduplicated client count with a Vision 21 query using the MARS Universe. The unduplicated client count is the number of clients associated with the number of paid claims in the given month.

BL 2010 Methodology

Add the 12 monthly numbers of unduplicated clients by month in a given year and divide by 12. The result is the average number of Medicaid clients served in FQHCs for the given year.

BL 2010 Purpose

This measure indicates how many Medicaid clients are served in FQHCs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	1	Cost Reimbursed Services
Measure Type	OP	
Measure No.	1	Average Monthly Number of Enrolled Federally Qualified Health Centers

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

FQHC look-alikes meet all the requirements to receive one of the grants under the Public Health Service Act but does not actually receive any of these grants, according to FQHC status qualification guidelines.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data source is Vision 21 from the Ad Hoc Query Platform, which is managed by HHSC. The Medicaid Contractor's Provider Enrollment Agreement provides information to the database. The Medicaid contractor currently generates reports in the form of an Access database from a query that gathers monthly information on the active FQHC providers. Data is provided to HHSC in an Excel Spreadsheet.

BL 2010 Methodology

The quarterly average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the three month period divided by three. The year-to-date average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the given period divided by the total number of months in that period.

BL 2010 Purpose

Captures the average monthly number of FQHCs and FQHC look-alikes.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	1	Cost Reimbursed Services
Measure Type	OP	
Measure No.	2	Average Number of Non-citizens Recipient Months Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reflects the number of Type 30 (TP 30) aliens residing in the United States who have an emergency medical condition and meet all Medicaid eligibility criteria.

BL 2010 Data Limitations

This measure includes all TP 30 program recipient months. TP 30 eligible persons are aliens residing in the United States who do not meet citizenship requirements for TANF or other medical programs. These persons are nonimmigrants, undocumented aliens, and certain legal permanent resident (LPR)

BL 2010 Data Source

Monthly RG-23 and RG-24 reports from the Premium Payable System.

BL 2010 Methodology

The Average Number of Undocumented Persons Recipient Months Per Month is the average number of TP 30 recipient months per month. It is the sum of the monthly TP 30 recipient months divided by the number of months summed. Data is provided on an incurred basis. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

BL 2010 Purpose

This measure reflects the average number of TP 30 aliens residing in the U.S. who have an emergency medical condition covered by Medicaid.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	2	Medicaid Vendor Drug Program
Measure Type	EF	
Measure No.	1	Average Number of Prescriptions Incurred Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-02 EF 01

Fall/Annual: N

BL 2010 Definition

Average Prescriptions Incurred per Recipient Month is the average number of Vendor Drug prescription claims incurred by recipient month each month.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Sources include Vendor Drug cost data reports provided by FIrst Health as well as the MH-492 and MH-493 statistical reports provided by the Department of Aging and Disability Services on a monthly basis. Because data are reported on an incurred basis, the most recent prescription and recipient month counts are completed using completion ratios.

BL 2010 Methodology

The average number of prescriptions incurred per recipient month is the sum of the monthly prescriptions in the reporting period divided by the sum of the recipient months for the reporting period.

BL 2010 Purpose

Captures the average number of prescriptions incurred per recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	2	Medicaid Vendor Drug Program
Measure Type	EF	
Measure No.	2	Average Cost Per Medicaid Prescription

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-02 EF 02

Fall/Annual: N

BL 2010 Definition

This measure is the total Medicaid prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year. For historical purposes, CHIP Phase I and Spillover are included.

BL 2010 Data Limitations

The Vendor Drug Program (VDP) covers self-administered outpatient Medicaid prescriptions paid through pharmacies and administered in the patient's home or nursing home. The main exception to this policy is IV therapies, which are covered by VDP. Prescriptions administered in physician's offices, hospitals, or clinics are not included in this measure. These prescriptions are paid by the state contractor. The Vendor Drug dollars do not include any rebates.

BL 2010 Data Source

State office computer report MH492 and MH493.

BL 2010 Methodology

This measure is the total Medicaid prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal

BL 2010 Purpose

Captures the total prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	2	Medicaid Vendor Drug Program
Measure Type	OP	
Measure No.	1	Total Medicaid Prescriptions Incurred

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of Medicaid Vendor Drug prescriptions incurred for payment in the reporting period for a given state fiscal year. For historical purposes, CHIP Phase I and Spillover are included.

BL 2010 Data Limitations

The Vendor Drug Program (VDP) covers self-administered outpatient Medicaid prescriptions paid through pharmacies and administered in the patient's home or nursing home. The main exception to this policy is IV therapies, which are covered by VDP. Prescriptions administered in physician's offices, hospitals, or clinics are not included in this measure. These prescriptions are paid by the state contractor.

BL 2010 Data Source

Computer printout MH492 and MH493.

BL 2010 Methodology

Total Number of Medicaid Prescriptions = the number of prescriptions incurred for payment in the reporting period for a given state fiscal year.

BL 2010 Purpose

This measure reports the number of prescriptions incurred for payment in the reporting period for a given state fiscal year.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	4	Medical Transportation
Measure Type	EF	
Measure No.	1	Average Cost Per One-Way Medical Transportation Trip

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure provides an efficiency indication of the cost of providing client transportation services through the Medical Transportation Program.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available.

BL 2010 Data Source

The data sources are the Transportation's Electronic Journal for Authorized Services (TEJAS) and the Transportation for Indigent Cancer Patient (TICP) data files maintained by the McAllen call center.

BL 2010 Methodology

The average cost is derived by dividing the total cost of services by the number of paid one-way trips.

BL 2010 Purpose

The purpose of this measure is to report the average cost of client transportation trips.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	4	Medical Transportation
Measure Type	OP	
Measure No.	1	Number of Recipient One-way Trips Provided by Medical Transportation

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 02-02-04 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of one-way trips provided (paid) by the Medical Transportation Program as reported in the Transportation's Electronic Journal for Authorized Services (TEJAS) and the Transportation for Indigent Cancer Patient (TICP) data files.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available.

BL 2010 Data Source

The data sources are the Transportation's Electronic Journal for Authorized Services (TEJAS) and the Transportation for Indigent Cancer Patient (TICP) data files maintained by the McAllen call center.

BL 2010 Methodology

The number of one-way trips provided (paid) by the Medical Transportation Program as reported in the TEJAS and TICP data files.

BL 2010 Purpose

The purpose of this measure is to report the number of one-way trips provided (paid) by the Medical Transportation Program.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	5	Medicaid Family Planning
Measure Type	EF	
Measure No.	1	Average Medicaid Family Planning Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-05 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of providing family planning services to eligible persons with funds from Title XIX.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. (Data are on an incurred basis.)

BL 2010 Data Source

Family Planning (Medicaid) Expenditure Projections Report.

BL 2010 Methodology

The average cost is calculated by dividing the total combined Medicaid Family Planning (Title XIX) expenditures in the reporting period by the total number of Family Planning recipient months in the same reporting period. This measure does not include Medicaid Managed Care Family Planning. Admin is not included. Genetics is included in this measure.

BL 2010 Purpose

This measure reports the average cost per Medicaid Family Planning recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	2	Other Medicaid Services
Strategy No.	5	Medicaid Family Planning
Measure Type	OP	
Measure No.	1	Average Medicaid Family Planning Recipient Months Per Month

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the average number of Medicaid Family Planning recipient months in the reporting period.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the available data. (Data are on an incurred basis.)

BL 2010 Data Source

Family Planning (Medicaid) Expenditure Projections Report.

BL 2010 Methodology

Average Recipient Months per Month is calculated by summing the number of Medicaid Family Planning recipient months and dividing by the number of months summed. This measure is Fee-for-Service only--it does not include the Medicaid Managed Care Family Planning eligibles or Women's Health Waiver. Genetics is included in this measure.

BL 2010 Purpose

This measure reports the average number of Medicaid Family Planning recipient months.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	1	Health Steps (EPSDT) Medical
Measure Type	EF	
Measure No.	1	Avg Cost Per THSteps (EPSDT) Medical Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-01 EF 01

Fall/Annual: N

BL 2010 Definition

This is the average cost per recipient month per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT)of Medical recipients eligible for at least one THSteps (EPSDT) Medical paid screen during the reporting period. Fee-for-Service (FFS) expenditures are included, but managed care expenditures are not.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Data is FFS only.

BL 2010 Data Source

THSteps (EPSDT) Medical Program Expenditure Projections Report.

BL 2010 Methodology

The average cost is calculated by dividing the total THSteps expenditures (includes client services and "other costs" (CPW & Ancillary Services)) in the reporting period by the total number of THSteps (EPSDT) Medical recipient months in the same reporting period. This measure does not include managed care Medical Program data. Admin is not included.

BL 2010 Purpose

This measure reports the THSteps (EPSDT) average cost per THSteps (EPDST) recipient months eligible for medical check-ups. (FFS only)

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	1	Health Steps (EPSDT) Medical
Measure Type	EX	
Measure No.	1	Number of THSteps (EPSDT) Medical Clients Served

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-01 EX 01

Fall/Annual: N

BL 2010 Definition

This is an unduplicated count of the number of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT)Fee-for-Service (FFS) medical clients who received at least one THSteps (EPSDT) paid medical screen during the reporting period.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. A limitation is that providers have 90 days in which to submit a claim after the date of service, and if a claim is denied, the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. This measure includes FFS data only.

BL 2010 Data Source

The data source is the HISR303A report generated by the Medicaid Claims Administrator. Other automated systems may replace the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

This is an unduplicated count of the number of THSteps (EPSDT) clients who received at least one THSteps (EPSDT) FFS paid medical screen during the reporting period.

BL 2010 Purpose

Measures the number of THSteps (EPSDT)FFS medical clients served.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	1	Health Steps (EPSDT) Medical
Measure Type	OP	
Measure No.	1	Average THSteps (EPSDT) Medical Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-01 OP

Fall/Annual: N

BL 2010 Definition

This is the average Fee-for-Service (FFS) recipient months per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) of Medical recipients eligible for at least one THSteps (EPSDT) Medical paid screen during the reporting period.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. This measure includes FFS data only.

BL 2010 Data Source

THSteps (EPSDT) Medical Program Expenditure Projections Report.

BL 2010 Methodology

Average recipient months per month is calculated by summing the number of THSteps Medical Program recipients each month and dividing by the number of

BL 2010 Purpose

Measures the average number of THSteps (EPSDT) FFS Medical recipient months.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	2	Health Steps (EPSDT) Dental
Measure Type	EF	
Measure No.	1	Avg Cost Per THSteps (EPSDT) Dental Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-02 EF 01

Fall/Annual: N

BL 2010 Definition

This is the average cost per recipient month per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) of dental and orthodontic recipients eligible for dental and orthodontic services during the reporting period.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

BL 2010 Data Source

THSteps (EPSDT) Dental Program Expenditure Projections Report.

BL 2010 Methodology

This cost is calculated by dividing the total dental and orthodontic ecpenditures in the reporting period by the total number of THSteps Dental recipient months in the same reporting period. (THSteps Dental recipient months are the same group of eligible persons as the THSteps Orthodontic recipient months, so do not sum). Clients eligible include all Medicaid children under age 21.

BL 2010 Purpose

Measures the average cost per eligible for THSteps (EPSDT) dental and orthodontic services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	2	Health Steps (EPSDT) Dental
Measure Type	EX	
Measure No.	1	Number of THSteps (EPSDT) Dental Clients Served

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-02 EX 01

Fall/Annual: N

BL 2010 Definition

This is an unduplicated count of the number of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental clients who received at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. A limitation is that providers have 90 days in which to submit a claim after the date of service, and if a claim is denied, the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting.

BL 2010 Data Source

The data source is the HISR303Areport generated by the Medicaid Claims Administrator. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

This is an unduplicated count of the number of THSteps(EPSDT) clients who received at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2010 Purpose

Measures the number of THSteps (EPSDT) dental and orthodontic clients served.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	2	Health Steps (EPSDT) Dental
Measure Type	OP	
Measure No.	1	Average THSteps (EPSDT) Dental Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-02 OP

Fall/Annual: N

BL 2010 Definition

This is the average recipient months per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental and/or orthodontic recipient months eligible for at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

BL 2010 Data Source

THSteps (EPSDT) Dental Program Expenditure Projections Report.

BL 2010 Methodology

Average recipient months per month is calculated by summing the number of THSteps Dental recipient months and dividing by the number of months summed.

BL 2010 Purpose

Measures the average number of THSteps (EPSDT) dental or orthodontic recipient months.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	2	Health Steps (EPSDT) Dental
Measure Type	OP	
Measure No.	2	# of THSteps (EPSDT) Active Dent Providers Providing Medicaid Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-02 OP

Fall/Annual: N

BL 2010 Definition

This is an unduplicated count of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental providers who have provided paid dental services to at least one THSteps (EPSDT) Medicaid eligible client during the state fiscal year.

BL 2010 Data Limitations

The data reported only reflects that number of dental providers who have provided paid dental services. This does not measure access to dental services across the state. Dentists have 90 days in which to submit a claim after the date of service and if a claim is denied the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due; therefore, estimations or projections may be included based on available data.

BL 2010 Data Source

The data source HISR301A is generated by the Medicaid Claims Administrator. Other automated systems may replace the current system. The data from this system may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting

BL 2010 Methodology

The calculation methodology includes a cumulative unduplicated count of THSteps (EPSDT) dental providers who have provided paid dental services to at least one THSteps (EPSDT) Medicaid eligible client during the state fiscal year.

BL 2010 Purpose

The purpose of the measure is to monitor the unique number of active THSteps (EPSDT) dental providers providing Medicaid services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	3	Health Steps (EPSDT) Comprehensive Care Program
Measure Type	EF	
Measure No.	1	Average Cost Per THSteps (EPSDT) CCP Recipient Month per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure is the average cost per child recipient month in the Texas Health Steps (THSteps) Early,Periodic, Screening, Diagnostic and Treatment (EPSDT)-Comprehensive Care Program (CCP) during the reporting period. Fee-for-Service (FFS) only.

BL 2010 Data Limitations

None.

BL 2010 Data Source

STMR650 Report and billing information provided by the Medicaid contractor for cost data; Premiums Payable System RG-23 & RG-24 for recipient months.

BL 2010 Methodology

Sum the total THSteps (EPSDT)-CCP FFS expenditures (including any cost settlements and/or adjustments for annual computations) during the reporting period and divide the total by the total number of CCP-FFS recipient months in the same time period.

BL 2010 Purpose

This measure is the average dollar amount spent per child recipient month receiving THSteps (EPSDT)-CCP benefits.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	3	Special Medicaid Services for Children
Strategy No.	3	Health Steps (EPSDT) Comprehensive Care Program
Measure Type	OP	
Measure No.	1	Average Number of THSteps (EPSDT) CCP Recipient Months per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-03-03 OP

Fall/Annual: N

BL 2010 Definition

This measure is the monthly average number of Fee-for-Service (FFS) recipient months in the Texas Health Steps (THSteps) Early Periodic Screening Diagnosis Treatment (EPSDT)-Comprehensive Care Program (CCP).

BL 2010 Data Limitations

None.

BL 2010 Data Source

Premiums Payable System RG-23 & RG-24.

BL 2010 Methodology

Sum the total child recipient months by month in the reporting period and divide the total by the number of months summed. Total child recipient months consists of TANF Children, Newborns, Expansion Children, Federal Mandate Children, Medically Needy under age 21, and Disabled and Blind under age 21. These are Fee-for-Service (FFS)THSteps-CCP recipient months.

BL 2010 Purpose

This measure is the monthly average number of FFS recipient months in the THSteps (EPSDT)-CCP program.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	2	Medicaid
Objective No.	4	Medicaid Support
Strategy No.	1	State Medicaid Office
Measure Type	OP	
Measure No.	1	Medicaid Acute Care Recipient Months Per Month: Managed Care

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 02-04-01 OP

Fall/Annual: N

BL 2010 Definition

The measure is the average monthly number of recipient months for Medicaid clients enrolled in Managed Care plans including Primary Care Case Management plans (PCCMs) during the reporting quarter. The measure includes Disabled and Blind STAR+PLUS in capitated HMOs. Managed Care recipient months are classified into eight risk groups (Aged and Medicare Related, Disabled and Blind, TANF Children, TANF Adults, Pregnant Women, Newborns, Expansion Children, and Federal Mandate Children. There is no Managed Care in the Medically Needy risk group).

BL 2010 Data Limitations

HHSC is not directly responsible for enrolling clients in the program. Acute care costs for Disabled and Blind STAR+PLUS in capitated HMOs are paid by

BL 2010 Data Source

The data is reported to HHSC through the Premium Payable System or its successor system.

BL 2010 Methodology

Staff calculate client months by gathering data from the Premiums Payable System, applying completion factors to incomplete client month data and using forecasting models and trends to project future client months.

BL 2010 Purpose

This is the measure of the impact of implementation of new managed care initiatives.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	1	Children's Health Insurance Program (CHIP)
Measure Type	EF	
Measure No.	1	Average CHIP Children Benefit Costs Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly cost per recipient month of health and dental premiums and vaccine costs (excluding prescription drugs) for the U.S. citizen CHIP II program for a reporting period.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each health and dental plan have incurred during the month. For vaccine costs, HHSC receives a quarterly invoice from Department of State Health Services, which shows the amount used for vaccinating all CHIP enrollees. The cost of vaccinating CHIP enrollees is estimated from the total vaccine cost.

BL 2010 Methodology

The amounts owed to the health and dental carriers are totaled for the reporting period. This total is divided by the number of U.S. citizen recipient months in the CHIP II program during the reporting period.

BL 2010 Purpose

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental plan providers on behalf of CHIP federally funded clients. Benefit costs are understood to include amounts paid to health plans, the dental contractor, and HHSC to cover contractor administration.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	1	Children's Health Insurance Program (CHIP)
Measure Type	OP	
Measure No.	1	Average CHIP Children Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure is the number of recipient months in the CHIP Phase II program for a reporting period.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data are obtained from the Administrative Services Contractor. The contractor produces monthly enrollment reports showing cumulative enrollment.

BL 2010 Methodology

The measure is calculated by totaling the recipient months for CHIP II eligibles from the enrollment report and dividing that number by the number of months in the period covered by the report.

BL 2010 Purpose

In SB 445, 76th Texas Legislature provides authority to create CHIP coverage to children in families with net income at or below 200% FPL. HHSC is responsible for overseeing CHIP Phase II and oversees program design and operations that are assigned or contracted to other state agencies or private

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	2	Immigrant Children Health Insurance
Measure Type	EF	
Measure No.	1	Average Legal Immigrant Benefit Costs Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly cost per recipient month of health and dental premiums and vaccine costs (excluding prescription drugs) for the Legal Immigrant children not eligible for the CHIP program for a reporting period.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each health and dental plan have incurred during the month. For vaccine costs, HHSC receives a quarterly invoice from Department of State Health Services (DSHS), which shows the amount used for vaccinating all CHIP enrollees. The cost of vaccinating Legal immigrant children is estimated from the total vaccine cost.

BL 2010 Methodology

The amounts owed to the health and dental carriers as well as DSHS are totaled for the reporting period. The total is divided by the number of Legal Immigrant children recipient months during the reporting period.

BL 2010 Purpose

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental plan providers on behalf of legal immigrant children enrolled in CHIP. Benefit costs are understood to include amounts paid to health plans, the dental contractor, and HHSC to cover contractor administration.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	2	Immigrant Children Health Insurance
Measure Type	OP	
Measure No.	1	Average Legal Immigrant Children Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly recipient months for the Legal Immigrant children.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The Administrative Services Contractor produces monthly CHIP II enrollment reports which includes the number of Legal Immigrants enrolled.

BL 2010 Methodology

The measure is calculated by counting the number of recipient months for Legal Immigrant CHIP enrollees from the enrollment report and dividing that number by the number of months in the period for which the measure is reported.

BL 2010 Purpose

In SB 445, the 76th Texas Legislature provides the authority to extend state-funded CHIP II coverage to children who would be CHIP II eligible but they entered the country after 8-22-96 and are not exempted from the five year ban from CHIP participation.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	3	School Employee Children Insurance
Measure Type	EF	
Measure No.	1	Average School Employee Children Benefit Cost Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly health care cost (i.e., premiums, delivery, dental, vaccines) excluding prescription drugs per recipient month for the School Employee Children.

BL 2010 Data Limitations

TexCare Partnership contractor will need information from TRS on eligible school districts, charter schools, and education service centers in TRS ActiveCare. It is unknown how many school employees will opt for CHIP coverage in lieu of other coverages. It will be difficult to forecast as other districts opt into TRS Active Care in 2005 and beyond.

BL 2010 Data Source

The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each health and dental plan have incurred during the month. For vaccine costs, HHSC receives a quarterly invoice from the Department of State Health Services, which shows the amount used for vaccinating all CHIP enrollees. The cost of vaccinating School Employee children is estimated from the total vaccine cost.

BL 2010 Methodology

The total amount of health expenditures less prescription drugs is divided by the number of School Employee Children recipient months for that time period.

BL 2010 Purpose

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental plan providers on behalf of School Employee children enrolled in CHIP. Benefit costs are understood to include amounts paid to health plans, the dental contractor, and HHSC to cover contractor administration.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	3	School Employee Children Insurance
Measure Type	OP	
Measure No.	1	Average School Employee Children Recipient Months Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-03 OP

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly recipient months per month for the School Employee Children.

BL 2010 Data Limitations

TexCare Partnership contractor will need information from TRS on eligible school districts, charter schools, and education service centers in TRS ActiveCare. It is unknown how many school employees will opt for CHIP coverage in lieu of other coverages. It will be difficult to forecast as other districts opt into TRS Active Care in 2005 and beyond.

BL 2010 Data Source

Data will be obtained from the contractor, who will produce monthly enrollment reports showing cumulative enrollment for School Employee Children enrolled in

BL 2010 Methodology

Take the total number of recipient months for School Employee children from the enrollment report and divide that number by the number of months in the reporting period.

BL 2010 Purpose

To provide an average monthly caseload for CHIP-enrolled School Employee Dependents. HB 3343, 77th Legislature, allows children of school employees, eligible for TRS ActiveCare, to continue in CHIP or enroll in CHIP in lieu of TRS' ActiveCare coverage. Payment for these children is pure state funds and may not include Title XXI federal funds.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	4	CHIP Perinatal Services
Measure Type	EF	
Measure No.	1	Average Perinate Benefit Cost Per Recipient Month

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 03-01-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly cost of health premiums (excluding prescription drugs and vaccine costs) for the CHIP Perinate program for a reporting

BL 2010 Data Limitations

None.

BL 2010 Data Source

Medicaid/CHIP and Decision Support-Database Management furnish a monthly report showing the costs each health plan have incurred during the month.

BL 2010 Methodology

The amounts owed to the health carriers are totaled for the reporting period. Divide the total cost by the total number of Perinate enrollees in the same

BL 2010 Purpose

In SB1, 79th Texas Legislature provides authority to create Perinate coverage under the CHIP program.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	4	CHIP Perinatal Services
Measure Type	OP	
Measure No.	1	Average Perinate Recipient Months Per Month

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 03-01-04 OP

Fall/Annual: N

BL 2010 Definition

This measure is the number of children enrolled in coverage under the CHIP Perinate program for a reporting period.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data are obtained from HHSC Decision Support-Database Management through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.

BL 2010 Methodology

The measure is calculated by totaling the number of Perinate enrollees from the enrollment report and dividing that number by the number of months in the period covered by the report.

BL 2010 Purpose

In SB1, 79th Texas Legislature provides authority to create Perinate coverage under the CHIP program.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	5	CHIP Vendor Drug Program
Measure Type	EF	
Measure No.	1	Average Number of Prescriptions Incurred Per Recipient Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-05 EF 01

Fall/Annual: N

BL 2010 Definition

Average Prescriptions Incurred per Recipient Month is the average number of CHIP prescription claims incurred by recipient month each month.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Sources include the MH-494 statistical report provided by the Texas Department of Human Services (or successor agency) on a monthly basis. Because data are reported on an incurral basis, the most recent prescription and recipient month counts are completed using completion ratios.

BL 2010 Methodology

The average number of prescriptions incurred per recipient month is the sum of the monthly prescriptions for the months in the reporting period divided by the sum of the recipient months for the same period.

BL 2010 Purpose

Captures the average number of CHIP prescriptions incurred per recipient month.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	5	CHIP Vendor Drug Program
Measure Type	EF	
Measure No.	2	Average Cost Per CHIP Prescription

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-05 EF 02

Fall/Annual: N

BL 2010 Definition

This measure is the total CHIP prescription costs (which includes CHIP, Immigrant children, School Employee children, and Perinates) incurred during the reporting period divided by the total number of prescriptions incurred during the reporting period.

BL 2010 Data Limitations

Prescriptions administered in physicians's offices, hospitals, or clinics are not included in this measure but would be included in the capitated rate paid to the CHIP provider.

BL 2010 Data Source

HHSC computer reports 342 and 346.

BL 2010 Methodology

Divide the total CHIP prescription costs incurred during the reporting period by the total number of CHIP prescriptions incurred during the reporting period. The CHIP prescription dollars do not include any rebates.

BL 2010 Purpose

The measure captures the total CHIP prescription cost incurred divided by the total number of CHIP prescriptions.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	3	Children's Health Insurance Program Services
Objective No.	1	CHIP Services
Strategy No.	5	CHIP Vendor Drug Program
Measure Type	OP	
Measure No.	1	Total Number of CHIP Prescriptions

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 03-01-05 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of CHIP prescriptions incurred for payment per year for CHIP-enrolled children (which includes CHIP Phase II, Immigrant children, School Employee children, and Perinates).

BL 2010 Data Limitations

Prescriptions administered in physicians' offices, hospitals, or clinics are not included in this measure but would be included in the capitated rate paid to the CHIP provider.

BL 2010 Data Source

The source is the MH-494 statistical report provided by First Health (or subsequent contractor) on a monthly basis. Because data are reported on an incurral basis, the most recent prescription counts are completed using completion ratios.

BL 2010 Methodology

Number of CHIP Prescriptions is the total number of prescriptions incurred for payment during the reporting period for children enrolled in CHIP (which includes CHIP Phase II, Immigrant children, School Employee children, and Perinates).

BL 2010 Purpose

This measure reports the number of CHIP prescriptions incurred for payment for the reporting period.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	EF	
Measure No.	1	Average Monthly Grant: TANF

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the dollar amount of the average monthly TANF grant per recipient. The TANF program provides a monthly financial assistance payment to eligible families with children and with no or one certified adult.

BL 2010 Data Limitations

State and Federal Legislation impacting this measure include: Time-limited benefits and other provisions of HB 1863 passed by 74th Texas Legislature; federal 60 month time limits; HB-1 passed by 76th Texas Legislature changed the earned income deduction for employed TANF families (effective March 00); HB-2292 of 78th Texas Legislature implemented a full family sanction for families out of compliance with the Personal Responsibility Agreement. Migration from the agency legacy system (SAVERR) to the new TIERS environment could result in different data sources. Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2010 Data Source

Data are obtained from ad hoc runs against the "TANF Warrant History" file: TP509260, which is downloaded from the agency mainframe (SAVERR and TIERS) to a local server computer.

BL 2010 Methodology

Data are calculated by dividing total dollar amount of grants to TANF recipients in reporting period by total number of TANF recipients per month. Historical data on TANF payments and recipients are pulled from the agency mainframe and downloaded to local server. Ad hoc computer programs using analytical software are run against this file. These programs determine the number of people who received TANF benefits and total benefit amount for a given month. The programs adjust for cancellations and supplemental payments after given month has ended. Completion factors may be applied to data to estimate final counts.

BL 2010 Purpose

This measure provides the unit cost of one of the service components funded under this strategy. This unit cost is a useful tool for projecting future funding

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	EF	
Measure No.	2	Average Monthly Grant: State Two-Parent Cash Assistance Program

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 04-01-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the dollar amount of the average monthly State Two-Parent Cash Assistance Program grant per recipient. The State Two-Parent Cash Assistance Program provides a monthly financial assistance payment to eligible families with two certified adults.

BL 2010 Data Limitations

State and Federal Legislation impacting this measure include: 77th Texas Legislature created a state funded TANF-MOE program for families with 2 certified adults. 78th Texas Legislature required denial of the TANF case if any Personal Responsibility Agreement requirement was not met. 80th Texas Legisalture changed funding from TANF-MOE to State General Revenue. Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2010 Data Source

Data are obtained from ad hoc runs against the 'TANF Warrant History' file: TP509260c, which is downloaded from the agency mainframe to a local server

BL 2010 Methodology

Data are derived by dividing total dollar amount of grants to State Two-Parent Cash Assistance Program recipients in reporting period by total number State Two-Parent Cash Assistance Program recipients per month. Historical data on two-parent payments and recipients are pulled from the agency mainframe computer and downloaded to a file on a local server. Ad hoc computer programs using analytical software are run against this file. These programs determine the number of people who received two-parent benefits and total benefit amount for a given month. The programs are adjusted for cancellations and supplemental payments after the given month has ended.

BL 2010 Purpose

This measure provides the unit cost of one of the service components funded under this strategy. This unit cost is a useful tool for projecting future funding

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	EX	
Measure No.	1	% of Potential Eligible Population Receiving TANF/State Cash Assist

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of TANF recipients expressed as a percent of the state's population potentially eligible to receive TANF and State Two-Parent Cash Assistance benefits. The population potentially eligible for TANF is comprised of persons at or below 100% of poverty in families with children under age 18 who are deprived of parental support due to the absence and/or disability of the parent(s). The population potentially eligible for State Two-Parent Cash Assistance is defined as persons at or below 100% of poverty in families with children under age 18 who are deprived of parental support due to the unemployment of the parent(s).

BL 2010 Data Limitations

The estimated potential eligible population is subject to change as a result of updates/revisions to the population estimates and projections. Migration from the agency's legacy system (SAVERR) to the TIERS environment could result in different data sources.

BL 2010 Data Source

Recipient data are from ad hoc runs against the Warrant history file (TP509260c). The population potentially eligible for TANF and State Two-Parent Cash Assistance is estimated using baseline information obtained from the last two March Current Population Surveys 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.

BL 2010 Methodology

Data are computed by totaling the number of TANF and State Two-Parent Cash Assistance recipients receiving benefits over all months in the reporting period and dividing by the number of months in the reporting period to determine the average monthly number of TANF and State Two-Parent Cash Assistance recipients. This result is divided by the number of persons potentially eligible for TANF, and then multiplied by 100 to obtain the percent of potentially eligible population receiving TANF and State Two-Parent Cash Assistance.

BL 2010 Purpose

This measure is an expression of the impact the agency is having on reaching and serving the population potentially eligible to receive TANF and State Two-Parent Cash Assistance grant services. It is an indicator of the percent of need being met.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	1	Average Number of TANF Recipients Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of persons who received a TANF grant during the reporting period. The TANF program provides a monthly financial assistance payment to low income families with children and with no or one certified parent.

BL 2010 Data Limitations

State and Federal Legislation impacting this measure include: Time-limited benefits and other provisions of House Bill 1863, passed by the 74th Texas Legislature; federal 60 month time limits; HB-1 passed by the 76th Texas Legislature changed the earned income deductions for employed TANF families; HB-2292 of 78th Texas Legislature implemented a full family sanction for families out of compliance with the Personal Responsibility Agreement.

BL 2010 Data Source

Data are obtained from ad hoc runs against the "TANF Warrant History" file: TP509260c, which is downloaded from the mainframe to a local server/computer.

BL 2010 Methodology

The Number of TANF Recipients for each month in the reporting period are totaled (numerator) and then divided by the number of months in the reporting period (denominator). Recipients are counted in each month they receive a grant; hence, this measure does not report an unduplicated count of recipients over

BL 2010 Purpose

This measure shows the number of Texans impacted by the agency's performance in implementing the provisions of this strategy. It provides a count of persons receiving the service component for which the majority of funding is appropriated under this strategy. The data is an indicator of service demand and workload, and is a useful tool for projecting future funding needs. It is also information frequently requested by legislators and the public.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	2	Avg Number of State Two-Parent Cash Assist Recipients Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of persons who received a State Two-Parent Cash Assistance Program grant during the reporting period. The State Two-Parent Cash Assistance program provides a monthly financial assistance payment to eligible families with two certified adults.

BL 2010 Data Limitations

State and Federal Legislation impacting this measure includes: 77th Texas Legislature: HB-1005 created a state funded TANF program for families with 2 certified adults. Oct 01, TANF families w 2 certified adults were moved to the new TANF state funded program (formerly TANF-UP). TANF families with no or 1 certified adult were moved to TANF; 78th Texas Legislature: HB2292 requiring denial of the TANF case if any Personal Responsibility Agreement requirement was not met and lowering the exemption amount for vehicles from $15,000 to$4,650. 79th Texas Legislature changed funding from TANF-MOE to State General Revenue.

BL 2010 Data Source

Data are obtained from ad hoc runs against the 'TANF Warrant History' file: TP509260, which is downloaded from the agency mainframe to a local server.

BL 2010 Methodology

The Number of State Two-Parent Cash Assistance Program Recipients for each month in the reporting period are totaled (numerator) and then divided by the number of months in the reporting period (denominator). Recipients are counted in each month they receive a grant; hence, this measure does not reflect an unduplicated count of recipients over time.

BL 2010 Purpose

This measure shows the number of Texans impacted by the agency's performance in implementing the provisions of this strategy. It provides a count of persons receiving one of the service components for which funding is appropriated under this strategy. The data is an indicator of service demand and workload, and is a useful tool for projecting future funding needs. It is also information frequently requested by legislators and the public.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	3	Average Number of TANF One-time Payments Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

Reports # of one-time (OT) payments per month in lieu of TANF/State Two-Parent Cash Assistance. TANF OT provides a $1000 emergency cash payment to families not receiving TANF/two-parent benefits and who meet all TANF eligibility requirements. Families are then ineligible for TANF/two-parent or 2nd OT pmt for 12 months. Children who leave family that received OT benefit are ineligible for TANF/two-parent for the month. The benefit was paid, but may be eligible if in a separate family that has not received a OT benefit. In month payment is made & 12 month ineligibility period, family is not subject to time limits. Families must meet all TANF requirements and at least one of the crisis criteria as outlined in the Texas Works Handbook.

BL 2010 Data Limitations

Migration from the agency's legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Data are obtained from ad hoc runs against the 'TANF Warrant History' file: TP509260, which is downloaded from the agency mainframe to a local server

BL 2010 Methodology

Data are computed by summing the number of TANF One-time payments in all months of the reporting period and dividing by the number of months in the reporting period to obtain the average number of payments per month.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons receiving one of the service components for which funding is appropriated under this strategy. This data is useful for projecting caseloads and future

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	4	Number of Children Receiving $30 Once a Year Grant

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of children who received the once-a-year grant of $30 per child. Children are eligible to receive this grant if they were eligible to receive TANF or State Two-Parent Cash Assistance benefits for the month of August. The amount of the once-a-year grant is defined in HB-1, Article II, Rider 31 of the 77th Regular Session of the Texas Legislature.

BL 2010 Data Limitations

Migration from the agency legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Data are obtained from ad hoc runs against the "TANF Warrant History" file: TP509260, which is downloaded from the agency mainframe to a local server

BL 2010 Methodology

An ad hoc report will provide a count of children who received the once-a-year grant.

BL 2010 Purpose

This measure shows the number of children in Texas impacted by the funds appropriated in this strategy for a once-a-year grant that is to be provided each August to assist TANF and two-parent families purchase school clothes and supplies. This data is a useful tool for projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	5	Average Monthly Number of TANF Grandparent Payments

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of TANF One-time Grandparent payments made during the reporting period. The 76th session of the Texas Legislature authorized the department to provide assistance payments to qualified grandparents on behalf of dependent children. The eligible grandparent population was expanded by SB297 of the 77th Legislature to include grandparents age 45 and older with an income of 200% of poverty or under.

BL 2010 Data Limitations

Data are from actual TANF One-time Grandparent payment records, not a sample. Corrections to the data are applied retrospectively. Only one TANF One-time Grandparent payment is counted per TANF Grandparent case. Migration from the legacy system to the new TIERS environment could result in different

BL 2010 Data Source

TANF One-time Grandparent payment data are from the agency's Client Server Support System Grandparent Payment System database. Data are sent from field staff to a centralized data entry unit. A copy of the database is made available monthly for analysis. A computer program is run which aggregates the number of payments for each month.

BL 2010 Methodology

The number of monthly TANF Grandparent payments is summed for all months in the reporting period. The total number of TANF One-time Grandparent payments made during the reporting period is divided by the number of months in the reporting period to determine the average per month.

BL 2010 Purpose

This measure provides decision makers with information on the utilization of TANF One-time Grandparent payments, which were mandated by SB 1423 of the 76th Texas Legislature and SB297 of the 77th Texas Legislature.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	6	Avg # TANF/State Cash Adults Per Month w/ State Time-limited Benefits

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the average number of adults receiving TANF or State Two-Parent Cash Assistance in the month who have used one or more state time-limited months. The term "time-limited" refers to the maximum length of time that a client is eligible to receive benefits. State time-limits are determined based on education, functional literacy and work history, and are for 12, 24,or 36 months.

BL 2010 Data Limitations

Mandatory clients (those w/o employment services exemptions or good cause for not participating) begin using their state time-limited benefits 1 mo. after they are contacted by TX Workforce Comm. (TWC) or a local entity directly or indirectly under contract with TWC for participation in the Choices prgm if they have a 12 or 24 mo. limit. Clients with a 36-mo. limit are given 12 mos. before their state time-limited benefits begin, to correct basic educational deficiencies. All of these clients continue to use state time-limited benefits unless they are given good cause not to participate, move outside the area served by the Choices prgm, their Choices case is closed, or they cease receiving TANF or State Two-Parent Cash Asst. Exempt clients who participate in the Choices program use their state time-limited benefits only in the months in which they participate in Choices. Migration from the legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Data are obtained from computer runs using monthly SAVERR strip files'TP550100CN. This file has the number of months that are counted toward a person's state time limit.

BL 2010 Methodology

Data are calculated by adding the monthly number of TANF and State Two-Parent Cash Assistance adults who have used one or more state time-limited months, and dividing by the number of months in the reporting period. Data are unduplicated within the month.

BL 2010 Purpose

This measure quantifies the population at-risk of losing TANF funded financial assistance or State Two-Parent Cash Assistance due to the state time-limited eligibility criteria stipulated in recent state welfare reform laws. This data is a useful tool for projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	1	Temporary Assistance for Needy Families Grants
Measure Type	OP	
Measure No.	7	Avg # TANF/State Cash Adults/Month with Federal Time-limited Benefits

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the average number of adults receiving TANF or State Two-Parent Cash Assistance in the month who have used one or more time-limited months. The term "time-limited" refers to the maximum length of time that a client is eligible to receive benefits. TANF and State Two-Parent Cash Assistance programs allow a maximum of 60 months of benefits.

BL 2010 Data Limitations

All adult clients begin using their time-limited benefits effective October 1999 or their first month on TANF or State Two-Parent Cash Assistance, if later. Months counted toward the state time limit from November1996 through September 1999 also count towards the 60-month time limit. Migration from the legacy system (SAVERR) to the new TIERS environment could result in different data sources.

BL 2010 Data Source

Data are obtained from computer runs using monthly SAVERR strip files-- TT005400, TP550100CN, TP687500.

BL 2010 Methodology

Data are calculated by summing for all months of the reporting period, the monthly number of TANF and State Two-Parent Cash Assistance adults who have used one or more 60 month time-limited months, and dividing by the number of months in the reporting period. Data are unduplicated within the month.

BL 2010 Purpose

This measure quantifies the population at-risk of losing TANF funded financial assistance or State Two-Parent Cash Assistance due to the 60-month time-limited eligibility criteria stipulated in recent federal welfare reform laws. This data is a useful tool for projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	2	Refugee Assistance
Measure Type	OP	
Measure No.	1	Number of Refugees Served

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-03 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of refugees receiving cash, medical or social services during the reporting period. Services include but are not limited to: employment services, English language instruction, vocational training, and health and emergency services. "Refugees" are individuals who are living outside their country of origin who cannot return to their homes due to fear of persecution based on their race, religion, or membership in a particular social/political

BL 2010 Data Limitations

This measure is calculated by merging two datasets (the publicly administered program for refugee medical assistance and the privatized program for cash and social services), which contain non-identical data elements. Because of this, some duplication in the data may occur. Additionally, with certain federal grants, contractor data are not included in the program's automated system. In such cases, data are collected and reported manually through quarterly reports.

BL 2010 Data Source

There are two sources of data for this measure. The first source is the Refugee Data Center, an on-line automated intake system which records the number of refugees receiving cash assistance and/or social services through contractors. The HHSC refugee program maintains this system. The second source is an HHSC-generated monthly spreadsheet identifying those refugees eligible for medical assistance.

BL 2010 Methodology

Data from the two sources are merged and duplicates eliminated to identify the number of refugees receiving one or more of the services (cash assistance, medical assistance, or social services) funded by this agency in the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons receiving one of the services funded under this strategy.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	1	Assistance Services
Strategy No.	3	Disaster Assistance
Measure Type	OP	
Measure No.	1	Number of Applications Approved

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-01-04 OP

Fall/Annual: N

BL 2010 Definition

Reports unduplicated number of applications for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) that were approved for a grant for a presidentially declared disaster. The maximum grant is $25,600 for each individual/household, and is adjusted annually. Grants are provided for disaster-related serious needs and necessary expenses not met by the victim's insurance, the Red Cross or other relief organizations. For property losses, the victim must be denied loan assistance by the Small Business Administration. IHP grants may consist of Housing Assistance provided directly by FEMA and Other Needs Assistance (for repair or replacement of personal property and vehicles or for medical or funeral assistance) provided by HHSC. Victims must apply for assistance within 60 days after the President declares a major disaster.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from reports on applications approved from the Disaster Assistance Reporting Information System (DARIS), which interfaces with the federal National Emergency Management Information System (NEMIS).

BL 2010 Methodology

Reported data are computed as follows: The number of applications approved is summed for each state fiscal year based either on the month of payment or the date the disaster is declared as determined for each disaster by HHSC executive leadership.

BL 2010 Purpose

This measure is a mechanism for assessing in the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the services delivered.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	1	Family Violence Services
Measure Type	EF	
Measure No.	1	HHSC Average Cost Per Person Receiving Family Violence Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the HHSC average cost per client receiving shelter services, non-residential services or both and the average cost per client receiving both services. "Shelter" is 24-hour-a-day temporary emergency residence provided in a secure location. Shelter for victims of family violence includes the following services: Emergency medical care, counseling services, emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources. "Non-resident services" refers to the delivery of the following in a non-live-in environment: Counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison, and information and referral to other resources.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence providers. Client services is defined as Residential and Non-residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2010 Methodology

Data are computed by taking the total available dollar amount (numerator), and dividing by the number of clients served (denominator).

BL 2010 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	1	Family Violence Services
Measure Type	EX	
Measure No.	1	Number of Women Battered in the Last 12 Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-02-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the estimated number of women battered during the last 12 months.

BL 2010 Data Limitations

The estimated number of women ages 18 or older is subject to change as a result of updates/revisions to the population data. Also, data source #1 noted below is based on a 1989 study.

BL 2010 Data Source

Data are based on the following two sources: 1) Domestic Violence in Texas: A Study of Statewide and Rural Spouse Abuse conducted by Grant, Preda, and Martin, 1989. This study estimates that the number of women over age 18 experiencing physical abuse as 8.8% and sexual abuse as 2.6%, combined for 11.4%. 2) The estimated number of women ages 18 and older is obtained from the population estimates and projections program of the Texas State Data

BL 2010 Methodology

Data are calculated by applying the proportion of women over age 18 who are expected to experience abuse, 11.4%, to the current estimate of Texas females ages 18 and older.

BL 2010 Purpose

This measure demonstrates the level of need for domestic violence services in Texas.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	1	Family Violence Services
Measure Type	EX	
Measure No.	2	Percent of Family Violence Program Budgets Funded by HHSC

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-02-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average percent of the cost of centers providing family violence services which is funded by HHSC.

BL 2010 Data Limitations

The total amount of funding available is the entire HHSC Family Violence client services allocation.

BL 2010 Data Source

The allocation amount and the projected total resources to the centers for providing family violence services are recorded on the approved budget submitted by the family violence center.

BL 2010 Methodology

Data are computed by taking the total amount of HHSC funding to centers (numerator), and dividing by the sum of the total amount of HHSC funding to centers and the total amount of other resources the centers apply to the shelter/program (denominator).

BL 2010 Purpose

This measure is important because it indicates the impact of funding appropriated to the agency on the operating budget of domestic violence centers that contract with the agency.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	1	Family Violence Services
Measure Type	OP	
Measure No.	1	Number of Women & Children Served by Family Violence Programs/Shelters

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-02-01 OP

Fall/Annual: N

BL 2010 Definition

Reports number of victims of family violence and their children who receive shelter, non-residential services, and clients who receive both services from family violence programs/shelters that contract with the state. "Shelter", as defined in the Texas Health and Human Services Dictionary of Services and Facilities, is 24-hour a day temporary emergency residence provided in a secure location. Shelter for victims of family violence includes the following services: emergency medical care, counseling services, emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources. Non-residential services may include counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison and information and referral to other resources. "Non-residential services" is the delivery of all of the above services in a non-live-in environment.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program.

BL 2010 Methodology

The automated system computes an unduplicated count of the number of persons who received residential and non-residential services during the months of the reporting period.

BL 2010 Purpose

This measure provides caseload information for this strategy. It provides a count of the total number of persons receiving services.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	1	Family Violence Services
Measure Type	OP	
Measure No.	2	Number of Participating Family Violence Programs/Shelters

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of Residential and Non-residential programs contracting with the state to provide family violence services. "Residential and Non-residential programs" are community-based, non-profit agencies that contract with the state to provide services to victims of family violence.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from a count of current residential and non-residential programs that are funded by the HHSC Family Violence Program.

BL 2010 Methodology

The number of residential and non-residential programs are counted at the end of the reporting period.

BL 2010 Purpose

This measure is an indicator of the availability of domestic violence services funded by this agency.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	1	Family Violence Services
Measure Type	OP	
Measure No.	3	Number of Hotline Calls

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 04-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of hotline calls from or about victims of family violence received by family violence programs/shelters that contract with HHSC. Hotline calls are calls made to a telephone number that is answered by trained shelter center volunteer(s), staff, or HHSC-approved service contractors in which immediate intervention through safety planning (assessing for danger); understanding and support; information, education, and referrals to victims of family violence is provided twenty-four hours a day, every day of the year.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program.

BL 2010 Methodology

The automated system computes a count of the number of hotline calls received during the months of the reporting period by family violence programs/shelters that contract with HHSC.

BL 2010 Purpose

This measure demonstrates the level of hotline services needed.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	2	Alternatives to Abortion. Nontransferable.
Measure Type	OP	
Measure No.	1	Number of Persons Receiving Services as Alternative to Abortion

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 04-02 OC 02

Fall/Annual: N

BL 2010 Definition

This measure report the number of clients who receive services for an alternative to abortion.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Numbers are based on data collected from service vendor.

BL 2010 Methodology

Cold count of clients actually served in current fiscal year.

BL 2010 Purpose

This measure is an indicator of the total number of clients who have received services as an alternative to abortions.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	3	Healthy Marriages
Measure Type	EF	
Measure No.	1	Average Cost Per Healthy Marriage Grant

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

Fall/Annual: N

BL 2010 Definition

The average amount awarded through grant contracts and subcontracts to local and community based organizations for capacity building and pre-marital and healthy marriage services to couples.

BL 2010 Data Limitations

None

BL 2010 Data Source

Program contract database, website and copies of contracts and subcontracts

BL 2010 Methodology

The sum of the amount of all funds awarded by HHSC divided by the number of healthy marriage grant contracts and subcontracts awarded during the reporting period. The measure will exclude funding awarded to sub-contractors in order to avoid double-counting the funds. The data will be obtained using standard data collection protocols. The annual amount of all existing awards will be counted in the first quarter and new ones will be added to the cumulative total in subsequent quarters. The denominator is the data in measure 4-2-3-OP-1.

BL 2010 Purpose

To provide information on the dispersal of program funds for capacity building and services to couples throughout the state.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	4	Encourage Self Sufficiency
Objective No.	2	Other Family Support Services
Strategy No.	3	Healthy Marriages
Measure Type	OP	
Measure No.	1	Average Number of Healthy Marriage Grants Awarded

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

Fall/Annual: N

BL 2010 Definition

The number of grant contracts and subcontracts awarded to local and community based organizations for capacity building and pre-marital and healthy marriage services to couples.

BL 2010 Data Limitations

None

BL 2010 Data Source

Program contract database, website and copies of contracts and subcontracts

BL 2010 Methodology

A count of the number of healthy marriage grant contracts and subcontracts awarded during the year will be obtained using standard data collection protocols. All existing awards will be counted in the first quarter and new ones will be added to the cumulative total in subsequent quarters.

BL 2010 Purpose

To provide information on the dispersal of program operators for capacity building and services to couples throughout the state.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	EF	
Measure No.	1	Average $ Recovered & Saved/Completed Investigation, Review and Audit

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

This is the measure of the average dollars recovered and saved per completed provider and recipient investigations, completed hospital and nursing facility reviews, and completed audits.

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

OIG case management systems and activity summary sheets. Staff in OIG enters information on dollars recovered and saved into data bases. Data is collected on a monthly basis and is maintained by OIG staff.

BL 2010 Methodology

This measure is calculated by adding the dollars recovered and dollars saved and dividing by the number of investigations, reviews, and audits completed during the same reporting period.

BL 2010 Purpose

This measure addresses how efficiently the Office of Inspector General is completing investigations, reviews and audits.

BL 2011 Definition

This is the measure of the average dollars recovered and saved per completed provider and recipient investigations, completed hospital and nursing facility reviews, and completed audits.

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

OIG case management systems and activity summary sheets. Staff in OIG enters information on dollars recovered and saved into data bases. Data is collected on a monthly basis and is maintained by OIG staff.

BL 2011 Methodology

This measure is calculated by adding the dollars recovered and dollars saved and dividing by the number of investigations, reviews, and audits completed during the same reporting period.

BL 2011 Purpose

This measure addresses how efficiently the Office of Inspector General is completing investigations, reviews and audits.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	EX	
Measure No.	1	Medicaid Providers Excluded

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 EX 01

Fall/Annual: N

BL 2010 Definition

This is a measure of the total number of providers excluded from the Medicaid program as a result of activities of the Office of Inspector General (OIG), the U. S. Health and Human Services Department's Office of Inspector General, licensure board actions, and/or court actions/convictions.

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

Case management system maintained by OIG.

BL 2010 Methodology

A sum of exclusions imposed as the result of OIG activities, activities of the Office of Inspector General of USHHS, licensure board actions, and/or court actions/convictions.

BL 2010 Purpose

This measure addresses activities taken by OIG to protect the integrity of the Medicaid program and assure quality medical care to Medicaid recipients.

BL 2011 Definition

This is a measure of the total number of providers excluded from the Medicaid program as a result of activities of the Office of Inspector General (OIG), the U. S. Health and Human Services Department's Office of Inspector General, licensure board actions, and/or court actions/convictions.

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

Case management system maintained by OIG.

BL 2011 Methodology

A sum of exclusions imposed as the result of OIG activities, activities of the Office of Inspector General of USHHS, licensure board actions, and/or court actions/convictions.

BL 2011 Purpose

This measure addresses activities taken by OIG to protect the integrity of the Medicaid program and assure quality medical care to Medicaid recipients.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	1	Number of Provider and Recipient Investigations

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the Medicaid Program Integrity (MPI) and the General Investigations sections of Office of Inspector General (OIG) that is responsible for investigating allegations, complaints, and referrals of Medicaid, TANF, and Food Stamp fraud, abuse, or waste.

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

OIG case management systems.

BL 2010 Methodology

The total unduplicated number of full-scale investigations that are closed during the reporting period. It is based on allegations, complaints, and referrals of fraud, abuse, or waste that are reflected in the OIG case management systems.

BL 2010 Purpose

This measures the effectiveness of a major activity of OIG. House Bill 2292, 78th Legislature, charged HHSC (OIG) with the investigation and enforcement of fraud, abuse, or waste in health and human services programs.

BL 2011 Definition

This is a measure of the Medicaid Program Integrity (MPI) and the General Investigations sections of Office of Inspector General (OIG) that is responsible for investigating allegations, complaints, and referrals of Medicaid, TANF, and Food Stamp fraud, abuse, or waste.

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

OIG case management systems.

BL 2011 Methodology

The total unduplicated number of full-scale investigations that are closed during the reporting period. It is based on allegations, complaints, and referrals of fraud, abuse, or waste that are reflected in the OIG case management systems.

BL 2011 Purpose

This measures the effectiveness of a major activity of OIG. House Bill 2292, 78th Legislature, charged HHSC (OIG) with the investigation and enforcement of fraud, abuse, or waste in health and human services programs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	2	Number of Audits Performed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measures the total number of programmatic and financial audits and reviews of HHS programs conducted for compliance by the Office of Inspector General. An audit is a financial review conducted and reported in accordance with Governmental Auditing Standards. A review is a financial review not in accordance with Governmental Auditing Standards. This includes desk reviews and site visits, single audit report reviews, investigative reviews, and other contract reviews. Internal audits conducted by Internal Audit departments and in accordance with the Institute of Internal Auditors Standards are not included.

BL 2010 Data Limitations

None.

BL 2010 Data Source

OIG case management systems.

BL 2010 Methodology

Total sum of audits and reviews conducted.

BL 2010 Purpose

To measure audits represents a positive approach to review funded HHS programs.

BL 2011 Definition

This measures the total number of programmatic and financial audits and reviews of HHS programs conducted for compliance by the Office of Inspector General. An audit is a financial review conducted and reported in accordance with Governmental Auditing Standards. A review is a financial review not in accordance with Governmental Auditing Standards. This includes desk reviews and site visits, single audit report reviews, investigative reviews, and other contract reviews. Internal audits conducted by Internal Audit departments and in accordance with the Institute of Internal Auditors Standards are not included.

BL 2011 Data Limitations

None.

BL 2011 Data Source

OIG case management systems.

BL 2011 Methodology

Total sum of audits and reviews conducted.

BL 2011 Purpose

To measure audits represents a positive approach to review funded HHS programs.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	3	Number of Nursing Facility Reviews

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the number of case mix reviews which are either on-site or desk reviews to assure nursing facilities submit accurate data which reflects actual resident conditions.

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

Nurse reviewers and/or administrative technicians in the field enter into the agency's database information collected during the on-site reviews. State office staff collects and accumulates information from all regions in a centralized tracking system.

BL 2010 Methodology

Nurse reviewers enter data in the field indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2010 Purpose

Case mix reviews determine the level of care provided by nursing facilities to Medicaid residents and the relationship of such care to the charges (billing) to the state. Case mix reviews also determine the need for corrective action procedures and/or referral to Medicaid Program Integrity.

BL 2011 Definition

This is a measure of the number of case mix reviews which are either on-site or desk reviews to assure nursing facilities submit accurate data which reflects actual resident conditions.

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

Nurse reviewers and/or administrative technicians in the field enter into the agency's database information collected during the on-site reviews. State office staff collects and accumulates information from all regions in a centralized tracking system.

BL 2011 Methodology

Nurse reviewers enter data in the field indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2011 Purpose

Case mix reviews determine the level of care provided by nursing facilities to Medicaid residents and the relationship of such care to the charges (billing) to the state. Case mix reviews also determine the need for corrective action procedures and/or referral to Medicaid Program Integrity.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	4	Number of Hospital Utilization Reviews

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of utilization reviews, which are on-site reviews of a statistically valid, random, sample of hospital medical records for admissions, readmission, outliers, transfers, appropriate DRG, and quality of care. The purpose of utilization review is to detect and correct improper Medicaid billing

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

Nurse reviewers and/or administrative technicians in the field enter into the agency's database information collected during the on-site review of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

BL 2010 Methodology

Nurse reviewers enter data in the field indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2010 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the Diagnoses Related Groups (DRG) assignments, the quality of patient care, and recover inappropriate Medicaid payments. Inpatient utilization reviews are required by public Law 92-603 to be conducted in all Title XIX participating hospitals.

BL 2011 Definition

This is a measure of utilization reviews, which are on-site reviews of a statistically valid, random, sample of hospital medical records for admissions, readmission, outliers, transfers, appropriate DRG, and quality of care. The purpose of utilization review is to detect and correct improper Medicaid billing

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

Nurse reviewers and/or administrative technicians in the field enter into the agency's database information collected during the on-site review of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

BL 2011 Methodology

Nurse reviewers enter data in the field indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2011 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the Diagnoses Related Groups (DRG) assignments, the quality of patient care, and recover inappropriate Medicaid payments. Inpatient utilization reviews are required by public Law 92-603 to be conducted in all Title XIX participating hospitals.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	5	Total Dollars Recovered (Millions)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the total monetary recoveries resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Recoveries include all departments within OIG: Quality Review, Information Technology, Audit, Medicaid Program Integrity, and General Investigations and

BL 2010 Data Limitations

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

BL 2010 Data Source

The sources of data are the OIG case management systems and the claims administrator system and databases. OIG staff collects data on recoveries on a monthly basis, entering the information in the appropriate system and/or database.

BL 2010 Methodology

The sum of dollars recovered by each section of OIG for the reporting period.

BL 2010 Purpose

This measure addresses the efforts of OIG to maximize recoveries in all HHS program. HB 2292, requires that the Commission, through OIG, coordinate investigative efforts to aggressively recover money.

BL 2011 Definition

This is a measure of the total monetary recoveries resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Recoveries include all departments within OIG: Quality Review, Information Technology, Audit, Medicaid Program Integrity, and General Investigations and

BL 2011 Data Limitations

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

BL 2011 Data Source

The sources of data are the OIG case management systems and the claims administrator system and databases. OIG staff collects data on recoveries on a monthly basis, entering the information in the appropriate system and/or database.

BL 2011 Methodology

The sum of dollars recovered by each section of OIG for the reporting period.

BL 2011 Purpose

This measure addresses the efforts of OIG to maximize recoveries in all HHS program. HB 2292, requires that the Commission, through OIG, coordinate investigative efforts to aggressively recover money.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	6	Total Dollars Saved (Millions)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the total dollars saved (cost savings) resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Cost savings, or dollars saved, are defined as documented savings to the state programs. Cost savings may arise from administrative actions/sanctions against a provider or recipient, policy changes initiated at the behest of OIG, and/or education efforts to providers, recipients, consultants, contractors, and

BL 2010 Data Limitations

OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.

BL 2010 Data Source

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the Office of Inspector General State Action Requests (SAR's) tracking
system; OIG's policy development tracking systems; OIG's training and education databases; and the claims administrator, TMHP. Data is collected on an

BL 2010 Methodology

The effect of actions taken by OIG is measured against claims payments by the claims administrator and/or other sources during the reporting period. The sum of cost savings is then calculated for the reporting period.

BL 2010 Purpose

This measure addresses the effectiveness of the Office of Inspector General (OIG). It addresses the efforts of OIG in the area of administrative actions and sanctions, policy recommendations and development, and effective education of providers.

BL 2011 Definition

This is a measure of the total dollars saved (cost savings) resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Cost savings, or dollars saved, are defined as documented savings to the state programs. Cost savings may arise from administrative actions/sanctions against a provider or recipient, policy changes initiated at the behest of OIG, and/or education efforts to providers, recipients, consultants, contractors, and

BL 2011 Data Limitations

OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.

BL 2011 Data Source

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the Office of Inspector General State Action Requests (SAR's) tracking
system; OIG's policy development tracking systems; OIG's training and education databases; and the claims administrator, TMHP. Data is collected on an

BL 2011 Methodology

The effect of actions taken by OIG is measured against claims payments by the claims administrator and/or other sources during the reporting period. The sum of cost savings is then calculated for the reporting period.

BL 2011 Purpose

This measure addresses the effectiveness of the Office of Inspector General (OIG). It addresses the efforts of OIG in the area of administrative actions and sanctions, policy recommendations and development, and effective education of providers.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	7	Referrals to OAG Fraud Control Unit

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the number of cases of suspected Medicaid provider fraud that are referred to and accepted by the Office of the Attorney General (OAG) for

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

OIG case management system. All referrals made to the Office of the Attorney General are entered into the case management system and collected on a monthly basis. Upon acceptance of a referral for investigation, the Office of the Attorney General notifies OIG through a letter of acceptance. OIG staff enters and maintains the status of the referral into the case management system.

BL 2010 Methodology

Sum of cases referred to and accepted by the Office of the Attorney General during the reporting period.

BL 2010 Purpose

This measure identifies the effectiveness of the Office of Inspector General in promptly and accurately identifying and referring cases of Medicaid fraud suitable for criminal or civil prosecution.

BL 2011 Definition

This is a measure of the number of cases of suspected Medicaid provider fraud that are referred to and accepted by the Office of the Attorney General (OAG) for

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

OIG case management system. All referrals made to the Office of the Attorney General are entered into the case management system and collected on a monthly basis. Upon acceptance of a referral for investigation, the Office of the Attorney General notifies OIG through a letter of acceptance. OIG staff enters and maintains the status of the referral into the case management system.

BL 2011 Methodology

Sum of cases referred to and accepted by the Office of the Attorney General during the reporting period.

BL 2011 Purpose

This measure identifies the effectiveness of the Office of Inspector General in promptly and accurately identifying and referring cases of Medicaid fraud suitable for criminal or civil prosecution.

Agency Code: **529** Agency: **Health and Human Services Commission**

Goal No.	7	Office of Inspector General
Objective No.	1	Client and Provider Accountability
Strategy No.	1	Office of Inspector General
Measure Type	OP	
Measure No.	8	Cases: Fraud and Abuse System

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 080-R-S70-1 07-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the number of viable cases identified by MFADS through the use of neural and/or learning technology. The MFADS uses neural models and fraud
detection algorithms to identify suspect cases of fraud, waste, or abuse for investigation by OIG. A case is an initiation of action against a Medicaid provider to

BL 2010 Data Limitations

No limitations.

BL 2010 Data Source

The OIG case management system.

BL 2010 Methodology

The sum of cases identified by the MFADS during the reporting period.

BL 2010 Purpose

Senate Bill 30, 75th Legislature, mandates that the Commission use learning or neural network technology to identify suspect cases of fraud, waste, or abuse for investigation.

BL 2011 Definition

This is a measure of the number of viable cases identified by MFADS through the use of neural and/or learning technology. The MFADS uses neural models and fraud
detection algorithms to identify suspect cases of fraud, waste, or abuse for investigation by OIG. A case is an initiation of action against a Medicaid provider to

BL 2011 Data Limitations

No limitations.

BL 2011 Data Source

The OIG case management system.

BL 2011 Methodology

The sum of cases identified by the MFADS during the reporting period.

BL 2011 Purpose

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 Facilities with a Certified Ombudsman

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 01-01 OC 01

BL 2010 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 2010 Data Limitations

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

BL 2010 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 2010 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 2010 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 Individuals Serv Per Mth: Total Community Services & Supports

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 01-01 OC 02

BL 2010 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., 1.3.7., 1.4.2., 1.4.4., 1.4.5, 1.5.1., and 1.6.4. Output measure 2 from strategy 1.4.2 and explanatory measure 2 from strategy 1.4.1 are

BL 2010 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., 1.3.7., 1.4.2., 1.4.4., 1.4.5., 1.5.1., and 1.6.4, output measure 2 of strategy 1.4.2 and explanatory measure 2 of strategy 1.4.1.

BL 2010 Data Source

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

BL 2010 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, 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 individuals with mental retardation (MR) receiving community, residential, and MR In-Home services.

BL 2010 Purpose

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

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 539 080-R-S70-1 01-01 OC 03

BL 2010 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 2010 Data Limitations

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

BL 2010 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 2010 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 2010 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 Individuals Served in Community Settings

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 01-01 OC 04

BL 2010 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 individuals 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 individuals 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 individuals receiving Medicaid-funded nursing facility services/month (strategy 1.6.1 output 1), the avg # of individuals receiving co-paid Medicaid/Medicare nursing facility services/month (strategy 1.6.2. output 1), the avg # of individuals 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 2010 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 2010 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 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the extent to which the agency's Long-term Services and Supports individuals 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 # Individ Deinstitutional/Diverted from Instituti Settings per Mth

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** **Cross Reference:** Agy 539 080-R-S70-1 01-01 OC 05

BL 2010 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 facility stay must have been eligible for reimbursement by Medicaid. The number of deinstitutionalized or diverted individuals is the total average number of Medicaid waiver individuals 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 individuals served per month (output measure 1 of strategy 1.6.4.).

BL 2010 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 2010 Data Source

Individuals 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 individuals 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 individuals 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 1.6.4.

BL 2010 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 2010 Purpose

This measure partially quantifies DADS' success in its "Promoting Independence" efforts. As individuals 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

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.	6	Percent LTC Ombudsman Complaints Resolved or Partially Resolved

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 01-01 OC 01

BL 2010 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 2010 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 2010 Data Source

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

BL 2010 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 2010 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 **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 01-02 OC 01

BL 2010 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 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 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 2010 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 2010 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/Individual: Medicaid Non-waiver Commity Svc & Supports

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 01-02 OC 02

BL 2010 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 2010 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 2010 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

BL 2010 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 2010 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 Individuals Serv Per Mth: Community Serv/Supp Waivers (Total)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 01-03 OC 01

BL 2010 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; Consolidated Waiver –1.3.6; and Texas Home Living Waiver –1.3.7.

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 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 **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 01-03 OC 02

BL 2010 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; Consolidated Waiver –1.3.6; Texas Home Living Waiver –1.3.7.

BL 2010 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 2010 Data Source

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

BL 2010 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 2010 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 **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 01-04 OC 01

BL 2010 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 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, specialize therapies and In-home and Family Support.

BL 2010 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 1.4.4 and 1.4.5, output 2 under strategy 1.4.2 and explanatory measure 2 under strategy 1.4.1.

BL 2010 Data Source

Specific data sources are detailed under each of the measures that comprise this "roll-up" measure. See output measure 1 under strategies 1.4.4 and 1.4.5, output measure 2 under strategy 1.4.2, and explanatory measure 2 under strategy 1.4.1.

BL 2010 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 2010 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/Individual Served: Total Non-Medicaid Commity Serv/Supp

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 01-04 OC 02

BL 2010 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 2010 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, 4, 5, and efficiency measures 1 and 2 of strategy 2, of this objective.

BL 2010 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 2010 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 2010 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 539 080-R-S70-1 01-04 OC 03

BL 2010 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 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” measure.

BL 2010 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 2010 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 2010 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 2010 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 539 080-R-S70-1 01-06 OC 01

BL 2010 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 daily living.

BL 2010 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 2010 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 2010 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 2010 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 **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 539 080-R-S70-1 01-06 OC 02

BL 2010 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 2010 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 2010 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 2010 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 2010 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: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 01-08 OC 01

BL 2010 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 2010 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 2010 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 state mental retardation campus-based facilities enter the annual review recommendations into the department's CARE system.

BL 2010 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 individuals placed in community during the fiscal year. The formula is numerator/denominator.

BL 2010 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	MR State Schools Services
Outcome No.	2	Number of Individuals with MR Who Moved from Campus to Community

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 01-08 OC 02

BL 2010 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 2010 Data Limitations

None

BL 2010 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 facility.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	2	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 539 080-R-S70-1 02-01 OC 01

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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

BL 2010 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 539 080-R-S70-1 02-01 OC 02

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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 2010 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 539 080-R-S70-1 02-01 OC 03

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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 2010 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 **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 02-01 OC 04

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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 2010 Purpose

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

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

Goal No.	2	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 539 080-R-S70-1 02-01 OC 05

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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.

BL 2010 Purpose

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

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

Goal No.	2	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 539 080-R-S70-1 02-01 OC 06

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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 2010 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 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 539 080-R-S70-1 02-01 OC 07

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 Data Source

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

BL 2010 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 2010 Purpose

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

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

Goal No.	2	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: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 02-01 OC 08

BL 2010 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 2010 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 2010 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 2010 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 2010 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 **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 539 080-R-S70-1 02-01 OC 09

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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 2010 Purpose

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

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

Goal No.	2	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 539 080-R-S70-1 02-01 OC 10

BL 2010 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 2010 Data Limitations

Does not apply.

BL 2010 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 2010 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

BL 2010 Purpose

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

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

Goal No.	2	1	Long-Term Services and Supports
Objective No.	1	1	Intake, Access, and Eligibility
Strategy No.	11	1	Intake, Access, and Eligibility to Services and Supports
Measure Type		EF	
Measure No.		1	Statewide Average Cost Per Care Coordination Client

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 539 080-R-S70-1 02-01 OC 11

BL 2010 Definition

This is a measure of the statewide average cost per individual provided care coordination, exclusive of the cost of services brokered or procured for the viewed in the context of its confidence interval.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure identifies the statewide average State Unit on Aging (DADS) cost per care coordination individual.

Goal No.	2	1	Long-Term Services and Supports
Objective No.	1	1	Intake, Access, and Eligibility
Outcome No.	11	1	% Residents Care Has Been Improved through Evidence-based Practices

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EF 01

Fall/Annual: N

BL 2010 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 2010 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 2010 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 2010 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 2010 Purpose

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
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	EF	
Measure No.	2	Statewide Average Cost Per Person Receiving Legal Assistance

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EF 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

Data for those persons for whom an intake form is completed are reported to the Department by area agencies on aging. The reported number of persons is the sum of persons reported from the area agencies on aging. Expenditures are reported by area agencies on aging and include accrued expenses.

BL 2010 Methodology

The average cost per legal assistance individual is calculated by dividing area agencies on aging expenditures used to provide legal assistance to persons age 60 or older by the unduplicated number of individuals receiving legal assistance services as reported to the Department by the area agencies on aging as funded by the State Unit on Aging (DADS).

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	EF	
Measure No.	3	Avg Mthly Cost Per Individual MR Receivg Assessment & Svc Coordination

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EF 03

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs the state each month, on average, to provide community assessment and service coordination mental retardation (MR) services to each individual regardless of age. It measures the Department of Aging and Disability Services' (DADS') appropriation authority cost per individual as defined by the companion output measure.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	EF	
Measure No.	4	Average Monthly Cost Per Case: Community Services and Supports

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EF 04

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost per community services and supports case. Costs include those associated with the functional eligibility and case coordination process.

BL 2010 Data Limitations

NA

BL 2010 Data Source

Two types of data are used to report this measure. The number of individuals to receive Community Services and Supports is obtained from the Department of Aging and Disability Services' (DADS') Service Authorization System (SAS) by means of ad hoc query. These raw individual counts by type of service are then multiplied by service specific weights to get a product or caseload equivalent. Data for direct costs are obtained from the department's Health and Human Services Administrative System (HHSAS) Financials. Primary Home Care and Medically Dependent Children Program nurses as well as Community Services and Supports Medically Dependent Children Program workers are included in the costs. Other sources used in the computation of this measure are identified under output measure 6.

BL 2010 Methodology

The sum of the Community Services and Supports and Community-based Alternatives functional eligibility and case coordination budget expended and cost pool data from Program Activity Code (PAC) 372 (CCAD Eligibility Determination), 377 (Nursing Facility Waiver Eligibility Determination), and 379 (Managed Care Program Support) for each of the months of the reporting period are divided by the sum of the number of persons determined eligible for Community Services and Supports in the months of the reporting period, and this is divided by the number of months in the reporting period to obtain the monthly cost per case.

BL 2010 Purpose

This measure is important because it is an indicator of the unit cost associated with implementing the provisions of this strategy as it pertains to providing DADS funded Community Services and Supports. This unit cost indicates the efficiency of DADS' operations and is a useful tool for projecting future funding

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
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	EX	
Measure No.	1	# Visits to Licensed Assisted Living Facilities by Certified Ombudsman

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EX 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

All visits to licensed Assisted Living Facilities by certified ombudsmen during the fiscal year will be included in this count.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is an explanation and identification of the level of effort by area agencies on aging in providing services to residents of licensed Assisted Living Facilities. This level of effort is identified by comparing the number of Assisted Living Facilities to the cumulative number of visits. The number of Assisted Living Facilities is identified in the Department of Aging and Disability Services (DADS) Regulatory Services Data Management section.

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
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	EX	
Measure No.	2	Total Expenditures for the Ombudsman Program

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EX 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Only expenditures reported by the area agencies on aging to the Department of Aging and Disability Services (DADS - the State Unit on Aging) on the quarterly report are included for this measure.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	EX	
Measure No.	3	Number of Assisted Living Facilities Visited By A Certified Ombudsman

Calculation Method: C **Key Measure: N** **New Measure: Y** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure identifies the cumulative, unduplicated number of licensed assisted living facilities visited by certified ombudsmen in the Long-Term Care (LTC) Ombudsman Program.

BL 2010 Data Limitations

All unduplicated visits to licensed assisted living facilities by certified ombudsmen during the fiscal year will be included in this count, as reported by local LTC Ombudsman Programs. This measure will only count one visit per assisted living facility.

BL 2010 Data Source

The number of visits to assisted living facilities is reported on a monthly basis by the local LTC Ombudsman Programs in the format specified by the Department of Aging and Disability Services (DADS).

BL 2010 Methodology

The calculation is the cumulative number of unduplicated visits to licensed assisted living facilities by certified ombudsmen.

BL 2010 Purpose

This measure is an explanation of the LTC Ombudsman Program coverage and advocacy efforts in licensed assisted living facilities. The measure provides information to decision-makers and state agency staff to recognize the scope of services provided by 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.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	OP	
Measure No.	1	Number of Certified Ombudsmen

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

The calculation is the total certified Ombudsmen listed on the quarterly active ombudsman list. The area agencies on aging report both the unduplicated number of active Ombudsmen for the quarter and for the fiscal year.

BL 2010 Purpose

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

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

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

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	OP	
Measure No.	3	Number of Persons Receiving Legal Assistance

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

Data for those persons for whom an intake form is completed are reported to the Department by area agencies on aging. The reported number of persons is the sum of persons reported from the area agencies on aging.

BL 2010 Methodology

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

BL 2010 Purpose

This measure indicates the amount of legal assistance services provided statewide by area agencies on aging.

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
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	OP	
Measure No.	4	Avg Mthly # Individuals w/MR Receiving Assessment & Serv Coordination

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated count of priority population eligible persons whose services are funded with the Department of Aging and Disability Services' (DADS') appropriation authority funds and who receive mental retardation (MR) community assessment and/or service coordination services. Assessment services are monthly services. Service coordination services may occur quarterly but are most frequently monthly services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period, regardless of how the services for the individuals were funded.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

To obtain the number of persons served with DADS appropriation authority funds, the numerator is the sum of the number of persons receiving MR assessment and/or service coordination services each month of the reporting period; the denominator is the number of months in the period. The formula is

BL 2010 Purpose

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

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
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	OP	
Measure No.	5	Average Number of Persons Eligible Per Month: Community Serv and Supp

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated monthly average number of individuals authorized by Community Services and Supports workers to receive one or more Community Services and Supports. These individuals (Income Eligible, Supplemental Security Income (SSI)) are eligible to receive the following services: Family Care, Primary Home Care, Meals Only, Day Activity and Health Services (DAHS) Only, Foster Care, Special Services to Persons with Disabilities, Residential Care, Emergency Response Services (ERS) Only, Medically Dependent Children Program, In-Home and Family Support, and Community-based Alternatives.

BL 2010 Data Limitations

Since a high percentage of individuals who receive meals, DAHS and/or ERS also receive other services, for Meals, DAHS and ERS, the monthly unduplicated average count of community services and supports individuals includes only those Meals, DAHS or ERS individuals who are not authorized to receive any other service. For services other than Meals, DAHS, or ERS, individuals are counted without regard to duplication.

BL 2010 Data Source

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

BL 2010 Methodology

The data reported for this measure are calculated by dividing the sum of the monthly number of Community Services and Supports individuals for all months of the reporting period by the number of months in the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload as it pertains to determining the eligibility of persons receiving the Department of Aging and Disability Services (DADS)-funded community services and supports. This information is useful as a tool for assessing future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	OP	
Measure No.	6	Average Case Equivalents Per Community Services and Supports Worker

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the avg case equivalents/Community Services and Supports (CS&S) worker. It is developed by using the unduplicated monthly avg # of individuals authorized by CS&S workers to receive 1 or more CS&S.Individuals (Income Eligibles,Supplemental Security Income(SSI)eligibles) are eligible to receive:Family Care,Primary Home Care,Meals Only,Day Activity and Health Services (DAHS)Only,Foster Care,Special Services to Persons with Disabilities,Residential Care,&Emergency Response Services Only,Medically Dependent Children Program,In-home & Family Support,&Community-based Alternatives.An elig worker is defined as a filled position with a budgeted job #that includes an alpha character identifier unique to elig workers.CS&S workers determine financial elig only for those individuals with income above the SSI level.They also determine functional elig for all CS&S individuals, they plan and authorize services for all individuals, as well as monitor services delivered by providers.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the level of effort (workload) expended by staff and indicates the efficiency of the agency's operations. It is also a useful tool for assessing future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	1	Intake, Access, and Eligibility
Strategy No.	1	Intake, Access, and Eligibility to Services and Supports
Measure Type	OP	
Measure No.	7	Avg Number of Standardized Community Serv Case Equivalents Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	2	Guardianship
Measure Type	EF	
Measure No.	1	Average Mthly Cost Per Adult Guardianship Ward Served by DADS Staff

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost of providing direct delivery guardianship services by the Department of Aging and Disability Services (DADS)

BL 2010 Data Limitations

As a comparative measure with the cost of guardianships provided by DADS contractors, this is limited by the fact that all of the assessments for capacity and identification of less restrictive alternatives for both direct delivery and contracted guardianships are performed by DADS staff, not contractors.

BL 2010 Data Source

Actual expenditures are from the Health and Human Services Administrative System – Financials System (HHSAS-FS) for Program Activity Code (PAC) 580 (Guardianship Staff Services). The number of wards receiving DADS guardianship services is currently from the Information Management Protecting Adults and Children in Texas (IMPACT) system; located in the guardianship detail table where the guardianship letter was issued on or before the end of the reporting month and the event activity type is coded as 'GUA'. This measure includes both new and on-going guardianship services provided directly by DADS staff. IMPACT will be replaced as a data source for the number of guardianships once the new guardianship data system developed by DADS is on-line.

BL 2010 Methodology

Annual expenditure projections for PAC 580 are made using an internal budget document that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per DADS direct delivery guardianship ward served is calculated by dividing the average monthly cost by the average monthly number of DADS direct delivery wards served.

BL 2010 Purpose

This measure is useful as a benchmark and to monitor changes in DADS staff costs for serving direct delivery Guardianship wards.

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
Strategy No.	2	Guardianship
Measure Type	EF	
Measure No.	2	Average Mthly Cost/Adult Guardianship Ward Served - DADS Contractors

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-02 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost of providing contracted guardianship services by private guardianship programs.

BL 2010 Data Limitations

As a comparative measure with the cost of guardianships provided by the Department of Aging and Disability Services (DADS) staff, this is limited by the fact that all of the assessments for capacity and identification of less restrictive alternatives for both direct delivery and contracted guardianships are performed by DADS staff, not contractors.

BL 2010 Data Source

Actual expenditures are from the Health and Human Services Administrative System – Financials System (HHSAS-FS) for Program Activity Code (PAC) 580 (Guardianship Staff Services). The actual cost of the contracts plus a representative share of the state office contract monitoring staff is used. The number of wards receiving DADS guardianship services through contractors is currently from the Information Management Protecting Adults and Children in Texas (IMPACT) system; located in the guardianship detail table where the guardianship letter was issued on or before the end of the reporting month and the event activity type is coded as 'GUA'. This measure includes both new and on-going guardianship services provided by DADS contractors. IMPACT will be replaced as a data source for the number of guardianships once the new guardianship data system developed by DADS is on-line.

BL 2010 Methodology

Annual expenditure projections for PAC 580 are made using an internal budget document that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per DADS contracted guardianship ward served is calculated by dividing the average monthly cost by the average monthly number of DADS contracted wards served.

BL 2010 Purpose

This measure is useful as a benchmark and to monitor changes in DADS costs for serving contracted Guardianship wards.

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
Strategy No.	2	Guardianship
Measure Type	EX	
Measure No.	1	Average Monthly Cost Per Adult Guardianship Ward

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-02 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost of providing guardianship services.

BL 2010 Data Limitations

None

BL 2010 Data Source

Actual expenditures are from the Health and Human Services Administrative System – Financials System (HHSAS-FS) for Program Activity Code (PAC) 580 (Guardianship Staff Services). The number of wards receiving the Department of Aging and Disability Services (DADS) guardianship services is from the Information Management Protecting Adults and Children in Texas (IMPACT) system; located in the guardianship detail table where the guardianship letter was issued on or before the end of the reporting month and the event activity type is coded as 'GUA'. This measure includes both new and on-going guardianship services. Due to possible modifications in the DADS fiscal system, PACs, service codes, and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented.

BL 2010 Methodology

Annual expenditure projections for PAC 580 are made using an internal budget document that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per DADS guardianship ward served is calculated by dividing the average monthly cost by the average monthly number of ward served.

BL 2010 Purpose

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

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
Strategy No.	2	Guardianship
Measure Type	EX	
Measure No.	2	Avg Mthly # Referrals DFPS to DADS for Assessment/Need Guardianship

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-02 EX 02

Fall/Annual: N

BL 2010 Definition

The measure shows the count of individuals for whom the Department of Family and Protective (DFPS) has validated abuse, neglect or exploitation and made a referral to the Department of Aging and Disability Services (DADS), and for whom DADS guardianship staff must perform an assessment to determine whether or not to apply for guardianship.

BL 2010 Data Limitations

The measure does not reflect the outcome of the assessment process; however, in combination with the measure showing the average number of guardianships, it provides a more complete picture of staff workloads.

BL 2010 Data Source

Data are currently captured manually by regional supervisors and reported on a spreadsheet to the state office where it is aggregated. Once the new guardianship data system being developed by DADS is finished, it will produce a standard monthly report of the number of referrals received. The numerator is the total number of referrals received for the year to date. The denominator is the number of months in the year to date.

BL 2010 Methodology

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

BL 2010 Purpose

The purpose of this measure is to show the average number of new cases that DADS guardianship staff must review each month and conduct a capacity assessment for.

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
Strategy No.	2	Guardianship
Measure Type	OP	
Measure No.	1	Avg Number of Wards Receiving Guardianship Services from DADS Staff

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-02 OP

Fall/Annual: N

BL 2010 Definition

The measure shows the count of wards for which guardianship has been established through court order. The count includes both new and on-going guardianships that will be served by the Department of Aging and Disability Services (DADS) staff. The latter on-going guardianships refers to guardianships initiated in previous months and without closure dates.

BL 2010 Data Limitations

The usefulness of the data as a workload indicator is limited by the fact that the measure does not include the number of cases being assessed for the appropriateness of guardianship or cases for which less restrictive alternatives are found. This makes comparison with the number of guardianships served by contractors difficult because DADS staff performs the assessments on wards referred to contractors for guardianship. Documentation can be delayed by the volume of work, which is impacted by vacancies, sick leave, vacation leave, turnover, Information Management Protecting Adults and Children in Texas (IMPACT) system downtime, etc.

BL 2010 Data Source

Using IMPACT, the data are gathered by counting DADS cases open during the reporting period and cases closed during the reporting period, the number of cases as documented on the guardianship detail table in which wards' guardianship letters were issued on or before the end of the report month and the event activity type was coded as 'GUA' (numerator). The count includes only direct-delivery guardianships. The denominator is the sum of months in the reporting period. The IMPACT detail table will be replaced with a report from a new DADS guardianship data system once it is in production, and this will provide a more accurate count.

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	2	Guardianship
Measure Type	OP	
Measure No.	2	Avg # Wards Rec Guardianship Svcs: Private Guardianship Programs

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-01-02 OP

Fall/Annual: N

BL 2010 Definition

The measure shows the count of wards for whom guardianship has been established through court order. The count includes both new and on-going guardianships for which DADS pays a contracted private guardianship program to provide services. The latter on-going guardianships refers to guardianships initiated in previous months and without closure dates.

BL 2010 Data Limitations

The usefulness of the data as a comparative workload indicator of wards served by DADS staff is limited by the fact that the measure does not include the number of cases being assessed for the appropriateness of guardianship or cases for which less restrictive alternatives are found, functions performed by DADS staff. Documentation can be delayed by the volume of work, which is impacted by vacancies, sick leave, vacation leave, turnover, Information Management Protecting Adults and Children in Texas (IMPACT) system downtime, etc.

BL 2010 Data Source

Using IMPACT, the data are gathered by counting DADS contracted cases open during the reporting period and cases closed during the reporting period, the number of cases as documented on the guardianship detail table in which wards' guardianship letters were issued on or before the end of the report month and the event activity type was coded as 'GUA' (numerator). The count includes only contracted guardianships. The denominator is the sum of months in the reporting period. IMPACT will eventually be replaced as a data source by a new guardianship data system being developed by DADS.

BL 2010 Methodology

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

BL 2010 Purpose

The purpose of this measure is to show the average number of adults for whom DADS purchased guardianship services during the reporting period. It indicates part of the workload volume in DADS guardianship program. If DADS did not contract for these services, they would have to be performed by DADS staff.

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
Strategy No.	1	Primary Home Care
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual Served: Primary Home Care

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of Medicaid non-waiver Community Services and Supports primary home care services 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 primary home care individuals is defined under output measure 1 of this strategy.

BL 2010 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 2010 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.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	2	Community Services and Supports - Entitlement
Strategy No.	1	Primary Home Care
Measure Type	OP	
Measure No.	1	Average Number of Individuals Served Per Month: Primary Home Care

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of individuals who, based upon approved-to-pay claims, received Medicaid-funded non-waiver Community Services and Supports, Primary Home Care.

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 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 2010 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 count (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	2	Community Services and Supports - Entitlement
Strategy No.	2	Community Attendant Services
Measure Type	EF	
Measure No.	1	Average Mthly Cost Per Individual Served: Community Attendant Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-02-02 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 2010 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.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	2	Community Services and Supports - Entitlement
Strategy No.	2	Community Attendant Services
Measure Type	OP	
Measure No.	1	Average # of Individuals Served Per Mnth: Community Attendant Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-02-02 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 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 2010 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 2010 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.	2	Community Services and Supports - Entitlement
Strategy No.	3	Day Activity and Health Services (DAHS)
Measure Type	EF	
Measure No.	1	Avg Mthly Cost Per Individual Served: Day Activity and Health Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-02-03 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 2010 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.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	2	Community Services and Supports - Entitlement
Strategy No.	3	Day Activity and Health Services (DAHS)
Measure Type	OP	
Measure No.	1	Average Number of Individuals Per Month: Day Activity/Health Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-02-03 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 2010 Data Source

Specific data sources for this measure are provided under outcome measure 1 of objective 1.2.

BL 2010 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 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of eligible persons who, because of the receipt of day activity and health services in adult day care centers, are able to remain in their communities, as opposed to being placed in another more restrictive setting.

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

Goal No.	1	Long-term Services and Supports
Objective No.	3	Community Services and Supports - Waivers
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual: Medicaid CBA Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of Medicaid Community-Based Alternative waiver services 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 Medicaid CBA waiver individuals is defined under output measure 1 of this strategy.

BL 2010 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 2010 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 and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of CBA waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	EX	
Measure No.	1	Average Number on Interest List Per Month: CBA Waiver

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly unduplicated number of persons who: 1) have requested Community-Based Alternative (CBA) waiver services through completion of the Community Services and Supports intake Form 2110, and 2) meet the institutional risk criteria used as part of the CBA waiver eligibility process, but are placed on an interest list for CBA due to funding constraints. In addition, 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 receiving other Community Services and Supports while waiting for CBA waiver services.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of persons on the interest list for CBA waiver services for all months of the reporting.

BL 2010 Purpose

This measure is an indicator of the unmet need for services provided under the CBA waiver as currently funded by this strategy and 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
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	EX	
Measure No.	2	# of Persons Receiving Svcs at the End of the Fiscal Year: CBA Waiver

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-03-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Community-Based Alternatives (CBA) waiver during the last month of the fiscal year being reported.

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons who received CBA waiver services during the last month of the fiscal year being reported.

BL 2010 Purpose

Due to the high demand for these services, as indicated by the number of persons waiting for waiver services, it is critical for the department to monitor how many persons are receiving the service annually/at the end of the year in order to determine the service level that will be carried into the next fiscal year and/or

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
Strategy No.	1	Community-based Alternatives (CBA)
Measure Type	OP	
Measure No.	1	Average Number of Individuals Served Per Month: Medicaid CBA Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 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 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate CBA waiver-funded services with related costs and outcomes.

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
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	EF	
Measure No.	1	Avg Mthly Cost Per Individual Served: Home & Community Based Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measure captures the average cost per month for serving Medicaid Home and Community-Based Services waiver (HCS) individuals.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of HCS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	EX	
Measure No.	1	# Individuals Receiving Services at the End of the Fiscal Year: HCS

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-02 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority population eligible persons receiving mental retardation Medicaid Home and Community-Based Services waiver (HCS) funded services at the end of the fiscal year.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons that received HCS waiver services at the end of the fiscal year.

BL 2010 Purpose

Due to the high demand for these services, as indicated by the number of persons waiting for waiver services, it is critical for the department to monitor how many persons are receiving the service annually in order to determine the service level that will be carried into the next Fiscal Year and/or Biennium.

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
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	EX	
Measure No.	2	Avg # Individs on Interest List Per Month: Home & Commity Based Svcs

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-02 EX 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

The accuracy of the HCS interest list is dependent upon the submission of accurate data by the Mental Retardation Authorities (MRAs). There may be duplication of names between interest lists for mental retardation services.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is an indicator of the unmet need for services provided under the HCS waiver as currently funded by this strategy and 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
Strategy No.	2	Home and Community-based Services (HCS)
Measure Type	OP	
Measure No.	1	Avg # Individuals Served Per Mth: Home & Commity Based Services (HCS)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-02 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate HCS waiver-funded services with related costs and outcomes.

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-03 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 2010 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 and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

The measure is calculated as follows: The sum of the monthly expenditures for CLASS waiver services by month-of-service for all months in the reporting period is divided by the average monthly number of CLASS individuals for all months of the reporting period; this result is then divided by the number of months in the reporting period.

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of CLASS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	3	Community Living Assistance and Support Services (CLASS)
Measure Type	EX	
Measure No.	1	Average Number on Interest List: Community Living Assistance & Support

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-03 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly unduplicated number of persons who have requested CLASS waiver services, but are placed on an interest list for CLASS due to funding constraints. Persons are placed on an interest list by means of a telephone call to the State Office Interest List Hotline or by completion of Form 3620, Intake Summary of Individual's Need for 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 may include persons who are waiting for CLASS while receiving other Community Services and Supports.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is an indicator of the unmet need for services provided under the Medicaid CLASS waiver as currently funded by this strategy and 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
Strategy No.	3	Community Living Assistance and Support Services (CLASS)
Measure Type	EX	
Measure No.	2	# of Persons Receiving Svcs at the End of the Fiscal Year: CLASS

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-03-03 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Community Living Assistance & Support Services (CLASS) waiver during the last month of the fiscal year being reported.

BL 2010 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 persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons who received CLASS waiver services during the last month of the fiscal year being reported.

BL 2010 Purpose

By reporting the number of persons served at the end of the fiscal year, this measure allows the State to determine the service level that will be carried into the next fiscal year and/or biennium.

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
Strategy No.	3	Community Living Assistance and Support Services (CLASS)
Measure Type	OP	
Measure No.	1	Average Number of Individuals Served Per Month: CLASS Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-03 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 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 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate CLASS waiver -funded services with related costs and outcomes.

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
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual: Deaf-Blind Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-04 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 2010 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 and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

The measure is calculated as follows: The sum of the monthly expenditures for CLASS waiver services by month-of-service for all months in the reporting period is divided by the average monthly number of CLASS individuals for all months of the reporting period; this result is then divided by the number of months in the reporting period.

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of CLASS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	EX	
Measure No.	1	Average Number on Interest List: Deaf-Blind Mult Disabilties Waiver

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-04 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly unduplicated number of persons who have requested Deaf-blind with Multiple Disabilities Waiver services, but are placed on an interest list for Deaf-blind with Multiple Disabilities Waiver services due to funding constraints. Persons are placed on an interest list by means of a telephone call to the State Office Interest List Hotline or by completion and submittal of Form 6501 Deaf-Blind Medicaid Waiver Interest List Form. 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 may include persons who are waiting for Deaf-blind with Multiple Disabilities Waiver services while receiving other Community Services and Supports

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of persons on the interest list for Deaf-blind with Multiple Disabilities Waiver (as described above) for all months of the reporting period, by the number of months in the reporting

BL 2010 Purpose

This measure is an indicator of the unmet need for services provided under the Deaf-blind with Multiple Disabilities Waiver as currently funded by this strategy and 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
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	EX	
Measure No.	2	# of Persons Receiving Services at the End of the Fiscal Year: DBMD

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-03-04 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Medicaid Deaf-blind with Multiple Disabilities waiver during the last month of the fiscal year being reported.

BL 2010 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. 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 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons who received Medicaid Deaf-blind with Multiple Disabilities waiver services during the last month of the fiscal year being reported

BL 2010 Purpose

By reporting the number of persons served at the end of the fiscal year, this measure allows the State to determine the service level that will be carried into the next fiscal year and/or biennium.

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
Strategy No.	4	Deaf-Blind Multiple Disabilities (DBMD)
Measure Type	OP	
Measure No.	1	Average Number of Individuals Served Per Month: Deaf-Blind Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-04 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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. 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 2010 Data Source

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

BL 2010 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 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate Medicaid Deaf-blind with Multiple Disabilities waiver-funded services with related costs

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
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual: MDCP Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-05 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 2010 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, and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of MDCP-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	EX	
Measure No.	1	Average Number on Interest List Per Month: MDCP Waiver

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-05 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly unduplicated number of persons who have requested Medically Dependent Children Program (MDCP) services, but are placed on an interest list for these services due to funding constraints. Persons are placed on an interest list by means of a telephone call to the State Office Interest List Hotline or through completion of a Form 3620, Intake/Summary of Individuals Need for 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.)

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of persons on the interest list for MDCP (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2010 Purpose

This measure is an indicator of the unmet need for services provided under the MDCP as currently funded by this strategy and 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
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	EX	
Measure No.	2	# Persons Receiving Svcs at the End of the Fiscal Year: MDCP

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-03-05 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Medically Dependent Children Program (MDCP) during the last month of the fiscal year being reported.

BL 2010 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 persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons who received MDCP services during the last month of the fiscal year being reported.

BL 2010 Purpose

By reporting the number of persons served at the end of the fiscal year, this measure allows the State to determine the service level that will be carried into the next fiscal year and/or biennium.

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
Strategy No.	5	Medically Dependent Children Program (MDCP)
Measure Type	OP	
Measure No.	1	Average Number of Individuals Served Per Month: MDCP Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-05 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 Methodology

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 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate MDCP- funded services with related costs and outcomes.

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
Strategy No.	6	Consolidated Waiver Program
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual: Consolidated Waiver (CWP)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-06 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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, 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 2010 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 and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query

BL 2010 Methodology

The sum of monthly expenditures for the Consolidated Home- and Community-based Services Waiver by month-of-service for all months in the reporting period is divided by the average monthly number of Consolidated Home- and Community-based Services Waiver individuals for all months of the reporting period; this is then divided by the number of months in the reporting period.

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of Medicaid Consolidated waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	6	Consolidated Waiver Program
Measure Type	EX	
Measure No.	1	# Persons Receiving Svcs at the End of the Fiscal Year: CWP

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-03-06 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Medicaid Consolidated Waiver Program during the last month of the fiscal year being reported.

BL 2010 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 persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive Consolidated Home- and Community-based Services Waiver services, is obtained from the department's Service Authorization System (SAS) by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

This is a simple unduplicated count of persons who received Medicaid Consolidated Waiver Program services during the last month of the fiscal year being

BL 2010 Purpose

By reporting the number of persons served at the end of the fiscal year, this measure allows the State to determine the service level that will be carried into the next fiscal year and/or biennium.

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
Strategy No.	6	Consolidated Waiver Program
Measure Type	OP	
Measure No.	1	Avg Number of Individuals Served/Mo: Consolidated Waiver Program (CWP)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-06 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served

BL 2010 Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive Consolidated Home- and Community-based Services Waiver services, is obtained from the department's Service Authorization System (SAS) by means of ad hoc query. Month-of-service to-date data that reports the number of clients for whom claims have been approved-to-pay and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 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 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate Medicaid Consolidated waiver-funded services with related costs and outcomes.

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
Strategy No.	7	Texas Home Living Waiver
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual Served: Texas Home Living Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-07 EF 01

Fall/Annual: N

BL 2010 Definition

This measure captures the average cost per month for serving Texas Home Living (TxHmL) Waiver individuals.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. It allows the agency to track the cost of TxHmL waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and 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
Strategy No.	7	Texas Home Living Waiver
Measure Type	EX	
Measure No.	1	# of Individuals Receiving Svcs at the End of the Fiscal Year: Tx HML

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-03-07 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority population eligible persons receiving mental retardation Texas Home Living (TxHmL) waiver funded services at the end of the fiscal year.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons that received TxHmL waiver services at the end of the fiscal year.

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	3	Community Services and Supports - Waivers
Strategy No.	7	Texas Home Living Waiver
Measure Type	OP	
Measure No.	1	Avg Number of Individuals Served Per Month: Texas Home Living Waiver

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-03-07 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated count of priority population eligible persons who receive Texas Home Living (TxHmL) Waiver funded services on a monthly basis.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate TxHmL waiver-funded services with related costs and outcomes.

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
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	1	Avg Mthly Cost Per Individual Served: Non-Medicaid Community Serv (XX)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of non-Medicaid Title XX-funded 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 Title XX-funded Community Services and Supports individuals is defined under output measure 1 of this strategy.

BL 2010 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals as well as cost per individual per month ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of individuals approved-to-pay to-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 2010 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.

BL 2010 Methodology

The sum of monthly expenditures for non-Medicaid Title XX-funded 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 Title XX-funded 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 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	2	Average Cost Per Home-delivered Meal (SSBG)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of a home-delivered meal funded by the Social Services Block Grant (SSBG). 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 meals served is defined under output measure 2 of this strategy.

BL 2010 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals 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 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 2010 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.

BL 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the average unit cost for one of the services (home-delivered meals) provided under this strategy. This unit cost is a tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	3	Statewide Average Cost Per Congregate Meal (AAA)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 03

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

The statewide average State Unit on Aging (DADS) cost per meal is calculated by dividing State Unit on Aging (DADS) appropriated expenditures reported by the AAAs used to provide congregate meals to persons age 60 or older and other eligible persons by the number of congregate meals funded by the State Unit on Aging (DADS) during the fiscal year.

BL 2010 Purpose

This measure identifies the statewide average cost per congregate meal.

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	4	Statewide Average Cost Per Home-delivered Meal (AAA)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 04

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The number of home delivered meals is based on data reported to the Department by area agencies on aging (AAAs). Data is reported only for those persons for whom an intake form is completed. Expenditures are reported by the AAAs and include accrued expenses.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	5	Statewide Average Cost Per Person Receiving Homemaker Services (AAA)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 05

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The number of persons receiving homemaker services is based on data reported to the Department by area agencies on aging (AAAs). Data is reported only for those persons for whom an intake form is completed. Expenditures are reported by the AAAs and include accrued expenses.

BL 2010 Methodology

The statewide average cost per person receiving homemaker services is calculated by dividing expenditures reported by the AAAs used to provide homemaker services to persons age 60 or older by the unduplicated number of individuals receiving homemaker services funded by the State Unit on Aging (DADS).

BL 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	6	Statewide Avg Cost Per Person Rec Personal Assistance Services (AAA)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 06

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The number of persons receiving personal assistance services is based on data reported to the Department by the area agencies on aging (AAAs). Data is reported only for those persons for whom an intake form is completed. Expenditures are reported by the AAAs and include accrued expenses.

BL 2010 Methodology

The statewide average cost per person receiving personal assistance services is calculated by dividing State Unit on Aging (DADS) expenditures reported by the AAAs used to provide personal assistance services to persons age 60 or older by the unduplicated number of individuals receiving personal assistance services funded by the State Unit on Aging (DADS).

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	EF	
Measure No.	7	Statewide Average Cost Per Modified Home (AAA)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EF 07

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	EX	
Measure No.	1	Avg # of Persons on Interest List Per Month: Non-Medicaid CSS (XX)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly duplicated number of persons who have requested one or more Title XX-funded non-Medicaid Community Services and Supports through completion of a Community Services and Supports Intake Form 2110, but are placed on an interest list for requested service(s) due to funding constraints. 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 Title XX-funded non-Medicaid Community Services and Supports while receiving other Community Services and Supports.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of persons on the interest list for (one or more) non-Medicaid Community Services and Supports (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2010 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.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	EX	
Measure No.	2	Avg # Individuals Receiving Non-Medicaid Communy Svcs & Supports XX

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received one or more non-Medicaid Title XX-funded Community Services and Supports and did not receive either entitlement or waiver services. Services included under this category are: Family Care, Home-delivered Meals, Emergency Response Services, Adult Foster Care, Day Activities and Health Services (funded through Social Services Block Grant), Consumer Managed Personal Attendant Services, Residential Care, and Special Services for Persons with Disabilities.

BL 2010 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. 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 2010 Data Source

Two types of data are used to report 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 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 2010 Methodology

Since a high percentage of individuals who receive Meals and/or Emergency Response Services also receive other services, an unduplicated monthly count of individuals receiving one or more non-Medicaid Title XX-funded community care services must be estimated. This is accomplished by multiplying counts for these two services by the percentage of individuals who are authorized to receive these services only, as opposed to these services in addition to other services, according to information obtained from SAS authorization data. 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 2010 Purpose

This measure provides a count of persons who received Non-Medicaid Title XX funded community services and supports, who did not receive other community services and supports (Medicaid entitlement or Medicaid Waiver services). This measure is important because when it is combined with the measure reporting the total number of persons receiving Medicaid entitlement services and the measure reporting the total number of persons receiving Medicaid waiver services, it yields the total number of persons receiving community supports and services through programs administered by the Department of Aging and Disability Services (DADS).

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
Strategy No.	1	Non-Medicaid Services
Measure Type	EX	
Measure No.	3	Avg # of Individuals Receiving Svcs at the End of the Fiscal Yr: XX/GR

Calculation Method: C **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average unduplicated number of individuals who, based upon approved-to-pay claims, received non-Medicaid Title XX-funded Community Services and Supports and did not receive either entitlement or waiver services at the end of the fiscal year. Services included are: Day Activities and Health Services (funded through Social Services Block Grant)

BL 2010 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. 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 2010 Data Source

Two types of data are used to report 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 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 2010 Methodology

The number of unduplicated individuals who received one or more Non-Medicaid Community Care (XX/GR) services in August of each fiscal year, as estimated using the “completion factor” method described above.

BL 2010 Purpose

A count of persons served at the end of the fiscal year is a useful tool for determining baseline service levels from biennium-to-biennium.

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
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	1	Average # of Individuals Per Mth Receiving Home-delivered Meals (SSBG)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received a home-delivered meal funded through the Social Services Block Grant (SSBG). Individuals are provided with hot, nutritious meals delivered directly to their home.

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

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

BL 2010 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 2010 Purpose

This measure provides a count of eligible persons who are receiving home-delivered meals, a service that contributes to enabling them to remain in their own home as opposed to being placed in another more restrictive setting.

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	2	Average Number of Home-delivered Meals Provided Per Month (SSBG)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of home-delivered meals on approved-to-pay claims submitted by Meals providers and funded through the Social Services Block Grant (SSBG).

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

Data are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the number of home-delivered meals provided (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the volume of services delivered (meals).

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	3	Number of Persons Receiving Congregate Meals (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The number of persons is based on data reported to the Department by the AAAs.

BL 2010 Methodology

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

BL 2010 Purpose

This is an output measure that identifies an unduplicated count of persons receiving a congregate meal funded by the State Unit on Aging (DADS).

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
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	4	Number of Congregate Meals Served (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	5	Number of Persons Receiving Home-delivered Meals (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	6	Number of Home-delivered Meals Served (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure identifies the number of home delivered meals served.

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	7	Number of Persons Receiving Homemaker Services (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The number of unduplicated persons receiving homemaker services is based on data reported to the Department by AAAs. Data is reported only for those persons for whom an intake form is completed.

BL 2010 Methodology

The number of persons 60 and older receiving homemaker services is the unduplicated total reported to the Department by the AAAs.

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	8	Number of Persons Receiving Personal Assistance (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The number of unduplicated persons receiving personal assistance services is based on data reported to the Department by the AAAs. Data is reported only for those persons for whom an intake form is completed.

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	9	Number of Homes Repaired/Modified (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

None.

BL 2010 Data Source

The unduplicated number of homes receiving repair/modification is based on data reported to the Department by the AAAs. Data is reported only for those persons for whom an intake form is completed.

BL 2010 Methodology

The number of homes receiving repair/modification is the unduplicated total reported to the Department by the AAAs.

BL 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	10	Number of One-way Trips (AAA)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Only State Unit on Aging (DADS) funded units are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging (DADS), they are not included in the measure calculation. In addition, AAAs determine the level and the types of transportation services that they

BL 2010 Data Source

The number of one-way demand-response trips is based on data reported to the Department by the AAAs. Data is reported only for those persons for whom an intake form is completed.

BL 2010 Methodology

The number of one-way demand-response trips is the total reported to the State Unit on Aging (DADS) by the AAAs.

BL 2010 Purpose

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

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
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	11	Number of Retired and Senior Volunteer Program (RSVP) Volunteers

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

None.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	1	Non-Medicaid Services
Measure Type	OP	
Measure No.	12	Avg # of Individuals Served Per Month: Non Medicaid Comm Care (XX/GR)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average unduplicated number of individuals who received one or more of the following Non Medicaid Community Care(XX / GR) services: adult foster care, client managed personal assistance services (CMPAS), day activity and health services (DAHS), emergency response services, home-delivered meals, personal assistance services (Family Care), residential care, and special services for persons with disabilities.

BL 2010 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals as well as cost per individual per month ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of individuals approved-to-pay to-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 2010 Data Source

Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

The sum of unduplicated individuals who received one or more Non-Medicaid Community Care (XX/GR) services reported by month-of-service for all months in the reporting period is divided by the number of months in the reporting period.

BL 2010 Purpose

This measure provides a count of eligible persons who are receiving Non Medicaid Community Care (XX / GR) services that contribute to enabling them to remain in their own home as opposed to being placed in another more restrictive setting.

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	2	Mental Retardation Community Services
Measure Type	EF	
Measure No.	1	Avg Mthly Cst Non-Medicaid Individual/MR Receiving Commity Residential

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-04-02 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	2	Mental Retardation Community Services
Measure Type	EF	
Measure No.	2	Average Mthly Cost Per Individual with MR Receiving Community Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-02 EF 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

The accuracy of the department's database is dependent upon accurate and timely information being entered into the data warehouse system by the local mental retardation authorities. If the local authority does not provide accurate data for the quarter, this measure will not be accurate. (At the end of the fiscal year, community centers report preliminary expenditure information, which is used for reporting in the Automated Budget and Evaluation System of Texas (ABEST). Final expenditure information may be entered into the Client Assignment and Registration (CARE) system up to 4 months following the end of the fiscal year. Therefore, end of year values for efficiency measures can be updated in ABEST when the information is available. The Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	2	Mental Retardation Community Services
Measure Type	EX	
Measure No.	1	# Non-Medicaid Individuals MR Receiving Commun Residential Svcs Per Yr

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-04-02 EX 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	2	Mental Retardation Community Services
Measure Type	EX	
Measure No.	2	Number of Individuals with MR Receiving Community Services Per Year

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-02 EX 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

This measure provides the actual number of persons who receive community services and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years. The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

The Data Verification Criteria Manual provides general guidance regarding timelines for closure of assignments to specific services.

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-02 EX 03

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	2	Mental Retardation Community Services
Measure Type	OP	
Measure No.	1	Avg Mtly # Non-Medicaid Individuals/MR Receiving Community Residential

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-04-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly unduplicated number of individuals who, based upon approved-to-pay claims, received one or more non-Medicaid Title XX-funded Community Services and Supports and did not receive either entitlement or waiver services. Services included under this category are: Family Care, Home-delivered Meals, Emergency Response Services, Adult Foster Care, Day Activities and Health Services (funded through Social Services Block Grant), Consumer Managed Personal Attendant Services, Residential Care, and Special Services for Persons with Disabilities.

BL 2010 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 clients approved-to-pay to-date. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the number of persons on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

Two types of data are used to report 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 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 2010 Methodology

Since a high percentage of individuals who receive Meals and/or Emergency Response Services also receive other services, an unduplicated monthly count of clients receiving one or more non-Medicaid Title XX-funded community care services must be estimated. This is accomplished by multiplying counts for these two services by the percentage of individuals who are authorized to receive these services only, as opposed to these services in addition to other services, according to information obtained from SAS authorization data. Individual 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 2010 Purpose

measure provides a count of persons who received Non-Medicaid Title XX funded community services and supports, who did not receive other community services and supports (Medicaid entitlement or Medicaid Waiver services). This measure is important because when it is combined with the measure reporting the total number of persons receiving Medicaid entitlement services and the measure reporting the total number of persons receiving Medicaid waiver services, it yields the total number of persons receiving community supports and services through programs administered by the Department of Aging and Disability Services (DADS).

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
Strategy No.	2	Mental Retardation Community Services
Measure Type	OP	
Measure No.	2	Average Monthly # of Individuals with MR Receiving Community Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-02 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

To obtain the number of persons served with DADS appropriation authority funds, DADS uses a production report which reflects the numbers of priority population persons served each month with general revenue (GR) funds and required local match. The numerator is the sum of the number of persons receiving MR community service each month of the reporting period. The denominator is the number of months in the period. The formula is

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	4	In-Home and Family Support
Measure Type	EF	
Measure No.	1	Average Monthly Cost of In-home Family Support Per Individual

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-04-04 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the department's Health and Human Services Administrative System (HHSAS) Financials.

BL 2010 Methodology

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

BL 2010 Purpose

This measure is important because it quantifies the average cost per unit of service. This unit cost is a tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	4	In-Home and Family Support
Measure Type	EX	
Measure No.	1	Average Number on Interest List Per Month: IHFS Individuals

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-04-04 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the count of persons who have requested In-Home Family Support (IHFS) services through completion of the Community Care intake Form 2110 but, due to funding limitations, have not been able to obtain 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.)

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of persons on the interest list for In Home and Family Support (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	4	In-Home and Family Support
Measure Type	EX	
Measure No.	2	# of Individuals Receiving Svcs at the End of the Fiscal Year: IHFS

Calculation Method: N **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-04 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the number of persons who received in-home/family support assistance in the month of August of each fiscal year. Clients are provided assistance for the purchase of supportive services that will enable them to remain independent. Clients are eligible for assistance up to $1200 per year in cash subsidy for the purpose of ongoing services and/or the purchase of equipment or architectural modifications.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the department's Health and Human Services Administrative System (HHSAS) Financials.

BL 2010 Methodology

Data for this measure are the sum of one month of data from 1 August to 31 August in each reporting fiscal year to report the number of in-home clients who receive assistance. Reported data reflects data capture due to one-month lag during normal reporting.

BL 2010 Purpose

measure provides a means to establish baseline funding levels from biennium to biennium

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
Strategy No.	4	In-Home and Family Support
Measure Type	OP	
Measure No.	1	Average Number of Individuals Per Month Receiving IHFS

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-04-04 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the department's Health and Human Services Administrative System (HHSAS) Financials.

BL 2010 Methodology

Data for this measure are the sum of one month of data from 1 August to 31 August in each reporting fiscal year to report the number of in-home Individuals who receive assistance. Reported data reflects data capture due to one-month lag during normal reporting.

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	4	Community Services and Supports - State
Strategy No.	5	Mental Retardation In-Home Services
Measure Type	EF	
Measure No.	1	Avg Annual Grant Per Individual with MR Receiving In-home FS Per Year

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-04-05 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	5	Mental Retardation In-Home Services
Measure Type	EX	
Measure No.	1	Avg # Individuals MR Interest List Per Mth: In-home & Family Support

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-04-05 EX 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

Pursuing IHFS services is initiated by individuals, family members, and legally authorized representatives following discussions of service options with staff of the local MRAs.

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
Strategy No.	5	Mental Retardation In-Home Services
Measure Type	EX	
Measure No.	2	# of Individuals Receiving Svcs at the End of the Fiscal Year: MR-IHFS

Calculation Method: N **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 01-04-05 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average number of persons with Mental Retardation (MR) who received in-home/family support assistance at the end of the fiscal year. Clients are provided assistance for the purchase of supportive services that will enable them to remain independent. Clients are eligible for assistance up to $3,600 a year.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

: Data are obtained from the department's Health and Human Services Administrative System (HHSAS) Financials.

BL 2010 Methodology

Data for this measure are the sum of one month of data from 1 August to 31 August in each reporting fiscal year to report the number of in-home clients who receive assistance. Reported data reflects data capture due to one-month lag during normal reporting.

BL 2010 Purpose

: This measure provides a means to establish baseline funding levels from biennium to biennium

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
Strategy No.	5	Mental Retardation In-Home Services
Measure Type	OP	
Measure No.	1	# of Individuals with MR Receiving In-Home and Family Support Per Year

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-04-05 OP

Fall/Annual: N

BL 2010 Definition

This is a simple count of persons that receive an In-Home and Family Support grant through community mental retardation services during a fiscal year. The program provides small financial grants to individuals with mental disabilities so that they may live independently or at home with their families. Uses of these funds include purchase of disability related services such as respite care, specialized therapies and support counseling, adaptive equipment and home modifications, as well as training and non-traditional supports such as in-home parent training to address challenging behaviors. Individuals make co-payments, based on income, and the ongoing annual grant amount cannot exceed $2,500. In addition, one-time grants for architectural modifications or specialized equipment are available.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-05-01 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 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 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure is important because it provides the unit cost associated with providing long-term care and acute care services to PACE recipients. This data is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	5	Program of All-inclusive Care for the Elderly (PACE)
Strategy No.	1	Program of All-inclusive Care for the Elderly (PACE)
Measure Type	OP	
Measure No.	1	Avg # of Recipients Per Month: Program for All Inclusive Care (PACE)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-05-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 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 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure provides a count of persons served through the agency's PACE project. This data is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	1	Average Daily Nursing Facility Rate

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-06-01 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved-to-pay are obtained from the department's MG 7000 report.

BL 2010 Methodology

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

BL 2010 Purpose

This measure is important because it quantifies the unit cost of the average rate of reimbursement to nursing facilities for the care provided to eligible Medicaid residents. Texas' reimbursement system has established different rates dependent on the level of care provided. This data is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	2	Avg Amount of Individual Income Applied to the Cost of Care Per Day

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-06-01 EF 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 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, the amount of patient's "applied income" associated with approved -to-pay claims, and the amounts approved-to-pay are obtained from the department's MG 7000 report.

BL 2010 Methodology

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

BL 2010 Purpose

This measure quantifies the unit cost for one of the components (clients' contribution) in the formula that computes the cost for a day of nursing facility care. This data is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	3	Net Nursing Facility Cost Per Medicaid Resident Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-06-01 EF 03

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Does not apply.

BL 2010 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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved-to-pay are obtained from the department's MG 7000 report.

BL 2010 Methodology

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

BL 2010 Purpose

This measure is important because it is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the total unit cost to DADS for providing Medicaid reimbursed services in a nursing facility. This data is a useful tool for projecting future funding

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
Strategy No.	1	Nursing Facility Payments
Measure Type	EF	
Measure No.	4	Average Monthly Cost Per Individual: Personal Needs Allowance

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-06-01 EF 04

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	OP	
Measure No.	1	Average Number Receiving Medicaid-funded Nursing Facility Services/Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-06-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

Two types of data are used to compute this measure. The number of individuals authorized to receive the above services is obtained from the department's System for Application, Verification, Eligibility Referral and Reporting (SAVERR) and the Service Authorization System (SAS). 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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from the department's MG 7000 report.

BL 2010 Methodology

Data are computed by taking the number of Medicaid days of nursing facility services ultimately incurred for a month of service and dividing by the number of calendar days in the month to derive an average daily census. This result is the average number of persons receiving services during the month. The reported data are calculated by dividing the sum of the monthly number of persons receiving Medicaid-funded nursing facility services for all months of the reporting period, by the number of months in the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons receiving the service that expends the majority of funding appropriated to this strategy. This count is an indication of service demand and is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	1	Nursing Facility Payments
Measure Type	OP	
Measure No.	2	Average Number Receiving Personal Needs Allowance Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-06-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

: Individual counts are obtained from the department's Health and Human Services Administrative System (HHSAS) Financials. The payment amount is established by rule and does not vary by individual.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	2	Medicare Skilled Nursing Facility
Measure Type	EF	
Measure No.	1	Net Medicaid/Medicare Copay Per Individual-Nursing Facility Svcs/Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-06-02 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

Month-of-service to-date data that reports by type-of-service, the number of clients for whom claims have been approved-to-pay, number of units of service approved-to-pay, amount of patients applied income associated with approved-to-pay claims, and amounts approved-to-pay are from DADS' MG 7000 report.

BL 2010 Methodology

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

BL 2010 Purpose

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

Purpose:

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the unit cost for the Medicare co-payment for eligible nursing facility residents. This data is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	2	Medicare Skilled Nursing Facility
Measure Type	OP	
Measure No.	1	Average Number Receiving Nursing Facility Copayments/Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-06-02 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

Two types of data are used to compute this measure. The number of individuals authorized to receive the above services is obtained from the department's System for Application, Verification, Eligibility Referral and Reporting (SAVERR)and the Service Authorization System (SAS). 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, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from the department's MG 7000 report.

BL 2010 Methodology

The reported data are calculated by dividing the sum of the monthly number of persons receiving co-paid Medicaid/ Medicare nursing facility services for all months of the reporting period by the number of months in the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons receiving one of the services funded under this strategy. This count is an indication of service demand and is a useful tool for projecting future funding

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
Strategy No.	3	Hospice
Measure Type	EF	
Measure No.	1	Average Net Payment Per Individual Per Month for Hospice

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-06-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average net cost per individual per month for Hospice Services. Expenditures are defined as payments made to providers for services delivered to clients, as well as incurred amounts for services delivered but not yet paid. The average monthly number of Medicaid Hospice clients is defined under output measure 1.

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

Month-of-service to-date data that reports by type-of-service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

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

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the total unit cost to the agency for providing Medicaid reimbursed hospice services. This data is a useful tool for projecting future funding needs.

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

Goal No.	1	Long-term Services and Supports
Objective No.	6	Nursing Facility and Hospice Payments
Strategy No.	3	Hospice
Measure Type	OP	
Measure No.	1	Average Number of Individuals Receiving Hospice Services Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-06-03 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 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 persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

BL 2010 Data Source

Month-of-service to-date data that reports, by type of service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from the department's Claims Management System (CMS) by means of ad hoc query.

BL 2010 Methodology

The reported data are calculated by dividing the sum of the monthly number of persons receiving Hospice services for all months of the reporting period by the number of months in the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons receiving one of the services funded under this strategy. This count is an indication of service demand and is a useful tool for projecting future funding

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
Strategy No.	4	Promote Independence by Providing Community-based Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Individual Served: Promoting Independence

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-06-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost of long term services and supports waiver services provided to Rider 14 individuals. 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 Rider 14, Promoting Independence individuals (80th Texas Legislature) is defined under output measure 1 of this strategy.

BL 2010 Data Limitations

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals as well as cost per individual per month ultimately served must be estimated for months that have not yet closed out, by using “completion factors” specific to each service applied to the number of 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 2010 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.

BL 2010 Methodology

The sum of monthly long-term services and supports waiver expenditures for Rider 14 individuals by month-of-service for all months in the reporting period is divided by the average monthly number of Rider 14 individuals for the months of the reporting period; this is then divided by the number of months in the

BL 2010 Purpose

This measure partially quantifies the Department of Aging and Disability Services (DADS) success in its “Promoting Independence” efforts. As individuals relocate from nursing facilities to community services and supports, Rider 14, 80th Legislature, allows the DADS to transfer funds from nursing facilities to community services and supports 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.	6	Nursing Facility and Hospice Payments
Strategy No.	4	Promote Independence by Providing Community-based Services
Measure Type	OP	
Measure No.	1	Avg # of Individuals Served Through Promoting Independence Per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-06-04 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of individuals who are successfully moved from a nursing facility into long-term services and supports waiver services provided in the community, and paid for by the State of Texas. Individuals must be residing in a Texas nursing facility immediately prior to transitioning, and their nursing home stay must have been eligible for reimbursement by Medicaid (80th Texas Legislature, Rider 14: Promoting Independence).

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Individuals meeting the above criteria are identified and tracked through the Department of Aging and Disability Services (DADS) Service Authorization System (SAS). Counts are reported through SAS on a monthly basis.

BL 2010 Methodology

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly number of Rider 14 clients (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2010 Purpose

This measure partially quantifies DADS' success in its "Promoting Independence" efforts. As clients relocate from nursing facilities to community care services, Rider 14, Eightieth Legislature, allows the Department to transfer funds from nursing facilities to community care services to cover the cost of shift in services.

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EF	
Measure No.	1	Monthly Cost Per ICF/MR Medicaid Eligible Individual

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EF 01

Fall/Annual: N

BL 2010 Definition

This efficiency measure is the average monthly cost per individual in Community Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	1	Number of Individuals in ICF/MR Medicaid Beds Per Year

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of individuals who received Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services during the fiscal year.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

This is a simple unduplicated count of persons that received ICF/MR services during the fiscal year.

BL 2010 Purpose

This measure reflects the system-wide level of activity occurring over time.

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	2	Number ICF/MR Individuals with Residential Length of Stay 0-12 Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure relates to the length of stay for an individual in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and reports the number of persons whose length of stay is one year or less. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	3	Number ICF/MR Individuals with Residential Length of Stay 13-23 Mths

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 03

Fall/Annual: N

BL 2010 Definition

This measure relates to the length of stay for an individual in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and reports the number of persons whose length of stay is 366 days through 730 days. A length of stay is defined as date of authorization to date of an absence from the facility for more

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	4	Number ICF/MR Individuals with Residential Length of Stay 24+ Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 04

Fall/Annual: N

BL 2010 Definition

This measure relates to the length of stay for an individual in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and reports the number of persons whose length of stay is 731 days or more. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	5	Average Monthly Number of Individuals in ICF/MR, 1-8 Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 05

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average monthly number of persons who reside in community Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) that have eight beds or less.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	6	Monthly Cost Per ICF/MR Medicaid Eligible Individual, 1 to 8 Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 06

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average cost per individual in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that have eight beds

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	7	Average Monthly Number of Individuals in ICF/MR, 9-13 Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 07

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average monthly number of persons who reside in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that have more than eight beds but less than 14 beds.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	8	Monthly Cost Per ICF/MR Medicaid Eligible Individual, 9-13 Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 08

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average cost per individual in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that have more than eight beds but less than 14 beds.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	9	Average Monthly Number of Individuals in ICF/MR, 14+ Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 09

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average monthly number of persons who reside in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) which have 14 beds or greater.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	EX	
Measure No.	10	Monthly Cost Per ICF/MR Medicaid Eligible Individual, 14+ Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 10

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average cost per individual in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that have 14 or more

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 11

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average number of certified beds in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that have eight beds or less.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The Department of Aging and Disability Services (DADS) maintains a database within the Client Assignment and Registration (CARE) system of all ICF/MR providers that contains information about location and size of each facility. The agency certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 12

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average number of certified beds in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR) which have greater than eight beds but less than 14.

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-07-01 EX 13

Fall/Annual: N

BL 2010 Definition

This explanatory measure is the average number of certified beds in community Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) which have 14 beds or greater.

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-07-01 OP

Fall/Annual: N

BL 2010 Definition

This output measure is the average number of people who reside in all Community Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	1	Long-term Services and Supports
Objective No.	7	Intermediate Care Facilities - Mental Retardation
Strategy No.	1	Intermed Care Facilities - for Persons w/ Mental Retardation (ICF/MR)
Measure Type	OP	
Measure No.	2	Average Number of ICF/MR Medicaid Beds Per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-07-01 OP

Fall/Annual: N

BL 2010 Definition

This output measure is the average number of certified beds in all Community Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

BL 2010 Data Limitations

None

BL 2010 Data Source

The Department of Aging and Disability Services (DADS) utilizes the Client Assignment and Registration (CARE) system database of all ICF/MR providers that contains information about location and size of each facility. DADS staff certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	1	MR State Schools Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per MR Campus Resident

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EF 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EF 03

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EX 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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
Strategy No.	1	MR State Schools Services
Measure Type	EX	
Measure No.	2	Avg # Day Individls w/MR Interested St School Placement Wait Admission

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EX 02

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

The calculation methodology for this measure includes length of time an individual actually waits for admission and the length of time it takes an individual to complete the application process. The accuracy of the SMRF interest list is dependent upon submission of written information to the SMRF by the Mental Retardation Authority (MRA).

BL 2010 Data Source

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

BL 2010 Methodology

At the end of the fiscal year, the total number of persons on the list from inception of the list who continue to be on the list or who have been admitted in a SMRF is calculated. This calculation will exclude those persons who are no longer on the list due to withdrawal of interest or inactivation. The number of days that the identified individuals either waited for admission or have been on the list since their start date is also calculated. The numerator is the number of days persons were on the list from the begin date to the admission date plus the number of days persons were on the list from the begin date to the current date. The denominator is the total number of persons on the list as either active or admitted. The formula is numerator / denominator.

BL 2010 Purpose

The length of time an individual waits for admission to a state mental retardation facility reflects the accessibility of services.

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

Goal No.	1	Long-term Services and Supports
Objective No.	8	MR State Schools Services
Strategy No.	1	MR State Schools Services
Measure Type	EX	
Measure No.	3	Number Interested In State School Placement

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EX 03

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

When a person seeking SMRF admission on behalf of an individual with mental retardation begins the application process, the name of the indivdual is entered into the Department of Aging and Disability Services (DADS) Client Assignment and Registration (CARE) system database as an "inquiry" for state mental retardation facility services. Staff of the SMRF input this data into the database.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 EX 04

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

Enrollment data are obtained from the department's CARE system. Standard production reports from the CARE system provide the unduplicated number of persons served during the year by the State Mental Retardation Facilities.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 01-08-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

None

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-08-01 OP

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

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

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 01-08-01 OP

Fall/Annual: N

BL 2010 Definition

This measure provides the number of persons with mental retardation (MR) requesting residential services in a specified SMRF, on average for any given

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	EF	
Measure No.	1	Average Cost Per Facility Visit

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

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

BL 2010 Data Limitations

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

BL 2010 Data Source

The average cost is based on direct costs attributed to the Department of Aging and Disability Services' (DADS) program activity codes 430 (Survey & Certification Title XVIII Services), 433 (Nursing Facility Survey and Certification), 434 (ICF/MR Survey and Certification), and 436 (Survey and Certification Generic Staff) as recorded in the department's Health and Human Services Administrative System. Included are salary, travel, and overhead (operating costs) expenses. Data for the number of on-site visits is obtained from the Compliance, Assessment, Registration, Enforcement System (CARES) using the ad hoc query system. This report will be titled "Facility On-Site Visits" in the future.

BL 2010 Methodology

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

BL 2010 Purpose

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

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	EF	
Measure No.	2	Average Cost Per Medicaid Facility and Hospice Service Contract Issued

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of issuing a Medicaid contract to a nursing facility, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) or hospice service provider. Issuance of a Medicaid provider contract results after the nursing facility or hospice provider has met all of the criteria discussed under output measure 10 of this strategy.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

The average cost is based on a percentage of the salary costs for the employees (Full-time Equivalents (FTEs) in the Facility Enrollment Section, Regulatory Services, who perform the nursing facility and hospice service Medicaid provider enrollment work. These FTE (full-time equivalent) salary costs are accounted for in the department's automated Health and Human Services Administrative System. The affected FTEs expend from 5% to 90% of their time on this effort. The percentage of time each FTE spends on this activity is determined by the Unit manager's administrative experience. Data are obtained from the Department of Aging and Disability Services (DADS) Provider Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Medicaid Facility Service Contracts Issued” in the future.

BL 2010 Methodology

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

BL 2010 Purpose

This measure provides the unit cost for issuing a Medicaid contract to eligible participating nursing facilities, ICF/MR and hospice service providers. It is an indicator of the efficiency of agency operations and is a tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	EX	
Measure No.	1	Number of Facilities Terminated from Licensure and/or Certification

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the number of facilities that are terminated from the Medicare (Title XVIII) and/or the Medicaid (Title XIX) program, the number of facilities that have had their license revoked, and the number of facilities that were denied license renewal during the reporting period. Reasons for denial of a license are described in the rules for nursing facilities (Section 19.214), for Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) (Section 90.17), for assisted living facilities (Section 92.17), and for adult day care facilities (Section 98.19).

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the Regulatory Services Provider Licensing Enforcement Sub-Unit’s Termination Log. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report does not have a name or number.

BL 2010 Methodology

The number of facilities terminated from licensure and/or certification programs during the months of the reporting period is totaled.

BL 2010 Purpose

This measure is a reflection of the agency's performance as it pertains to initiating corrective actions/enforcement (of facilities out of compliance).

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	EX	
Measure No.	2	Number of Medicaid Facility Contracts Terminated

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reports the number of nursing facilities, Intermediate Care Facilities for Persons with Mental Retardation and Hospice facilities that have had their Medicaid provider contract terminated for failure to meet the Medicaid contracting requirements, for revocation or denial of their license, or for termination of their Medicaid certification.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the Regulatory Services Provider Licensing Enforcement Sub-Unit’s Termination Log. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report does not have a name or number.

BL 2010 Methodology

The number of Medicaid facility contracts terminated during the months of the reporting period is summed.

BL 2010 Purpose

This measure is a reflection of the agency's performance as it pertains to initiating corrective actions/enforcement (of facilities out of compliance).

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	1	Number of Long-term Care Facility Certifications Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This is the total number of facility certifications issued for nursing facilities (NF) and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR). This includes Medicare only nursing facilities, dually certified (Medicare/Medicaid) nursing facilities, Medicaid only nursing facilities, and ICF/MR facilities for persons with related conditions.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the federal Automated Survey Processing Environment (ASPEN) system and compiled by Data Management and Analysis Sub-Unit. 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 “Number of Long-term Care Facility Certifications Issued” in the future.

BL 2010 Methodology

The number of Long Term Care facility certifications issued for each of the components during the months of the reporting period is totaled. The components are then summed.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the workload expended by the agency in response to its charge of certifying residential care facilities for participation in the Medicare/Medicaid programs. This data is useful in projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	2	Number of Long-term Care Facility Licenses Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of facility licenses issued for all types of facilities (nursing facilities, Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), assisted living facilities, and adult day care facilities). Data includes new and renewed licenses. A license is considered as issued once it has been printed. Each license has a new expiration date printed on it. (This date may differ from the date on which the license is actually printed.) Nursing facilities and ICFs/MR are licensed for a two-year period and assisted living facilities and adult day care facilities are licensed for one year.

BL 2010 Data Limitations

This measure excludes change of ownership during a licensure period, change of facility name during a licensure period, bed decrease and increase changes, change of facility administrator for nursing facilities and ICFs/MR, and change in ownership of facility stock.

BL 2010 Data Source

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) and CARES Central Data Repository (CDR). 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 “Number of Long-term Care Facility Licenses Issued” in the future.

BL 2010 Methodology

The number of Long-term Care facility licenses issued during the months of the reporting period is summed.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the workload expended by the agency in response to its charge to license the various types of residential care facilities. This data is a useful tool for projecting future funding

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	3	# of On-site Nursing Facility/ICF-MR Monitoring Visits Completed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of monitoring visits to nursing facilities and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) during the reporting period. A monitoring visit is an on-site visit in addition to the annual inspection/survey to determine financially unstable facilities' compliance with state and federal standards. However, if during a monitoring visit, more than one type of activity is performed (a survey, follow-up to investigation and a new investigation) each type of activity is counted separately for reporting purposes.

BL 2010 Data Limitations

Does not apply.

BL 2010 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 “# of on-site Nursing Facility/ICF/MR Monitoring Visits Completed” in the future.

BL 2010 Methodology

The total number of completed monitoring visits is calculated by summing the number of monitoring visits to nursing facilities with visits to ICFs/MR during the months of the reporting period.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy and indicates how many regulatory visits nursing facilities average per month to determine compliance with state and federal regulations.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	4	Number of Inspections Completed Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of inspections conducted by the Department of Aging and Disability Services (DADS), Regulatory Services. An inspection is defined as one of the following: a re-certification survey (ICF/MR facilities), a standard survey (certified nursing facilities), an initial survey (ICF/MR facilities or certified nursing facilities), an initial or annual licensing inspection (licensed only nursing facilities, assisted living facilities or adult day care facilities), or change of ownership. A licensing inspection done in conjunction with a survey of a certified facility is not counted as a separate inspection.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) and CARES Central Data Repository (CDR). 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 “Number of Inspections Completed Per Year” in the future.

BL 2010 Methodology

The numbers of inspections completed in long-term care facilities (nursing facilities, ICFs/MR , assisted living facilities and adult day care facilities) during the months of the reporting period are totaled.

BL 2010 Purpose

This measure is important because it is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency’s workload of inspecting facilities to ensure their compliance with state and federal standards. This data is a useful tool for projecting

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	5	Number of First Follow-up Visits Completed Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of first follow-up visits completed during the fiscal year for all types of facilities (nursing facilities, Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), assisted living facilities, and adult day care facilities). The number of visits resulting in adverse actions and the number of visits not resulting in adverse actions are both included in the count.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 the required calculations. The report will be titled “Number of First Follow-up Visits Completed Per Year” in the future.

BL 2010 Methodology

The number of first follow-up visits completed during the months covered by the reporting period is summed.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload of conducting first follow-up visits to those long-term care facilities not in compliance with state and federal standards at the time of the initial survey, most recent re-certification survey, most recent licensing inspection or complaint/incident investigation, bed change visits, or facility status verification visit to determine if the facility (usually unlicensed) is in compliance with licensure standards. This data is useful in determining future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	6	Number of Investigations Completed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of complaint investigations and the number of incident investigations completed in nursing facilities, ICF-MR facilities, assisted living facilities, adult day care facilities and unlicensed facilities For purposes of this measure, a complaint investigation is defined as the on-site investigation of all allegations associated with an individual complaint intake (assigned an identification number upon intake). An incident investigation is defined as the on-site investigation of all areas of facility compliance associated with an incident as reported by the facility. Facility staff is required to self-report incidents that have resulted in or has the potential of resulting in injury or harm to a resident.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data is obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR), which pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Number of Investigations Completed” in the future.

BL 2010 Methodology

The number of complaint and incident investigations completed during the months of the reporting period is summed.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload in pursuing the validity of inappropriate treatment of residents and/or the existence of other sub-standard conditions. This data is useful in determining future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	7	Total Dollar Amount Imposed from Fines

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total dollar amount of administrative penalties imposed for all types of facilities during the state fiscal year. It also includes the total amount of civil monetary penalties (CMP) imposed by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs imposed by the federal Centers for Medicare and Medicaid Services (CMS) on facilities participating in the Medicare/Medicaid (dually certified) or Medicare programs. An administrative penalty is imposed after the state-licensing agency, (DADS) Regulatory Services Licensing, has reviewed the staff recommendation of penalty based upon the findings of the facility's deficient practice(s) and decided on a final penalty. For CMPs, a penalty is imposed after the State Medicaid agency and/or CMS have reviewed the state survey/investigative team's recommendation of a penalty based on the facility's deficient practice(s) and decided on a final penalty.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR), which pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Total Dollar Amount Imposed from Fines” in the future.

BL 2010 Methodology

The total dollar amounts imposed for fines during the months of the reporting period are summed.

BL 2010 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	8	Total Dollar Amount Assessed from Fines

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total dollar amount of administrative penalties assessed for all types of facilities during the reporting period. It also includes the total amount of civil monetary penalties (CMP) assessed by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs assessed by the federal Centers for Medicare and Medicaid Services (CMS) for facilities participating in Medicare/Medicaid (dually certified) or Medicare programs. A penalty is assessed after the appeal/review process is completed and waiver, negotiated settlement, or hearing proceedings are finalized, and an assessment amount is agreed upon or set.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data is obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR), which pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Total Dollar Amount Assessed from Fines” in the future.

BL 2010 Methodology

The total dollar amounts assessed from fines during each month of the reporting period are totaled. Monthly totals are summed to obtain the year-to-date

BL 2010 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	9	Total Dollar Amount Collected from Fines

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total dollar amount of administrative penalties collected for all types of facilities during the reporting period. It also includes the total amount of civil monetary penalties (CMP) collected by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs collected by the federal Centers for Medicare and Medicaid Services (CMS) for facilities participating in Medicare/Medicaid (dually certified) or Medicare programs. A penalty amount collected is the amount that facilities have actually paid to the State Medicaid agency and/or the CMS for penalties assessed.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained monthly from the Accounting Division reports of accounts received for the payment of administrative penalties and civil monetary penalties. They are derived from a combination of the class (appropriation budget) and the cash account (0004500). The reports are named Administrative Penalties, and Civil Monetary Penalties.

BL 2010 Methodology

The total dollar amounts collected from fines during the months of the reporting period are summed. Monthly data are totaled over the reporting period.

BL 2010 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	10	Number of Medicaid Facility and Hospice Service Contracts Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of Medicaid provider contracts issued to nursing facilities, ICF/MR's, and hospice service providers. Contracts issued include new facilities or services contracted, ownership changes resulting in a contract issuance, and re-applications after a facility or service's contract is terminated. Enrollment into the Medicaid program involves the facility/service meeting all Medicaid contracting criteria including acceptable completion of the enrollment/application process, compliance with the pertinent state licensing regulations and compliance with the applicable federal and state Medicaid certification regulations. A Medicaid contract is issued after the facility/service is licensed and/or certified. Based on this contract, the facility or service is eligible for vendor payments for the Medicaid indivduals residing in the facility or Medicaid indivduals receiving hospice services.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the Department of Aging and Disability Services (DADS) Provider Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled "Number of Medicaid Facility Service Contracts Issued" in the future.

BL 2010 Methodology

The number of Medicaid nursing facility contracts issued during the months of the reporting period is summed; the number of ICF/MR contracts issued during the months of the reporting period is summed; and the number of hospice service contracts issued during the months of the reporting period is also summed. These three sums are totaled to obtain the reported data.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the workload expended by the agency in response to its charge of issuing contracts to Medicaid certified nursing facility, ICF/MR and hospice service providers. This data is a tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	11	Number of Home and Community Support Services Agency Licenses Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of licenses issued by the Department of Aging and Disability Services' (DADS) Regulatory Services Home and Community Support Services Agency (HCSSA) staff. For reporting purposes, a license is considered as issued once it has been printed. Each license has a new expiration date printed on it. (This date may differ from the date on which the license is actually printed.) HCSSAs are licensed for one year.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the HCSSA Integrated System Central Data Repository (CDR). Data will be contained in an ad hoc report from the CDR done at the end of the reporting period. This report will be titled "Number of Home and Community Support Services Agency Licenses Issued" in the future.

BL 2010 Methodology

Data for the appropriate number of months in the reporting period is summed.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload of inspecting agencies to ensure their compliance with state and Federal requirements. This data is a useful tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	12	Number Home & Community Support Services Agency Inspections Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of inspections conducted during the reporting period by the Department of Aging and Disability Services (DADS) Regulatory Services Home and Community Support Services Agency (HCSSA). For reporting purposes, an inspection is defined as one of the following: an initial licensing survey; an initial certification survey (Medicare certified agencies), a re-survey (licensed only). A licensing inspection done in conjunction with a survey of a Medicare certified agency is not counted as a separate inspection.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the regional HCSSA workload report (Excel worksheet) submitted monthly and compiled by the Data Management and Analysis Sub-Unit. Data will be contained in an ad hoc report done at the end of the reporting period. This report will be titled “Number of Home & Community Support Services Agency Inspections Conducted” in the future.

BL 2010 Methodology

Monthly data, covering the appropriate months of the reporting period, are totaled.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	13	Number of Complaint Investigations Conducted: HCSSA

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of complaint investigations conducted in Home and Community Support Services Agencies (HCSSA). A complaint investigation is defined as an on-site visit conducted for the purpose of determining compliance with federal and state requirements when a complaint has been filed with the department.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the regional HCSSA workload report (Excel worksheet) submitted monthly and compiled by Data Management and Analysis Sub-unit. Data will be contained in an ad hoc report done at the end of the reporting period. This report will be titled “Number of Complaint Investigations Conducted: HCSSA” in the future.

BL 2010 Methodology

For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	14	# Substantiated Complaint Allegation Abuse/Neglect: Nursing Facilities

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of substantiated complaint allegations of resident abuse and/or neglect in nursing facilities during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional 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 inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse and neglect of children residing in nursing facilities is defined by Texas Family Code, Section 261.001.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegation Abuse/Neglect: Nursing Facilities” in the future.

BL 2010 Methodology

This measure is computed by summing the number of substantiated complaint allegations of abuse/neglect in nursing facilities during the months of the reporting period.

BL 2010 Purpose

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

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	15	# Substantiated Complaint Allegations of Abuse/Neglect: ALF

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of substantiated complaint allegations of abuse and/or neglect in assisted living (AL) facilities during the state fiscal year. Abuse and neglect are defined by state and federal regulations. {See outcome measure 4 for the definitions of abuse and neglect.}

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegations of Abuse/Neglect: ALF” in the future.

BL 2010 Methodology

The numbers of substantiated complaint allegations of abuse/neglect in assisted living facilities during the months of the reporting period are totaled.

BL 2010 Purpose

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

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	16	# Substantiated Complaint Allegations of Abuse/Neglect: Adult Day Care

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of substantiated complaint allegations of abuse and/or neglect in adult day care facilities during the state fiscal year. Abuse and neglect are defined by state and federal regulations. {See outcome measure 4 for the definitions of abuse and neglect.}

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegations of Abuse/Neglect: Adult Day Care” in the future.

BL 2010 Methodology

The numbers of substantiated complaint allegations of abuse/neglect in adult day health care centers during the months of the reporting period are totaled.

BL 2010 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in adult day health care centers. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	17	Number of Substantiated Complaint Allegations of Abuse/Neglect: ICF/MR

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of substantiated complaint allegations of abuse and/or neglect in Intermediate Care Facilities for the Mentally Retarded (ICF/MR) 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

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “Number of Substantiated Complaint Allegations of Abuse/Neglect: ICF/MR” in the future.

BL 2010 Methodology

This measure is computed by summing the number of substantiated complaint allegations of abuse/neglect in ICFs/MR during the months of the reporting

BL 2010 Purpose

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in ICFs/MR. 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
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	18	# Substantiated Complaint Allegations Physical Plant: NF

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in nursing facilities (NF) during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegations Physical Plant: NF” in the future.

BL 2010 Methodology

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2010 Purpose

This measure is important because it provides the actual number of known unsafe conditions 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
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	19	# Substantiated Complaint Allegations Unsafe Physical Plant: ALF

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in assisted living facilities (ALF) during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegations Unsafe Physical Plant: ALF” in the future.

BL 2010 Methodology

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2010 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in assisted living facilities. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	20	# Substantiated Complaint Allegations Unsafe Physical Plant: ADC

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in adult day care (ADC) facilities during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegations Unsafe Physical Plant: ADC” in the future.

BL 2010 Methodology

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2010 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in adult day care facilities. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	21	# Substantiated Complaint Allegations of Unsafe Physical: ICF/MR

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in Intermediate Care Facilities for the Mentally Retarded (ICF/MR) during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the 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 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 “# Substantiated Complaint Allegations of Unsafe Physical Plant: ICF/MR” in the future.

BL 2010 Methodology

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

BL 2010 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in ICFs/MRs. 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
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	22	# of Initial HCS and TxHmL Reviews Completed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of initial reviews completed on Home Community Services (HCS) and Texas Home Living (TxHmL) contracts. An initial review is defined as an on-site visit conducted for the purpose of determining compliance with state requirements for certification with the department.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from an Access database which records all reviews completed. The Access database is maintained by Waiver Survey and Certification staff. Data is entered into the database as review reports are submitted. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

BL 2010 Methodology

For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload of certifying HCS and TxHmL contracts to ensure their compliance with state requirements. This data is a useful tool for projecting future funding

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	23	# of Initial Hcs & TxHmL Recertification Reviews Completed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of annual reviews completed on Home Community Services (HCS) and Texas Home Living (TxHmL) contracts. An annual certification review is defined as an on-site visit conducted for the purpose of determining compliance with state requirements for re-certification with the

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from an Access database which records all reviews completed. The Access database is maintained by Waiver Survey and Certification staff. Data is entered into the database as review reports are submitted. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

BL 2010 Methodology

For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the agency's workload of certifying HCS and TxHmL contracts to ensure their compliance with state requirements. This data is a useful tool for projecting future funding

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	24	Number of Abuse/Neglect Reports Received: HCS and TxHmL Providers

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of final reports received from Texas Department of Family and Protective Services (DFPS) related to allegations of abuse, neglect or exploitation of persons served in the Home and Community-Based Services (HCS) or Texas Home Living (TxHmL) waivers.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from an Access database. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

BL 2010 Methodology

The numbers of final reports related to allegations of abuse, neglect or exploitation of persons served in the HCS or TxHmL waivers during the months of the reporting period are totaled.

BL 2010 Purpose

This measure is important because it shows the actual number of reports received related to abuse, neglect or exploitation of persons who receive HCS or TxHmL waiver services. It is a tool for assessing the frequency and outcomes of the DFPS investigations related to the HCS and TxHmL waivers.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	1	Facility and Community-Based Regulation
Measure Type	OP	
Measure No.	25	Number of Abuse/Neglect Reports Reviewed: HCS and TxHmL Providers

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 539 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of reviews conducted by Waiver Survey and Certification staff of final reports received from Texas Department of Family and Protective Services (DFPS) related to allegations of abuse, neglect or exploitation of persons who receive services through the Home and Community-Based Services (HCS) and Texas Home Living (TxHmL) waivers.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from data entry in an Access database. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

BL 2010 Methodology

The numbers of reviews conducted by Waiver Survey and Certification staff related to final reports received from DFPS related to exploitation of persons served in the HCS and TxHmL waivers.

BL 2010 Purpose

This measure is important because it represents the workload for staff related to follow up on allegations of abuse, neglect or exploitation. It is a tool for assessing the care consumers receive and compliance of HCS and TxHmL contractors to state requirements. It is also useful as a tool for forecasting future

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	EF	
Measure No.	1	Average Cost Per License Issued: Nursing Facility Administrators

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost per license issued to nursing facility administrators. The issuance of licenses establishes the minimal competency of practitioners.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

The number of nursing facility administrator licenses is currently entered in a FoxPro system maintained by the Texas Department of Aging and Disability Services (DADS). The cost of nursing facility administrator licensing staff will be obtained from the Health and Human Services Administrative System.

BL 2010 Methodology

The average cost is calculated by dividing the total cost of the direct charge for nursing facility administrator licensing staff by the total number of licenses issued. The total cost of nursing facility administrator licensing staff includes salary, travel, and overhead of direct staff identified by budgeted-job-number plus a portion of the cost of salary, travel, and overhead of the Licensing Unit supervisor and the Credentialing general administration staff allocated to this function based on full-time equivalents (FTEs). The program activity code overhead costs will be allocated to this function based on FTE. The Credentialing staff will report the total number of licenses issued each reporting period.

BL 2010 Purpose

This measure quantifies the unit cost associated with issuing licenses to nursing facility administrators. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	EF	
Measure No.	2	Average Cost Per Credential Issued: Nurse/Medication Aides

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 02-01-02 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost per issuance of nurse aide certifications and medication aide permits. The issuance of certifications and permits establishes the minimal competency of practitioners.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Nurse Aide Competency Evaluation Service (NACES) reports the number of nurse aide tests given each month. The number of nurse aide certifications is entered in the Nurse Aide Registry. The number of medication aide permits is entered in the Automated Review Management System (ARMS) maintained by Promissor, Inc., which the Department of Aging and Disability Services (DADS) Credentialing staff has access to. The cost of nurse aide registry staff and medication aide staff are obtained from the Health and Human Services Administrative System.

BL 2010 Methodology

Divide tot cost of reimbursable nurse aide(NA)tests+tot $ of direct charge NA registry staff who process certs in the Credentialing Sec. & 95% of medication aide(MA)staff by tot # of certs & permits issued. Tot $ of reimbursable NA tests is obtained by multiplying the set fee/test X the tot # of tests given. Fee/test is set by contract w Promisssor. The $ of NA registry staff who process certs (ID by BJN) includes $ of salary, travel & overhead + portion of $ of salary, travel & overhead of NA Unit supervisor & Credentialing general admin staff allocated to this functon based on FTE. $ of MA staff issuing permits (ID by BJN) includes $ of salary, travel & overhead X 95% + portion of salary, travel & overhead $ of Licensing Unit supervisor & Credentialing general admin staff allocated to this function based on FTE. PAC overhead $ will be allocated to this function based on FTE. Credentialing staff will report the tot # certifications, permits & licenses issued each reporting period.

BL 2010 Purpose

This measure quantifies the unit cost associated with issuing credentials to nurse aides and medication aides. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	EF	
Measure No.	3	Average Cost Per Complaint Resolved: Nursing Facility Administrators

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 02-01-02 EF 03

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost per referral or complaint on nursing facility administrators. The resolution of the referrals and complaints maintains the function of establishing the minimal competency of practitioners.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Referrals are received from the Regulatory Services staff and complaints are received from the public. The number of referrals and complaints received is captured by the CARTS (Complaints and Referral Tracking Systems) database maintained by the Professional and Credentialing Enforcement unit of Regulatory Services. The cost of the Complaints and Investigations unit will be obtained from the Health and Human Services Administrative System.

BL 2010 Methodology

The average is calculated by dividing the total cost of direct charge staff in the Investigations branch plus the reimbursements made to the Nursing Facilities Administrators Advisory Committee members for travel expenses by the total number of referrals and complaints received. The calculation of this average will be exclusive of the costs for legal support. The cost of staff in the Investigations branch (excluding one BJN) includes the cost of salary, travel, and overhead plus a portion of the cost of salary, travel, and overhead of the Professional Credentialing Enforcement general administration staff allocated to this function based on full-time equivalents (FTE). The program activity code overhead costs will be allocated to this function based on FTE. The staff in the Investigations branch will report the number of referrals and complaints received for the reporting period.

BL 2010 Purpose

This measure quantifies the unit cost associated with pursuing the validity of complaints and referrals of nursing facility administrators. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	EF	
Measure No.	4	Average Cost Per Complaint Resolved: Nurse/Medication Aides

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 539 080-R-S70-1 02-01-02 EF 04

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost per referral on nurse aides, medication aides, and uncredentialed direct care personnel. The resolution of the referrals maintains the function of establishing the minimal competency of practitioners.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Referrals are received from Regulatory Services staff. The number of referrals received is tracked in the Employee Misconduct Registry (EMR) and Nurse Aide and Medication Aide tracking databases. The cost of the staff handling referrals on nurse aides, medication aides, and uncredentialed staff is obtained from the Health and Human Services Administrative System.

BL 2010 Methodology

Divide tot cost($) of a staff in the Nurse Aide Registry (NAR)unit, 5% of a medication aide (MA), 100% of Employee Misconduct Registry (EMR) staff & 5% of a progr spec ingen admin supvising EMR staff by tot # of referrals & complaints received. Calculation excludes $ for legal support & intake of complaints/ investigations for NAs. Staff $ of NAR unit handling NA complaints (ID by BJN) include salary, travel & overhead (STO) + part $ of STO of NAR unit supervsor & Credentalng gen admin staff alloc to this function based on FTE. MA staff $ (ID by BJN) include STO X 5% + part of STO $ of Licensng supervsor & Credentalng gen admin staff alloc to this function based on FTE. EMR staff $ (ID by BJN) include STO + 5% of STO of a prog spec in gen admin directly supervsing EMR staff & part STO of Credentalng gen admin staff alloc to this functionbased on FTE. PAC OH $ are alloc based on FTE. Complaints/Investigations Unit reports # of referrals/complaints received in the reporting period.

BL 2010 Purpose

This measure quantifies the unit cost associated with pursuing the validity of complaints and referrals of nurse aides, medication aides, and uncredentialed direct care personnel. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	OP	
Measure No.	1	Number of Licenses Issued Per Year: Nursing Facility Administrators

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of licenses issued or renewed for nursing facility administrators during all months of the reporting period.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the automated nursing facility administrator database.

BL 2010 Methodology

Data are calculated by totaling the number of licenses issued and renewed during the months of the reporting period.

BL 2010 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	OP	
Measure No.	2	Number of Credentials Issued Per Year: Nurse/Medication Aides

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 539 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of credentials issued or renewed for nurse aides and medication aides during all months of the reporting period.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Data are obtained from the Automated Review Management System (ARMS).

BL 2010 Methodology

Data are computed by totaling the number of permits and certifications issued or renewed during the months of the reporting period.

BL 2010 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	OP	
Measure No.	3	Number of Complaints Resolved/Year: Nursing Facility Administrators

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the total number of complaints and referrals against nursing facility administrators that were resolved during all months of the reporting period. Complaints and referrals are resolved by the Department of Aging and Disability Services (DADS), either administratively by the Professional Credentialing Enforcement branch or through formal Hearings conducted by the Department's Legal Division.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

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

BL 2010 Methodology

Data are computed by totaling the number of complaints and referrals dismissed by the Department and number of cases resolved through formal hearing or settlement during the months of the reporting period.

BL 2010 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	2	Credentialing/Certification
Measure Type	OP	
Measure No.	4	Number of Complaints Resolved/Year: Nurse/Medication Aides/Direct Care

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of referrals against medication aides, nurse aides, and uncredentialed staff that have been resolved. The uncredentialed staff is all direct care personnel not licensed by another state agency in long-term care facilities licensed by the Department of Aging and Disability Services (DADS). Referrals are resolved by DADS either administratively by the Professional Credentialing Enforcement branch or through formal hearings conducted by the department's Legal Division.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

This information is collected manually. Manual collections of data are pen and paper tabulations of information manually pulled from Employee Misconduct Registry, Nurse Aide and Mediation Aide tracking database. There are no report titles or identifying numbers associated with this process.

BL 2010 Methodology

Data are computed by tabulating the number of referrals with final action of dismissal or imposition of sanctions for each month of the reporting period. These monthly numbers for each of the months in the reporting period are summed.

BL 2010 Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This data is useful in projecting future funding needs.

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

Goal No.	2	Regulation, Certification, and Outreach
Objective No.	1	Regulation, Certification, and Outreach
Strategy No.	3	Long-Term Care Quality Outreach
Measure Type	EF	
Measure No.	1	Average Cost Per Quality Monitoring Program Visit

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 539 080-R-S70-1 02-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of a unit of work of the Quality Monitoring Program during the reporting period. In the case of Quality Monitoring Visits, each visit represents a number of units of work equal to the number of days required to conduct the visit. Rapid Response Team visits, requiring two or more monitors, will represent two or more units of work. Work units for Provider Technical Assistance Meetings that require the participation of quality monitor program staff is equal to the number of facilities that attend the educational meeting.

BL 2010 Data Limitations

Does not apply.

BL 2010 Data Source

Units of work are obtained from a visit database that records actual units of work and checked against monthly activity reports collected by the Quality Monitoring Program managers. The average cost per unit of work is calculated from the program budget and the units of work. There is no specific report name

BL 2010 Methodology

The total number of completed work units is determined from the quality monitoring visits, rapid response team visits and facility participation in provider technical assistance meetings occurring during the reporting period. The quarterly program budget is one-fourth of the annual total distributed to the regions for

BL 2010 Purpose

This measure is a mechanism for assessing the unit cost of implementing the provisions of this strategy.

Agency Code: 538 Agency: **Assistive and Rehabilitative Services, Department of**

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

Goal No. 1 Goal No. 2 Ensure Children and Their Families Reach Their Developmental Goals
Objective No. 1 Objective No. 1 Ensure Targeted Families Receive Resources and Supports
Outcome No. 1 Outcome No. 3 Percent of Population Under Age Three Served

Calculation Method: N Key Measure: Y New Measure: N Target Attainment: H Priority: H Cross Reference: Agy 538 080-R-S70-1 01-01 OC 01

Measure Type OP
Measure No. 1 Number of Quality Monitoring Visits to Nursing Facilities

BL 2010 Definition

This measure reports the number of Quality Monitoring Program Work Units that are comprised of Quality Monitoring Visits, Rapid Response Team visits, and Provider Technical Assistance Meetings for nursing facilities during the reporting period. Quality Monitoring visits are usually performed by a single quality monitor; Rapid Response Team visits require two or more quality monitors. Both visit types involve individual facilities. Provider Technical Assistance Meetings, like Rapid Response Team visits, are multidisciplinary; in addition, they provide technical assistance to multiple providers at once. Visit priority is assigned through the use of an Early Warning System algorithm. In this measure, a "visit" is defined as the deployment of an individual monitor to a facility; more precisely this is the program's unit of work, and Rapid Response Team visits may represent 2 or more units of work (because they may require 2 or more monitors).

CONTINUED BELOW IN DATA LIMITATIONS

BL 2010 Data Limitations

Does Not apply

BL 2010 Purpose

This performance measure is important because it evaluates progress towards serving the number of children targeted for intervention.

CONTINUATION OF DEFINITION

Provider Technical Assistance Meeting work units are determined from number of facilities that actually attend each such meeting. Technical assistance meetings involve a small number of facilities (usually fewer than ten) brought together for an intensive technical assistance session.

BL 2010 Data Source

Units of work are obtained from a visit database that records actual units of work and checked against monthly activity reports collected by the Quality Monitoring Program managers. There is no specific report name or number.

BL 2010 Methodology

The total number of completed monitoring visits is determined by counting the number of visits identified as Quality Monitoring visits (including Rapid Response visits) occurring during the reporting period. Similarly, Provider Education Meetings are counted from records of the events.

Calculation Method: C Key Measure: N New Measure: N Target Attainment: L Priority: H Cross Reference: Agy 539 080-R-S70-1 02-01-03 OP

Fall/Annual: N

BL 2010 Definition

The number of children who received comprehensive intervention services through ECI service providers expressed as a percentage of the total number of Texas children under three years of age.

BL 2010 Data Limitations

The accuracy of local program reporting is periodically verified through monitoring. Accurate reporting requires local programs to meet timelines for data entry into TKIDS.

BL 2010 Data Source

Local providers enter data into the Texas Kids Intervention Data System (TKIDS). Using TKIDS data, determine the number of children receiving comprehensive services in the fiscal year. Population projections are obtained from data files provided by the Texas State Data Center.

BL 2010 Methodology

Determine the total number of children served by counting the number of cases that were in the enrolled disposition anytime during the reporting period. Exclude from the count cases that were closed with a reason indicating invalid data entry and cases in which children turned three years old before the first day of the reporting period. Count only once cases that transferred from one local program to another. Determine an estimate of the Texas birth-to-three population for the year using a four-year cohort of children age 0-1, 1-2 and 2-3 for the year and children 0-1 for the following year. Divide the total number of children served by the Texas birth-to-three population estimate. Multiply by 100 to obtain a percentage.

BL 2010 Purpose

This performance measure is important because it evaluates progress towards serving the number of children targeted for intervention.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Outcome No.	2	Percent Growth in Number of Children Enrolled

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 538 080-R-S70-1 01-01 OC 02

BL 2010 Definition

The average number of children enrolled in comprehensive services during the fiscal year expressed as a percent of the average number of children enrolled in comprehensive services during the previous fiscal year.

BL 2010 Data Limitations

The accuracy of local program reporting is periodically verified through monitoring. Accurate reporting requires local program to meet timelines for data entry into TKIDS. This measure can only be calculated on an annual basis.

BL 2010 Data Source

Local providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of children enrolled in comprehensive services on the last day of the month, as indicated by cases in the enrolled disposition on the last day of the month.

BL 2010 Methodology

Determine the monthly enrollment by counting the total number of cases in the enrolled disposition on the last day of the month. Exclude cases that were closed with a reason indicating invalid data entry, cases in which children turned three years old before or on the last day of the month, and cases that were exited and/or closed on the last day of the month. Compute the average monthly enrollment for the fiscal year. Subtract from that the average monthly enrollment for the previous fiscal year. Divide the result by the average monthly enrollment for the previous fiscal year. Multiply by 100 to obtain a percentage.

BL 2010 Purpose

This measure is important because it provides information on trends in the rate of growth of the number of children served from year to year. This data is essential to project future service and fiscal needs.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	2	Blind Children's Vocational Discovery and Development Services
Outcome No.	1	Percent of Children Successfully Completing Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 538 080-R-S70-1 01-02 OC 01

BL 2010 Definition

Measures the percent of children completing program services in the Blind Children's Vocational Discovery and Development Program.

BL 2010 Data Limitations

The source of the data is records entered by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance

BL 2010 Data Source

Service personnel in field offices enter all data for the children they serve into the agency's database. Criteria for successful and unsuccessful closures and coding requirements are contained in the Blind Children's Vocational Discovery and Development Program's service delivery manual. Monthly reports document the number of successful and unsuccessful closures in the program.

BL 2010 Methodology

The total number of consumers meeting the requirements for successful closure is divided by the total number of consumers closed during the reporting

BL 2010 Purpose

This measure reflects the percentage of children who complete program services. Completing program services is the desired outcome of service for each child. Potential results of services may include the restoration of vision, halting the progressive loss of vision, or the blind child and family having the tools and resources needed to maximize the child's independence, educational opportunity, vocational discovery, and development required for success as an

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Outcome No.	1	Average Earnings Per Business Enterprises of Texas Consumer Employed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 538 080-R-S70-1 02-01 OC 01

BL 2010 Definition

Measures the average earnings per manager employed through Business Enterprises of Texas (BET).

BL 2010 Data Limitations

The source of the data is records of Supervising Business Consultants (SBCs) who contact and serve managers. These records are a reliable source of data and a reliable indicator of the performance attained. The method utilized for the estimation of the last two months of manager net earnings is detailed but is subject to the usual concerns associated with the projection of future events.

BL 2010 Data Source

SBCs support and monitor managers employed through the strategy. They record data about each manager supported/monitored. Using the agency's Cumulative Statement of BET Stand Operations mainframe computer application and the strategy's roster of assigned Licensed Managers as the source of data, the average earnings per manager is calculated.

BL 2010 Methodology

Average earnings are computed by dividing the number of managers employed during the reporting period into the net proceeds of managers employed. The annual performance is calculated by dividing the annual number of managers employed into the annual net proceeds of managers employed. In completing this calculation, an estimation of the last two months of manager net earnings must be projected due to the processing and reconciliation lag time related to the submission of monthly manager earnings statements. The annual net earnings estimation is completed by utilizing the available reconciled earnings data and projecting the remainder of the fiscal year net earnings with considerations for anticipated earnings variations due to pending facility closures and openings, anticipated increases or decreases of facility manager bases, pending facility renovations, anticipated changes in facility security restrictions, and anticipated changes to facility product offerings.

BL 2010 Purpose

This measure states the average earnings of managers employed through the BET during the reporting period and consists of net earnings from the management of a cafeteria, snack bar, and/or vending facility. Average earnings reflect the quality of employment opportunities in the program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Outcome No.	2	Percent of VR Consumers Exiting Program & Remaining Employed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 538 080-R-S70-1 02-01 OC 02

BL 2010 Definition

Measures percent of successful rehabilitants exiting the Vocational Rehabilitation Program whose employment remains recorded on the State UI wage

BL 2010 Data Limitations

Unemployment Insurance (UI) wage records do not capture information for each individual exiting the program. For instance, consumers in federal employment and those who are self-employed are not reported in the UI system. Therefore not all of the employed exiters can be counted. UI wage records become available approximately six months after the fact. As a result, reports on this measure will be based on the most current information available through the UI system, which will report on consumer populations exiting the program between 12 and 23 months earlier.

BL 2010 Data Source

DARS/Division for Blind Services contracts with the Texas Workforce Commission to obtain data from unemployment insurance, UI wage records related to specific DARS consumer records.

BL 2010 Methodology

The Social Security numbers of VR exiters with employment outcomes (obtained or maintained) are cross-matched with the SSNs in the TWC UI wage records database to identify those exiters whose exit quarter employment is captured in the UI database.
For those exiters whose exit quarter employment is matched in the UI database, the SSNs are crossmatched with the SSNs in the UI database to identify those exiters who continue to appear in the UI wage records during the 2nd and 3rd quarters after the employment quarter. The employment quarter is equivalent to the 1st quarter. The percentage reported is the percentage of exiters who continue to have earnings reported in the UI database during the 2nd and 3rd quarters after the employment quarter. The numerator is the number of matched exiters who continue to have earnings in the 2nd and 3rd quarters after the employment quarter. The denominator is the number of exiters whose exit quarter employment is matched in the UI database.

BL 2010 Purpose

This measure addresses the extent to which services provided by the strategy enable individuals to obtain and retain employment. Employment retention is a desired outcome of the Vocational Rehabilitation Program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Outcome No.	3	Percent of VR Consumers Who Achieve Employment Outcomes

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 538 080-R-S70-1 02-01 OC 03

BL 2010 Definition

Measures the percent of consumers who achieve employment outcomes in the Vocational Rehabilitation Program.

BL 2010 Data Limitations

The source of the data is records entered by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance attained. However, the flow of individuals completing their services and achieving employment does not lend itself to routine 25% increments throughout the year. Thus, performance early in the year is likely to vary significantly from the 25% and 50% standard.

BL 2010 Data Source

Service delivery personnel in field offices enter all data for the consumers they serve into the agency's database. A record of each consumer is begun at the point an application for services is taken or a referral is received. Caseload carrying staff records service results, including detailed information regarding employment results. The number of individuals who achieve successful employment and sustain it a minimum of 90 days, as well as the number of individuals exiting the program without achieving employment, are included in a quarterly Information Resources report.

BL 2010 Methodology

The number of consumers who exit the program after achieving successful employment and sustaining it a minimum of 90 days is divided by the total number of consumers exiting the program after receiving services. The first quarter reports year-to-date the total number of consumers exiting the program, delineating between those who achieve their rehabilitation goals and those who did not achieve their rehabilitation goals. Subsequent quarters reflect consumers closed either successfully or unsuccessfully employed during the respective quarter. (Activity for quarters two through four is calculated by subtracting the year-to-date total from the current quarter from the year-to-date total for the previous quarter.) The sum of all quarters equals the unduplicated year-to-date count of number of consumers exiting the program after receiving services.

BL 2010 Purpose

Employment is the desired result of the Vocational Rehabilitation Program. Services provided are directed to identifying and improving, removing or accommodating for the individual's visual limitations. A consumer is considered successful when all services needed and planned to obtain or retain employment goals are completed and the individual has been employed in a suitable occupation for a minimum of 90 days.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Outcome No.	1	Percent of Certified Interpreters with No Recent Ethics Violations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 538 080-R-S70-1 02-02 OC 01

BL 2010 Definition

This measures the percentage of certified interpreters with no recent violations. This is a measure of customer service satisfaction with the quality of interpreters certified by the program.

BL 2010 Data Limitations

This measure is limited by factors outside of the agency's control.

BL 2010 Data Source

Agency reports on complaints resolved and agency database documenting the number of certified interpreters are the data sources.

BL 2010 Methodology

Subtract the number of interpreters with recent violations from the number of certified interpreters and then divide by the number of certified interpreters.

BL 2010 Purpose

To ensure interpreter compliance with rules and standards of ethical behavior to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Outcome No.	1	Percent of VR Consumers Who Achieve Employment Outcomes

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 538 080-R-S70-1 02-03 OC 01

BL 2010 Definition

Percent of eligible people with disabilities placed in competitive employment or other appropriate settings who have completed vocational rehabilitation services. Number of eligible people is defined as those who have applied, been determined eligible and who received planned services under an Individualized Plan for Employment (IPE).

BL 2010 Data Limitations

The percentage is not achieved evenly through out the fiscal year, since at the beginning of each fiscal year consumers are continuing services begun in the previous fiscal year.

BL 2010 Data Source

Data is from DRS' consumer statistical system. Field staff working with consumer collect, input, and update consumer data concerning eligibility, ongoing service status, and closure status into this system.

BL 2010 Methodology

The percentage is found by dividing the number persons (consumers) who are successfully placed into employment or other appropriate settings by the total number of eligible consumers who received services under an Individualized Plan for Employment (IPE) who were closed either successfully or unsuccessfully. Non-cumulative

BL 2010 Purpose

This measure allows DRS to evaluate the success rate for successful rehabilitation of eligible consumers into employment. This measure is an important indicator for factors impacting the VR service delivery system. "This measure has been identified as a "formal" measure representing job placement rate at DRS, pursuant to SB 429 (77R)".

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Outcome No.	2	Percent of Consumers Served Who Have Significant Disabilities

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 538 080-R-S70-1 02-03 OC 02

BL 2010 Definition

Percent of consumers who achieve an employment outcome in competitive, self-, or BEP employment who have significant disabilities. The number of rehabilitants achieving an employment outcome in competitive, self-, or BEP employment whose disabilities are considered significant divided by the total number of rehabilitants achieving an employment outcome in competitive, self-, or BEP employment.

BL 2010 Data Limitations

Consumers receiving services within a fiscal year are carried-over from one quarter to the next.

BL 2010 Data Source

The number of rehabilitants and number of rehabilitants with significant disabilities are from DRS' consumer statistical system. Field staff working with consumers collect, input, and update consumer data concerning eligibility, ongoing service status, and significance level of disabling condition, into this

BL 2010 Methodology

The number of rehabilitants achieving an employment outcome in competitive, self-, or BEP employment whose disabilities are identified as significant divided by the total number of rehabilitants achieving an employment outcome in competitive, self-, or BEP employment. Information is reported quarterly.

BL 2010 Purpose

DRS is required under the Rehabilitation Act to serve consumers with significant disabilities, and this measure enables DRS to closely monitor its activity in this area. Data collection for this measure also provides insight into disability groups served and types of disability related services provided. Consumers with "significant" disabilities typically present more complex problems which require more time and a more varied array of services to rehabilitate.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Outcome No.	3	Percent of VR Consumers Exiting Program & Remaining Employed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 538 080-R-S70-1 02-03 OC 03

BL 2010 Definition

Measures percent of successful rehabilitants exiting the Vocational Rehabilitation Program whose employment remains recorded on the state UI wage

BL 2010 Data Limitations

Unemployment Insurance (UI) wage records do not capture information for each individual exiting the program. For instance, consumers in federal employment and those who are self-employed are not reported in the UI system. Therefore not all of the employed exiters can be counted. UI wage records become available approximately six months after the employed quarter. As a result, reports on this measure will be based on the most current information available through the UI wage records, which will report on consumer populations exiting the program between 12 and 23 months earlier.

BL 2010 Data Source

DARS/Division for Rehabilitation Services contracts with the Texas Workforce Commission to obtain data from Unemployment Insurance wage records related to specific DARS consumer records.

BL 2010 Methodology

The Social Security numbers (SSNs) of VR exiters with employment outcomes are cross-matched with the SSNs in the TWC UI wage records database to identify those exiters whose exit quarter employment is captured in the UI database.
For those exiters whose exit quarter employment is matched in the UI database, the SSNs are cross-matched with the SSNs in the UI database to identify those exiters who continue to appear in the UI wage records during the second and third quarters after the employment quarter. The employment quarter is equivalent to the first quarter.
The percentage reported is the percentage of exiters who continue to have earnings reported in the UI database during the second and third quarters after the employment quarter. The numerator is the number of matched exiters who continue to have earnings in the second and third quarters after the employment quarter. The denominator is the number of exiters whose exit quarter employment is matched in the UI database.

BL 2010 Purpose

This measure addresses the extent to which services provided by the strategy enable individuals to obtain and retain employment. Employment retention is a desired outcome of the Vocational Rehabilitation Program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	3	Provide Disability Determination Services within SSA Guidelines
Objective No.	1	Increase Decisional Accuracy and Timeliness of Determinations
Outcome No.	1	Percent of Case Decisions That Are Accurate

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: L** **Cross Reference:** Agy 538 080-R-S70-1 03-01 OC 01

BL 2010 Definition

The percentage of cases that can be processed without being returned to the State agency for further development or for correction of decisions based on evidence in the file as reported monthly by the SSA Office of Quality Performance.

BL 2010 Data Limitations

Quality attributes are determined by SSA policy. The cases receiving a quality review are a random sample and do not include all case categories. The guidance for this review is found in SSA's Programs Operations Manual System (POMS), Section 30005.001ff. For example, "Group I" (Decisional Errors) are the only errors that affect the DDS accuracy rate. "Group II" (Onset) and "Group III" (Technical) are not factored into the DDS's accuracy rate. The reviews are done by SSA components.

BL 2010 Data Source

Based on evidence reported monthly by the SSA Office of Quality Performance.

BL 2010 Methodology

Determined by SSA formula. Figures are non-cumulative.

BL 2010 Purpose

Shows improvement in the accuracy in disability determination decisions.

Agency Code: 538 Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	3	1	Provide Disability Determination Services within SSA Guidelines
Objective No.	1	1	Increase Decisional Accuracy and Timeliness of Determinations
Outcome No.	2	1	Number of Case Processing Days Below Target

Measure Type EF

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** **Cross Reference:** Agy 538 080-R-S70-1 03-01 OC 02

Measure No. 1 Average Monthly Cost Per Child: Comprehensive Services/State & Federal

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

Fall/Annual: N

BL 2010 Definition

Number of case processing days that are below target. The target is the case processing time goal established by the State agency (DDS). Processing time is the average number of days from the time the state agency receives the claim until the completed determination is put into the National Disability Determination Services System (NDDSS).

BL 2010 Data Limitations

The reasons that cases are put on 'medical hold' in order that evaluation would follow a medical stabilization period. There are 'administrative hold' reasons for issues awaiting legislative or policy clarification. The hold process obviously increases the number of case processing days.

BL 2010 Data Source

Information is reported monthly by the National Disability Determination Services System. This measure is determined by internal calculations using information from NDDSS. It is not directly derived from NDDSS.

BL 2010 Methodology

This number is subtracted from the target to arrive at days below target. Weekends and holidays are counted. This measure is determined by subtracting the number of actual processing days to clear a case from the target. The higher the measure, the better the performance. Non-cumulative.

BL 2010 Purpose

The measure is useful because it focuses solely on results, serves the needs of multiple audiences, and is the basis for documenting annual performance trends. As a measure, it is a basis not only for determining aggregate divisional timeliness but also for timeliness comparisons at the director, unit and

BL 2010 Definition

A monthly average of state and federal funds expended for services divided by the monthly average of children receiving comprehensive services in the reporting period. State and federal funds are revenues Early Childhood Intervention receives from the Texas Legislature, the U.S. Department of Education, Title XIX (DRS, TCM, MAC), and other State and Federal sources specifically for early childhood intervention services.

BL 2010 Data Limitations

The accuracy of State and Federal funds expended for ECI services is verified periodically through monitoring and reviews of annual audits. State and Federal funds expenditure data may not be complete as provider monthly requests for reimbursement are not submitted until 30 days after the end of the month.

BL 2010 Data Source

The Program Accounting System (HHSAS), which is reconciled to Uniform Statewide Accounting System (USAS). Quarterly and annual financial reports, financial report items: State and Federal funds, expended by quarter for ECI services. TKIDS: number served in comprehensive services.

BL 2010 Methodology

DARS appropriation authority includes all general revenue and federal funds allocated to the ECI services strategy. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. The numerator is the total DARS appropriation authority funds utilized to fund ECI services. The denominator is the average monthly number of comprehensive children served in ECI services. The formula is numerator/denominator.

BL 2010 Purpose

This measure is important because it provides information regarding the cost to Early Childhood Intervention of providing comprehensive services to eligible children. This data can be used for projecting future expenditures and evaluating performance.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	EF	
Measure No.	2	Average Monthly Cost Per Child: Comprehensive Services/Local

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

Fall/Annual: N

BL 2010 Definition

A monthly average of local funds collected and expended for comprehensive services divided by the monthly average of children receiving comprehensive services in the reporting period. Local funds include all revenue expended by ECI providers for comprehensive services other than the State and Federal funds described in the efficiency measure for Comprehensive Services/State and Federal funds.

BL 2010 Data Limitations

The accuracy of local funds expended for ECI services is periodically verified through monitoring and reviews of annual audits. Local funds expenditure data may not be complete as provider quarterly and annual reports are not submitted until 30 days after the end of the quarter.

BL 2010 Data Source

Quarterly and annual financial reports, financial report items: funding sources that comprise local funds expended for early childhood intervention services. TKIDS: number served in comprehensive services.

BL 2010 Methodology

DARS appropriation authority includes all local funds allocated to the ECI Services. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. The numerator is the total local funds utilized to fund the ECI Services program. The denominator is the average monthly number of comprehensive children served in ECI services. The formula is numerator/denominator.

BL 2010 Purpose

This measure is important because it provides the agency with information regarding the cost of providing comprehensive services to eligible children from sources other than Early Childhood Intervention. This data can be used for projecting future expenditures and comparing local costs and performance.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	EX	
Measure No.	1	Average Amount of Medicaid Dollars Per Medicaid Enrolled Child

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 01-01-03 EX 01

Fall/Annual: N

BL 2010 Definition

Total Medicaid dollars collected by ECI providers as a result of early childhood intervention services divided by the number of Medicaid children served in comprehensive services in the reporting period. Medicaid includes funds from Targeted Case Management (TCM), THSteps-Comprehensive Care Program (CCP), and Developmental Rehabilitation Services (DRS).

BL 2010 Data Limitations

The accuracy of Medicaid funds collected by ECI providers for early childhood intervention services is verified periodically through monitoring. The number of Medicaid children served includes children who are enrolled in Medicaid at any time during the year.

BL 2010 Data Source

Quarterly and annual financial reports, financial report item: Medicaid funds collected by ECI providers. Texas Medicaid Provider Procedures Manual item: FFP rate for providers who receive the federal matching share portion of Medicaid reimbursement. TKIDS: number of Medicaid children served in

BL 2010 Methodology

Calculate Medicaid dollars collected by summing collections reported by or attributed to ECI providers from TCM, THSteps-CCP, and DRS. Add the estimated state matching share for TCM and DRS. Sum the Medicaid children served by each provider to get the total statewide Medicaid children served. Divide the Medicaid dollars collected by the number of Medicaid children served.

BL 2010 Purpose

This measure is important because it evaluates progress toward maximizing Medicaid dollars collected by ECI providers.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	EX	
Measure No.	2	Total Local Community Expenditures (Non-Medicaid)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 01-01-03 EX 02

Fall/Annual: N

BL 2010 Definition

Total Local Community Contributions (non-Medicaid). Local funds expended by ECI providers in the reporting period for early childhood intervention services. Local funds include all funds except State and Federal funds from Early Childhood Intervention and Medicaid funds not included in the State and Federal funds.

BL 2010 Data Limitations

The accuracy of local funds expended by ECI providers for early childhood intervention services is verified periodically through monitoring.

BL 2010 Data Source

Quarterly and annual financial reports, financial report item: local funds expended by ECI providers for early childhood intervention services.

BL 2010 Methodology

Calculate the sum of local funds expended by ECI providers in the reporting period for early childhood intervention services.

BL 2010 Purpose

This measure is important because it allows us to track the total dollar amount of local community contributions over time.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	OP	
Measure No.	1	Average Monthly Number of Referrals to Local Programs

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

Fall/Annual: N

BL 2010 Definition

A monthly average of referrals (unduplicated by month) to local ECI contract providers.

BL 2010 Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2010 Data Source

Local contract providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated monthly referrals, as identified by cases that entered the referral disposition in the reporting period.

BL 2010 Methodology

The unduplicated number of referrals is summed for each month of the reporting period, and the total is divided by the number of months in the reporting

BL 2010 Purpose

This measure is important because it aids the agency in evaluating the impact of state and local public awareness and child find activities, and because higher referrals reflect more effective outreach activities.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	OP	
Measure No.	2	Average Monthly Number of Children Receiving Follow Along Services

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

Fall/Annual: N

BL 2010 Definition

A monthly average of children who are receive follow along services (unduplicated by month) in ECI programs.

BL 2010 Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2010 Data Source

Local contract providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated children receiving follow along services monthly, as indicated by cases in the follow along disposition in the reporting period.

BL 2010 Methodology

The unduplicated number of children receiving follow along services is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

BL 2010 Purpose

Follow along services are offered to families whose children are not eligible for ECI, but are at risk and may need comprehensive services at a later date. This measure assists in the analysis of referral trends and helps identify changes needed in eligibility criteria.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	OP	
Measure No.	3	Average Monthly Number of Children Receiving Eligibility Services

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

Fall/Annual: N

BL 2010 Definition

A monthly average of children who receive eligibility determination services (unduplicated by month) in ECI programs.

BL 2010 Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2010 Data Source

Local contract providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated children receiving eligibility determination services monthly, as indicated by cases that entered the eligibility determination disposition in the reporting period or received a screening prior to the start of the eligibility determination disposition.

BL 2010 Methodology

The unduplicated number of children receiving eligibility determination services is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

BL 2010 Purpose

This measure is important because it informs the agency of the level of effort directed toward identifying children, determining eligibility and establishing a plan for services.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	OP	
Measure No.	4	Number of Monitoring Visits Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 01-01-03 OP

Fall/Annual: N

BL 2010 Definition

The number of on-site monitoring trips conducted to determine fiscal and/or program compliance.

BL 2010 Data Limitations

This measure does not include in-house monitoring activities.

BL 2010 Data Source

Entries are recorded in the ECI Monitoring Trip Log, which is a log of fiscal and/or programmatic monitoring visits conducted by agency staff.

BL 2010 Methodology

Sum the log entries for fiscal and/or programmatic monitoring trips completed during the reporting period.

BL 2010 Purpose

This measure is important because it describes the level of agency activity directed toward maintaining quality services and compliance with Federal and State laws, rules, and policies as measured by the number of on-site monitoring trips.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	1	Early Childhood Intervention Services
Measure Type	OP	
Measure No.	5	Average Monthly Number of Children Served in Comprehensive Services

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

Fall/Annual: N

BL 2010 Definition

A monthly average of children who are receive comprehensive intervention services (unduplicated by month) in ECI programs.

BL 2010 Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2010 Data Source

Local contract providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated children receiving comprehensive services monthly, as indicated by cases in the enrolled disposition in the reporting period.

BL 2010 Methodology

The unduplicated number of children receiving comprehensive services is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

BL 2010 Purpose

This measure is important because it is an indication of the number of children eligible for and receiving comprehensive services. This measure is a reflection of the level of performance of the agency and local providers.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	2	Respite Services
Measure Type	OP	
Measure No.	1	Average Monthly Number of Children Receiving Respite Services

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 01-01-04 OP

Fall/Annual: N

BL 2010 Definition

A monthly average of children (and their families) who are receive respite services in ECI programs.

BL 2010 Data Limitations

The accuracy of the data is dependent upon the accurate and timely submission of respite reports by local contractors. Counts cannot be unduplicated across programs because the State does not collect this data at the client-level.

BL 2010 Data Source

Local contract providers submit Respite Reports at the end of each quarter. These reports include an item that identifies the number of children receiving respite each month in the quarter.

BL 2010 Methodology

The number of children receiving respite is summed for each month of the reporting period, and the total is divided by the number of months in the reporting

BL 2010 Purpose

Some families of children with developmental delays and disabilities need respite. Monitoring the level of respite services provided to ECI families is important to project future service needs and fiscal needs.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	3	Ensure Quality ECI Services by Training, Evaluation and Assistance
Measure Type	EF	
Measure No.	1	Average Time for Complaint Resolution

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 01-01-05 EF 01

Fall/Annual: N

BL 2010 Definition

The number of calendar days per complaint resolved, summed for all complaints resolved, that elapsed from receipt of a request for agency investigation to the date upon which final action on the complaint was taken by the Executive Director, divided by the number of complaints resolved. The calculation excludes complaints determined to be not under the jurisdiction of the agency's statutory authority.

BL 2010 Data Limitations

This measure applies only to jurisdictional complaints.

BL 2010 Data Source

Entries are made in the ECI Complaint Log. The ECI Complaint Log is a list, by fiscal year, of complaints filed against the agency or its local providers, and the date of final disposition. Issuance of a letter of findings or documentation of complaint withdrawal is considered final disposition and resolution.

BL 2010 Methodology

The number of days required for the final disposition of a complaint is determined by the number of calendar days from the date the written complaint was received by the ECI state office staff to the date of the complaint's final disposition. Final disposition is determined by the date of the findings letter or letter verifying complaint withdrawal.

BL 2010 Purpose

This measure is important because it provides the agency with information regarding the time state staff spend investigating formal complaints in order to evaluate the efficiency of the process and the agency's compliance with federal statute.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	1	Ensure Targeted Families Receive Resources and Supports
Strategy No.	3	Ensure Quality ECI Services by Training, Evaluation and Assistance
Measure Type	OP	
Measure No.	1	Number of Specialists Completing Credentialing

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 538 080-R-S70-1 01-01-05 OP

Fall/Annual: N

BL 2010 Definition

This is the number of new Early Intervention Specialist (EIS) Professionals who complete the EIS Professional Competency Demonstration System during the

BL 2010 Data Limitations

Rates of growth and turnover of EIS Professional staff positions are difficult to estimate.

BL 2010 Data Source

Data are entered into the registry of EIS Professionals, which is a database of all ECI personnel who are enrolled in the Competency Demonstration System.

BL 2010 Methodology

Calculate the unduplicated total count of certificates of completion issued within the quarter.

BL 2010 Purpose

This measure is important because it provides the agency with information regarding the number of newly credentialed Early Intervention Specialists who can provide services to ECI children. This data assists the agency in planning to meet future professional shortages.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	2	Blind Children's Vocational Discovery and Development Services
Strategy No.	1	Habilitative Services for Blind and Visually Impaired Children
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Child Served

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: L** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 01-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

Measures the average monthly cost per child served in the Blind Children's Vocational Discovery and Development Program (BCVDDP).

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data sources are the DARS' Accounting System (HHSAS) for expenditures and encumbrances and Performance Measure 01-02-01-OP-01: "Average Monthly Number of Children Receiving Habilitative Services" for consumer data.

BL 2010 Methodology

DARS appropriation authority includes all general revenue and federal funds allocated to the Habilitative Services for Children strategy. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. The numerator is the total DARS appropriation authority funds utilized to fund the habilitative services for children program. The denominator is the average monthly number of children receiving habilitative services. The formula is numerator/denominator.

BL 2010 Purpose

This measure tracks the average monthly cost per child served through the Habilitative Services for Children strategy. It provides one indication of the efficiency of the program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	2	Blind Children's Vocational Discovery and Development Services
Strategy No.	1	Habilitative Services for Blind and Visually Impaired Children
Measure Type	EX	
Measure No.	1	# Receiving Habilitative Services (End-of-Year)

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

Fall/Annual: N

BL 2010 Definition

Measures the number of children receiving services at the end of the fiscal year by the Blind Children's Vocational Discovery and Development Program.

BL 2010 Data Limitations

Data reliability is dependent on the accuracy of information entered by field staff into the DBS consumer statistical system.

BL 2010 Data Source

Data is from the DBS consumer statistical system. Field staff who work with consumers collect, input, and update consumer data in this system.

BL 2010 Methodology

The DBS consumer statistical system assigns a unique identification number for each case. Cases in open status at any time during the fiscal year are included in the count.

BL 2010 Purpose

DBS establishes a target for the population in need of services that can reasonably be served within available resources. This measure tracks and demonstrates progress toward meeting that target.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	2	Blind Children's Vocational Discovery and Development Services
Strategy No.	1	Habilitative Services for Blind and Visually Impaired Children
Measure Type	OP	
Measure No.	1	Average Monthly Number of Children Receiving Habilitative Services

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

A monthly average of children receiving services during the reporting period by the Blind Children's Vocational Discovery and Development Program.

BL 2010 Data Limitations

Data reliability is dependent on the accuracy of information entered by field staff into the DBS consumer statistical system.

BL 2010 Data Source

Data is from the DBS consumer statistical system. Field staff who work with consumers collect, input, and update consumer data in this system.

BL 2010 Methodology

The DBS consumer statistical system assigns a unique identification number for each case. Cases in open status at any time during the reporting period are included in the calculated average. The numerator is the total unduplicated number of cases receiving services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2010 Purpose

DBS establishes a target for the population in need of services that can reasonably be served within available resources. This measure tracks and demonstrates progress toward meeting that target.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	3	Autism Services
Strategy No.	1	Autism Program
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Child Receiving Autism Services

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

Fall/Annual: N

BL 2010 Definition

A monthly average of state funds expended for services divided by the average monthly number of children receiving autism services in the reporting period.

BL 2010 Data Limitations

Data reliability is dependent on the accuracy of information submitted to DARS by autism grantees.

BL 2010 Data Source

Data sources for this measure are 1) Monthly Services and Funds Report, and 2) Consumer Data Report.

BL 2010 Methodology

DARS appropriation authority includes all general revenue funds allocated to the Autism Program strategy. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. The numerator is the total DARS appropriation authority funds utilized to fund the autism program. The denominator is the average monthly number of children receiving autism services. The formula is numerator/denominator.

BL 2010 Purpose

This measure allows DARS to monitor grant funds expended and to ensure costs are in line with monthly projections.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	3	Autism Services
Strategy No.	1	Autism Program
Measure Type	EX	
Measure No.	1	# Receiving Autism Services (End-of-Year)

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

Fall/Annual: N

BL 2010 Definition

Measures the number of children served at the end of the fiscal year by the DARS Autism Program.

BL 2010 Data Limitations

Data reliability is dependent on the accuracy of information submitted to DARS by autism grantees.

BL 2010 Data Source

Data sources for this measure are: 1) Monthly Services and Funds Report and 2) Consumer Data Report.

BL 2010 Methodology

Sum of unduplicated children served during the fiscal year.

BL 2010 Purpose

Autism grantees establish a target for the number of children with autism to be served within available resources. This measure tracks progress toward meeting that target.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	1	Ensure Children and Their Families Reach Their Developmental Goals
Objective No.	3	Autism Services
Strategy No.	1	Autism Program
Measure Type	OP	
Measure No.	1	Average Monthly Number of Children Receiving Autism Services

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

Fall/Annual: N

BL 2010 Definition

A monthly average of unduplicated children who are receiving or who have received autism services in the DARS Autism Program.

BL 2010 Data Limitations

Data reliability is dependent on the accuracy of information submitted to DARS by autism grantees.

BL 2010 Data Source

Data sources for this measure are: 1) Monthly Services and Funds Report, and 2) Consumer Data Report.

BL 2010 Methodology

Cases in open status at any time during the reporting period are included in the calculated average. The numerator is the total unduplicated number of cases receiving services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is

BL 2010 Purpose

Autism grantees establish a target for the number of children with autism to be served within available resources. This measure tracks progress toward meeting that target.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	1	Independent Living Services - Blind
Measure Type	EF	
Measure No.	1	Average Cost Per Consumer Served

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

Measures the average cost per consumer served in the Independent Living Program.

BL 2010 Data Limitations

The source of the data is records entered by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance attained. However, the flow of individuals served does not occur in 25% quarterly increments throughout the year. Individuals served on the last day of the previous state fiscal year “carry forward” into the first quarter of the subsequent year. Thus, performance early in the year is likely to vary significantly from the 25% or 50% standard. It is also important that average cost information be used carefully by external parties for accurate comparison between agencies, assuring data is compiled consistently and that the comparisons are parallel.

BL 2010 Data Source

Operational costs for the Independent Living strategy as reflected on the agency's Internal Operating Budget mainframe application are the source for this item. The data reflect the strategy's central and district office expenditures and outstanding encumbrances.

BL 2010 Methodology

The total strategy expenditures and encumbrances divided by the number of consumers served.

BL 2010 Purpose

This measure states the average cost per consumer served through the Independent Living strategy. It provides one indication of the efficiency of the program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	1	Independent Living Services - Blind
Measure Type	OP	
Measure No.	1	Number of Consumers Served

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of consumers served in the Independent Living Program.

BL 2010 Data Limitations

The source of data is records entered into the agency's database by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance attained. However, the flow of individuals served does not occur in 25% quarterly increments throughout the year. Individuals served on the last day of the previous state fiscal year "carry forward" into the first quarter of the subsequent year. Thus, performance early in the year is likely to vary significantly from the 25% or 50% standard.

BL 2010 Data Source

Service personnel in field offices enter all data for the consumers they serve into the agency's database. A record of each consumer is begun at the point an application for services is taken or a referral is received. Regular updates record significant data including accomplishments of goals. Criteria for successful case closure is detailed in the Independent Living Manual. A database report compiles the total count of individuals who achieved their goals.

BL 2010 Methodology

The first quarter reports the total number of consumers served in the strategy year-to-date. Subsequent quarters reflect consumers added to caseloads during the respective quarter. (Activity for quarters two through four is calculated by subtracting the year-to- date total for the current quarter from the year-to-date total for the previous quarter.) The sum of all quarters equals an unduplicated count of the number of consumers served year-to-date.

BL 2010 Purpose

Visual loss is a common experience as people age. As the number of older Texans increases, the number of individuals likely to experience serious reduction in their vision also increases dramatically. Instruction from trained professionals in adaptive skills and information about adaptive aids help the consumer develop the self-confidence and new skills necessary to independently manage their daily lives. Depending on individual need, services might include: (1) accessing community activities and services; (2) counseling to facilitate adjusting to the vision loss; (3) specialized skills training in adaptive approaches to performing daily living activities such as traveling safely, preparing meals, using print enlarging devices, handling correspondence, financial management, etc. This measure reflects an unduplicated count of the number of those served by the strategy during the state fiscal year. Criteria defining blindness or severe visual impairment are included in agency manuals.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	1	Independent Living Services - Blind
Measure Type	OP	
Measure No.	2	Number of Consumers Who Achieved Independent Living Goals

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of consumers who achieved Independent Living goals.

BL 2010 Data Limitations

The source of the data is records entered by service delivery personnel who contact and serve consumers. It is a reliable indicator of the performance attained. However, because individuals' needs vary, the time it takes a consumer to complete services also varies and does not necessarily mirror the fixed quarterly reporting periods. Thus, performance in the early quarters of the fiscal year may vary significantly from the 25% and 50% standard.

BL 2010 Data Source

Service personnel in field offices enter all data for the consumers they serve into the agency's database. A record of each consumer is begun at the point an application for services is taken or a referral is received. Regular updates record significant data, including accomplishment of goals. Criteria for successful case closure is detailed in the Independent Living Manual. A database report compiles the total count of individuals who achieved their goals.

BL 2010 Methodology

The first quarter equals the total number of consumers who achieved their independent living goals year-to-date. Subsequent quarters reflect consumers completing their goals during the respective quarter. (Activity for quarters two through four is calculated by subtracting the year-to-date total for the current quarter from the year-to-date total for the previous quarter.) The sum of all quarters equals an unduplicated count of the number of consumers served year- to-

BL 2010 Purpose

Vision loss is a very personal experience, touching individuals in different ways. Program staff and consumers identify the individual's goals and services needed to achieve them. This measure reflects the extent to which consumers realize those personal goals.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	2	Blindness Education, Screening and Treatment Program
Measure Type	EF	
Measure No.	1	Average Cost Per Individual Served by BEST Program

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

Measures the average cost per individual receiving screening and treatment services by the BEST program.

BL 2010 Data Limitations

The source of data for individuals receiving screening services is the screening provider and is an actual count of individuals served by the program. Internal data is used to record and count the total number of individuals receiving treatment services.

BL 2010 Data Source

Expenditures and outstanding encumbrances for the program are recorded through internal accounting. Vendors submit documentation to substantiate requests for funds. Data includes year-to-date costs for BEST screening and treatment services and the year-to-date total expenditures for the individuals served by each component of the program.

BL 2010 Methodology

Performance is calculated by totaling year-to-date expenditures and outstanding encumbrances for BEST program services relating to identification and treatment that prevents blindness, divided by the number of individuals receiving these services.

BL 2010 Purpose

This measure is an indication of the efficiency of the program. It reflects the average per person cost for vision loss prevention service provided by the agency.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	2	Blindness Education, Screening and Treatment Program
Measure Type	OP	
Measure No.	1	# Individuals Receiving Screening & Treatment Svcs in BEST Program

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of individuals served by the BEST program.

BL 2010 Data Limitations

Actual performance on screening and treatment will be influenced by the degree of coordination with existing networks and available funds.

BL 2010 Data Source

Source of data varies by project component. The vendors provide data for the screening component. Agency staff develop a report using vendor data for the screening component and consumer data from the agency's database for the treatment component.

BL 2010 Methodology

Performance is calculated by totaling the number of individuals receiving an eye screening and the number of individuals receiving eye treatment services. The first quarter reports the total number of individuals receiving screening or treatment for preventable causes of blindness who are served in the strategy year-to-date. Subsequent quarters reflect additional individuals served by BEST during the respective quarter. (Activity for quarters two through four is calculated by subtracting the year-to-date total for the current quarter from the year-to-date total for the previous quarters.) The sum of all quarters equals an unduplicated count of the number of individuals served year-to-date.

BL 2010 Purpose

A large number of Texans face serious vision loss or blindness. The population most at risk includes individuals over age 40, those predisposed to diabetes and glaucoma and Texans who are not covered by an adequate health insurance plan. The BEST program includes three components designed to prevent vision loss: public education about blindness and prevention strategies, screenings to identify individuals with conditions which may cause blindness, and treatment procedures necessary to prevent blindness. Performance indicates how many consumers have received vision loss prevention services provided by the agency. The program will be implemented only to the extent that funds are available through voluntary donations.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	3	Voc Rehab Services for Persons Who are Blind or Visually Impaired
Measure Type	EF	
Measure No.	1	Average Cost Per Consumer Served

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

Measures the average cost per consumer served in the Vocational Rehabilitation Program (VR).

BL 2010 Data Limitations

The source of the data is records entered into the agency's database by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance attained. However, the flow of individuals served does not occur in 25% quarterly increments throughout the year. Individuals served on the last day of the previous state fiscal year "carry forward" into the first quarter of the subsequent year. Thus, performance early in the year is likely to vary significantly from the 25% or 50% standard.

BL 2010 Data Source

Operational costs for VR as reflected under activity level Vocational Rehabilitation in the agency's Internal Operating Budget mainframe application serve as the source for this item. The data reflect the strategy's central and district office expenditures and outstanding encumbrances.

BL 2010 Methodology

The total strategy expenditures and encumbrances divided by the number of individuals served.

BL 2010 Purpose

This measure states the average cost per consumer served through the VR strategy. It provides one indication of the efficiency of the program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	3	Voc Rehab Services for Persons Who are Blind or Visually Impaired
Measure Type	OP	
Measure No.	1	Number of Consumers Served

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-01-03 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of consumers served in the Vocational Rehabilitation Program.

BL 2010 Data Limitations

The source of data is records entered into the agency's database by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance attained. However, the flow of individuals served does not occur in 25% quarterly increments throughout the year. Individuals served on the last day of the previous state fiscal year "carry forward" into the first quarter of the subsequent year. Thus, performance early in the year is likely to vary significantly from the 25% or 50% standard.

BL 2010 Data Source

Service delivery personnel in field offices enter all data for the consumers they serve into the agency's database. A record of each consumer is begun at the point an application for services is taken or a referral is received. An Information Resources report compiles the number of consumers entered by service delivery personnel during the year.

BL 2010 Methodology

The first quarter reports the total number of consumers served in the strategy year-to-date. Subsequent quarters reflect consumers added to caseloads during the respective quarter. (Activity for quarters two through four is calculated by subtracting the year-to-date total from the current quarter from the year-to-date total for the previous quarter.)The sum of all quarters equals an unduplicated count of the number of consumers served year-to-date.

BL 2010 Purpose

People who are blind or significantly visually impaired are more likely to experience unemployment or underemployment than their sighted peers. Employers and the business community are generally unaware of their employment potential and the adaptive options available to "level the playing field". Few resources provide the specialized services required to assist people who are blind with getting or retaining employment. Vocational Rehabilitation bridges the gap by addressing how vision affects each individual uniquely. Services are planned with that person to overcome individual concerns that affect successful employment (e.g., independent travel, personal appearance/self-care, managing finances, alternatives to reading and writing regular print, technology needs, etc.)This measure reports the number of individuals receiving services from the strategy during the reporting period.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	3	Voc Rehab Services for Persons Who are Blind or Visually Impaired
Measure Type	OP	
Measure No.	2	Number of Consumers Who Achieved Employment Outcomes

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-01-03 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of consumers who achieved employment outcomes in the Vocational Rehabilitation Program.

BL 2010 Data Limitations

The source of the data is records entered by service delivery personnel who contact and serve consumers. This is a reliable indicator of the performance attained. However, the flow of individuals completing their services and achieving employment does not lend itself to routine 25% increments throughout the year. Thus, performance early in the year is likely to vary significantly from the 25% and 50% standard.

BL 2010 Data Source

Service delivery personnel in field offices enter all data for the consumers they serve into the agency's database. A record of each consumer is begun at the point an application for services is taken or a referral is received. Caseload carrying staff records service results, including detailed information regarding employment results. The number of individuals who achieve successful employment and sustain it a minimum of 90 days is included in a quarterly Information

BL 2010 Methodology

The first quarter reports the total number of consumers who have achieved their employment outcome year-to-date. Subsequent quarters reflect consumers closed as successfully employed during the respective quarter. (Activity for quarters two through four is calculated by subtracting the year-to-date total from the current quarter from the year-to-date total for the previous quarter.) The sum of all quarters equals the unduplicated count of the number of consumers who achieved employment outcome year-to-date.

BL 2010 Purpose

Employment is the desired result of the Vocational Rehabilitation Program. Services provided are directed to identifying and improving, removing or accommodating for the individual's visual limitations. A consumer is considered successful when all services needed and planned to obtain or retain employment goals are completed and the individual has been employed in a suitable occupation a minimum of 90 days.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	4	Provide Employment in Food Service Industry for Persons Who are Blind
Measure Type	EX	
Measure No.	1	Number of Facilities Supported and Monitored by BET Staff

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-01-04 EX 01

Fall/Annual: N

BL 2010 Definition

Measures the number of facilities supported and monitored by the Business Enterprises of Texas (BET) staff, which are utilized for creating employment opportunities for blind managers licensed through BET.

BL 2010 Data Limitations

The source of the data is the BET Vending Facility Database. This is a reliable indicator of performance obtained.

BL 2010 Data Source

Using the BET Vending Facility Database, the number of facilities under contract, and supported and monitored by BET staff, during the reporting period is

BL 2010 Methodology

Calculate the sum of facilities under contract, and supported and monitored by BET staff, in the reporting period.

BL 2010 Purpose

This measure reports performance related to the number of facilities under contract, and supported and monitored by the Business Enterprises of Texas staff, that are available for conversion to manned facilities. A facility consists of vending machines. The measure gauges the success of the program in maintaining the resources to expand employment opportunities for blind Texans.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	4	Provide Employment in Food Service Industry for Persons Who are Blind
Measure Type	OP	
Measure No.	1	Number of Indiv. Employed by BET Businesses (Managers and Employees)

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-01-04 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of individuals (managers and employees) benefiting from employment opportunities created as a result of the BET program. A manager is defined as a blind individual licensed to participate in the BET program. An employee is defined as an individual employed by a licensed BET manager.

BL 2010 Data Limitations

The source of the data is records of BET Business Consultants who support and monitor businesses maintained by this strategy and managers licensed to operate businesses maintained by BET. These are reliable indicators of the performance attained.

BL 2010 Data Source

The Business Enterprises of Texas Manager/Facility Roster will be utilized for determining the current number of licensed managers operating businesses at the end of each quarter. The BET monthly facility reports presented by licensed managers will be utilized for determining the number of individuals (managers and employees) benefiting from employment created by BET Businesses at the end of each quarter. The numbers derived from these two sources will be totaled to determine quarterly performance.

BL 2010 Methodology

Using the current Business Enterprises of Texas Manager/Facility Roster, the number of licensed managers who are employed at the end of each quarter is calculated. Utilizing the monthly facility reports submitted by licensed managers, the number of employees at the end of each quarter is calculated. This calculation insures an unduplicated count of managers and their employees.

BL 2010 Purpose

This measure states the number of licensed managers and employees benefiting from employment through the strategy during the reporting period. It is important to measure the overall employment benefit to Texans through this strategy.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	1	Rehabilitation Services for Persons Who Are Blind or Visually Impaired
Strategy No.	4	Provide Employment in Food Service Industry for Persons Who are Blind
Measure Type	OP	
Measure No.	2	Number of Businesses Operated by Blind Managers

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-01-04 OP

Fall/Annual: N

BL 2010 Definition

Measures the number of businesses operated by blind managers that are supported and monitored by Business Enterprises of Texas (BET) staff.

BL 2010 Data Limitations

The source of the data is the records of the BET Business Consultants that support and monitor businesses operated within the BET program. These are reliable indicators of performance obtained.

BL 2010 Data Source

Using the BET Facility rosters as the source of data, the number of existing and new businesses operated by blind managers during the reporting period is

BL 2010 Methodology

Calculate the unduplicated total count of businesses operated by blind managers within the quarter. Year-to-date performance is calculated by adding the number of new businesses opened at any time during the year and subtracting those businesses that closed from the count of businesses calculated in the first quarter. For the year-to-date calculation, a business is only counted in the quarter in which it first became operational.

BL 2010 Purpose

This measure reports the number of businesses operated by blind managers licensed by the Business Enterprises of Texas. A business may consist of a cafeteria, a snack bar, and/or manned vending machines. The measure gauges the success of the program in maintaining and expanding employment

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	1	Contract For Services for Persons Who Are Deaf or Hard of Hearing
Measure Type	EF	
Measure No.	1	Average Cost Per Individual Served

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measures the average cost per individual served.

BL 2010 Data Limitations

This measure is limited by the type of project proposed by contractors for the various services provided.

BL 2010 Data Source

Reports submitted by contractors on the number of individuals receiving some type of communication access and agency records of program costs are the sources of data.

BL 2010 Methodology

The total strategy expenditures and encumbrances divided by the number of individuals served.

BL 2010 Purpose

To determine the cost of communication access services based on the number of individuals served.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	1	Contract For Services for Persons Who Are Deaf or Hard of Hearing
Measure Type	OP	
Measure No.	1	Number Receiving Communication Access Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measures the total number of individuals who are deaf or hard of hearing who received communication access services. Communication access includes services such as interpreting, CART, information and referral, services to senior citizens and case coordination.

BL 2010 Data Limitations

This measure is limited to measuring only persons who are deaf or hard of hearing. This measure does not include those individuals with whom persons who are deaf or hard or hearing are trying to communicate. This measure is limited by the type of project proposed by contractors for the various services provided.

BL 2010 Data Source

Reports submitted by contractors on the number of individuals receiving some type of communication access service and agency records are the sources of data. Data does not include services provided under the interagency contracts.

BL 2010 Methodology

Calculate the total number of individuals receiving some type of communication access service.

BL 2010 Purpose

To promote an effective system of services to individuals who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	1	Contract For Services for Persons Who Are Deaf or Hard of Hearing
Measure Type	OP	
Measure No.	2	Number of On Site Reviews of Contracted Entities

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 538 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of contractor on site reviews completed each quarter. These on site reviews are used to determine contractors' performances in compliance with contracts.

BL 2010 Data Limitations

This measure is limited by the number of contracts awarded.

BL 2010 Data Source

A count provided by agency staff who conduct on site reviews is the data source. This does not include other monitoring activities that occur which are done on a monthly basis as a desk review.

BL 2010 Methodology

Calculate the number of on site reviews conducted by agency staff.

BL 2010 Purpose

To ensure contractors' compliance with contracts to promote an effective system of services to individuals who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	EF	
Measure No.	1	Average Cost Per Consumer Educated and Interpreter Trained

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 538 080-R-S70-1 02-02-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measures the average cost of consumer education and interpreter training provided to both adults and children.

BL 2010 Data Limitations

This measure is limited by the amount of donations/grants the agency may receive, the amount of administrative fees generated from interagency contracts and the types of projects proposed and contracted.

BL 2010 Data Source

Agency records of participant sign-in sheets and of the costs associated with education and training are the data sources.

BL 2010 Methodology

The total amount of funds expended for consumer education and interpreter training divided by the number of consumers educated and interpreters trained will provide the average cost for the agency to train an individual.

BL 2010 Purpose

To determine the cost of the training and education provided based on the number of participants.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	EF	
Measure No.	2	Average Cost Per Interpreter Certificate Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-02-02 EF 02

Fall/Annual: N

BL 2010 Definition

This measures the average cost per interpreter certificate issued.

BL 2010 Data Limitations

There are no data limitations anticipated.

BL 2010 Data Source

Agency records of program costs and a personal computer database showing number of certificates issued are the data sources.

BL 2010 Methodology

The total amount of funds expended for the program divided by the number of certificates issued.

BL 2010 Purpose

To assist the agency in assessing actual costs to administer the program and to set fee levels to recover costs.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	EF	
Measure No.	3	Average Time for Ethics Complaint Resolution

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-02-02 EF 03

Fall/Annual: N

BL 2010 Definition

This measures the average number of days to resolve a certified interpreter ethics complaint. This measure is related to attaining customer satisfaction.

BL 2010 Data Limitations

This measure is limited by the complexity of the issue to be resolved and the number of individuals involved.

BL 2010 Data Source

Agency records of the dates complaints are received and the dates complaints are resolved is the data source

BL 2010 Methodology

Count the number of days between the dates complaints are received and the dates complaints are resolved divided by the number of complaints resolved during a fiscal year.

BL 2010 Purpose

To ensure interpreter compliance with rules and standards of ethical behavior to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	OP	
Measure No.	1	Number of Consumers Educated and Interpreters Trained

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measures the total number of consumers educated and interpreters trained.

BL 2010 Data Limitations

This measure is limited by the amount of donations/grants the agency may receive, the amount of administrative fees generated from interagency contracts and the types of projects proposed and contracted.

BL 2010 Data Source

Agency records of participant sign-in sheets from each education and training event is the data source.

BL 2010 Methodology

Calculate the total number of individuals who were provided education and training.

BL 2010 Purpose

To eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	OP	
Measure No.	2	Number of Interpreter Certificates Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of interpreter certificates issued during a fiscal year.

BL 2010 Data Limitations

This measure is limited by factors outside of the agency's control.

BL 2010 Data Source

Agency database documenting the effective date and the expiration date of a certificate is the data source.

BL 2010 Methodology

Using the agency's database to count the number of certificates issued.

BL 2010 Purpose

To increase the availability and skill levels of interpreters to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	OP	
Measure No.	3	Number of Level 1 (Entry Level) Certifications Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of entry level interpreter certificates issued during a fiscal year.

BL 2010 Data Limitations

This measure is limited by factors outside the agency's control.

BL 2010 Data Source

Agency database documenting the effective date and the expiration date of a certificate is the data source.

BL 2010 Methodology

Using the agency's database to count the number of certificates issued at the entry levels.

BL 2010 Purpose

To increase the availability of interpreters to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	OP	
Measure No.	4	Number of Advanced Skills Certifications Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of advanced skill interpreter certificates issued during a fiscal year.

BL 2010 Data Limitations

This measure is limited by factors outside of the agency's control.

BL 2010 Data Source

Agency database documenting the effective date and the expiration date of a certificate is the data source.

BL 2010 Methodology

Use agency's database to count the number of certificates issued at the advanced levels.

BL 2010 Purpose

To increase the skill levels of interpreters to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	2	Ensure the Quality of Programs through Educ., Training, & Regulation
Measure Type	OP	
Measure No.	5	Number of Individuals Tested

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of interpreters tested during a fiscal year. This is a measure of productivity.

BL 2010 Data Limitations

This data is limited by the number of individuals wanting to take the test.

BL 2010 Data Source

Agency records of the number of interpreters tested during a fiscal year is the data source.

BL 2010 Methodology

Calculate the number of interpreters tested.

BL 2010 Purpose

To increase the availability of interpreters to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	3	Ensure Telephone Access for Deaf and Persons with Other Disabilities
Measure Type	EF	
Measure No.	1	Average Cost Per Equipment/Service Application Processed

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 538 080-R-S70-1 02-02-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measures the average cost for the agency to process each application for specialized telecommunications equipment or services.

BL 2010 Data Limitations

There are no data limitations.

BL 2010 Data Source

Agency records of program costs and agency database of number of applications received are the sources of data.

BL 2010 Methodology

The total amount of funds expended to administer the equipment/service voucher program divided by the number of equipment/service applications processed will give an average cost for the agency to process each application.

BL 2010 Purpose

To determine the cost of the program based on the number of applications received.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	3	Ensure Telephone Access for Deaf and Persons with Other Disabilities
Measure Type	EF	
Measure No.	2	Average Time to Process an Equipment/Service Application Received

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-02-03 EF 02

Fall/Annual: N

BL 2010 Definition

This calculates the average time to process an application into the database from the date the application was received.

BL 2010 Data Limitations

There are no data limitations.

BL 2010 Data Source

Agency database of applications which documents the date the application was received and the date the application was entered into the database.

BL 2010 Methodology

The number of days from the date the application was received to the date the application was entered divided by the number of applications entered.

BL 2010 Purpose

To provide an indication of the responsiveness of agency staff to process an application and generate a voucher or follow-up letter.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	3	Ensure Telephone Access for Deaf and Persons with Other Disabilities
Measure Type	OP	
Measure No.	1	Number of Equipment/Service Applications Received

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-02-03 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of applications for assistance in purchasing specialized telecommunications devices or services that are received by the agency during a fiscal year.

BL 2010 Data Limitations

This measure is limited by factors outside of the agency's control.

BL 2010 Data Source

Agency database documenting the number of applications received is the data source.

BL 2010 Methodology

Use the agency's database to count the number of applications received.

BL 2010 Purpose

To ensure equal access to the telephone system for persons with a disability.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	2	Provide Services to Persons Who Are Deaf or Hard of Hearing
Strategy No.	3	Ensure Telephone Access for Deaf and Persons with Other Disabilities
Measure Type	OP	
Measure No.	2	Number of Equipment/Service Vouchers Issued

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-02-03 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of financial assistance vouchers issued by the agency during the fiscal year to eligible clients enabling them to purchase adaptive equipment or services necessary to access the telephone system.

BL 2010 Data Limitations

This measure does not provide an accurate account of the number of multiple vouchers issued for replacement of lost or expired vouchers.

BL 2010 Data Source

Agency database documenting voucher print date is the data source.

BL 2010 Methodology

Agency database generates a count of vouchers issued for financial assistance.

BL 2010 Purpose

To ensure equal access to the telephone system for persons with a disability.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	1	Rehabilitate & Place People w/Disabilities in Competitive Employment
Measure Type	EF	
Measure No.	1	Cost Per Consumer Served

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-03-01 EF 01

Fall/Annual: N

BL 2010 Definition

The estimated VR accrual basis expenditures fiscal year to date divided by the total number of consumers served fiscal year to date.

BL 2010 Data Limitations

The percentage is not achieved evenly throughout the fiscal year, since the new fiscal year includes consumers carried forward from the previous fiscal year.

BL 2010 Data Source

Field staff working with consumers collect, input, and update the consumer data into the consumer statistical system and record/process service purchases into the financial system.

BL 2010 Methodology

Estimated VR Expenditures fiscal year to date as reported at the end of each quarter divided by the total number of consumers served. Figures are non

BL 2010 Purpose

This measure states the average cost per consumer served through the Vocational Rehabilitation Program. It provides an indication of the efficiency of the

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	1	Rehabilitate & Place People w/Disabilities in Competitive Employment
Measure Type	EX	
Measure No.	1	Number of Applicants for Vocational Rehabilitation Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-01 EX 01

Fall/Annual: N

BL 2010 Definition

The number of persons applying for VR services as evidenced by completion of an applicant profile.

BL 2010 Data Limitations

None

BL 2010 Data Source

Data is from the DRS' automated consumer statistical system. Field staff working with consumers collect, input, and update consumer data concerning application to the program in the automated case management/consumer record system.

BL 2010 Methodology

A count of the number of persons applying for VR services as evidenced by completion of an applicant profile. Cumulative.

BL 2010 Purpose

Measure provides an indication of DRS' outreach efforts to potentially eligible population in need.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	1	Rehabilitate & Place People w/Disabilities in Competitive Employment
Measure Type	EX	
Measure No.	2	% People w/Disabilities Who May Qualify for VR Svcs Receiving Svcs

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 538 080-R-S70-1 02-03-01 EX 02

Fall/Annual: N

BL 2010 Definition

Percent of people with disabilities who may qualify for vocational rehabilitation services receiving services through DRS. The number of people receiving services during a fiscal year per DRS' automated consumer statistical system divided by the estimated number of people with disabilities who may qualify for vocational rehabilitation services.

BL 2010 Data Limitations

DRS cannot draw reliable conclusions from the estimation of people with disabilities who may qualify for VR services since there is no nationally recognized definition of disability. There is also no data available either at the state or national level that accurately describes disability as it is relevant to the vocational rehabilitation program. The definition of "who may qualify for VR services" is derived from 2000 U. S. Census data for Texas and does not define people with disabilities consistently with the federal regulations which guide DRS. The Census definition and therefore the number of persons with disabilities who may qualify for VR services may change every decade as different questions are asked about disability.

BL 2010 Data Source

Data is from DRS' automated consumer statistical system. Field staff working with consumers collect, input, and update consumer data concerning application, eligibility and ongoing service status in the automated case management/consumer record system. Estimate of people with disabilities who may qualify for services are from annual projections provided by the Texas State Data Center at Texas A&M University and HHSC, which are based on national census data.

BL 2010 Methodology

The number of people receiving services during a fiscal year divided by the estimated number of people with disabilities who may qualify for vocational rehabilitation services. Estimate of people with disabilities who may qualify for vocational rehabilitation services are for population, aged 16-64 with a disability who report "having any difficulty working at a job or business". Non-Cumulative

BL 2010 Purpose

This measure is intended to report the percent of people in Texas with disabilities who may qualify for vocational rehabilitation services and do receive services from DRS.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	1	Rehabilitate & Place People w/Disabilities in Competitive Employment
Measure Type	OP	
Measure No.	1	Number of Consumers Served

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-01 OP

Fall/Annual: N

BL 2010 Definition

The total number of individuals making application and provided services, including those services related to determining eligibility for VR, and those eligible consumers already receiving services in a prior fiscal year who continue services in the current fiscal year.

BL 2010 Data Limitations

Number is not achieved evenly through the fiscal year.

BL 2010 Data Source

Data is from DRS' consumer statistical system. Field staff working with consumers collect, input, and update consumer data concerning eligibility and ongoing service status into this system.

BL 2010 Methodology

The measure is a volume count of those consumers making application and provided services including services related to determining eligibility this fiscal year plus those eligible consumers already receiving services in a prior fiscal year who continue services in the current fiscal year. Figures are non-cumulative.

BL 2010 Purpose

Based on anticipated appropriations, DRS establishes a projection for the population in need of VR services that it can reasonably serve with funding levels. This measure tracks and demonstrates the progress made toward meeting that projected need.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	1	Rehabilitate & Place People w/Disabilities in Competitive Employment
Measure Type	OP	
Measure No.	2	Number of Consumers Who Achieved Employment Outcomes

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-01 OP

Fall/Annual: N

BL 2010 Definition

Number of consumers who are successfully placed (maintain employment 90 days) into competitive employment or other appropriate setting.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data is from DRS' consumer statistical system. Field staff working with consumers collect, input, and update consumer data concerning rehabilitated status and employment status into this system. Employment information is verified through routine monitoring efforts.

BL 2010 Methodology

The measure is a volume count of consumers in the consumer statistical system whose status is rehabilitated and employed. Figures are cumulative.

BL 2010 Purpose

The DRS mission is to assist eligible consumers with disabilities to achieve employment. This measure is a key indicator of Agency progress toward the accomplishment of that mission. Rehabilitation and employment assist consumers with disabilities to become more self-sufficient and reduces or eliminates the need for other public assistance programs.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	1	Rehabilitate & Place People w/Disabilities in Competitive Employment
Measure Type	OP	
Measure No.	3	Number of Eligible Consumers Provided Vocational Rehabilitation Svcs

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-01 OP

Fall/Annual: N

BL 2010 Definition

The number of persons determined eligible for services during the reporting period and receiving services plus those consumers determined eligible and receiving services in a prior fiscal year who continue services in the current fiscal year.

BL 2010 Data Limitations

Number is not achieved evenly through the fiscal year.

BL 2010 Data Source

Data is from DRS' consumer statistical system. Field staff working with consumers collect, input, and update consumer data concerning eligibility and ongoing service status into this system.

BL 2010 Methodology

The measure is a volume count of those persons found eligible for services this fiscal year plus those eligible consumers already receiving services in a prior fiscal year who continue services in the current fiscal year. Figures are non-cumulative.

BL 2010 Purpose

Based on anticipated appropriations, DRS establishes a projection for the population in need of VR services that it can reasonably serve with funding levels. This measure tracks and demonstrates the progress made toward meeting that projected need.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	2	Work w/Independent Living Centers & State Independent Living Council
Measure Type	EF	
Measure No.	1	Cost Per Person Served by Independent Living Centers

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 02-03-02 EF 01

Fall/Annual: N

BL 2010 Definition

Estimated Independent Living contract amounts expended by DRS supported IL Centers divided by the number of persons served in DRS supported IL

BL 2010 Data Limitations

The number of consumers served by IL Centers is provided by the centers. DRS does not control the data that is submitted.

BL 2010 Data Source

Consumer information is provided by quarterly reports from DRS supported IL Centers and estimated expenditures are based upon data from DRS financial information system.

BL 2010 Methodology

Estimated IL contract amounts expended by DRS supported IL Centers divided by the number of persons served in DRS supported IL Centers. Non-

BL 2010 Purpose

The purpose of this measure is to calculate the financial resources (costs) needed to serve each consumer.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	2	Work w/Independent Living Centers & State Independent Living Council
Measure Type	OP	
Measure No.	1	Number of People Receiving Services from Independent Living Centers

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 02-03-02 OP

Fall/Annual: N

BL 2010 Definition

Number of people receiving services from DRS supported Independent Living Centers as reported in quarterly reports received from DRS supported IL

BL 2010 Data Limitations

The Division for Rehabilitation Services has no control over the timing of receiving the report data from the centers. Reports on measures submitted contain the available data at the time of report compilation, which is typically one month behind the reporting period.

BL 2010 Data Source

Data collected by the Centers is sent to DRS monthly.

BL 2010 Methodology

Centers are responsible for maintaining demographics on consumers served and monthly reports submitted provide a total count served for the month and on a fiscal year-to-date basis. Figures are non-cumulative.

BL 2010 Purpose

DRS provides flow through funds to centers in order for them to provide independent living core services within their catchments areas. The volume of consumers receiving services is an indicator that centers are achieving their intended purpose.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	3	Provide Consumer-driven Independent Living Services
Measure Type	EF	
Measure No.	1	Avg Monthly Cost/Person Rec'g DRS Supported Independent Living Svcs

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: L** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 02-03-03 EF 01

Fall/Annual: N

BL 2010 Definition

Measures the average monthly cost per person receiving DRS Supported Independent Living Services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Consumer data is provided by DRS' consumer statistical system. Expenditure data is provided through the agency financial system (HHSAS).

BL 2010 Methodology

DARS appropriation authority includes all general revenue and federal funds allocated to the Independent Living Services strategy. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. The numerator is the total DARS appropriation authority funds utilized to fund the independent living services program. The denominator is the average monthly number of people receiving DRS supported independent living services. The formula is numerator/denominator.

BL 2010 Purpose

This measure tracks the average monthly cost per person served through the ILS - General strategy. It provides one indication of the efficiency of the program.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	3	Provide Consumer-driven Independent Living Services
Measure Type	EX	
Measure No.	1	# People Rec'g DRS Supported Independent Living Services (End-of-Year)

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

Fall/Annual: N

BL 2010 Definition

Number of people receiving Division for Rehabilitation Services supported Independent Living Services as reported by DRS' consumer statistical system at the end of the fiscal year.

BL 2010 Data Limitations

None.

BL 2010 Data Source

DRS' consumer statistical system. Field staff working with consumers collect, input, and update the consumer data into this system, from which it is summed for the number served.

BL 2010 Methodology

At the end of the fiscal year, the sum of unduplicated people served. People served is defined as consumers noted in the consumer statistical system whose status in the reporting period was:

- Unsuccessful closure with a plan
- Successful closure
- Post closure
- Post closure completed
- Plan initiated and other resources currently paying for services
- Plan initiated with a purchase order start date on or after plan initiated date for non-diagnostic services

BL 2010 Purpose

The purpose of the Independent Living Services is to increase the independence of people with disabilities in their daily activities. The measure shows the number of consumers provided services. It is important because the agency seeks to serve the maximum number of people with limited resources, and the volume served tracks progress toward the goal the agency set.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	3	Provide Consumer-driven Independent Living Services
Measure Type	OP	
Measure No.	1	Avg Monthly # of People Rec'g DRS Supported Independent Living Svcs

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: H** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 02-03-03 OP

Fall/Annual: N

BL 2010 Definition

A monthly average of people receiving Division for Rehabilitation Services supported Independent Living as reported by DRS' consumer statistical system.

BL 2010 Data Limitations

None.

BL 2010 Data Source

DRS' consumer statistical system. Field staff working with consumers collect, input, and update the consumer data into this system, from which an average of the unduplicated count by month is calculated.

BL 2010 Methodology

The numeric average of unduplicated people served. For each quarter of the fiscal year, the number of people served in each month of the quarter is averaged. For the second, third, and fourth quarters, year-to-date calculations are also obtained. The numerator is the total unduplicated number of people receiving Division for Rehabilitation Services supported Independent Living services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator. People served includes the following:

- Unsuccessful closure with a plan
- Successful closure
- Post closure
- Post closure completed
- Plan initiated and other resources currently paying for services
- Plan initiated with a purchase order start date on or after plan initiated date for non-diagnostic services

BL 2010 Purpose

The purpose of the Independent Living Services is to increase the independence of people with disabilities in their daily activities. The measure shows the average monthly number of consumers provided services. It is important because the agency seeks to serve the maximum number of people with limited resources, and the volume served tracks progress toward the goal the agency set.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	3	Provide Consumer-driven Independent Living Services
Measure Type	OP	
Measure No.	2	Number of Consumers Who Achieved Independent Living Goals

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 538 080-R-S70-1 02-03-03 OP

Fall/Annual: N

BL 2010 Definition

The number of eligible consumers who achieved the independent living goals on their individualized written rehabilitation programs, thereby increasing their level of independent functioning in the home and community.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data is from DRS automated consumer statistical system. Field staff working with consumers collect, input, and update consumer data on achievement of IL goals in the automated case management/consumer record system.

BL 2010 Methodology

Count of the total number of individuals with Independent Living Cases closed "successful" in the reporting period. Non-cumulative.

BL 2010 Purpose

This measure establishes a standard of accountability that DRS can monitor in support of the IL measure for persons receiving IL services.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	4	Provide Services to People with Spinal Cord/Traumatic Brain Injuries
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per CRS Consumer

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: L** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-04 EF 01

Fall/Annual: N

BL 2010 Definition

Measures the average monthly cost per person receiving Comprehensive Rehabilitation Services.

BL 2010 Data Limitations

The agency can not control rising costs of service. This affects the average number of consumers served. Reimbursements from comparable benefits can be difficult to predict. This affects the actual dollars spent and the average cost per consumer.

BL 2010 Data Source

Consumer data is provided by DRS' consumer statistical system. Expenditure data is provided through the agency financial system (HHSAS).

BL 2010 Methodology

DARS appropriation authority includes all general revenue funds allocated to the Comprehensive Rehabilitation Services (CRS) strategy. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. The numerator is the total DARS appropriation authority funds utilized to fund the CRS program. The denominator is the average monthly number of people receiving comprehensive rehabilitation services. The formula is

BL 2010 Purpose

This measure provides information that shows the efficiency of how funds are used. It is important because it provides information on changes in the cost of services. As costs per CRS consumer increases, the number of consumers served decreases.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	4	Provide Services to People with Spinal Cord/Traumatic Brain Injuries
Measure Type	EX	
Measure No.	1	Number of People Receiving Comprehensive Services (End-of-Year)

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-04 EX 01

Fall/Annual: N

BL 2010 Definition

Number of people receiving Comprehensive Rehabilitative Services as reported by DRS' consumer statistical system at the end of the fiscal year.

BL 2010 Data Limitations

None.

BL 2010 Data Source

As funds are allocated to consumers, DRS' consumer statistical system collects and updates information. This information is monitored for accuracy. The data from this system is the source for calculations of this measure.

BL 2010 Methodology

At the end of the fiscal year, the sum of unduplicated people served. People served is defined as consumers noted in the consumer statistical system whose status in the reporting period was:

- Successful closure,
- Post closure,
- Post closure completed,
- Unsuccessful closure plan initiated with funds allocated, or
- Plan initiated with funds allocated.

BL 2010 Purpose

The measure demonstrates provision of critical rehabilitation services to eligible Texans. It is important because an estimated 80% of the consumers age 16 and above who suffer and survive a traumatic spinal cord or traumatic brain injury do not have the resources necessary to pay for inpatient and outpatient comprehensive rehabilitation services and Post Acute Brain Injury rehabilitation services. Research indicates that those who have access to appropriate rehabilitation services tend to experience greater independence and productivity over their lifetime. This results in lowered dependence on public services and an overall savings to the public.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	2	Rehabilitation Services for Persons with Disabilities
Objective No.	3	Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.	4	Provide Services to People with Spinal Cord/Traumatic Brain Injuries
Measure Type	OP	
Measure No.	1	Average Monthly Number of People Comprehensive Rehabilitation Services

Calculation Method: N **Key Measure: Y** **New Measure: Y** **Target Attainment: H** **Priority: H** Cross Reference: Agy 538 080-R-S70-1 02-03-04 OP

Fall/Annual: N

BL 2010 Definition

A monthly average of people receiving Comprehensive Rehabilitation Services as reported by DRS' consumer statistical system.

BL 2010 Data Limitations

None.

BL 2010 Data Source

As funds are allocated to consumers, DRS' consumer statistical system collects and updates information. This information is monitored for accuracy. The data from this system is the source for calculations of this measure.

BL 2010 Methodology

The numeric average of unduplicated people served. For each quarter of the fiscal year, the number of people served in each month of the quarter is averaged. For the second, third, and fourth quarters, year-to-date calculations are also obtained. The numerator is the total unduplicated number of people receiving Comprehensive Rehabilitation Services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator. People served is defined as consumers noted in the consumer statistical system whose status in the reporting period was:

- Successful closure,
- Post closure,
- Post closure completed,
- Unsuccessful closure plan initiated with funds allocated, or
- Plan initiated with funds allocated.

BL 2010 Purpose

The measure demonstrates provision of critical rehabilitation services to eligible Texans. It is important because an estimated 80% of the consumers age 16 and above who suffer and survive a traumatic spinal cord or traumatic brain injuries do not have the resources necessary to pay for inpatient and outpatient comprehensive rehabilitation services and Post Acute Brain Injury rehabilitation services. Research indicates that those who have access to appropriate rehabilitation services tend to experience greater independence and productivity over their lifetime. This results in lowered dependence on public services and an overall savings to the public.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	3	Provide Disability Determination Services within SSA Guidelines
Objective No.	1	Increase Decisional Accuracy and Timeliness of Determinations
Strategy No.	1	Determine Federal SSI and SSDI Eligibility
Measure Type	EF	
Measure No.	1	Cost Per Disability Case Determination

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 538 080-R-S70-1 03-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

Total DDS expenditures per the financial information system divided by the total number of cases determined as reported by the National Disability Determination Services System.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The National Disability Determination Services System. The NDDSS is the Social Security Administration (SSA) management information system for all state DDS's. The DDS's on a weekly basis report workload and staffing information to SSA. This system is found on SSA's DALNET (Dallas SSA Regional Office

BL 2010 Methodology

Total DDS expenditures divided by the total number of cases determined. Figures are non-cumulative.

BL 2010 Purpose

This measure is intended to calculate the cost per case of determining whether an individual is eligible for benefits when they apply to the Social Security Administration for disability benefits.

Agency Code: **538** Agency: **Assistive and Rehabilitative Services, Department of**

Goal No.	3	Provide Disability Determination Services within SSA Guidelines
Objective No.	1	Increase Decisional Accuracy and Timeliness of Determinations
Strategy No.	1	Determine Federal SSI and SSDI Eligibility
Measure Type	OP	
Measure No.	1	Number of Disability Cases Determined

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 538 080-R-S70-1 03-01-01 OP

Fall/Annual: N

BL 2010 Definition

Total number of cases determined as reported by the National Disability Determination Services System (NDDSS). A case is established on an individual and may include multiple claims.

BL 2010 Data Limitations

Data is collected through National Disability Determination Services System.

BL 2010 Data Source

The National Disability Determination Services System. The NDDSS is the Social Security Administration (SSA) management information system for all state DDS's. The DDS's on a weekly basis report workload and staffing information to SSA. This system is found on SSA's DALNET (Dallas SSA Regional Office

BL 2010 Methodology

Total number of cases determined and cleared as reported by the National Disability Determination Services System. Figures are cumulative.

BL 2010 Purpose

The purpose of this measure is to determine whether persons who apply to the Social Security Administration for disability benefits are eligible for benefits.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Outcome No.	1	Average Hold Time for Statewide Intake Phone Calls (English)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-01 OC 01

BL 2010 Definition

Average hold time for handled or abandoned phone calls received at DFPS statewide intake is the elapsed time, in minutes, that callers to the English language application at Statewide Intake (SWI) waited to talk to an agent at Statewide Intake (SWI) or to disconnect from the call.

BL 2010 Data Limitations

None

BL 2010 Data Source

English Language Queue calls from the Automated Call Distributor (ACD) database.

BL 2010 Methodology

Divide the total seconds of wait time for all English Language Queue calls handled by SWI agents or abandoned before being handled by SWI agents during the reporting period (numerator) by the sum of the total number of English Language Queue calls for the reporting period (denominator) to obtain the average hold time in seconds for handled and abandoned calls. Then divide by 60 to convert average hold time to minutes.

BL 2010 Purpose

This measure is used for management purposes, for staffing and resource allocation.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	1	Percent CPS Priority 1 Reports Initiated within 24 Hours of Report

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

BL 2010 Definition

CPS Priority I reports, determined by the current stage priority, are reports that have met the statutory definition of child abuse/neglect and are assigned for investigation. To determine the CPS Priority I reports that had an investigation initiated within 24 hours of the report, subtract the date and time the report was received from the date and time the investigation was initiated.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT.

BL 2010 Methodology

Divide the total number of unduplicated CPS reports designated as Priority I in the intake stage for which an investigation was initiated within 24 hours of being reported to FPS during the reporting period (numerator) by the total number of unduplicated CPS reports designated as Priority 1 in the intake stage where the start date is during the reporting period (denominator). In order to ensure the reports are unduplicated, do not include merged reports. Multiply by 100 to achieve a percentage.

BL 2010 Purpose

This measure provides an indication of the responsiveness of CPS staff to reports of child abuse/neglect that allege a child to be in life threatening

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	2	Incidence Child Abuse/Neglect Confirmed by CPS Per 1,000 TX Children

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 01

BL 2010 Definition

This measure compares the children in CPS confirmed investigations of abuse/neglect for the reporting period to the Texas child population. CPS confirmed investigations are determined by a disposition of ‘Reason to Believe’ (RTB).

BL 2010 Data Limitations

The Population Forecasts report includes estimates and projections. This measure also does not reflect the true basis for service delivery because service delivery is risk-based rather than incident-based. The number confirmed is dependent upon the number of reports.

BL 2010 Data Source

IMPACT. The Texas child population is the count of children who are under the age of 18 years which is obtained from the Texas Comptroller of Public Accounts Population Forecasts report from Texas A&M.

BL 2010 Methodology

Divide the number of children identified as confirmed victims in completed CPS investigations for which a disposition of 'RTB' (indicating confirmed) has been determined substantiating the allegations of abuse/neglect in the reporting period (numerator) by the Texas child population during the reporting period divided by 1,000 (denominator).

BL 2010 Purpose

This measure is used for internal management purposes, particularly with regards to analyzing variances and determining resource allocations.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	3	Percent At-risk Children Who Receive Protective Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 03

BL 2010 Definition

This measure indicates the percentage of children in completed CPS investigations found to have been at-risk of child abuse/neglect and received protective services during the reporting period.

BL 2010 Data Limitations

This measure does not reflect the variability of risk rating, non-purchased services provided during the investigation and general availability of relevant services within the community.

BL 2010 Data Source

IMPACT.

BL 2010 Methodology

Divide the number of children who were found to be at risk of child abuse/neglect and received at least one protective service during the reporting period (numerator) by the total number of children involved in an investigation of child abuse/neglect who are found to be at risk through an assessment (denominator) and multiply by 100 to achieve a percentage. Protective services are safety services during an investigation, opened into in-home services or opened into substitute care. Count the child only once for all the services he/she may receive.

BL 2010 Purpose

The purpose of this measure is to obtain the percentage of children involved in an investigation of child abuse/neglect who are found through an assessment to be at-risk of abuse/neglect and who receive safety services during the investigation or receive in-home or substitute care services at the conclusion of the investigation in the reporting period. This measure is a useful management tool helpful in noting variances across regions/units.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	4	Percent Absence of Maltreatment within Six Months (CPS)

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

BL 2010 Definition

Absence of Repeat Maltreatment is the percent of all children who were confirmed victims of a validated report of maltreatment during the first six months of the reporting period who did not have a subsequent validated instance of maltreatment within a six-month period.

BL 2010 Data Limitations

None.

BL 2010 Data Source

IMPACT.

BL 2010 Methodology

Divide the total number of unique confirmed victims in investigations completed during the first six months of the reporting period for whom there is not a second validated maltreatment for abuse or neglect in a completed investigation where the difference between the two intake dates is between 3 and 183 days (numerator) by the total number of unique confirmed victims in completed investigations where the investigation stage closure date is within the first six months of the reporting period (denominator) and divide by 100 to achieve a percentage.

BL 2010 Purpose

The purpose for this measure is to assess the degree to which children did not experience repeat maltreatment after an initial validation of maltreatment in the CPS system of care. This measure is intended to monitor the occurrence of repeat maltreatment within six months. This measure is one of the National Standard Data Indicators (Safety Indicator 1) used to assess states' performance on the Federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	5	% Children in Substitute Care Under 12 Mos w/ Two or Fewer Placements

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

BL 2010 Definition

Calculate the percent of children who are in DFPS substitute care for 8 days or more and less than 12 months and who have had two or fewer placement settings. Children in substitute care - are children age 0 - 17 who are in DFPS' legal responsibility and who are placed outside of their own homes (home of origin). This measure is useful in determining placement stability.

BL 2010 Data Limitations

None

BL 2010 Data Source

From IMPACT, count the total number of children in substitute care for 8 days or more and less than 12 months on the last day of the reporting period. Include both children who entered, exited, or remained in substitute care during the year if the time in substitute care is 8 days or more and less than 12 months. An entry into substitute care is recorded as a conservatorship removal followed by a substitute care placement. For this group, count the number of placement settings where the start date of the placement is prior to the last day of the reporting period. Placements with start dates that equal the end date are not counted. Placements into hospitals, psychiatric hospitals or a brief absence from the placements (such as an unauthorized absence, summer camp, trial visits with biological or adoptive families, or repite care) are not counted.

BL 2010 Methodology

Data Source cont:
For children placed in foster homes that change their CPA affiliation, or in a foster home that becomes an adoptive home, since the placement setting did not change, it is not counted. For this group of children, count the number of placement settings in this substitute care episode.

Methodology:
Divide the number of children in substitute care for 8 days or more and less than twelve months who have had two or fewer placements (numerator) by the number of children in substitute care for 8 days or more and less than twelve months (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to determine the stability of placements for children in foster care for less than 12 months. This measures is one of the National Standard Data Indicators (C4-1) used to assess states' performance as measured by the Federal Child and Family Services Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	6	Percent of Children Re-entering Care within 12 Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 16

BL 2010 Definition

Children in substitute care - are children age 0 - 17 who are in DFPS' legal responsibility and who are placed outside of their own homes (home of origin). Of all children who exited substitute care during the year prior to the reporting period, what percentage re-entered care within twelve months of the prior substitute care episode. Discharge from a prior substitute care episode is recorded as a termination of FPS legal status or a placement in an “own home”

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the number of children who exited substitute care in the year prior to the reporting period who re-enter substitute care within 12 months of the prior discharge (numerator) by the number of children who exited substitute care in the year prior to the reporting period (denominator) and multiply by 100 to

BL 2010 Purpose

A primary goal of child welfare services is to achieve permanency for children as quickly as possible after they enter substitute care, without jeopardizing their continued safety. This measure examines the percentage of children discharged from substitute care who re-enter substitute care within 12 months of a prior episode. This measure is intended to monitor the issue of “substitute care re-entry,” a target of the Adoption and Safe Families Act of 1997. The percentage is important in assessing the durability of permanency for children over time. This measure is one of the National Standard Data Indicators (C1-4) used to assess state’s performance as measured by the Federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	7	Percent of Children Who Remain Safe in Substitute Care

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 17

BL 2010 Definition

This measure assesses the number of children in substitute care during the reporting period that are safe from abuse/neglect perpetrated by a substitute caretaker. Children in substitute care - are children age 0 - 17 who are in DFPS' legal responsibility and who are placed outside of their own homes (home

BL 2010 Data Limitations

None

BL 2010 Data Source

Using IMPACT, find the unduplicated number of children in substitute care during the reporting period (denominator). Determine how many of these children were not confirmed victims of abuse/neglect by a substitute care provider in an investigation completed during the reporting period (numerator).

BL 2010 Methodology

Divide the unduplicated number of children in substitute care during the reporting period who were not confirmed victims of abuse/neglect by a substitute care provider in an investigation completed during the reporting period (numerator) by the unduplicated number of children in substitute care during the reporting period (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to assess the number and percentage of children who remain safe (do not experience maltreatment) while in substitute care. This measure is intended to monitor the issue of “maltreatment in substitute care,” which is a target issue addressed by the Adoption and Safe Families Act of 1997. It is important in assessing the effectiveness of substitute care in protecting children from experiencing maltreatment while in protective care. This Measure is one of six National Standard Data Indicators used to assess state’s performance as measured by federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	8	Percent Children Achieving Legal Resolution with 12 Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 04

BL 2010 Definition

Legal resolution means that the court has dismissed the suit, awarded another party managing conservatorship or FPS was awarded permanent managing conservatorship (PMC) with or without termination of parental rights. This measure is important to assist the department in tracking, monitoring and reducing the amount of time children spend in FPS temporary managing conservatorship. It is an important indicator of success meeting guidelines in the state's permanency planning law.

BL 2010 Data Limitations

Due to legal and system delays of entry of legal status information into IMPACT, some final legal dispositions occurring during the reporting period may not be made available on IMPACT until after these outcomes are run. This may result in an undercount of cases being evaluated for the time period.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the total number of children in FPS conservatorship for whom legal resolution was achieved within 12 months, as determined from the length of time calculations (numerator) by the total number of children for whom legal resolution was achieved during the reporting period (denominator) and multiply by 100 to achieve a percentage. Legal resolution is determined by a legal status in IMPACT indicating PMC was awarded or FPS legal responsibility was terminated. If legal responsibility termination occurs during the reporting period, but PMC occurred in a previous reporting period, do not count child in the current reporting period. Length of time is calculated from date of care, custody and control or temporary managing conservatorship, whichever occurs earliest, to date PMC (rights not terminated or rights terminated all), or to date FPS legal responsibility was terminated.

BL 2010 Purpose

Methodology cont:
If a child has both PMC and FPS legal responsibility terminated during the same legal episode, calculate length of time to PMC.

Purpose:
State law requires permanency or legal resolution to be achieved within 12 months (365 days) of entering FPS legal responsibility. This measure will assist FPS in determining how many children reach this time frame.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	9	Percent Children Achieving Permanency with 18 Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 05

BL 2010 Definition

Permanent placement with appropriate legal status occurs when the child returns home and conservatorship is dismissed, the child is placed with relatives who are awarded managing conservatorship, or the child's adoption is consummated. This measure only counts children for whom the agency's conservatorship was dismissed during the reporting period.

BL 2010 Data Limitations

Due to legal and system delays of entry of legal status information into IMPACT, some final legal dispositions occurring during the reporting period may not be made available on IMPACT until after these outcomes are run. This may result in an undercount of cases being evaluated for the time period.

BL 2010 Data Source

Using IMPACT, the length of time for the first two types of placement is measured by counting the number of days from the date FPS was awarded temporary managing conservatorship through the date the child was either returned home or placed with relatives. The child must have left FPS conservatorship during the reporting period. The length of time for the third type of permanent placement is measured by counting the number of days from the date all parental rights were terminated through the date the child's adoption was consummated. The child whose adoption was consummated must have the adoption consummated during the reporting period. One factor beyond the agency's control is securing an appropriate adoptive placement for some children who are more difficult to place and who do not have an identified adoptive family at the point of termination of parental rights.

BL 2010 Methodology

Divide the total number of children achieving permanent placement with appropriate legal status during the reporting period and the length of time of the placement is within 18 months (numerator) by the total number of children achieving permanent placement with appropriate legal status during the reporting period (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to find the percentage of children who achieved a permanent placement with appropriate legal status within 18 months of coming into FPS conservatorship or, when the plan is adoption, from the time all parental rights are terminated to date adoption is consummated. This measure is intended to determine the success of CPS in achieving permanency. This measure is important to assist the department in tracking and monitoring the amount of time children spend in foster care before a permanent placement is obtained.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	10	Percent in FPS Conservatorship Until the Age of Majority

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 06

BL 2010 Definition

These are the children who for various reasons are unable to return home, to be placed with relatives on a permanent basis, or to be adopted. This measure is important as it determines the percent of children who remain in long term foster care. The measure provides data for FPS to assess the workload and resources needed to provide services to this population of children to prepare them for adulthood, or to transition them to other support agencies for

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the number of children who leave FPS and have reached the age of majority or their legal status is equal to emancipation during the reporting period (numerator) by the total number of children who left FPS conservatorship in the reporting period (denominator) and multiply by 100 to achieve a percentage. A child achieves the age of majority when he or she turns 18, or when the disabilities of minority are removed by the court before he or she turns 18 years of age. This measure could increase as a result of permanency legislation if courts give FPS permanent managing conservatorship of more children rather than seeking legal resolution by terminating parental rights or seeking to transfer conservatorship to other family members.

BL 2010 Purpose

The purpose of this measure is to determine the effectiveness of effort to find alternatives for children other than remaining in long term care. This measure helps assess over-all cost for these children and determine other needed programs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	11	Average Length of Time in Out-of-Home Care Per Child

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 08

BL 2010 Definition

The average length of time in out-of-home care per child (reported in months), for all children who experience an out-of-home placement, is calculated for all children who terminated FPS services during the reporting period. Data is calculated from the latest episode. An episode is calculated from the FPS terminating date during the reporting period to the earliest placement date with no termination date between the two dates.

BL 2010 Data Limitations

Due to legal and system delays of entry of legal status information into IMPACT, some final legal dispositions occurring during the reporting period may not be made available on IMPACT until after these outcomes are run. This may result in an undercount of cases being evaluated for the time period.

BL 2010 Data Source

Data for this measure is taken from IMPACT. The time in care for each child who experiences out-of-home care for whom FPS services closed during the reporting period is calculated, as follows:
1. For children returning home and closing in Family Reunification, the time in each out-of-home placement is calculated and then added together.
2. For children closing in Relative Care, Adoption by Non-Relative, Foster Care and Long Term Care, the time in each and every out-of-home placement is calculated and added together, including time in adoptive placement, until the adoption is consummated.
3. For children closing services in Adult Living, the time in each out-of-home placement except the Adult Living Placement is calculated and added together.

BL 2010 Methodology

Divide the sum of the calculated time in out-of-home care for all children during the reporting period (numerator)by the unduplicated number of children experiencing out-of home care during the reporting period (denominator). Children and placements are unduplicated. The measure is not cumulative because out-of-home care occurs only during the uninterrupted period of service during the reporting period. An out-of-home placement is not the home of

BL 2010 Purpose

The purpose of this measure is to obtain the average length of time a child has been removed from his/her own home. This measure is important as it establishes a baseline for study, assists in noting trends and in working to reduce the average length of time in out-of-home care for children. Since the measure includes children whose permanency plan is long term foster care and emancipation, this population of children will increase the outcome.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	12	Median Length of Stay in Foster Care

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 09

BL 2010 Definition

This measure allows FPS to calculate a midpoint for length of time in care which is consistent with the way national data is captured. This measure counts all children who have left foster care, determined by the legal status and legal status date.

BL 2010 Data Limitations

Due to legal and system delays of entry of legal status information into IMPACT, some final legal dispositions occurring during the reporting period may not be made available on IMPACT until after these outcomes are run. This may result in an undercount of cases being evaluated for the time period.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

For all children who have left foster care with a legal status of child emancipated, child aged-out or FPS responsibility terminated during the reporting period, or last removed from a licensed placement, whichever is first; Calculate in months the time in each and every paid foster care placement from the date of first placement during the episode to the date they left foster care. An episode is calculated from the closed legal status date during the reporting period to the earliest placement date with no legal status closure date between the two dates. Even though the legal status closure date puts the child in the reporting period, the calculation of time in foster care is calculated from the start date of the first placement to the end date of the last placement. Do not include relative placements in the calculation. Sort data in ascending order. The time interval at which 50% of all children have left care is the midpoint or median of the time children leave foster care.

BL 2010 Purpose

The purpose of this measure is to establish the median or midpoint time of stay in Foster Care per child for all children who experienced a paid foster care placement and leave FPS foster care during the reporting period.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	13	Percent of Children Reunified within 12 Months of Entry

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 15

BL 2010 Definition

This measure assesses timliness to reunification. Of all children who were reunified with their parents or caretakers at the time of discharge from substitute care, the percentage that were reunified within twelve months.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the total number of children who have been in care for at least 8 days and exited DFPS conservatorship to reunification during the reporting period, and the time to exit was within 12 months of the latest removal (numerator) by the total number of children who have been in care for at least 8 days and who exited DFPS conservatorship to reunification during the reporting period (denominator)and multiply by 100 to achieve a percentage. To calculate the time to reunification, subtract the most recent date of an entering legal status from the effective date that DFPS conservatorship was dismissed. Using the Trial Home Visit Adustment, if the child is placed in their own home with a reason of reunification and the discharge date is more than 30 days after the placement start date, then use the placement start date plus 30 days as the date of reunification.

BL 2010 Purpose

A primary goal of child welfare services is to achieve permanency for children as quickly as possible after they enter substitute care, without jeopardizing their continued safety. This measures timely permanency for children who are reunified. This measure is one of the National Standard Data Indicators (C1-1) used to assess state's performance as measured by the Federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	14	Percent of Adoptions Consummated within 24 Months

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 13

BL 2010 Definition

This measure assesses timliness to adoption. Of the children who exit substitute care to a finaliized adoption, the percent who exited wtihin 24 months of their entry date. For those children whose adoptions are consummated during the reporting period, determine the length of time from the latest date of entering legal status to the date the adoption is consummated. The consummation date must be during the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the total number of children that have a legal status of adoption consummated during the year whose adoptions were consummated within 24 months of the entering legal status (according to AFCARS guidelines, substitute care episodes begin with a date of removal from home/entering legal status)(numerator) by the total number of children whose adoptions were consummated during the reporting period (denominator) and multiply by 100 to

BL 2010 Purpose

A primary goal of child welfare services is to achieve permanency for children as quickly as possible after they enter substitute care, without jeopardizing their continued safety. This measure is for timely exits to adoption. The percentage achieving adoption within 24 months is used to compare to the federal substanial conformity baseline and to assess the need for additional recruitment efforts. This Measure is one of six National Standard Data Indicators (C2-1) used to assess state's performance as measured by the Federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	15	Median Length of Stay of Adoptions Consummated

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

BL 2010 Definition

This measure allows FPS to calculate a midpoint for length of time in care for children adopted during the reporting period. This measure calculates the time in care for children who exit substitute care to a finalized adoption during the reporting period.

BL 2010 Data Limitations

Due to legal and system delays of entry of legal status information into IMPACT, some final legal dispositions occurring during the reporting period may not be made available in IMPACT until after these outcomes are run. This may result in an undercount of cases being evaluated for the time period.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Calculate in months the length of time in care for children whose adoptions were consummated during the reporting period. Length of time is calculated from the entering legal status date to the date the adoption is consummated. Sort data in ascending order. The time interval at which 50% of all children have a consummated adoption is the midpoint or median.

BL 2010 Purpose

A primary goal of child welfare services is to achieve permanency for children as quickly as possible after they enter substitute care, without jeopardizing their continued safety. This measures timely permanency for children who are adopted. This measure is one of the National Standard Data Indicators (C2-2) used to assess state's performance as measured by the Federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	16	Child Protective Services Caseworker Turnover Rate

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

BL 2010 Definition

This measure is the percentage of classified regular full- and part-time CPS caseworkers who voluntarily and involuntarily separate from the agency during the fiscal year. The definition is based on the methodology used by the State Auditor's Office to calculate classified employee turnover for fiscal year 2007.

BL 2010 Data Limitations

There may be some minimal loss of data due to data entry transactions occurring after calculation.

BL 2010 Data Source

The HHSAS-HR system is used to identify full- and part-time employees with job class codes that correspond to CPS caseworker positions, including:

- 1570C CPS Senior Investigator
- 5024C CPS Investigator II
- 5024F Faith Based CPS Specialist II
- 5024K Kinship Caregiver CPS Specialist II
- 5024Y CPS Spec II
- 5025C CPS Investigator III
- 5025F Faith Based CPS Specialist III
- 5025K Kinship Caregiver CPS Specialist III
- 5025Y CPS Specialist III
- 5026C CPS Investigator IV
- 5026F Faith Based CPS Specialist IV
- 5026KKinship Caregiver CPS Specialist IV
- 5026Y CPS Worker IV
- 5027C CPS Investigator V
- 5027Y CPS Worker V specifying CPS direct delivery staff

Job class codes are subject to change. Should this occur, current equivalent codes will be substituted and documented in the performance folder.

BL 2010 Methodology

Divide the average number of CPS caseworkers during the fiscal year (numerator) by the number of separations during the fiscal year (denominator), and multiply by 100. The average number of CPS caseworkers is calculated by totaling the number of CPS caseworkers (defined as someone who worked at any time during a quarter) for each quarter of the fiscal year, and then dividing this total by the number of quarters.

BL 2010 Purpose

The purpose of this measure is to provide an annual turnover rate for CPS caseworkers. The measure would allow the agency to compare turnover rates across fiscal years to assist in identifying retention trends in the CPS caseworkers.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Outcome No.	17	Percent of CPS Caseworkers Retained for Six Months Following BSD

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 18

BL 2010 Definition

This measure calculates the percentage of CPS caseworkers retained with the agency at least six months following the completion of Basic Skills Development (BSD) training.

BL 2010 Data Limitations

There may be some minimal loss of data due to data entry transactions occurring after calculation.

BL 2010 Data Source

The HHSAS-HR system is used to identify CPS caseworkers providing direct delivery services to clients with the following job class codes:
1570C CPS Senior Investigator;
5024C CPS Investigator II;
5024F Faith Based CPS Specialist II;
5024K Kinship Caregiver CPS Specialist II;
5024Y CPS Specialist II;
5025C CPS Investigator III;
5025F Faith Based CPS Specialist III;
5025K Kinship Caregiver CPS Specialist III ;
5025Y CPS Specialist III;
5026C CPS Investigator IV;
5026F Faith Based CPS Specialist IV;
5026KKinship Caregiver CPS Specialist IV;
5026Y CPS Specialist IV;
5027C CPS Investigator V, and
5027Y CPS Specialist V specifying CPS direct delivery staff.

Job class codes are subject to change. Should this occur, current equivalent codes will be substituted and documented in performance folder.

BL 2010 Methodology

Divide the count of CPS caseworkers who completed BSD training during the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year and remained with the agency six months or more following the completion of the BSD training (numerator) by the count of CPS caseworkers who completed BSD training during the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to provide an annual retention rate for CPS caseworkers who have completed BSD.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Outcome No.	1	Percent of STAR Youth with Better Outcomes 90 Days after Termination

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 11

BL 2010 Definition

A better outcome for STAR youth is achieved if the youth's presenting problems did not re-occur 90 days after case terminated.

BL 2010 Data Limitations

The reported results are dependent on the ability of STAR providers to contact youth for follow-up. Historically, this has been as much as 50% of closed cases. One presenting problem is recorded and followed up on for each youth. After termination of services, the same youth can present again with either the same or a different problem, which is evaluated independent of any previous presenting problems and outcomes.

BL 2010 Data Source

Youth may present with one or more of the following problems: runaway, truancy, family conflict or delinquent behavior. After assessing the youth's circumstances, STAR providers designate a prevailing problem. The prevailing problem is entered into the PEIS Database and remains the prevailing problem until case termination. Providers attempt to contact clients approximately 90 days after case termination. If successful, Form 2075F is completed with youth or family and entered on follow-up screen in PEIS Database. If the prevailing problem did not re-occur after termination of services, the youth is counted as having a better outcome.

BL 2010 Methodology

Divide the total youth having a better outcome (numerator) by the total number of follow-up forms processed that had a follow-up date during the fiscal year (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The object of this measure is to assess the level of better outcomes achieved by the STAR program as recorded on the 2075F follow-up form approximately 90 days after case termination.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Outcome No.	2	Percent of CYD Youth Not Referred to Juvenile Probation

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 530 080-R-S70-1 01-02 OC 12

BL 2010 Definition

This measure counts the unduplicated number of Community Youth Development (CYD) participants age 10 years and older who were not referred to juvenile probation.

BL 2010 Data Limitations

Due to the lack of a unique identifier of participants, data between the two systems is matched by comparing the first four characters of the first and last names, zip code and birth date which may result in under counting the number of youth referred or not referred to JPC.

BL 2010 Data Source

A spreadsheet is provied by the Juvenile Probation Commission and matched to data in the PEIS (Prevention and Early Intervention Services) Database by comparing the first four characters of the first and last names, zip code and date of birth.

BL 2010 Methodology

Divide the total number of CYD participants age 10 years and older from the PEIS Database who were not referred to juvenile probation (numerator) by the total number of CYD participants age 10 years and older (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to assess the level of positive outcomes achieved by the CYD program.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Outcome No.	1	Incidence of Adult Abuse/Neglect/Exploitation Per 1,000 Persons Served

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-03 OC 01

BL 2010 Definition

This measure compares the number of confirmed in-home investigations of abused, neglected, or exploited elderly and persons with disabilities reported to FPS with the number of elderly and persons with disabilities in the general Texas population.

BL 2010 Data Limitations

National studies have estimated that maltreatment of vulnerable adults is under-reported by as much as 60%. The data reported in this measure only reflects the incidence based upon reports to APS.

BL 2010 Data Source

The original source for the estimated population of aged and disabled persons is the state population center at Texas A&M University, as conveyed by HHSC. IMPACT.

BL 2010 Methodology

Divide the number of APS 'Confirmed incidents' defined as investigations of abuse, neglect, and exploitation of elderly or disabled persons that are coded as 'VAL' (validated) or ‘VNF’ (Valid with no fault) during the reporting period (numerator) by the population of aged and disabled persons during the reporting period (denominator) and multiply the result by 1,000.

BL 2010 Purpose

This measure provides a method for evaluating the level of confirmed maltreatment of vulnerable adults in Texas.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Outcome No.	2	Percent Adults Found to be Abused/Neglected/Exploited Who Are Served

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-03 OC 02

BL 2010 Definition

Of investigations confirming abuse, neglect, or exploitation, this measure indicates the percent of cases which continue into the service delivery stage.

BL 2010 Data Limitations

Progression to service delivery is dependent upon capacitated clients' acceptance of services. APS clients with capacity have the right to refuse services. Several investigation cycles may be necessary before the victim is either willing to accept services or becomes incapacitated to the point that involuntary intervention is necessary.

BL 2010 Data Source

Data is gathered from the closure codes found in the investigation stage closure window in IMPACT during the reporting period

BL 2010 Methodology

Divide the number of investigation stages with closure codes of 'valid, continue as APS,' meaning that the cases progress to the service delivery stage and receive, at a minimum, direct delivery services from the APS worker (numerator) by the sum of the following at the closure of the investigation: valid cases receiving services, valid cases for which services were refused, valid cases for which protective services were not required, and valid cases in which services were needed but not available (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The number of APS clients receiving services provides an indicator of the program's effectiveness and of the availability of necessary resources to alleviate maltreatment.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Outcome No.	3	Incidence of MHMR Abuse/Neglect/Exploitation Per 1,000 Persons Served

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-03 OC 03

BL 2010 Definition

This measure compares the number of confirmed investigations of abuse, neglect, or exploitation of persons receiving mental health or mental retardation services, which include state schools, state hospitals, state centers, community MHMR centers, and Medicaid waiver programs to the total number of persons being served by these entities.

BL 2010 Data Limitations

Due to data being gathered by another agency and reported to FPS, it is difficult to accurately project the number of persons who will be receiving services through mental health or mental retardation programs. CARE counts all individuals enrolled, regardless of whether or not services are received. This may inflate the denominator.

BL 2010 Data Source

Impact; Department of Aging and Disability Services' Client Assignment and Registration (CARE) system; and the Home and Community-based services (HCS) Automated Enrollment and Billing system. Both systems are maintained by the Health and Human Services Commission.

BL 2010 Methodology

Divide the the number of confirmed mental health or mental retardation incidents which are those investigations of abuse, neglect, or exploitation that are coded as 'CON' (confirmed) in IMPACT at the completion of the investigation stage during the reporting period (numerator) by the unduplicated count of clients who are receiving mental health or mental retardation services during the reporting period, as gathered from the CARE report system and the HCS Automated Enrollment and Billing system (denominator) and multiply the result by 1,000.

BL 2010 Purpose

Assuming that FPS investigations are prompt, thorough, and accurate, this measure is an indicator of the quality of care being provided in mental health or mental retardation settings.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Outcome No.	4	Percent of Repeat Maltreatment within Six Months (APS)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-03 OC 04

BL 2010 Definition

Repeat Maltreatment is the percent of all clients served by APS in-Home program who were confirmed victims of a validated report of maltreatment who had a subsequent validated instance of maltreatment within a six-month period.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the total number of unique victims for whom there is a second validated maltreatment for abuse or neglect in a completed investigation and the difference between the two intake dates is between 3 and 183 days (numerator) by the total number of unique confirmed victims in completed investigations where the investigation stage closure date is within the first six months of the reporting period (denominator) and multiply by 100 to achieve a percentage. Victim-Perpetrators of medical or mental health self neglect are excluded from the numerator and denominator.

BL 2010 Purpose

The purpose for this measure is to assess the degree to which APS victims experience repeat maltreatment after an initial validation of maltreatment in the APS system of care. This measure is intended to monitor the occurrence of repeat maltreatment within six months. This measure is modeled after the Recurrence of Maltreatment Data Indicator from the National Standard Data Indicators used by the Children's Bureau, Administration for Children and Families, US Department of Health and Human Services, to assess states' performance on the Federal Child and Family Service Review.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Outcome No.	5	Adult Protective Services Caseworker Turnover Rate

Calculation Method: N **Key Measure: N** **New Measure: Y** **Target Attainment: L** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-03 OC 05

BL 2010 Definition

This measure is the percentage of classified regular full- and part-time APS caseworkers who voluntarily and involuntarily separate from the agency during the fiscal year. The definition is based on the methodology used by the State Auditor's Office to calculate classified employee turnover fo fiscal year 2007.

BL 2010 Data Limitations

There may be some minimal loss of data due to data entry transactions occurring after calculation.

BL 2010 Data Source

The HHSAS-HR system is used to identify full- and part-time employees with job class codes that correspond to APS caseworker positions including:
5023Z APS Specialist I;
5024Z APS Specialist II;
5025Z APS Specialist III;
5026Z APS Specialist IV; and
5027A APS Specialist V.
Job Class codes are subject to change. Should this occur, current equivalent codes will be substituted and documented in the performance folder.

BL 2010 Methodology

Divide the average number of APS caseworkers during the fiscal year (numerator) by the number of separations during the fiscal year (denominator) and multiply by 100 to achieve a percentage. The average number of APS caseworkers is calculated by totaling the number of APS caseworkers (defined as someone who worked at any time during a quarter) for each quarter of the fiscal year, and then dividing this total by the number of quarters.

BL 2010 Purpose

The purpose of this measure is to provide an annual turnover rate for APS caseworkers. The measure would allow the agency to compare turnover rates across fiscal years to assist in identifying retention trends in the APS caseworkers.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Outcome No.	6	Percent of APS Caseworkers Retained for Six Months Following BSD

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-03 OC 06

BL 2010 Definition

This measure calculates the percentage of APS caseworkers retained for at least six months following the completion of Basic Skills Development (BSD)

BL 2010 Data Limitations

There may be some minimal loss of data due to data entry transactions occurring after calculation.

BL 2010 Data Source

Active APS caseworkers providing direct delivery services is determined are identified by the following job class codes:
5023Z APS Specialist I;
5024Z APS Specialist II;
5025Z APS Specialist III;
5026Z APS Specialist IV; and
5027A APS Specialist V

The Session End Date of the training is from HHSAS-HRMS Administrator Training Database where the date is during four quarters. The four quarters would include the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year.

Due to possible modifications in the FPS fiscal system, PACs, and job classes are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

Data Source cont:
The numerator for this measure is the count of APS caseworkers who completed BSD training during the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year and remained with the agency six months or more following the completion of the BSD training.

The denominator for this measure is the count of APS caseworkers who completed BSD training during the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year.

Methodology:
Divide the numerator by the denominator and multiply by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to provide an annual retention rate for APS caseworkers who have completed BSD.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Outcome No.	1	Percent of Validated Investigations Placing Children at High Risk

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

BL 2010 Definition

Children are considered to be at risk when violations of high risk standards occur at licensed and registered child care operations. A regulatory weighting system has been implemented that assigns a weight or categorizes individual minimum standard regulations based on the risk to children. Priority one investigations allege the death of a child, immediate threat of death, serious injury or life threatening abuse or neglect to a child, standards violations that pose a high risk to children or situations in which the preservation of evidence is an issue. Priority two investigations allege abuse or neglect of a child that does not indicate an immediate danger of death or serious injury, serious supervision problems, serious accidental injury, serious safety or health hazards, injury or serious mistreatment of a child that results in bruising.

BL 2010 Data Limitations

Definition cont:
Priority three investigations allege minor violations of the law or minimum standards that involve low risk to children in care or illegal operations with no standards violations or abuse/neglect allegations.

Data Limitations:
None

BL 2010 Data Source

Child care investigators enter the results of their investigations into the Child-care Licensing Automation Support System (CLASS). Information is obtained from queries on investigation information contained in the CLASS investigation tables. .

BL 2010 Methodology

Divide the number of validated priority one and priority two investigations during the reporting period that have a violation that is considered to be high risk (numerator) by the number of all validated investigations (priority one plus priority two plus priority three investigations) of reported risk in regulated operations within the reporting period (denominator) and multiply by 100 to achieve a percentage

BL 2010 Purpose

The purpose of this measure is to evaluate the agency's success in protecting children in care from those situations that pose the highest risk. It is an important measure in determining whether the program is meeting its objective.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Outcome No.	2	Percent of Licensed Facilities with No Recent Violations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 530 080-R-S70-1 01-04 OC 02

BL 2010 Definition

An operation is said to be operating in compliance with minimum standards when no violations are observed during an inspection by a licensing

BL 2010 Data Limitations

None

BL 2010 Data Source

Child care licensing representatives enter into the Child-care Licensing Automation Support System (CLASS) the violations of minimum standards which they observe during monitoring inspections or investigations. A record is kept of the violations that occur at each operation by the date on which they were observed and cited. Data to calculate the numerator and denominator are taken from CLASS.

BL 2010 Methodology

Divide the result of subtracting the total number of licensees and registrants operating at the end of the reporting period that had violations anytime during the previous three-year period from the total number of licensees and registrants operating at the end of the reporting period (numerator) by the total number of licensees and registrants operating at the end of the reporting period (denominator) and multiply the result by 100 to achieve a percentage.

BL 2010 Purpose

The purpose of this measure is to determine what percent of regulated facilities are operating in compliance with agency minimum standards. The information can be used to target facilities that need more regulatory attention, i.e., those which do not fall into this group.

Agency Code: 530 Agency: **Family and Protective Services, Department of**

Goal No.	5	1	Regulate Child Day Care and Residential Child Care
Objective No.	1	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Outcome No.	3	1	Percent of Complaints Resulting in Disciplinary Action
Measure Type		EF	
Measure No.		1	Average Cost per SWI Report of Abuse/Neglect/Exploitation

Calculation Method: N Key Measure: N New Measure: N Target Attainment: L Priority: M Cross Reference: Agy 530 080-R-S70-1 01-04 OC 03

BL 2010 Definition

A complaint is a report made to licensing staff that alleges a violation of the law or minimum standards. Disciplinary actions may occur as a result of a violation, but more often the operation is cited, given a date by which to achieve compliance, and re-inspected to be sure the correction has been made. Only the most serious violations, several non-compliances that create an endangering situation or patterns of repeated non-compliances result in disciplinary actions. Those actions are: Evaluation, a closer than routine period of monitoring; probation, a specific conditioning of the license or registration for a time period of 6 to 12 months; denying an application or request for an amendment; revocation; emergency suspension and closure; adverse amendment or reissuance of the license, certificate or registration with conditions; suspension for failure to pay fees; and imposition of monetary penalties.

BL 2010 Definition

This measure reports the average cost of a report of abuse/neglect/exploitation that has been assigned for investigation.

BL 2010 Data Limitations

None

BL 2010 Data Limitations

None

BL 2010 Data Source

Complaints, violations, and disciplinary actions are all entered into the Child-care Licensing Automation Support System (CLASS) with the date the action occurred. Also entered into CLASS is the date of any complaints that are investigated and whether or not violations were found.

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELedger) for PACs 105 (Statewide Intake Direct Delivery Staff), PAC 106 (Statewide Intake Program Support and Training), PAC 107 (Statewide Intake Automated Systems), PAC 108 (Statewide Intake - Expedited Background Checks) and related CPS Reform PACs. The number of reports is the number reported in the program specific Output Measures for Number of Reports of Abuse/Neglect (Child Care Facilities, CPS Reports, APS Reports, and MHMR Reports).

BL 2010 Methodology

Divide the number of complaints resolved that resulted in disciplinary action (numerator) by the total number of documented complaints resolved during the reporting period (denominator) and multiply the result by 100 to achieve a percentage.

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

BL 2010 Purpose

The purpose of this measure is to determine how often a complaint results in disciplinary actions. This will assist licensing staff in identifying the most serious violators.

BL 2010 Methodology

Annual expenditure projections for PACs 105, 106, 107, 108, and related CPS Reform PACs are made using an internal budget document (OOELedger)that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, the annual expenditure projection is multiplied by the percent of the year elapsed for the reporting period and then is reduced by the previous quarter(s) dollars to get the estimated expenditures attributable to the quarter being reported.

BL 2010 Purpose

Methodology cont:
Divide the expenditure amount for the reporting period (numerator) by the sum of the number of reports (denominator) as reported in the following Output Measures (01-01-01.02 Number of CPS Reports of Child Abuse/Neglect, 01-01-01.03 Number of Reports of APS Adult Abuse/Neglect/Exploitation, 01-01-01.04 Number of MH and MR Reports of Abuse/Neglect/Exploitation and 01-01-01.05 Number of Reports of Child Abuse/Neglect in Childcare Facilities).

When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in agency costs attributable to the CPS intake function.

Calculation Method: C Key Measure: N New Measure: N Target Attainment: L Priority: M Cross Reference: Agy 530 080-R-S70-1 01-01-01 EF 01

Fall/Annual: N

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Strategy No.	1	Provide System to Receive/Assign Reports of Abuse/Neglect/Exploitation
Measure Type	EF	
Measure No.	2	Statewide Intake Monthly Workload Equivalency Measure (WEM)

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-01-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure provides average weighted workload for intake caseworkers. Each intake alleging abuse, neglect or exploitation is weighted in relation to the hours it takes to work a CPS intake. Since all stages are weighted against a CPS intake, they can be summed and divided by the number of caseworkers to arrive at a workload equivalency

BL 2010 Data Limitations

None

BL 2010 Data Source

An intake case is one or more alleged incidents of abuse/neglect or exploitation relating to children, elderly or disabled adults, children in licensed daycare or residential settings, or persons in facilities for the mentally retarded or mentally ill.

The Work Measurement Study (WMS) established the hours each month to work an intake for each program area. Each intake type has hours and a weighting factor. The hours and weighting factors for each type of intake are derived from the most recent WMS.

Actual number of intake stages open any time during the month are from IMPACT.

Actual number of workers is number of filled caseload workers charged to PAC 105 (Statewide Intake Direct Delivery Staff), 108 (SWI – Expedited Background Checks) and related CPS Reform PACs. Due to possible modifications in the FPS fiscal system, PAC, service codes and/or worker classification codes are

BL 2010 Methodology

Data Source cont:
Should this occur, the current equivalent codes will be substituted and documented in the performance folder. When new a WMS study is conducted, updated data will be used.

Time spent working a CPS intake during a given month is the standard for weighting other types of intakes. Weighting factor for CPS intakes is one. All other intakes are assigned a weighting factor based on the time to work that stage compared to the time to work a CPS intake. WMS hours for each type of intake are divided by the WMS hours for a CPS intake to calculate a weighting factor.

Methodology:
Multiply number of stages counted during the month for each type of stage by that stage's weighting factor to obtain weighted stages in each category. Divide the sum of weighted stages for all stage types for the reporting period (numerator)by the total number of intake caseworkers, excluding trainees (with less than 50 days of service) and supervisors (denominator).

BL 2010 Purpose

Methodology cont:
Trainees with 50 to 182 days of service are counted as half (.5) a worker. An intake caseworker is an active employee in HHSAS-FS charged to PAC 105, 108 and related CPS Reform PACs. When calculating the 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated.

Purpose:
This measure indicates an average weighted amount of work handled by intake caseworkers and can be used to compare workloads.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Strategy No.	1	Provide System to Receive/Assign Reports of Abuse/Neglect/Exploitation
Measure Type	OP	
Measure No.	1	Number of Calls Received by Statewide Intake Staff

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

Calls are defined as any entry in IMPACT made as a result of a phone call, e-mail, fax, or regular piece of mail received by Statewide Intake Staff (SWI). Total number of contacts provides data indicative of the volume of contacts processed by SWI staff. This information, when coupled with additional information such as the types of contacts handled, can be used to measure workload. This information is helpful in determining staffing levels at SWI.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the number of contacts received by SWI staff for the reporting period using the date the contact was initiated. Total contacts will equal all information and referrals, special requests and calls related to abuse, neglect or exploitation minus the total number of calls marked for deletion. Calls received by SWI include calls related to all programs within FPS as well as a few other state agencies. The annual or year-to-date count will be the sum of all the months in the reporting

BL 2010 Purpose

Total contacts provide a measure of the volume of work completed by Statewide Intake (SWI) staff. This information is useful in projecting workloads and staffing needs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Strategy No.	1	Provide System to Receive/Assign Reports of Abuse/Neglect/Exploitation
Measure Type	OP	
Measure No.	2	Number of CPS Reports of Child Abuse/Neglect

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

Number of reports of child abuse/neglect provide a measure of the volume of work completed by Statewide Intake (SWI) staff and the associated workload. This information is useful in projecting staffing levels for intake and investigation staff as well as providing an indicator of the number of families likely to require subsequent services.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the total number of reports received by SWI staff with allegations of child abuse or neglect assigned for assessment or investigation during the reporting period using the date the intake stage was closed.. The annual or year-to-date count will be the sum of all CPS reports during the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to count all child abuse/neglect reports received by SWI staff that are assigned for investigation. The number of total reports provides a measure of the volume of work and is useful in projecting workloads and staffing.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Strategy No.	1	Provide System to Receive/Assign Reports of Abuse/Neglect/Exploitation
Measure Type	OP	
Measure No.	3	Number of APS Reports of Adult Abuse/Neglect/Exploitation

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

Number of reports of Elderly/Disabled abuse counts the reports of abuse, neglect, or exploitation of a vulnerable adult that are assigned for investigation or assessment. 'Vulnerable adult' refers to a person aged 65 or older or an adult age 64 or under with a disability.

BL 2010 Data Limitations

Research and experience around the country indicate that maltreatment of vulnerable adults is under-reported. Not only are victims often isolated and incapacitated, they may be too ashamed of the situation or fearful of the consequences to seek assistance.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

The measure is calculated by counting, the total number of reports of adult abuse, neglect, and exploitation received by SWI staff for which there is an intake assigned for assessment or investigation during the reporting period using the date the intake stage was closed. The annual count is equal to the sum of the twelve months' intakes assigned to the investigation stage. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is useful as a benchmark of the volume of reports made to DFPS.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Strategy No.	1	Provide System to Receive/Assign Reports of Abuse/Neglect/Exploitation
Measure Type	OP	
Measure No.	4	Number of MH and MR Reports of Abuse/Neglect/Exploitation

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

The measure counts reports made to FPS of maltreatment of persons served in mental health or mental retardation settings, which include state schools, state hospitals, state centers, community MHMR centers, Medicaid waiver programs, mental health or mental retardation state-operated community services, and their contractors and outreach programs.

BL 2010 Data Limitations

This measure is affected by factors that are beyond FPS' control within the systems of mental health or mental retardation facilities, community MHMR centers, and Medicaid waiver programs.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

The measure is calculated by counting, the total number of reports of mental health and mental retardation abuse, neglect, and exploitation received by SWI staff for which there is an intake assigned for assessment or investigation during the reporting period using the date the intake stage was closed. The annual count is equal to the sum of the twelve months' intakes assigned to the investigation stage. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The measure gauges the level of awareness of the general public and staff of their obligation to report maltreatment in mental health or mental retardation

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	1	Provide Access to DFPS Services by Managing a 24-hour Call Center
Objective No.	1	Provide 24-hour Access to Services Offered by DFPS Programs
Strategy No.	1	Provide System to Receive/Assign Reports of Abuse/Neglect/Exploitation
Measure Type	OP	
Measure No.	5	Number of Reports of Child Abuse/Neglect in Child Care Facilities

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

Reports of child abuse/neglect in daycare and residential child care facilities that provide a measure of the volume of work completed by Statewide Intake (SWI) staff and the associated workload. This information is useful in projecting staffing levels for both intake and investigation staff.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the total number of reports received by SWI staff with allegations of child abuse or neglect in a daycare or residential childcare facility assigned for assessment or investigation during the reporting period using the date the intake stage was closed. The annual or year-to-date count will be the sum of all Daycare and Residential Childcare reports during the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to count all child abuse/neglect reports in daycare and residential childcare facilities received by SWI staff that are assigned for assessment or investigation. The number of total reports provides a measure of the volume of work and is useful in projecting workloads and staffing.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	1	Average Daily Cost per CPS Direct Delivery Service (All Stages)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average daily cost attributable to direct delivery services. Direct delivery services includes these stages: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services), and KIN (Kinship) with a primary assignment to CPS staff or outsourced staff who are paid out of Strategy B.1.1 (CPS Direct Delivery Services) or a related CPS reform PAC.

BL 2010 Data Limitations

The agency does not track costs for stages of direct delivery services. This calculation involves using actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances.

BL 2010 Data Source

Actual expenditures for CPS direct delivery services are from HHSAS-FS and an internal budget document (OOELedger) for Strategy B.1.1 (CPS Direct Delivery Staff) or a related CPS reform PAC. All PACs in Strategy B.1.1, and related CPS Reform PACs, are included. The number of CPS Direct Delivery stages is obtained from Output Measure 02-01-01.01 Average Daily Number of Direct Delivery Services (all stages).

Due to possible modifications in the FPS fiscal system, PACs are subject to change. Should this occur, current equivalent codes will be substituted and documented in the performance folder.

BL 2010 Methodology

Annual expenditure projections for PACs listed above are made using an internal budget document (OOELedger.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period and reduced by previous quarter(s) dollars to get estimated expenditures attributable

BL 2010 Purpose

Methodology cont:
These amounts are totaled & divided by number of days in the reporting period to arrive at average daily cost for reporting period, the numerator. The denominator is the average daily number of direct delivery services (all stages). Divide the numerator by the denominator to calculate the Average Daily Cost per Direct Delivery Service. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in agency costs attributable to the provision of direct delivery services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	2	CPS Daily Workload Equivalency Measure (WEM)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EF 03

Fall/Annual: N

BL 2010 Definition

This measure provides average daily weighted workload for CPS caseworkers paid out of Strategy B.1.1 or related CPS Reform PAC for different stages of direct delivery services. Supervisors carrying cases are not included in definition of a caseworker. Each stage is weighted in relation to hours in a day it takes to work an investigation. Since all stages are weighted against an investigation they can be summed & divided by the number of caseworkers to arrive at a workload equivalency.

Data Limitations:Investigation stages more than 60 days of age are excluded however caseworkers with INV caseload containing only INV more than 60 days of age are not excluded. Data from HHSAS-HR is point-in-time at end of month, so if a worker changed DEPTIDs during the month, only the last one for the month is captured. See Data Limitation for Output Measure 03-01-01-00 Average Number of Direct Delivery Services (All Stages).

BL 2010 Data Limitations

Data Source:
The Work Measurement Study (WMS) established hours each day to work different stages of direct delivery services. Time spent working an active investigation is the standard for weighting other stages. Weighting factor for investigations is equal to one. Weighting factors for other stages are computed by dividing time to work that stage by the time to work an investigation. The stages included are Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO) & Foster/Adopt Home Development (FAD; if approved or receiving casework services).

All INV open more than 60 days are excluded. All stages assigned to someone other than a DFPS caseworker paid out of Strategy B.1.1 or related CPS Reform PAC are excluded.

BL 2010 Data Source

Cont. Data Source:For numerator, count stages open any time during the day for months in reporting period, if primary assignment is to a caseworker paid out of Strategy B.1.1 or related CPS Reform PAC in HHSAS-HR & assigned to the following DEPTIDs 0-89 (INV unit), 90-B9 (FBSS unit), CO-H9 (Conservatorship unit), IO–J9 (FAD unit). Multiply average number of daily stages for each stage by that stage's weighting factor to obtain weighted stages in each category. For denominator, count caseworkers with primary assignments that were open any time during day for months during reporting period if caseworker is paid out of Strategy B.1.1 or related CPS Reform PAC in HHSAS-HR & assigned to following DEPTIDs 0-89 (INV unit), 90-B9 (FBSS unit), CO-H9 (Conservatorship unit), IO–J9 (FAD unit).

Exclude trainees with less than 85 days of service. Trainees with 85-140 days of service are counted as half (.5) a worker.

BL 2010 Methodology

Cont. Data Source:
Due to possible FPS fiscal system modifications, PACs, service codes &/or worker classification codes are subject to change. Should this occur, substituted codes will be documented in the performance folder. When a new WMS study is conducted updated data will be used.

Methodology:Divide numerator (sum of weighted stages for all stage types for reporting period) by denominator (sum of caseworkers with a primary assignment during reporting period). When calculating 2nd, 3rd, & 4th quarters, year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including close of appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate & reliable.

BL 2010 Purpose

This measure is an indicator of an average daily weighted amount of work handled by CPS workers & can be used to compare workloads.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	3	CPS Daily Caseload per Worker: Investigation

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for CPS investigation caseworkers. Supervisors carrying investigation cases are not included in the definition of investigation caseworker. Investigation workers are defined by a unit designation of 00 – 89 in the DEPTID data element stored in HHSAS-HR.

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changed DEPTIDs during the month, only the last one for the month is captured. An IMPACT application revision implemented in May 2006 prevents closure of the SUB stage when children are reunified and remain in DFPS conservatorship. For May 2006 forward, counting SUB stages will capture all reunified children. Prior to May 2006, reunified children could have had an open family reunification (FRE) stage, an open SUB stage, or both. In order to include all reunified children in the count of stages without duplication, each child with an "Own Home" placement with a placement start date during the reporting period who does not have an open SUB stage will be counted. This methodology will capture all reunified children one time; family reunification stages will not be counted separately.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day and for which the primary assignment is to a CPS investigation caseworker with the appropriate job class and unit designation paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services) and Kinship (KIN).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to an investigative caseworker paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR and assigned to DEPTID 00-89.

BL 2010 Methodology

Data Source cont:
For the denominator, calculate the total number of investigation caseworkers with primary assignments for each day during the report period, excluding trainees with less than 85 days of service. Trainees with 85-140 days of service are counted as half (.5) a worker.

Due to possible modifications in the FPS fiscal system, PACs, job classes & DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by a CPS investigation caseworker. The intent is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	4	CPS Daily Caseload per Worker: Family-Based Safety Services

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for CPS Family Based Safety Services (FBSS) caseworkers. Supervisors carrying cases are not included in the definition of Family Based Safety Services caseworker. FBSS workers are defined by a unit designation of 90 - B9 in the DEPTID data element stored in

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changed DEPTIDs during the month, only the last one for the month is captured. An IMPACT application revision implemented in May 2006 prevents closure of the SUB stage when children are reunified and remain in DFPS conservatorship. For May 2006 forward, counting SUB stages will capture all reunified children. Prior to May 2006, reunified children could have had an open family reunification (FRE) stage, an open SUB stage, or both. In order to include all reunified children in the count of stages without duplication, each child with an "Own Home" placement with a placement start date during the reporting period who does not have an open SUB stage will be counted. This methodology will capture all reunified children one time; family reunification stages will not be counted separately.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day and for which the primary assignment is to a FBSS caseworker with the appropriate job class and unit designation paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services) and Kinship (KIN).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to a FBSS caseworker paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR and assigned to DEPTID 90 - B9

BL 2010 Methodology

Data Source cont:
For the denominator, calculate the total number FBSS caseworkers with primary assignments for each day during the report period, excluding trainees with less than 85 days of service. Trainees with 85 to 140 days of service are counted as half (.5) a worker.

Due to possible modifications in the FPS fiscal system, PACs, job classes and DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. When calculating the 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by a FBSS caseworker. The intent is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	5	CPS Daily Caseload per Worker: Substitute Care Services

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for CPS Substitute Care caseworkers. Supervisors carrying cases are not included in the definition of Substitute Care Services caseworker. The caseworkers are called conservatorship (CVS) staff in HHSAS-HR while the stage is referred to substitute care. Children in substitute care - are children age 0-17 who are in DFPS' legal responsibility & who are placed outside of their own homes (home of origin). Substitute Care caseworkers are defined by a unit designation of C0-H9 in the DEPTID data element stored in HHSAS-HR.

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changed DEPTIDs during the month, only the last one for the month is captured. An IMPACT application revision implemented in May 2006 prevents closure of the SUB stage when children are reunified and remain in DFPS conservatorship. For May 2006 forward, counting SUB stages will capture all reunified children. Prior to May 2006, reunified children could have had an open family reunification (FRE) stage, an open SUB stage, or both. In order to include all reunified children in the count of stages without duplication, each child with an "Own Home" placement with a placement start date during the reporting period who does not have an open SUB stage will be counted. This methodology will capture all reunified children one time; family reunification stages will not be counted separately.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day & for which the primary assignment is to a CPS Substitute Care caseworker with the appropriate job class & unit designation paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services) & Kinship (KIN).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to a substitute care caseworker paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR & assigned to DEPTID C0-H9.

BL 2010 Methodology

Data Source cont:
For the denominator, calculate the total number of substitute care caseworkers with primary assignments for each day during the report period, excluding trainees with less than 85 days of service. Trainees with 85-140 days of service are counted as half (.5) a worker.

Due to possible modifications in the FPS fiscal system, PACs, job classes & DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate & reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by a CPS conservatorship (substitute care) caseworker. The intent of this measure is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	6	CPS Daily Caseload per Worker: Foster/Adoptive Home Development

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for CPS foster/adopt home development (FAD) caseworkers. Supervisors carrying cases are not included in the definition of FAD caseworker. FAD workers are defined by a unit designation of I0 - J9 in the DEPTID data element stored in HHSAS-HR.

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changed DEPTIDs during the month, only the last one for the month is captured. An IMPACT application revision implemented in May 2006 prevents closure of the SUB stage when children are reunified and remain in DFPS conservatorship. For May 2006 forward, counting SUB stages will capture all reunified children. Prior to May 2006, reunified children could have had an open family reunification (FRE) stage, an open SUB stage, or both. In order to include all reunified children in the count of stages without duplication, each child with an "Own Home" placement with a placement start date during the reporting period who does not have an open SUB stage will be counted. This methodology will capture all reunified children one time; family reunification stages will not be counted separately.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day and for which the primary assignment is to a FAD caseworker with the appropriate job class and unit designation paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services) and Kinship (KIN).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to a FAD caseworker paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR and assigned to DEPTID I0-J9.

BL 2010 Methodology

Data Source cont:
For the denominator, calculate the total number of FAD caseworkers with primary assignments for each day during the report period, excluding trainees with less than 85 days of service. Trainees with 85 to 140 days of service are counted as half (.5) a worker.

Due to possible modifications in the FPS fiscal system, PACs, job classes and DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. When calculating the 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by a FAD caseworker. The intent is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	7	CPS Daily Caseload per Worker: Kinship

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for CPS kinship caseworkers. Supervisors carrying kinship cases are not included in the definition of kinship caseworker. Kinship workers are defined by a unit designation of KA-KD in the DEPTID data element stored in HHSAS-HR.

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changed DEPTIDs during the month, only the last one for the month is captured.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day and for which the primary assignment is to a CPS kinship caseworker with the appropriate job class and unit designation paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD); if approved or receiving casework services), and Kinship (KIN).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to a kinship caseworker paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR and assigned to DEPTID KA-KD.

BL 2010 Methodology

Data Source cont:
For the denominator, calculate the total number of kinship caseworkers with primary assignments for each day during the report period, excluding trainees with less than 85 days of service. Trainees with 85 to 140 days of service are counted as half (.5) a worker.

Due to possible modifications in the FPS fiscal system, PACs, job classes and DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. When calculating the 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by a CPS kinship caseworker. The intent is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EF	
Measure No.	8	Average Daily Number CPS Stages Not Assigned to a DFPS Caseworker

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

Fall/Annual: N

BL 2010 Definition

Direct delivery services include stages for which the primary assignment is to CPS non-caseworker staff or outsourced staff paid out of Strategy B.1.1 (CPS Direct Delivery Services) or a related CPS reform PAC. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB; including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services) and Kinship (KIN).

BL 2010 Data Limitations

HHSAS-HR data is point-in-time at the end of the month, so if a worker changed job class or PAC during the month, only the last one for the month is captured. An IMPACT application revision implemented in May 2006 prevents closure of the SUB stage when children are reunified and remain in DFPS conservatorship. For May 2006 forward, counting SUB stages will capture all reunified children. Prior to May 2006, reunified children could have had an open family reunification (FRE) stage, an open SUB stage, or both. In order to include all reunified children in the count of stages without duplication, each child with an "Own Home" placement with a placement start date during the reporting period who does not have an open SUB stage will be counted. This methodology will capture all reunified children one time; family reunification stages will not be counted separately.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day and for which the primary assignment is to CPS non-caseworker staff or outsourced staff paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. Due to possible modifications in the FPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

BL 2010 Methodology

The numerator is the sum of the counts of open stages for each day in the reporting period. The denominator is the number of days in the reporting period. Divide the numerator by the denominator.When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of the measure is to show the number of direct delivery service stages open each day where the primary assignment is to CPS non-caseworker staff or outsourced staff paid out of Strategy B.1.1 (CPS Direct Delivery Staff) and related CPS Reform PACs. This measure provides an indicator for the numbers of children and families served during the reporting period by non-caseworker staff paid out of Strategy B.1.1 (CPS Direct Delivery Staff) and related CPS Reform PACs and is a useful tool to gauge the staff and dollars needed to serve the child welfare population.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	1	Number of Deaths of Children in FPS Conservatorship

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure counts those children in FPS conservatorship who died regardless if abuse/neglect was a factor.

BL 2010 Data Limitations

Because this data requires a complete investigation and legal determination for cause of death, the final update in IMPACT can take an extended period of

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the children in FPS legal responsibility who died during the reporting period regardless of allegation or whether the cause of death was due to abuse and/or neglect. The date of death and the legal status date must be during the reporting period. The annual or year-to-date count will be the sum of all such deaths during the reporting period.

BL 2010 Purpose

The purpose of this measure is to count the number of children who died while in FPS conservatorship.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	2	# of Deaths of Children as a Result of Abuse/Neglect while in FPS

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure counts those children in FPS conservatorship who died due to child abuse/neglect.

BL 2010 Data Limitations

Because this data requires a complete investigation and legal determination for cause of death, the final update in IMPACT can take an extended period of time. For example, a CPS Investigator may be waiting for the results of an autopsy/coroner's report to substantiate whether or not abuse/neglect was involved in the child's death.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the children in FPS legal responsibility who died due to abuse/neglect during the reporting period. This measure includes children in either an out-of-home living arrangement or those living at home but in FPS conservatorship at the time of death. The date of death and the legal status date must be during the reporting period. The reason for death shows if the death was due to abuse/neglect. The annual or year-to-date count will be the sum of all such deaths

BL 2010 Purpose

The purpose of this measure is to count the number of children who died while in FPS conservatorship and their death was attributed to the statutory definition of child abuse/neglect.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	3	Number of Deaths of Children as a Result of Abuse/Neglect

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 03

Fall/Annual: N

BL 2010 Definition

This measure counts those children who died and FPS attributed the death to a statutory definition of abuse/neglect.

BL 2010 Data Limitations

Because this data requires a complete investigation and legal determination for cause of death, the final update in IMPACT can take an extended period of time. For example, a CPS Investigator may be waiting for the results of an autopsy/coroner's report to substantiate whether or not abuse/neglect was involved in the child's death.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the total number of children under 18 years of age who died during the reporting period due to abuse/neglect. This is designated in IMPACT by a fatality code of 'ABN' (Abuse/Neglect – In Open Case), 'ABO' (Abuse/Neglect – In Closed Case), or 'ABP' (Abuse/Neglect – No Prior Case) as entered in the 'CD_PERSON_DEATH' data element of the Person table. In addition, the date of death must occur during the reporting period as entered in the 'DT_PERSON_DEATH' data element of the Person table. This captures all FPS investigated child deaths, whether investigated by CPS, APS (facilities), CCL, or RCCL.The annual or year-to-date count will be the sum of all such deaths during the reporting period.

BL 2010 Purpose

The purpose of this measure is to count the total number of children whom FPS determined to have died as a result of abuse/neglect (determinations made by the CPS, Licensing or MHMR facility programs).

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	4	Percent of CPS Workers with Two or More Years of Service

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 04

Fall/Annual: N

BL 2010 Definition

CPS caseworkers providing direct delivery services to clients are identified with the following job class codes: 1570C CPS Senior Investigator; 5024C CPS Investigator II; 5024F Faith Based CPS Specialist II; 5024K Kinship Caregiver CPS Specialist II; 5024Y CPS Spec II; 5025C CPS Investigator III; 5025F Faith Based CPS Specialist III; 5025K Kinship Caregiver CPS Specialist III ; 5025Y CPS Specialist III; 5026C CPS Investigator IV; 5026F Faith Based CPS Specialist IV; 5026K Kinship Caregiver CPS Specialist IV, 5026Y CPS Specialist IV, 5027C CPS Investigator V, and 5027Y CPS Specialist V specifying CPS direct delivery staff. Staff tenure is calculated from date of hire.

BL 2010 Data Limitations

None

BL 2010 Data Source

Information for this measure is taken quarterly from HHSAS-HR.

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

BL 2010 Methodology

Divide the total number of CPS direct delivery caseworkers with two or more years of service (numerator) by the total number of CPS direct delivery caseworkers (denominator) and multiply by 100 to achieve a percentage.

BL 2010 Purpose

This measure is a useful indicator of staff competencies and a general reflection of staff satisfaction.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	5	Average Number of FPS Children per Month in FPS Foster Homes

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 05

Fall/Annual: N

BL 2010 Definition

All children in FPS conservatorship and residing in FPS foster family or foster group homes are counted in this measure. This includes children living in FPS foster/adopt homes.

BL 2010 Data Limitations

None

BL 2010 Data Source

The total number of children in FPS conservatorship in a FPS foster home is counted for each month of the reporting period. FPS conservatorship is determined by legal status. The living arrangement and placement dates as recorded in the child's placement record on IMPACT further identify the children to be counted. Youth who have aged out of FPS conservatorship but remain in paid foster care are counted as children for the purpose of this measure.

The numerator for this measure is the sum of the total number of children in FPS conservatorship in FPS foster family or foster group homes each month during the reporting period. The denominator for this measure is the number of months in the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator.

BL 2010 Purpose

The purpose of this measure is to identify the number of children in FPS conservatorship living in FPS-verified foster homes. This measure assists FPS in determining resources needed for recruiting and developing foster homes.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	6	Average Number of FPS Children per Month in Non-FPS Foster Homes

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 06

Fall/Annual: N

BL 2010 Definition

Children in FPS conservatorship and residing in Child Placing Agency (CPA) homes and in independent homes are counted in this measure. This includes children living in FPS foster/adopt homes.

BL 2010 Data Limitations

None

BL 2010 Data Source

This measure counts the total number of children in FPS conservatorship in CPA homes or independent foster families or foster group homes each month during the reporting period. FPS conservatorship is determined by legal status. The living arrangement and placement dates as recorded in the child's placement record on IMPACT further identify the children to be counted. Youth who have aged out of FPS conservatorship but remain in paid foster care are counted as children for the purposed of this measure.

The numerator for this measure is the sum of the total number of children in FPS conservatorship in CPA homes or independent foster families or foster group homes each month during the reporting period. The denominator for this measure is the number of months in the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator.

BL 2010 Purpose

The purpose of this measure is to identify the number of children in FPS conservatorship living in CPA homes or independent foster homes or foster group homes. This measure assists FPS in determining resources needed for children in foster care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	EX	
Measure No.	7	Average Number of FPS Children per Month in Residential Facilities

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 EX 07

Fall/Annual: N

BL 2010 Definition

Children in FPS conservatorship and residing in residential facilities are counted in this measure.

BL 2010 Data Limitations

None

BL 2010 Data Source

This measure counts the total number of children in FPS conservatorship in contracted residential non-family-like settings each month during the reporting period. FPS conservatorship is determined by legal status. The living arrangement and placement dates as recorded in the child's placement record on IMPACT further identify the children to be counted. Youth who have aged out of FPS conservatorship but remain in paid foster care are counted as children for the purposed of this measure.

The numerator of this measure is the sum of the total number of children in FPS conservatorship in residential settings each month during the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator.

BL 2010 Purpose

The purpose of this measure is to identify the number of children in FPS conservatorship living in residential facilities. This measure assists FPS in determining resources needed for children in residential facilities.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	1	Number of Completed CPS Investigations

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

A completed CPS investigation is when the agency has reached a finding of abuse/neglect. The completion is determined by investigation stage closure date. The investigation stage closure date cannot be null and must occur during the reporting period.

BL 2010 Data Limitations

Measure does not count investigations completed by the caseworker that are awaiting supervisory closure.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the number of completed CPS investigations where the investigation stage closure date is during the reporting period and the disposition has been determined regarding the allegations of child abuse/neglect. The annual or year-to-date count will be the sum of all completed investigations during the

BL 2010 Purpose

The purpose of this measure is to track the number of investigations of child abuse/neglect completed by CPS staff during the reporting period. This measure provides useful information for management purposes. It is helpful for noting variances and determining resource allocation.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	2	Number of Confirmed CPS Cases of Child Abuse/Neglect

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure counts the number of completed CPS investigations determined by the investigation stage closure date with a disposition of 'Reason To Believe.' This equates to confirmed CPS cases of child abuse/neglect. The investigation stage closure date must be during the reporting period.

BL 2010 Data Limitations

This measure does not reflect the true basis for service delivery because service delivery is risk-based rather than incident-based. The number confirmed is also dependent upon the number reported.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the number of completed confirmed CPS investigations where date of stage closure for investigation stage is during the reporting period with a disposition of 'RTB' (Reason to Believe). The 'RTB' indicates that the allegation of abuse/neglect has been substantiated or confirmed in the completed investigation. The annual or year-to-date count will be the sum of all confirmed cases during the reporting period.

BL 2010 Purpose

The purpose of this measure is to track the number of investigations of child abuse/neglect completed by CPS staff for which the allegations of child abuse/neglect have been substantiated. The measure is useful for internal management purposes with regard to noting regional variances and determining

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	3	Number of Child Victims in Confirmed CPS Cases of Child Abuse/Neglect

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

When a child is identified as a victim in a CPS investigation, and the investigation has a disposition of 'RTB,' (Reason To Believe), then the investigation has been substantiated or confirmed as a child abuse/neglect case. This measure counts the number of confirmed victims in completed investigations. The investigations must have an investigation closure date during the reporting period.

BL 2010 Data Limitations

This measure does not reflect the true basis for service delivery because service delivery is risk-based rather than incident-based. The number confirmed is also dependent upon the number reported.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the number of children identified as confirmed victims where the investigation stage closure date occurs during the reporting period with a disposition of 'RTB'. Confirmed victims are identified by the codes 'DB' (Designated Victim/Perpetrator) or 'DV' (Designated Victim) in IMPACT. The measure counts all confirmed victimizations; therefore, if a confirmed victim is in more than one substantiated investigation, the confirmed victim is counted for each investigation. The annual or year-to-date count will be the sum of all confirmed victims during the reporting period.

BL 2010 Purpose

The purpose of this measure is to track the number of children identified as confirmed victims in investigations completed by CPS staff for which the allegations of child abuse/neglect have been substantiated. This information is useful for internal management purposes with regard to noting regional variances and determining resource allocations.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	4	Average Number of FPS-verified Foster Home Beds per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure counts the number of beds which equals capacity in active FPS-verified foster homes.

BL 2010 Data Limitations

This data reflects the number of beds, but does not indicate the types of foster homes needed in relation to the children in foster care

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the sum of the total number of licensed capacity (beds) in active FPS foster homes each month in the reporting period (numerator) by the number of months in the reporting period (denominator). Foster homes are identified by a facility type code and category code in IMPACT. Each month the number of beds in all verified FPS foster homes, including legal risk, and kinship are counted if active during the reporting month. This count is exclusive of FPS adoptive and FPS foster/adoptive homes. The numeric value indicating the licensed capacity in the home is used to count the capacity. In this measure beds and capacity are the same. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable

BL 2010 Purpose

The purpose of this measure is to identify the number of licensed capacity (beds) in FPS foster homes per month. In comparison to the number of children in substitute care per month, it may identify the need for additional foster home recruitment in order to provide a wider choice selection for the children being placed. The importance of this measure is the establishment of a baseline and the demonstration of program needs for increasing the number of foster and adoptive families. The measure assists FPS in determining resource needs for recruiting and developing foster homes. FPS recruitment efforts generally focus on the specific characteristics associated with children in foster care and awaiting adoption.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	5	Average Number of FPS-approved Adoptive Home Beds per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure counts the number of beds which equals capacity in active FPS approved adoptive homes. This measure assists FPS in determining resource needs for recruiting adoptive homes.

BL 2010 Data Limitations

This data reflects the number of beds, but does not indicate the types of homes needed for the children waiting to be placed in an adoptive home.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the licensed capacity (beds) for approved active FPS adoptive homes each month in the reporting period (numerator) by the number of months in the reporting period (denominator). Adoptive homes are identified by a facility type code in IMPACT. Each month, the number of licensed capacity (beds) for approved FPS Adoptive homes active during the reporting period are counted. This count is exclusive of FPS Foster and FPS foster/adoptive homes. The numeric value indicating the licensed capacity in the home is used to count the capacity. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to identify the number of licensed capacity in approved foster and foster/adoptive homes per month. It may identify the need for additional adoptive home recruitment in order to provide a wider choice for the children waiting to be placed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	6	Average Number of FPS-approved Foster/Adoptive Home Beds per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure counts the number of beds which equals capacity in active FPS-verified foster/adopt homes.

BL 2010 Data Limitations

This data reflects the number of beds, but does not indicate the types of foster homes needed in relation to the children in foster care.

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the sum of the total number of licensed capacity (beds) in active FPS foster/adoptive homes each month in the reporting period (numerator) by the number of months in the reporting period (denominator). Foster/Adoptive homes are identified by a facility type code and category code in IMPACT. Each month the number of beds in all verified FPS foster/adoptive homes are counted if active during the reporting month. This count is exclusive of FPS foster homes and FPS adoptive homes. The numeric value indicating the licensed capacity in the home is used to count the capacity. In this measure beds and capacity are the same.

When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable

BL 2010 Purpose

The purpose of this measure is to identify the number of licensed capacity (beds) in FPS foster/adoptive homes per month. In comparison to the number of children in substitute care per month, it may identify the need for additional foster/adoptive home recruitment in order to provide a wider choice selection for the children being placed. The importance of this measure is the establishment of a baseline and the demonstration of program needs for increasing the number of foster and adoptive families. The measure assists FPS in determining resource needs for recruiting and developing foster and adoptive homes. FPS recruitment efforts generally focus on the specific characteristics associated with children in foster care and awaiting adoption.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	7	Average Number of FPS Children per Month in Out-of-home Care

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

All children in FPS conservatorship living in foster homes, foster group homes, residential type settings, institutions, hospitals, nursing homes, Texas Youth Commission (TYC) facilities, juvenile detention facilities, relative's homes, adoptive homes, maternity homes, independent living arrangements, or other non-own home placements are counted in this measure. The children not living in their own home or home of origin are classified as out-of-home care.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the total number of children in a living arrangement other than their own home each month of the reporting period (numerator) by the number of months in the reporting period (denominator). FPS conservatorship is determined by legal status. The living arrangement and placement dates as recorded in the child's placement record in IMPACT further identify the children to be counted. Youth who have aged out of FPS conservatorship but remain in paid foster care are counted as children for the purposes of this measure. When calculating the second quarter, third quarter and fourth quarter, the year-to-date total is recalculated.

BL 2010 Purpose

The purpose of this measure is to identify the number of children in FPS conservatorship living in out-of-home care. This measure assists FPS in determining resources needed for recruiting and developing foster homes.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	8	Number of Children in FPS Conservatorship Who Are Adopted

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

The legal status of consummated adoption designates that the child has been legally adopted.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Count the number of children whose adoptions are consummated during the reporting period. This data is obtained from the Legal Status in IMPACT. Children counted in this measure had to have been in FPS conservatorship prior to the adoption being consummated. The quarterly totals are subject to change when late reports are received. The annual or year-to-date count will be the sum of all adoptions consummated during the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to count the number of children in FPS conservatorship whose adoptions are consummated during the reporting period. This measure provides necessary information for resource needs such as staffing, recruitment of additional homes and pre and post adoption services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	9	Average Daily Number of CPS Direct Delivery Services (All Stages)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

Direct delivery services include stages for which the primary assignment is to CPS staff or outsourced staff paid out of Strategy B.1.1 (CPS Direct Delivery Services) or a related CPS reform PAC. The following stages are included: Intake (INT) (if not progressed to INV in the same day), Investigation (INV), Family Preservation (FPR), Sub Care Child (SUB;including children reunified), Family Sub Care (FSU), Adoption (ADO), Foster/Adopt Home Development (FAD; if approved or receiving casework services), and Kinship (KIN).

BL 2010 Data Limitations

An IMPACT application revision implemented in May 2006 prevents closure of the SUB stage when children are reunified and remain in DFPS conservatorship. For May 2006 forward, counting SUB stages will capture all reunified children. Prior to May 2006, reunified children could have had an open family reunification (FRE) stage, an open SUB stage, or both. In order to include all reunified children in the count of stages without duplication, each child with an "Own Home" placement with a placement start date during the reporting period who does not have an open SUB stage will be counted. This methodology will capture all reunified children one time; family reunification stages will not be counted separately.

BL 2010 Data Source

For each day during the reporting period count stages from IMPACT that were open at any time during the day and for which the primary assignment is to CPS staff or outsourced staff paid out of Strategy B.1.1 or a related CPS Reform PAC in HHSAS-HR. Due to possible modifications in the FPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in

BL 2010 Methodology

The numerator is the sum of the counts of open stages for each day in the reporting period. The denominator is the number of days in the reporting period. Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable

BL 2010 Purpose

The purpose of the measure is to show the number of direct delivery service stages that are open each day and are served by CPS staff and outsourced staff paid out of strategy B.1.1 or a related CPS Reform PAC. This measure is a useful tool to gauge the staff and dollars needed to serve the child welfare

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	1	Provide Direct Delivery Staff for Child Protective Services
Measure Type	OP	
Measure No.	10	Average Number of Children in FPS Conservatorship per Month

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure provides the average monthly number of children in FPS conservatorship regardless of their living arrangement. FPS conservatorship is determined by legal status. Youth who have aged out of FPS conservatorship even if they remain in paid foster care are not counted for the purposes of this

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Divide the sum of the unduplicated number of children in FPS conservatorship for each month of the reporting period (numerator) by the number of months in the reporting period (denominator). When calculating the second quarter, third quarter and fourth quarter, the year-to-date total is recalculated.

BL 2010 Purpose

The purpose of this measure is to identify the number of children in FPS conservatorship. This measure assists FPS in determining resources needed for supervision of children in the agency's conservatorship.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	2	Provide Program Support for Child Protective Services
Measure Type	EX	
Measure No.	1	Number of CPS Caseworkers Who Completed Basic Skills Development

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-02 EX 01

Fall/Annual: N

BL 2010 Definition

This measure counts the number of CPS Caseworkers who completed Basic Skills Development (BSD) training during the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

HHSAS-HRMS Administrator Training Database.

BL 2010 Methodology

The calculation is a count of the number of caseworkers for whom the session end date in the HHSAS-HRMS Administrator Training Database is during the reporting period.

Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure monitor the volume of CPS caseworkers completing BSD.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	3	TWC Foster Day Care Purchased Services
Measure Type	EF	
Measure No.	1	Average Daily Cost for TWC Foster Day Care Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide child day care during the reporting period for children in foster care. Days of care reported are converted into full-time equivalent days for this measure.

BL 2010 Data Limitations

The reporting of this measure is dependent on the receipt of accurate and reliable data from TWC.

BL 2010 Data Source

FPS contracts with Texas Workforce Commission (TWC) for child care services that are provided through the Local Workforce Development Boards' Child Care Contractors. Those contractors have agreements with providers to serve children whose care is subsidized by TWC. Client information, including the cost of care, is collected by TWC, and TWC reports expenditures on CPS children to FPS by transmitting data electronically in an Excel file during the first half of each month for the current reporting period and the previous fiscal year.

BL 2010 Methodology

Due to lags in the billing process, a completion factor using historical trends in actual paid day care claims is applied to reported data in an internal budget document (OOELedger.xls) for PACs 221, 222, & related CPS Reform PACs. Projected expenditures in OOELedger.xls are based on cumulative expenditure data provided by TWC. Exclude administrative costs not directly used to purchase child care services. Numerator: Average monthly expenditure amount, calculated by totaling the projected expenditures for the reporting period & dividing by the number of months in the reporting period. Denominator: Average monthly number of foster day care days reported in Output Measure 02-01-03.01, Average Number of Days of TWC Foster Day Care Paid per Month.

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for day care provided to children in foster care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	3	TWC Foster Day Care Purchased Services
Measure Type	EX	
Measure No.	1	Number of Children Receiving TWC Foster Day Care Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-03 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of children who received TWC foster day care during the report period.

BL 2010 Data Limitations

The reporting of this measure is dependent on the receipt of accurate and reliable data from TWC.

BL 2010 Data Source

TWC reports to FPS the unduplicated number of FPS children who received paid units of care billed by their contract providers. TWC transmits data electronically for the current reporting period and the previous year. Retrieve number of children receiving services through PACs 221 (IV-E foster care child day care, TWC's Budget #11), PAC 222 (Non-IV-E foster care child day care, TWC's Budget #12), and related CPS Reform PACs. Count children regardless of how many days are spent in paid child care per month. Children are unduplicated by service month, PAC and IMPACT Person ID.

Because billings can take several months to receive & process, estimate the number of children served using a completion factor based on historical trends of actual paid claims data applied to the number of children billed to date.

BL 2010 Methodology

Data Source cont:
Completion factors are determined for the sum of all PACs based on previous fiscal year's information for same reporting period versus previous year's year-end total. Use the overall total completion factor for reporting period.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Count the unduplicated number of children receiving TWC foster day care during the reporting period. The annual or year to date count will be the sum of all unduplicated children during the reporting period.

BL 2010 Purpose

To monitor the volume of FPS children who received foster day care services subsidized by TWC and provided through the Local Workforce Development Boards' Child Care Contractors in order to determine project utilization.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	3	TWC Foster Day Care Purchased Services
Measure Type	OP	
Measure No.	1	Average Number of Days of TWC Foster Day Care Paid per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-03 OP

Fall/Annual: N

BL 2010 Definition

This measure reports average number of days of foster child day care provided to FPS children each month. A full-time day of day care is defined as 6-8 hours of day care service provided for a FPS child.

BL 2010 Data Limitations

The reporting of this measure is dependent upon the timely receipt of accurate and reliable data from TWC. The unduplication methodology used to calculate this measure may result in duplication due to clients receiving monthly services in multiple PACs.

BL 2010 Data Source

FPS contracts with Texas Workforce Commission (TWC) for child care services that are provided through the Child Care Management Services (CCMS) network of providers under contract with TWC. Since TWC manages the CCMS system, all client information is captured by TWC, who reports to FPS the paid units of care billed by their contract providers for FPS children. TWC transmits data electronically in an Excel file during the first half of each month for the current reporting period and the previous fiscal year. Number of days is retrieved from monthly trends report as units of PAC 221 (IV-E Foster Care Child Day Care, TWC's Budget #11), PAC 222 (Non-IVE Foster Care Child Day Care, TWC's Budget #12), and related CPS Reform PACs.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

The numerator is the total number of foster day care days provided, calculated by summing the number of days of foster day care counted from the TWC report for PACs 221, 222, and CPS Reform PACs each report period month. The denominator is the number of months in the reporting period.

Because billings can take several months to receive & process, estimate the number of children served using a completion factor based on historical trends of actual paid claims data applied to the number of days billed to date. Completion factors are determined for the sum of all PACs based on previous fiscal year's information for same reporting period versus previous year's year-end total. Use the overall total completion factor for reporting period.

Divide the numerator by the denominator. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
To monitor the volume of FPS children who received foster day care services subsidized by TWC and provided through the Local Workforce Development Boards' Child Care Contractors in order to determine project utilization.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	4	TWC Relative Day Care Purchased Services
Measure Type	EF	
Measure No.	1	Average Daily Cost for TWC Relative Day Care Services

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

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide child day care during the reporting period for children in relative care. Days of care reported are converted into full-time equivalent days for this measure.

BL 2010 Data Limitations

The reporting of this measure is dependent on the receipt of accurate and reliable data from TWC.

BL 2010 Data Source

FPS contracts with Texas Workforce Commission (TWC) for child care services that are provided through the Local Workforce Development Boards' Child Care Contractors. Those contractors have agreements with providers to serve children whose care is subsidized by TWC. Client information, including the cost of care, is collected by TWC, and TWC reports expenditures on CPS children to FPS by transmitting data electronically in an Excel file during the first half of each month for the current reporting period and the previous fiscal year.

BL 2010 Methodology

Due to lags in the billing process, a completion factor using historical trends in actual paid claims is applied to reported data to estimate the final count for the month/year. Actual expenditures are from HHSAS-FS and an internal budget document (OOELedger) for PAC 225 & related CPS Reform PACs. Projected expenditures are based on cumulative expenditure data provided by TWC. Exclude administrative costs not directly used to purchase child care services. The denominator is the average monthly number of relative day care days reported in Output Measure 02-01-04.01, Average Number of Days of TWC Relative Day Care Paid per Month. The numerator is the average monthly expenditure amount, calculated by totaling the projected expenditures for the reporting period & dividing by the number of months in the reporting period.

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for day care provided to children in relative care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	4	TWC Relative Day Care Purchased Services
Measure Type	EX	
Measure No.	1	Number of Children Receiving TWC Relative Day Care Services

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

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of children who received TWC relative day care during the report period.

BL 2010 Data Limitations

The reporting of this measure is dependent on the receipt of accurate and reliable data from TWC.

BL 2010 Data Source

TWC reports to FPS the unduplicated number of FPS children who received paid units of care billed by their contract providers. TWC transmits data electronically for the current reporting period and the previous year. Retrieve number of children receiving services through PAC 225 (Relative Caregiver Day Care Services) and related CPS Reform PACs. Count children regardless of how many days are spent in paid child care per month. Children are unduplicated by service month, PAC and IMPACT Person ID.

Due to lags in the billing process, a completion factor using historical trends in actual paid claims is applied to reported data to estimate the final count for the month/year.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

Count the unduplicated number of children receiving TWC relative day care during the reporting period. The annual or year to date count will be the sum of all unique children during the reporting period.

BL 2010 Purpose

To monitor the volume of FPS children who received relative day care services subsidized by TWC and provided through the Local Workforce Development Boards' Child Care Contractors in order to determine project utilization.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	4	TWC Relative Day Care Purchased Services
Measure Type	OP	
Measure No.	1	Average Number of Days of TWC Relative Day Care Paid per Month

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

Fall/Annual: N

BL 2010 Definition

This measure reports average number of days of protective child day care provided to FPS children each month. A full-time day of day care is defined as 6-8 hours of day care service provided for a FPS child.

BL 2010 Data Limitations

The reporting of this measure is dependent upon the timely receipt of accurate and reliable data from TWC. The unduplication methodology used to calculate this measure may result in duplication due to clients receiving monthly services in multiple PACs.

BL 2010 Data Source

FPS contracts with Texas Workforce Commission (TWC) for child care services that are provided through the Child Care Management Services (CCMS) network of providers under contract with TWC. Since TWC manages the CCMS system, all client information is captured by TWC, who reports to FPS the paid units of care billed by their contract providers for FPS children. TWC transmits data electronically in an Excel file during the first half of each month for the current reporting period and the previous fiscal year. Number of days is retrieved from monthly trends report as units of PAC 225 (Relative Caregiver Day Care Services) and related CPS Reform PACs.

BL 2010 Methodology

The denominator is the number of months in the reporting period. The numerator is the total number of relative day care days provided, calculated by summing the number of days of relative day care counted from the TWC report for PAC 225 and CPS Reform PACs each report period month.

Due to lags in the billing process, a completion factor using historical trends in actual paid claims is applied to reported data to estimate the final count for the month/year.

Divide the numerator by the denominator. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

To monitor the volume of FPS children who received relative day care services subsidized by TWC and provided through the Local Workforce Development Boards' Child Care Contractors in order to determine project utilization.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	5	TWC Protective Day Care Purchased Services
Measure Type	EF	
Measure No.	1	Average Daily Cost for TWC Protective Day Care Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide protective child day care during the reporting period for children still at home. Days of care reported are converted into full-time equivalent days for this measure.

BL 2010 Data Limitations

The reporting of this measure is dependent on the receipt of accurate and reliable data from TWC.

BL 2010 Data Source

FPS contracts with Texas Workforce Commission (TWC) for child care services that are provided through the Local Workforce Development Boards' Child Care Contractors. Those contractors have agreements with providers to serve children whose care is subsidized by TWC. Client information, including the cost of care, is collected by TWC, and TWC reports expenditures on CPS children to FPS by transmitting data electronically in an Excel file during the first half of each month for the current reporting period and the previous fiscal year.

BL 2010 Methodology

Due to lags in the billing process, a completion factor using historical trends in actual paid day care claims is applied to reported data in an internal budget document (OOELEDGER.xls) for PAC 220 and related CPS Reform PACs. Projected expenditures in OOELEDGER.xls are based on cumulative expenditure data provided by TWC. Exclude administrative costs not directly used to purchase child care services. Numerator: Average monthly expenditure amount, calculated by totaling the projected expenditures for the reporting period & dividing by the number of months in the reporting period. Denominator: Average monthly number of protective child care days reported in Output Measure 02-01-05.01.

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for day care provided to children in the CPS system.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	5	TWC Protective Day Care Purchased Services
Measure Type	EX	
Measure No.	1	Number of Children Receiving TWC Protective Day Care Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-04 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of children still at home who received TWC Protective child care during the report period.

BL 2010 Data Limitations

The reporting of this measure is dependent on the receipt of accurate and reliable data from TWC

BL 2010 Data Source

TWC reports to FPS the unduplicated number of FPS children who received paid units of care billed by their contract providers. TWC transmits data electronically for the current reporting period and the previous year. Retrieve number of children in PAC 220 (Protect Child Day Care, TWC's #14) and related CPS Reform PACs. Count children regardless of how many days are spent in paid child care per month.

Because billings can take several months to receive & process, estimate the number of children served using a completion factor based on historical trends of actual paid claims data applied to the number of children billed to date. Completion factors are determined for the sum of all PACs based on previous fiscal year's information for same reporting period versus previous year's year-end total. Use the overall total completion factor for reporting period.

BL 2010 Methodology

Data Source cont:
Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Count the unduplicated number of children receiving TWC Protective day care during the reporting period. The annual or year to date count will be the sum of

BL 2010 Purpose

To monitor the volume of FPS children who received protective day care services subsidized by TWC and provided through the Local Workforce Development Boards' Child Care Contractors in order to determine project utilization.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	5	TWC Protective Day Care Purchased Services
Measure Type	OP	
Measure No.	1	Average Number of Days of TWC Protective Day Care Paid per Month

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-04 OP

Fall/Annual: N

BL 2010 Definition

This measure reports average number of days of protective child day care provided to FPS children each month. A full-time day of day care is defined as 6-8 hours of day care service provided for a FPS child.

BL 2010 Data Limitations

The reporting of this measure is dependent upon the timely receipt of accurate and reliable data from TWC.

BL 2010 Data Source

FPS contracts with Texas Workforce Commission (TWC) for child care services that are provided through the Child Care Management Services (CCMS) network of providers under contract with TWC. Since TWC manages the CCMS system, all client information is captured by TWC, who reports to FPS the paid units of care billed by their contract providers for FPS children. TWC transmits data electronically in an Excel file during the first half of each month for the current reporting period and the previous fiscal year. Number of days is retrieved from monthly trends report as units of PAC 220 (Protective Child Day Care) and related CPS Reform PACs.

BL 2010 Methodology

The numerator is the total number of protective child care days provided, calculated by summing the number of child care days counted from the TWC report for PAC 220 and related CPS Reform PACs each report period month. The denominator is the number of months in the reporting period. Data are subject to change due to a lag in billing & payment of claims. A completion factor is used to provide completion totals for the reporting period. Completion factors are based on historical data. Previous fiscal year's end of year data compared to what the previous year's data looked like at the same time last year for the same reporting period.

Divide the numerator by the denominator. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
To monitor the volume of purchased full-time and part-time day care service days provided to FPS children and determine project utilization for determining budget and resource needs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	6	Adoption Purchased Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost per Child Adoption Placement Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-05 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide contracted adoption placement services to a child during the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PAC 212 (Purchased Adopt Svcs - Statewide Contracts) and related CPS Reform PACs. Number of clients receiving contracted adoption placement services is the unduplicated count of children reported in Output Measure 02-01-06.01, “Average Number of Children: Adoption Placement Purchased Services.” Clients are unduplicated by service month, PAC, and IMPACT person ID.

BL 2010 Methodology

Annual expenditure projections for PAC 212 and related CPS Reform PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures & adding estimates for accruals & encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period & then reduced by previous quarter(s) dollars to get estimated expenditures for the quarter being reported. These amounts are totaled & divided by number of reporting period months to arrive at average monthly cost for reporting period.

Numerator: Average monthly cost. Denominator: Average monthly number of children receiving contracted adoption placement services reported in Output Measure (02-01-06.01 “Average Number of Children: Adoption Placement Purchased Services”)

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the average cost per client for purchased services. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for contracted adoption placement services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	6	Adoption Purchased Services
Measure Type	OP	
Measure No.	1	Average Number of Children: Adoption Placement Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measure is an average monthly unduplicated count of children who receive adoption placement services purchased from a contract provider.

BL 2010 Data Limitations

None

BL 2010 Data Source

Within IMPACT, data are based on paid claims for service months during the reporting period. Identify purchased services using PAC 212 (Purchased Adopt Svcs - Statewide Contracts) and related CPS Reform PACs. Unduplicate clients by service month, PAC and IMPACT person ID.

Because billings can take months to receive & process, estimate number of clients served using completion factor based on historical trends in actual paid claims applied to number of clients billed on paid claims to date. Completion factors are determined for the overall total based on previous fiscal year's information for the same reporting period versus the previous year's year-end total. Use the overall total completion factor for performance reporting period.

Numerator: Sum of the unduplicated number of children who received contracted adoption placement services during reporting period. Denominator: Total number of months in reporting period.

BL 2010 Methodology

Data Source cont:
Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Divide the numerator by the denominator. When calculating 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to

BL 2010 Purpose

This measure provides useful information about the number of children receiving contracted adoption placement services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	7	Post-Adoption Purchased Services
Measure Type	EF	
Measure No.	1	Average Cost per Client for Post-adoption Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-06 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide CPS post-adoption purchased services from a contracted provider during the reporting period. These services include information and referral, case management and service planning, parent groups, parenting programs, adoption registry- related services, therapeutic counseling, respite care and placement services. Clients counted are FPS children (the department served as the child's managing conservator and placed the child for adoption), non-FPS children (a licensed Texas child-placing agency served as the child's managing conservator and placed the child for adoption, and the department is currently providing Title IV-E adoption assistance to the child), and their adoptive families.

BL 2010 Data Limitations

None

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PAC 208 (Post Adoption Services) and related CPS Reform PACs. The number of clients receiving CPS post-adoption purchased services is the unduplicated count of clients reported in Output Measure 02-01-07.01“Average Number of Clients Receiving Post-Adoption Purchased Services per Month.” Clients are unduplicated by service month using IMPACT person ID.

BL 2010 Methodology

Annual expenditure projections for PAC 208 and related CPS Reform PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period and then reduced by previous quarter(s) dollars to get estimated expenditures for the quarter being reported. These amounts are totaled, and divided by number of reporting period months to arrive at average monthly cost for reporting period. Average monthly cost is the numerator. The denominator is the unduplicated number of clients receiving CPS post-adoption purchased services in Output Measure 02-01-07.01.

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the average cost per client for purchased services. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for CPS post-adoption purchased services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	7	Post-Adoption Purchased Services
Measure Type	OP	
Measure No.	1	Average Number of Clients Receiving Post-adoption Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-06 OP

Fall/Annual: N

BL 2010 Definition

The purpose of this measure is to provide an average monthly unduplicated number of clients receiving purchased post-adoption services from a contracted provider. These services include information and referral, case management and service planning, parent groups, parenting programs, adoption registry-related services, therapeutic counseling, respite care and placement services. Clients counted are FPS children (the department served as the child's managing conservator and placed the child for adoption), non-FPS children (a licensed Texas child-placing agency served as the child's managing conservator and placed the child for adoption, and the department is currently providing Title IV-E adoption assistance to the child), and their adoptive families.

BL 2010 Data Limitations

None

BL 2010 Data Source

Using IMPACT, data are based on claims paid to providers for service months during the reporting period. Identify post-adoption services by PAC 208 (Post Adoption Services) and related CPS Reform PACs. Unduplicate clients by service month & IMPACT person ID.

Because it can take several months for all billings to process for a month of service, the number of clients ultimately served must be estimated for months with incomplete data by using historical trends from months with complete billings. Projected data are used to provide complete data for the reporting period. Completion factors are determined for the PAC based on previous fiscal year's information for the same reporting period versus the previous year's year-end total.

Numerator: Sum of the total unduplicated number of clients receiving post-adoption services each report period month. Denominator: Total number of reporting

BL 2010 Methodology

Data Source cont:
Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to

BL 2010 Purpose

This measure provides useful information on the number of clients receiving post-adoption services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	8	Preparation for Adult Living Purchased Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost per Youth: Preparation for Adult Living Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-07 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide Preparation for Adult Living (PAL) services during the reporting period.

BL 2010 Data Limitations

The unduplication methodology used to calculate the denominator of this measure may result in duplication due to clients receiving monthly services in multiple PACs. PAC 207, 209, and related CPS Reform PACs may not have client counts, but the expenditures are included.

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PACs 204 (Prep for Independent Living (IV-E-IL)), 206 (Cert Prj (IV-E-IL)), 207 (C. Ed Davis PAL Scholarship Fund), 209 (PAL ETV Program), and related CPS Reform PACs. Number of youth receiving PAL services is the unduplicated count of youth reported in Output Measure 02-01-08.01 “Average Number of Youth Receiving Preparation for Adult Living Services.” Clients are unduplicated by service month, PAC, and IMPACT person ID.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance

BL 2010 Methodology

Annual expenditure projections for PACs 204, 206, 207, 209, and related CPS Reform PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures & adding estimates for accruals & encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period & then reduced by previous quarter(s) dollars to get estimated expenditures for the quarter being reported. These amounts are totaled & divided by number of reporting period months to arrive at average monthly cost for reporting period.

Numerator: Average monthly cost. Denominator: Average monthly number of youth receiving PAL services in Output Measure 02-01-08.01, “Average Number of Youth: Preparation for Adult Living Services."

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the average cost per client for purchased services. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for CPS purchased services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	8	Preparation for Adult Living Purchased Services
Measure Type	OP	
Measure No.	1	Average # Youth: Preparation for Adult Living Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-07 OP

Fall/Annual: N

BL 2010 Definition

This measure is an average monthly unduplicated count of youth who receive Preparation for Adult Living (PAL) services purchased from a contract provider.

BL 2010 Data Limitations

The unduplication methodology used to calculate the denominator of this measure may result in duplication due to clients receiving monthly services in multiple PACs. PAC 207, 209, and related CPS Reform PACs may not have client counts, but the expenditures are included.

BL 2010 Data Source

Within IMPACT, data are based on paid claims for service months during the reporting period. Identify purchased services using PACs 204 (Prep for Independent Living (IV-E-IL)), 206 (Cert Prj (IV-E-IL)), 207 (C. Ed Davis PAL Scholarship Fund), 209 (PAL ETV Program), and related CPS Reform PACs. Unduplicate clients by service month, PAC and IMPACT person ID.

Because billings can take months to receive & process, estimate number of clients served using completion factor based on historical trends in actual paid claims applied to number of clients billed on paid claims to date. Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Numerator: Sum of the unduplicated number of youth who received PAL services during reporting period. Denominator: Total number of months in reporting period.

BL 2010 Methodology

Data Source cont:
Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Divide the numerator by the denominator. When calculating 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to

BL 2010 Purpose

This measure provides useful information about the number of youth receiving PAL services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	9	Substance Abuse Purchased Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost per Client for Substance Abuse Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-08 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to CPS for substance abuse purchased services.

BL 2010 Data Limitations

The unduplication methodology used to calculate the denominator of this measure may result in duplication due to clients receiving monthly services in multiple

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for substance abuse purchased services for PACs 243 (Subs Prevent/Treat Svcs - Child Welfare Prj TANF), 244 (Sub Abuse Prevent/Treat Svcs - Child Welfare Prj Non-TANF), 245 (Subs Abuse Prevent/Treat Svcs - In-Hm -TANF), 246 (Subs Abuse Prevent/Treat Svcs - In-Hm Non-TANF), 247 (Drug Test - Family Based Safe Svcs -TANF), 248 (Drug Test - All Other), and related CPS Reform PACs. Clients are unduplicated by service month, PAC, and IMPACT person ID.

Number of clients receiving substance abuse purchased services is the count of clients reported in Output Measure 02-01-09.01 “Average Number of Clients Receiving Substance Abuse Services.”

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

Annual expenditure projections for substance abuse PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures & adding estimates for accruals & encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period & then reduced by previous quarter(s) dollars to get estimated expenditures for the quarter being reported. These amounts are totaled & divided by number of reporting period months to arrive at average monthly cost for reporting period.

Numerator: Average monthly cost. Denominator: Average monthly number of clients receiving purchased substance abuse services reported in Output Measure 02-01-09.01

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the average cost per client for purchased services. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for substance abuse purchased services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	9	Substance Abuse Purchased Services
Measure Type	OP	
Measure No.	1	Average # Clients: Substance Abuse Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-08 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly number of clients who received CPS substance abuse purchased services during the reporting period.

BL 2010 Data Limitations

The unduplication methodology used to calculate this measure may result in duplication due to clients receiving monthly services in multiple PACs.

BL 2010 Data Source

Using IMPACT, data are based on paid claims for service months during the reporting period. Identify substance abuse purchased services by PACs, 243 (Subs Prevent/Treat Svcs - Child Welfare Prj (TANF), 244 (Sub Abuse Prevent/Treat Svcs - Child Welfare Prj Non-TANF), 245 (Subs Abuse Prevent/Treat Svcs - In-Hm -TANF), 246 (Subs Abuse Prevent/Treat Svcs - In-Hm Non-TANF), 247 (DrugTesting - Family Based Safe Svcs -TANF), 248 (Drug Test - All Other), and related CPS Reform PACs. Unduplicate clients by service month, PAC, & IMPACT person ID.

Because billings can take several months to receive & process, estimate the number of clients served using a completion factor based on historical trends of actual paid claims data applied to the number of clients billed to date. Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

Data Source cont:
Numerator: Sum of the unduplicated number of clients who received substance abuse purchased services during reporting period. Denominator: Total number of months in reporting period.

Due to possible modifications in FPS fiscal system, PACs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator by the denominator. When calculating 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

To monitor the volume of clients receiving CPS substance abuse purchased services from a contracted provider.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	10	Other Purchased Child Protective Services
Measure Type	EF	
Measure No.	1	Average Monthly Cost per Client: Other CPS Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-09 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost to provide other purchased services during the reporting period to a client who needs the service to facilitate the achievement of the service plan and/or to comply with a court order that mandates their participation in the service.

BL 2010 Data Limitations

Not all clients receiving purchased services can be counted due to the administrative type contracts included under this strategy (i.e., Youth for Tomorrow) that do not track services to individual clients. The unduplication methodology used to calculate the denominator of this measure may result in duplication due to clients receiving monthly services in multiple PACs.

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PACs 200 (Child Welfare Projects), 202 (In-hm Svcs Proj), 205 (In-hm Svcs Case Mgmt Sv), 210 (Child Welfare Projects – TANF), 211 (In-Home Services – TANF), 213 (Adoption Promotion Recruitment Campaign), 214 (Burial for Wards of State), 215 (CPS Tele Medicine Assessments) , 232 (CPS Temp Foster Care – IV-E), 233 (CPS Temp Foster Care – Non IV-E), 251 (Intensified Family Preservation/ Reunification), 252 (Concrete Services), 253 (Strengthening Families Through Enhanced In-Home Support Program), and related CPS Reform PACs. Number of clients receiving other purchased services is the unduplicated count of clients reported in Output Measure 02-01-10.01. Clients are unduplicated by service month, PAC, and IMPACT person ID.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

Annual expenditure projections for PACs 200, 202, 205, 210, 211, 214, 232, 233, 251, 252, and related CPS Reform PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures & adding estimates for accruals & encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period & then reduced by previous quarter(s) dollars to get estimated expenditures for the quarter being reported. These amounts are totaled & divided by number of reporting period months to arrive at average monthly cost for reporting period.

Numerator: Average monthly cost. Denominator: Unduplicated number of clients receiving other purchased services in Output Measure 02-01-10.01.

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the average cost per client for purchased services. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in costs for other CPS purchased services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	10	Other Purchased Child Protective Services
Measure Type	OP	
Measure No.	1	Average Number of Clients Receiving Other CPS Purchased Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-09 OP

Fall/Annual: N

BL 2010 Definition

This measure is an average monthly unduplicated count of clients who receive other services purchased from a contract provider. These services include CPS contracted case management of family preservation or family reunification.

BL 2010 Data Limitations

Not all clients receiving purchased services can be counted due to the administrative type contracts included under this strategy (i.e. Parent's Anonymous and contracts with Child Welfare Boards) that do not track services to individual clients. The unduplication methodology used to calculate this measure may result in duplication due to clients receiving monthly services in multiple PACs.

BL 2010 Data Source

Within IMPACT, data are based on paid claims for service months during the reporting period. Identify purchased services using PACs 200 (Child Welfare Projects), 202 (In-hm Svcs Proj), 205 (In-hm Svcs Case Mgmt Sv), 210 (Child Welfare Prj - TANF), 211 (In-hm Svcs-TANF), 213, (Adoption Promotion Recruitment Campaign), 214 (Burial for Wards of State), 215 (CPS Tele-Medicine Assessments), 226 (Relative Caregiver Home Assessments), 232 (CPS Temp Foster Care – IV-E), 233 (CPS Temp Foster Care – Non IV-E), 251 (Intensified Family Preservation/ Reunification), 252 (Concrete Services), 253 (Strengthening Families Through Enhanced In-Home Support Program), and related CPS Reform PACs. Unduplicate clients by service month, PAC and IMPACT person ID.

Because billings can take months to receive & process, estimate number of clients served using completion factor based on historical trends in actual paid claims applied to number of clients billed on paid claims to date.

BL 2010 Methodology

Data Source cont:
Completion factors are determined for the overall total (sum of all PACs) based on previous fiscal year's information for the same reporting period versus the previous year's year-end total. Use the overall total completion factor for performance reporting period.

Numerator: Sum of the unduplicated number of clients who received purchased services during reporting period. Denominator: Total number of months in reporting period.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator by the denominator. When calculating 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

Purpose:
This measure provides useful information about the number of clients receiving other purchased services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	EF	
Measure No.	1	Average Monthly FPS Expenditures for Foster Care

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-10 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports average monthly FPS cost of foster care. All levels of care are included. Co-payments used to help offset foster care cost are not included since they are subtracted from the cost of care prior to making payment.

BL 2010 Data Limitations

None

BL 2010 Data Source

For each service month during reporting period, actual expenditure, client, co-pay & days of care data are extracted from IMPACT using PACs 260 and 261, service codes, and object codes. Since modifications in FPS fiscal system may change PACs, service codes, & object codes, all current codes are documented in performance folder.

Methodology:
Record the number of FPS paid days of foster care for each service code as reported on foster care paid invoices. It takes up to 2 years to close billings for a month of service, so foster care paid data must be estimated for months with incomplete billings by using a completion factor from historical data. Completion factors are applied to the total daily clients to yield estimated daily clients. These are converted to total foster care days using a historical conversion factor.

BL 2010 Methodology

Methodology cont:
From the total days the income days are subtracted to yield total expected FPS paid foster care days for report period months with processed bills. Multiply the expected FPS paid days by the appropriate service code rate to yield the expected FPS expenditures for service months that have processed bills. For report period month without processed bills, project total daily foster care clients from a cohort based flow-model. The total income days are also projected from the model and are subtracted from the total foster care days to yield the projected FPS paid days. Multiply the projected FPS paid days of care by the service code rate to obtain projected foster care expenditures.

BL 2010 Purpose

Methodology cont:
Numerator: Sum of expected monthly expenditures & projected monthly expenditures for all levels of care reported for each report period month. Denominator: Number of report period months. Divide numerator by denominator.

When calculating 2nd, 3rd, & 4th quarters, recalculate previous quarters & year-to-date total. Values entered in ABEST are updated until no completion factors are required. Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate & reliable.

Purpose:
This measure is useful as a benchmark & to monitor changes in average monthly cost of foster care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	EF	
Measure No.	2	Average Monthly Copayments for Foster Care

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-10 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports average monthly child income used to help offset foster care costs, termed co-payment -- the difference between amount billed and amount FPS actually paid.

BL 2010 Data Limitations

None

BL 2010 Data Source

For each service month during reporting period, actual expenditure, client, co-pay & days of care data are extracted from IMPACT using PACs 260 and 261, service codes, & object codes. Due to modifications in FPS fiscal system, PACs, service codes, and object codes are subject to change. Thus, all current codes are documented in performance folder.

BL 2010 Methodology

For service months during the reporting period, record the amount of co-payment dollars applied to the cost of foster care for each service code as reported on foster care paid invoices.

For report period month without processed bills, project total client co-pay dollars at the service code level from a cohort based flow-model. Divide projected co-pay dollars by the appropriate service code rate to yield the projected co-pay days for report period month without processed bills.

Numerator: Sum of total actual recorded co-pay & total projected co-pay for all levels of care each report period month. Denominator: Number of report period months. Divide numerator by denominator. When calculating 2nd, 3rd, and 4th quarters, recalculate previous quarters & year-to-date total. Values entered in ABEST are updated until no completion factors are required.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate and reliable until all billings are complete.

Purpose:
This measure is useful as a benchmark and to monitor changes in average monthly child income used to help offset the cost of foster care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	EF	
Measure No.	3	Average Monthly FPS Payment per Foster Child (FTE)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-10 EF 03

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly FPS cost for a child (FTE) in foster care. Co-payments used to help offset the cost of foster care (such as a child's social security income, trust fund, etc.) are not included since they are subtracted from the cost of care prior to the payment being made.

BL 2010 Data Limitations

None

BL 2010 Data Source

Average expenditures are from IMPACT as reported in Efficiency Measure 02-01-11.01, “Expenditures – Foster Care: All,” which is the numerator for this measure. Average children (FTE) are taken from IMPACT as reported in the Output Measure 02-01-11.02, “Average Number of Children (FTE) Served in Paid Foster Care per Month," which is the denominator for this measure.

BL 2010 Methodology

Divide the numerator by the denominator to calculate the average monthly payment per child (FTE) in paid foster care. Due to estimation, previously reported totals are subject to change when subsequent reports are prepared. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is useful as a benchmark and to monitor changes in the average monthly cost of foster care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	EF	
Measure No.	4	Average Monthly Cost per Child: Caregiver Monetary Assistance

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-10 EF 04

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly number of unduplicated children who received relative caregiver assistance during the report period. Relative caregiver assistance includes a one-time integration payment of $1,000 per sibling group, after a DFPS approved placement, and an annual expense reimbursment payment for child related expenses, one $500 payment per child for child-related expenses if the expenses meet eligibility requirements.

BL 2010 Data Limitations

The authorization for the integration payment is made for only one child in the sibling group. In order to count all children benefiting from the assistance, all other siblings residing with the same kinship placement will also be counted.

BL 2010 Data Source

Actual expenditures are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for relative caregiver assistance by PAC 292 (Relative/Other Designated Caregiver Reimbursement Program). Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

BL 2010 Methodology

Annual expenditure projections for PAC 292 is made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures & adding estimates for accruals & encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period & then reduced by previous quarter(s) dollars to get estimated expenditures for the quarter being reported. These amounts are totaled & divided by number of reporting period months to arrive at average monthly cost for reporting period. The average monthly cost is the numerator. The denoinator is the number of unduplicated children receiving relative caregiver assistance in Output Measure 02-01-11.03.

Divide the numerator by the denominator to calculate the average cost per child receiving relative caregiver assistance. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
To monitor the average monthly costs of relative caregiver assistance.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	EX	
Measure No.	1	Number of Children in Paid Foster Care

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-10 EX 01

Fall/Annual: N

BL 2010 Definition

This measure is the unduplicated number of children being served in paid foster care.

BL 2010 Data Limitations

None

BL 2010 Data Source

Count the number of unduplicated clients that received foster care for the fiscal year.Count the number of children in paid foster care for the fiscal year. For the month(s) that do not have processed foster care bills apply a historical ratio of unduplicated clients to Paid FTEs to the projected number of Paid FTEs from the cohort-based flow-model to yield the projected number of unduplicated foster care clients. Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate and reliable until all billings are complete.

BL 2010 Methodology

Count the number of unduplicated clients that received foster care for the fiscal year. For the month(s) that do not have processed foster care bills apply a historical ratio of unduplicated clients to Paid FTEs to the projected number of Paid FTEs from the cohort-based flow-model to yield the projected number of unduplicated foster care clients.

Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate and reliable until all billings are complete.

BL 2010 Purpose

This measure provides important data to estimate how many children will receive foster care services during a fiscal year. The data is very useful in analyzing trends and projecting agency costs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	EX	
Measure No.	2	Number of Children Receiving Caregiver Monetary Assistance

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-10 EX 02

Fall/Annual: N

BL 2010 Definition

This measure counts the unduplicated number of unduplicated children receiving relative caregiver assistance during the fiscal year. Relative caregiver assistance includes a one-time integration payment of $1,000 per sibling group, after a DFPS approved placement, and an annual expense reimbursment payment for child related expenses, one $500 payment per child for child-related expenses if the expenses meet eligibility requirements.

BL 2010 Data Limitations

The authorization for the integration payment is made for only one child in the sibling group. In order to count all children benefiting from the assistance, all other siblings residing with the same kinship placement will also be counted.

BL 2010 Data Source

Count children who received or benefitied from relative caregiver assistance during the fiscal year. A child is noted in IMPACT as receiving relative caregiver assistance by appearing in paid claims processed against PAC 292 (Relative/Other Designated Caregiver Reimbursement Program) during the reporting period or by being placed in the same kinship placement as a sibling who is in a paid claim for the integration payment.

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

BL 2010 Methodology

Count the number of unduplicated children that received relative caregiver assistance for the fiscal year.

Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate and reliable until all billings are complete.

BL 2010 Purpose

This measure provides important data to estimate how many children received relative caregiver assistance during a fiscal year. The data is very useful in analyzing trends and projecting agency costs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	OP	
Measure No.	1	Average Number of FPS-paid Days of Foster Care per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-10 OP

Fall/Annual: N

BL 2010 Definition

This measure is the sum of paid days of foster care for all levels of care divided by the number of months in the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

For each service month during reporting period, actual expenditure, client, co-pay & days of care data are extracted from IMPACT using PACs 260 and 261, service codes, and object codes. Clients are only counted once within each level of care. Client counts are duplicated since a child may have received services funded by more than one PAC and may have had more than one level of care during a given month.

Due to possible modifications in FPS fiscal system, PACs, service codes, & object codes are subject to change. Therefore, all current codes are documented in performance folder.

Methodology:
Record the number of FPS paid days of foster care for each service code as reported on foster care paid invoices. It takes up to 2 years to close billings for a month of service, so completion factors are derived from historical data and is applied to the total daily clients to yield estimated daily clients. These are converted to total foster care days using a historical conversion factor.

BL 2010 Methodology

From the total days the income days are subtracted to yield the expected FPS paid foster care days. Sum the expected FPS paid days across all service levels to yield the total expected FPS paid days.

For a report period without processed bills, project total daily foster care clients, from a cohort based flow-model. These are converted to total foster care days using a conversion factor. The total income days are also projected from the model and are subtracted from the total foster care days to yield the projected FPS paid days.Numerator: Sum of expected foster care days & projected foster care days for all levels of care reported each month in report period. Denominator: Number of report period months.

Divide the numerator by the denominator. When calculating 2nd, 3rd, and 4th quarters, recalculate previous quarters & year-to-date total. Values entered in ABEST are updated until no completion factors are required.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate and reliable.

Purpose:
The purpose of this measure is to calculate the average monthly days of care billed and paid at all levels for both IV-E and non IV-E paid foster care. This measure is important as it provides a baseline for estimating federal reimbursement, expenditures and projecting costs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	OP	
Measure No.	2	Average Number of Children (FTE) Served in FPS-paid Foster Care per Mo

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-10 OP

Fall/Annual: N

BL 2010 Definition

An FTE is calculated by dividing the number of paid foster care days in a month by the number of calendar days in a month. The sum of FTE's for the report period is divided by the number of months in the report period to obtain the average number of FTE children served in paid foster care per month.

BL 2010 Data Limitations

None

Data Source:
For each service month during reporting period, actual expenditure, client, co-pay & days of care data are extracted from IMPACT using PACs 260 and 261, service codes, and object codes. Clients are only counted once within each service code.

BL 2010 Data Source

Due to possible modifications in FPS fiscal system, PACs, service codes, and object codes are subject to change. Therefore, all current codes are documented in performance folder.

Methodology:
Record the number of FPS paid days of foster care for each service code as reported on foster care paid invoices. It takes up to 2 years to close billings for a month of service, so completion factors are derived from historical data and are applied to the total daily clients to yield estimated daily clients. These are converted to total foster care days using a historical conversion factor. From the total days the income days are subtracted to yield the expected FPS paid foster care days.

BL 2010 Methodology

Sum the expected FPS paid days across all service levels to yield the total expected FPS paid days. Divide the expected number of FPS paid days of foster care by the number of days in the service month to yield the number of expected Full Time Equivalent (FTE) clients for the service month.

For reporting period month without processed bills, project total daily foster care clients from a cohort based flow-model. The total income days are also projected from the model and are subtracted from the total foster care days to yield the projected FPS paid days. The projected FPS paid days of foster care is divided by the number of days in the month to yield the number of projected Full Time Equivalent (FTE) clients for the reporting month.

BL 2010 Purpose

Methodology cont:
The numerator is sum of expected FTEs & projected FTEs for all levels of care reported for each month in reporting period. The denominator is number of reporting period months.

Divide numerator by denominator to calculate average number of children (FTE) served in paid foster care per month. When calculating 2nd, 3rd, and 4th quarters, recalculate previous quarters & year-to-date total. Values entered in ABEST are updated until no completion factors are required. Values reported in ABEST are also updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Additionally, values reported in ABEST are updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure calculates average number of FTEs, children, served in paid foster care per month. This measure provides a baseline for estimating expenditures and projecting staff costs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	11	Foster Care and Relative Monetary Assistance Payments
Measure Type	OP	
Measure No.	3	Average Monthly Number of Children: Caregiver Monetary Assistance

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-10 OP

Fall/Annual: N

BL 2010 Definition

This measure is an average monthly unduplicated count of children who received relative caregiver assistance. Relative caregiver assistance includes a one-time integration payment of $1,000 per sibling group, after a DFPS approved placement, and an annual expense reimbursment payment for child related expenses, one $500 payment per child for child-related expenses if the expenses meet eligibility requirements.

BL 2010 Data Limitations

The authorization for the integration payment is made for only one child in the sibling group. In order to count all children benefiting from the assistance, all other siblings residing with the same kinship placement will also be counted.

BL 2010 Data Source

Count children who received or benefited from relative caregiver assistance during the fiscal year. A child is noted in IMPACT as receiving relative caregiver assistance by appearing in paid claims processed against PAC 292 (Relative/Other Designated Caregiver Reimbursement Program) during the reporting period or by being placed in the same kinship placement as a sibling who is in a paid claim for the integration payment. Because billings can take several months to receive and process, estimate the number of children served using a completion factor based on historical trends of actual paid claims data applied to the number of children who were billed or who benefited from the assistance to date. Completion factors are determined for the sum of this PAC based on previous fiscal year's information for same reporting period versus previous year's year-end total. Use the overall total completion factor for reporting period.

BL 2010 Methodology

Data Source cont:
Numerator: Sum of the unduplicated number of children who received relative caregiver assistance during the reporting period. Denominator: Total number of months in the reporting period.

Due to modifications in the FPS fiscal system, PACs may change. Should this occur, current equivalent codes will be substituted and documented in performance folder. accurate and reliable.

Methodology:
Divide the numerator by the denominator. When calculating the 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

To monitor the average monthly number of FPS children who receive relative caregiver assistance.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	12	Adoption Subsidy Payments
Measure Type	EF	
Measure No.	1	Average Monthly Payment per Adoption Subsidy

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-11 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly payment provided to adoptive families to defray the costs associated with caring for special-needs children.

BL 2010 Data Limitations

Because this data is based on the billing process, a projection is made using a cohort based flow-model for the last month in the reporting period due to the lag in the billing process.

BL 2010 Data Source

The number of dollars paid for adoption subsidy payments is taken from IMPACT using PAC 265 (Title IV-E Adoption Subsidy Payments) and PAC 266 (Non-IVE Adoption Subsidy Payments). Payments from these two PACs are designated for children/families receiving recurring adoption subsidy payments. However, it is possible for a child to receive only one payment. This measure DOES NOT track non-recurring or medical only payments which are designated by payment from PAC 280. It takes up to 2 years to close billings for a month of service, so children provided adoption subsidy payments must be estimated for months with incomplete billings by using a completion factor from historical data. A projection is made for the last month in the reporting period using a cohort based flow-model due to the lag in the billing process. The number of children receiving adoption subsidy payments is the number reported in Output Measure "Average Number of Children Provided Adoption Subsidy per Month."

BL 2010 Methodology

Data Source cont:
Due to possible modifications in the FPS fiscal system, PACs, service codes and/or object codes are subject to change. Should this occur, the current equivalent codes would be substituted and documented in the performance folder.

Methodology:
The numerator for this measure is the average monthly expenditure, which is calculated by totaling the projected and completed expenditures for the reporting period and then dividing the total by the number of reporting period months. The denominator is the average monthly number of children receiving adoption subsidies for the reporting period.

Divide the numerator by the denominator to arrive at the average monthly payment per adoption subsidy payment. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated.

BL 2010 Purpose

Methodology cont:
Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in the cost of adoption subsidy payments.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	2	Protect Children Through an Integrated Service Delivery System
Objective No.	1	Reduce Child Abuse/Neglect and Mitigate Its Effect
Strategy No.	12	Adoption Subsidy Payments
Measure Type	OP	
Measure No.	1	Average Number of Children Provided Adoption Subsidy per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-11 OP

Fall/Annual: N

BL 2010 Definition

This measure is the sum of the monthly unduplicated counts of children provided IV-E or non IV-E adoption subsidy payments per month divided by the number of months in the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

For each service month during reporting period, count the number of children who received an adoption subsidy payment from PAC 265 (Title IV-E Adoption Subsidies) or PAC 266 (Non-IVE Adoption Subsidies) from IMPACT. Payments from these two PACs are designated for children/families receiving recurring adoption subsidy payments. However, it is possible for a child to receive only one payment. This measure DOES NOT track children who receive non-recurring or medical only payments which are designated by payment from PAC 280. These children are identified from paid claims. It takes up to 2 years to close billings for a month of service, so children provided adoption assistance must be estimated for months with incomplete billings by using a completion factor from historical data. For the last month of the reporting period when bills have not been processed, clients are projected from a cohort based flow-model.

BL 2010 Methodology

Data Source cont:
In subsequent reporting periods projected client totals are replaced with actual client data as bills for previous periods are processed.

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

Methodology:
The total of the monthly unduplicated counts of children receiving IV-E or non IV-E adoption subsidy payments per month is the numerator. The total number of months in the reporting period is the denominator.

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to count the average number of children receiving IV-E or non IV-E adoption subsidy payments per month. The measure is beneficial in evaluating and projecting expenditures and costs to determine future needs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	1	Services to At-Risk Youth (STAR) Program
Measure Type	EF	
Measure No.	1	Average Monthly FPS Cost per STAR Youth Served

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-12 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average cost incurred by FPS to serve a youth that is actively participating in the STAR program. The cost incurred by FPS is the sum of expenditures to STAR contracted service providers during the reporting period.

BL 2010 Data Limitations

The agency is dependent on STAR program contracted service providers to provide data. There are instances when a participant may receive services from more than one STAR service provider during the same month. When this occurs, the participant is included in the count for each provider that provided service, causing a small number of participants to be counted more than once. The number of participants counted more than once is less than 1% in any given month.

BL 2010 Data Source

The total client service program cost for STAR contracted service providers is taken from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PACs 300 (Services to At-Risk Youth), 301 (Services to At-Risk Youth - TANF) and PAC 302 (Universal Prevention Services). The number of youth actively participating in the STAR program is taken from the Prevention and Early Intervention Services (PEIS) Database. The number of participants is unduplicated for each contracted service provider per month.

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

BL 2010 Methodology

An expenditure projection for PACs 300, 301 and 302 is made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period and adding estimates for accruals. This expenditure amount for the reporting period is the numerator. The total number of youth actively participating in the STAR program during the reporting period is divided by the number of months in the reporting period to get the average monthly number of youth served (denominator).

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is used as a benchmark and to monitor increases in the cost of service.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	1	Services to At-Risk Youth (STAR) Program
Measure Type	OP	
Measure No.	1	Average Number of STAR Youth Served per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-12 OP

Fall/Annual: N

BL 2010 Definition

This measure calculates the average number of STAR program youth who actually received services during a reporting period.

BL 2010 Data Limitations

The agency is dependent on STAR program contracted service providers to provide data. There are instances when a participant may receive services from more than one STAR contracted service provider during the same month. When this occurs, the participant is included in the count for each contracted service provider that provided service, causing a small number of participants to be counted more than once. The number of participants counted more than once is less than 1% in any given month.

BL 2010 Data Source

Services consist of emergency residential service (where the client is housed in an emergency facility), individual youth and family crisis counseling, , family unit counseling, youth skills based training, and family skills based training. Because it takes several months for all services to be reported in the Prevention and Early Intervention Services (PEIS) Database for a service month, the number of youth served must be estimated for the months that are not complete using a standard projection methodology. The number of participants is unduplicated for each contracted service provider per month. The numerator is the total number of youth reported who received any of the services listed above. The denominator is the number of months in the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is a good indicator of the volume of services being provided by STAR contracted service providers.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	2	Community Youth Development (CYD) Program
Measure Type	EF	
Measure No.	1	Average Monthly Cost per CYD Youth Served

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-13 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average cost incurred by FPS to serve a youth that is actively participating in the Community Youth Development (CYD) program. The cost incurred by FPS is the sum of expenditures to CYD contracted service providers during the reporting period.

BL 2010 Data Limitations

The agency is dependent on CYD program contracted service providers to provide data. There are instances when a participant may receive services from more than one CYD contracted service provider during the same month. When this occurs, the participant is included in the count for each contracted service provider that provided service, causing a small number of participants to be counted more than once. The number of participants counted more than once is less than 1% in any given month.

BL 2010 Data Source

The total client service program cost for CYD contracted service providers is taken from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PAC 310 (Community Youth Development Grants). The number of youth actively participating in the CYD program is taken from the Prevention and Early Intervention Services (PEIS) Database. The number of participants is unduplicated for each contracted service provider per month.

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

BL 2010 Methodology

An expenditure projection for PAC 310 is made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period and adding estimates for accruals. This expenditure amount for the reporting period is the numerator. The total number of youth actively participating in the CYD program during the reporting period is divided by the number of months in the reporting period to get the average monthly number of youth served (denominator).

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is used as a benchmark and to monitor increases in the cost of service.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	2	Community Youth Development (CYD) Program
Measure Type	OP	
Measure No.	1	Average Number of CYD Youth Served per Month

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-02-13 OP

Fall/Annual: N

BL 2010 Definition

This measure is the average monthly number of Community Youth Development (CYD) program youth who actually received a service (i.e., attended a paid activity) during the reporting period.

BL 2010 Data Limitations

The agency is dependent on CYD program contractors to provide data. There are instances when a participant may receive services from more than one CYD contractor during the same month. When this occurs, the participant is included in the count for each contractor that provided service, causing a small number of participants to be counted more than once. The number of participants counted more than once is less than 1% in any given month.

BL 2010 Data Source

Information resides on monthly summary sheets completed by providers and entered into the Prevention and Early Intervention Services (PEIS) Database. Each provider has a unique provider agreement and services vary by provider. Summary of services provided: employment skills training, alternative recreation activities, youth educational/tutoring programs, mentoring, and life skills training. Because it takes several months for all services to be reported in the PEIS Database for a service month, the number of youth served must be estimated for the months that are not complete using a standard projection methodology. The number of participants is unduplicated for each contracted service provider per month. The numerator is the total number of youth reported who received services included in the provider agreement. The denominator is number of months in reporting period.

BL 2010 Methodology

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to calculate the number of CYD youth who actually receive counseling, skills training, & prevention services and is a good indicator of impact and quality services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	3	Texas Families: Together and Safe Program
Measure Type	EF	
Measure No.	1	Avg Monthly Cost per Family Served in the Texas Families Program

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-14 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost incurred by FPS to serve a family participating in the Texas Families: Together and Safe program. The cost incurred by FPS is the sum of expenditures to Texas Families contracted service providers during the reporting period.

BL 2010 Data Limitations

The data collected are reported to FPS by the contracted service providers providing the services.

BL 2010 Data Source

The total client service program cost for Texas Families contracted service providers is taken from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PAC 321(Texas Families: Together and Safe). For each month during the reporting period, the number of families participating in the Texas Families program is taken from the Prevention and Early Intervention Services (PEIS) Database (or its predecessor).

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

BL 2010 Methodology

An expenditure projection for PAC 321 is made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period and adding estimates for accruals. This expenditure amount for the reporting period is the numerator. The denominator for this measure is the total number of families participating in the program during the reporting period divided by the number of months. The denominator for this measure is reported in the Output Measure “Average Number of Families Served in the Texas Families Program per Month.”

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is useful as a benchmark and to monitor increases in the cost of service.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	3	Texas Families: Together and Safe Program
Measure Type	OP	
Measure No.	1	Average Number of Families Served in the Texas Families Program

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-02-14 OP

Fall/Annual: N

BL 2010 Definition

This measure calculates the average unduplicated number of families served in the Texas Families: Together and Safe program for each month during the reporting period.

BL 2010 Data Limitations

The data collected are reported to FPS by the outside entity providing the services.

BL 2010 Data Source

Information is taken from the Prevention and Early Intervention Services (PEIS) Database (or its predecessor). The numerator is the total number of unduplicated families who received services from the Texas Families: Together and Safe Program each month during the reporting period. The denominator is the number of months in the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to get an average monthly, unduplicated number of families that were served by the Texas Families: Together and Safe Program during the fiscal year. This count is a good indicator of volume of services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	4	Provide Child Abuse Prevention Grants to Community-based Organizations
Measure Type	OP	
Measure No.	1	Number of Community-based Child Abuse Prevention Grants Awarded

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-02-15 OP

Fall/Annual: N

BL 2010 Definition

This measure is the unduplicated number of grants awarded for child abuse and neglect prevention services through the Community Based Child Abuse Prevention (CBCAP) program during the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

IMPACT

BL 2010 Methodology

Sum the unduplicated number of active grants during the reporting period that have a signed contract with the Community-Based Child Abuse Prevention (CBCAP) program. When calculating the 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is

BL 2010 Purpose

This measure identifies the number of grants for child abuse and neglect prevention services awarded through the CBCAP program and is an important indicator of community based child abuse and neglect prevention services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	5	Provide Funding for Other At-Risk Prevention Programs
Measure Type	EF	
Measure No.	1	Average Monthly Cost per Person: Other At-risk Prevention Programs

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-02-16 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the monthly average cost incurred by FPS to serve a person who is actively participating in the Other At-Risk Prevention Programs. The cost incurred by FPS is the sum of expenditures to Other At-Risk Prevention Services contracted service providers during the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

The total client service program cost for Other At-Risk Prevention Services contracted service providers is taken from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PACs 370 (Other At-Risk Prevention Services - Child Abuse/Neglect) and 371 (Other At-Risk Prevention Services - Juvenile Delinquency). The number of persons served is the count from Output Measure 03-01-05.01 Average Number of Persons Served in At-Risk Prevention Services Programs. The number of persons served is unduplicated for each contracted service provider per month.

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

BL 2010 Methodology

An expenditure projection for PACs 370 and 371 is made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period and adding estimates for accruals. The sum of the expenditures for the reporting period is the numerator. The denominator is the count from Output Measure 03-01-05.01 Average Number of Persons Served in At-Risk Prevention Services Programs.

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is used as a benchmark and to monitor increases in the cost of service.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	3	Prevention and Early Intervention Programs
Objective No.	1	Provide Contracted Prevention and Early Intervention Programs
Strategy No.	5	Provide Funding for Other At-Risk Prevention Programs
Measure Type	OP	
Measure No.	1	Average Monthly Number Served: Other At-risk Programs

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-02-16 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of persons receiving services from programs funded under strategy C.1.5 "Other At-Risk Prevention Programs".

BL 2010 Data Limitations

Other At-Risk Prevention Programs contractors provide service data to DFPS.

BL 2010 Data Source

Information is taken from the Prevention and Early Intervention Services (PEIS) Database (or its predecessor). Because it takes several months for all services to be reported in the PEIS Database for a service month, the number of youth served must be estimated for the months that are not complete using a standard projection methodology. The numerator is the sum of persons served each month by each contract provider. (Persons served are unduplicated by service provider). The denominator is the number of months in the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is a good indicator of the number of persons receiving a service through the Other At-Risk Prevention Programs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	EF	
Measure No.	1	Average Daily Cost per APS Direct Delivery Service (All Stages)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average daily cost attributable to direct delivery of services. Direct delivery services included are for investigation (INV) and In-Home Services (SVC).

BL 2010 Data Limitations

The agency does not track costs for stages of direct delivery services. This calculation involves using actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances.

BL 2010 Data Source

Actual expenditures for APS direct delivery services are from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PACs 410 (APS Direct Delivery), 415 (Adult Protective Direct Delivery Litigation), 420 (APS Purchased Client Services), and 423 (APS Texas Tele-Medicine Assessments). The number of APS Direct Delivery stages is obtained from Output Measure 04-01-01.03, Average Daily Number of Direct Delivery Services (all stages).

Due to possible modifications in the FPS fiscal system, PACs are subject to change. Should this occur, current equivalent codes will be substituted and documented in the performance folder.

BL 2010 Methodology

Annual expenditure projections for PACs listed above are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, annual expenditure projections are multiplied by percent of year elapsed for reporting period and reduced by previous quarter(s) dollars to get estimated expenditures attributable to report quarter.

These amounts are totaled & divided by number of days in the reporting period to arrive at average daily cost for reporting period, the numerator. The

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the Average Daily Cost per Direct Delivery Service. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to & including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark & to monitor changes in agency costs attributable to the provision of direct delivery services.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	EF	
Measure No.	2	APS Daily Workload Equivalency Measure (WEM)

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-03-01 EF 03

Fall/Annual: N

BL 2010 Definition

This measure provides average daily weighted workload for APS in-home caseworkers paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR for the different stages of direct delivery services. Supervisors carrying cases are not included in the definition of caseworker. Each stage is weighted in relation to the hours in a day it takes to work an investigation. Since all stages are weighted against an investigation, they can be summed and divided by the number of caseworkers to arrive at a workload equivalency.

BL 2010 Data Limitations

Investigation stages more than 60 days of age are excluded, however caseworkers with a an INV caseload comprised only of INV more than 60 days of age are not exlcuded.

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changes jobs during the month, only the last record for the month is captured.

BL 2010 Data Source

The Work Measurement Study (WMS) established the hours each day to work different stages of direct delivery services. Time spent working an active investigation is the standard for weighting other stages. Weighting factor for investigations is equal to one. Weighting factors for other stages are computed by dividing time to work that stage by the time to work an investigation.

The stages included are Investigation (INV) and In-home service delivery (SVC). All INV open more than 60 days are excluded. All stages assigned to someone other than a DFPS caseworker paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR are excluded.

For numerator, count stages open any time during the day for the months in the reporting period, if the primary assignment is to a caseworker paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR. Multiply the average number of daily stages for each stage by that stage's weighting factor to obtain weighted stages in each category.

BL 2010 Methodology

Data Source cont:
For the denominator, count caseworkers with primary assignments that were open any time during the day for the months during the reporting period if the caseworker is paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR.

Exclude trainees with less than 57 days of service. Trainees with 57 to 152 days are counted as half (.5) of a worker.

Due to possible modifications in the FPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, substituted codes will be documented in the performance folder. When new a WMS study is conducted, updated data will be used.

Methodology:
Divide the numerator (sum of weighted stages for all stage types for the reporting period) by the denominator (sum of caseworkers with a primary assignment during the reporting period).

BL 2010 Purpose

Methodology cont:
When calculating the 2nd, 3rd, and 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	EF	
Measure No.	3	APS Daily Caseload per Worker (In Home)

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for APS in-home caseworkers. Supervisors carrying cases are not included in the definition of caseworker.

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so if a worker changes jobs during the month, only the last record for the month is captured.

BL 2010 Data Source

For each day during the reporting period count stages from IMPACT that were open at any time during the day and for which the primary assignment is to an APS in-home caseworker with the appropriate job class and paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR. The following stages are included: Investigation (INV), and In-home service delivery (SVC).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting for which the primary assignment is to an APS in-home caseworker with the appropriate job class and paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR.

For the denominator, calculate the total number of caseworkers with primary assignments for each day during the report period, excluding trainees with less than 57 days of service. Trainees with 57 to 152 days of service are counted as half (.5) of a worker.

BL 2010 Methodology

Data Source cont:
Due to possible modifications in the FPS fiscal system, PACs, job classes and DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by an APS in-home caseworker. The intent is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	EF	
Measure No.	4	Average Daily Number APS Stages Not Assigned to a Caseworker

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

Fall/Annual: N

BL 2010 Definition

Direct delivery services include stages for which the primary assignment is to APS non-caseworkers paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR. The following stages are included: Investigation (INV), and Service Delivery (SVC).

BL 2010 Data Limitations

HHSAS-HR data is point-in-time at the end of the month, so if a worker changed jobs during the month, only the last one for the month is captured.

BL 2010 Data Source

For each day during the reporting period, count stages from IMPACT that were open at any time during the day and for which the primary assignment is to APS non-caseworkers paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR. Due to possible modifications in the FPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the

BL 2010 Methodology

The numerator is the sum of the counts of open stages for each day in the reporting period. The denominator is the number of days in the reporting period. Divide the numerator by the denominator. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of the measure is to show the number of direct delivery service stages open each day where the primary assignment is to APS non-caseworker. This measure provides an indicator for the number of clients served by non-caseworkers paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR and is a useful tool to gauge the staff and dollars needed to to serve the elderly and disabled adult protective services population.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	EX	
Measure No.	1	Percent of APS Workers with Two or More Years of Service

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-03-01 EX 01

Fall/Annual: N

BL 2010 Definition

APS workers are defined as Active FPS staff with a job classification code designated as worker classification.

BL 2010 Data Limitations

The usefulness of the retention rate as a performance measure is limited by local economic factors, such as wages in the private sector, beyond the agency's control. Some other factors that affect this measure, such as labor market, are beyond the department's control.

BL 2010 Data Source

The total number of APS workers with two or more years of service is the numerator. The total number of APS workers is the denominator. Information for this measure is taken from HHSAS-HR. The start date of employment for staff working in APS prior to the creation of FPS comes from a survey researching FPS workers' employment experience. APS specialists in PAC 410 (APS Direct Delivery) are the type of workers included in this measure.

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

BL 2010 Methodology

Divide the numerator by the denominator and multiply by 100 to achieve a percentage.

BL 2010 Purpose

This measure is a useful indicator of staff competencies and a general reflection of staff satisfaction.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	EX	
Measure No.	2	Average Monthly Number of APS Clients Receiving Protective Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-03-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reflects the average monthly number of service delivery cases handled by APS workers each month.

BL 2010 Data Limitations

Clients receive services in the investigation stage and these services are not captured in this measure. Some other factors that affect this measure, such as labor market, are beyond the department's control.

BL 2010 Data Source

Using IMPACT, add the total number of cases in the service delivery stage and the stage type is regular that were open during the month to calculate the numerator. The numerator is the sum of the number of regular cases open in the service delivery stage for each month of the reporting period. The denominator is the sum of months in the reporting period.

BL 2010 Methodology

Divide the numerator by the denominator.

BL 2010 Purpose

The purpose of this measure is to show the average number of APS clients receiving protective services each month. (In the data collection for this measure, the number of cases is identical to the number of clients, because each case only represents one client.). This measure is a useful indicator of staff competencies and a general reflection of staff satisfaction.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	OP	
Measure No.	1	Number of Completed APS Investigations

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-01 OP

Fall/Annual: N

BL 2010 Definition

This measure counts the number of investigations that APS staff completed during a reporting period.

BL 2010 Data Limitations

Does not count investigations completed by the caseworker but awaiting supervisory closure.

BL 2010 Data Source

Using IMPACT, count the number of completed APS investigations where the investigation stage closure date is during the reporting period and the disposition has been determined.

BL 2010 Methodology

The calculation is a count of the number of APS investigations during the reporting period in which an investigation stage closure date is indicated on IMPACT. The quarterly and annual counts are equal to the sum of the number of investigation stage closures during each month of the respective reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to track the number of investigations of abuse/neglect/exploitation of the elderly or disabled adults completed during the reporting period. This measure provides useful information for management purposes.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	OP	
Measure No.	2	Number of Confirmed APS Investigations

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-01 OP

Fall/Annual: N

BL 2010 Definition

This measure counts the number of completed investigations in which the disposition confirmed maltreatment of a vulnerable adult. The disposition is the worker's determination of the validity of the report and is made at the completion of the investigation. ‘Confirmed maltreatment of a vulnerable adult’ refers to reports of abuse, neglect, or exploitation of elderly persons or adults with disabilities that the caseworker finds to be valid.

BL 2010 Data Limitations

None

BL 2010 Data Source

Using IMPACT, the measure is gathered by counting during the reporting period the number of APS investigations for which a stage closure date is shown in the investigation stage and the disposition is coded as 'VAL' (valid) or ‘VNF’ (valid with no fault).

BL 2010 Methodology

The quarterly and annual counts are equal to the sum of the number of investigations confirmed during each month of the respective reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to track the number of completed investigations of abuse/neglect/exploiation of the elderly or disabled adults for which the allegations of abuse/neglect/exploiation of the elderly and disabled adults have been substantiated. The measure is useful for internal management purposes.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	1	Provide Direct Delivery Staff for Adult Protective Services
Measure Type	OP	
Measure No.	3	Average Daily Number of APS Direct Delivery Services (All Stages)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-03-01 OP

Fall/Annual: N

BL 2010 Definition

Direct delivery services include stages for which the primary assignment is to APS in-home staff paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR. The following stages are included: Investigation (INV), and In-home service delivery (SVC) stages.

BL 2010 Data Limitations

None

BL 2010 Data Source

For each day during the reporting period count stages from IMPACT that were open at any time during the day and for which the primary assignment is to APS in-home staff paid out of Strategy D.1.1 (APS Direct Delivery Staff) in HHSAS_HR. Due to possible modifications in the FPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the

BL 2010 Methodology

The numerator is the sum of the counts of open stages for each day in the reporting period. The denominator is the number of days in the reporting period. Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of the measure is to show the number of direct delivery stages that are open each day and are served by APS in-home staff. This measure is a useful tool to gauge the staff and dollars needed to serve the elderly and disabled adult protective services population.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	2	Provide Program Support for Adult Protective Services
Measure Type	EX	
Measure No.	1	Number of APS Caseworkers who Completed Basic Skills Development

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-03-02 EX 01

Fall/Annual: N

BL 2010 Definition

This measure counts the number of APS Caseworkers who completed Basic Skills Development (BSD) training during the reporting period.

BL 2010 Data Limitations

Fluctuations in this measure can be attributable to additional FTEs appropriated by the legislature and ongoing APS employee retention efforts.

BL 2010 Data Source

HHSAS-HRMS Administrator Training Database.

BL 2010 Methodology

The calculation is a count of the number of caseworkers for whom the session end date in the HHSAS-HRMS Administrator Training Database is during the reporting period.

Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure monitors the volume of APS caseworkers completing BSD.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	3	MH and MR Investigations
Measure Type	EF	
Measure No.	1	Average Monthly Cost per Investigation in MH and MR Settings

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average monthly cost attributable to investigations that remain open and that are closed during the reporting period, and includes investigations conducted in mental health or mental retardation settings, which may include state schools, state hospitals, state centers, community MHMR centers, and Medicaid waiver programs.

BL 2010 Data Limitations

None

BL 2010 Data Source

Total program cost is from HHSAS-FS and an internal budget document (OOELEDGER.xls) for Mental Health or Mental Retardation Investigations Strategy PACs 445 (Investigations in Mental Health or Mental Retardation Facilities), 452 (Mental Health or Mental Retardation Program Support), 498 (MHMR Cost Pool Staff) and 499 (MHMR Training Cost Pool Staff). Number of investigations is from IMPACT. Open investigations have no investigation completion or closure dates. Closed investigations are indicated by a completion or stage closure date during the reporting period.

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

BL 2010 Methodology

Annual expenditure projections for mental health or mental retardation investigations PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. Each quarter, annual expenditure projections are multiplied by the percent of the year elapsed and reduced by previous quarter(s) dollars to get estimated expenditures attributable to the report quarter. Quarterly amounts are totaled and divided by the number of reporting period months to yield the average monthly cost (numerator). The average monthly number of investigations is calculated by dividing the cumulative count of cases investigated during the reporting period by the number of reporting period months (denominator).

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to calculate the average monthly cost per investigation. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark and to monitor changes in agency costs attributable to the investigation function.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	3	MH and MR Investigations
Measure Type	EF	
Measure No.	2	APS Daily Caseload per Worker (MH and MR Investigations)

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

Fall/Annual: N

BL 2010 Definition

This measure provides the average daily caseload for APS investigators in MH and MR settings. MH and MR investigations require formal written witness statements and often involve multiple alleged victims and perpetrators. MH and MR investigations must be initiated within 1 hour of intake. With limited exceptions, investigations must be completed within 14 days of intake.

BL 2010 Data Limitations

Data from HHSAS-HR is point-in-time at the end of the month, so only the last record for the month is captured.

BL 2010 Data Source

For each day during the reporting period count stages from IMPACT that were open at any time during the day and for which the primary assignment is to an APS Investigator for MH and MR settings with the appropriate job class and paid out of PAC 445 (Investigations in State-Operated MHMR Facilities) in HHSAS_HR. The following stages are included: Investigation (INV).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to an APS investigator in MH and MR settings with the appropriate job class and paid out of PAC 445 (Investigations in State-Operated MHMR Facilities) in HHSAS_HR.

For the denominator, calculate the total number of caseworkers with primary assignments for each day during the report period, excluding trainees with less

BL 2010 Methodology

Data Source cont:
Due to possible modifications in the FPS fiscal system, PACs, job classes and DEPTIDs are subject to change. Should this occur, current equivalent codes will be substituted & documented in performance folder.

Methodology:
Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled each day by investigators in MH and MR settings. The intent is to approximate what a caseworker would state if asked about the workload being managed.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	3	MH and MR Investigations
Measure Type	EX	
Measure No.	1	Number of Deaths from Abuse/Neglect/Exploitation: MH and MR Settings

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-03-03 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the number of deaths due to abuse or neglect of persons receiving mental health or mental retardation services, which include state schools, state hospitals, state centers, community MHMR centers, and Medicaid waiver programs.

BL 2010 Data Limitations

The data is limited due to self-reporting by mental health or mental retardation facilities.

BL 2010 Data Source

The data are gathered from IMPACT using allegation disposition and serious injury codes.

BL 2010 Methodology

The measure equals the count of the number of cases with investigation completion dates within the reporting period in which at least one allegation disposition is coded as 'CON' (confirmed), there is a DOD (date of death) indicated, the reason for death is abuse or neglect and resulting fatality is indicated by the code of 'Fatal' in the seriousness of the injury field.

BL 2010 Purpose

This measure captures the number of deaths from maltreatment in mental health and mental retardation programs. The number of deaths from maltreatment in mental health or mental retardation programs is an important indicator of problems in the service delivery system, i.e., that care and treatment are substandard.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	3	MH and MR Investigations
Measure Type	OP	
Measure No.	1	Number of Completed Investigations in MH and MR Settings

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-03 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of completed investigations of maltreatment of persons served in mental health or mental retardation settings, which may include state schools, state hospitals, state centers, community MHMR centers, and Medicaid waiver programs.

BL 2010 Data Limitations

None

BL 2010 Data Source

An investigation completion is indicated by a closure or completion date during the reporting period. Investigation closures must be counted in order to capture all completed investigations. Due to an IMPACT design problem, the investigation completion date for rapid closures is left blank and a closed date is entered. In APS Facility (AFC) investigations, rapid closures are used when investigations determine that situations reported to FPS are not within the purview of FPS to continue to investigate. Examples of such cases include client rights issues, administrative issues, and clinical practice issues appropriate for peer review.

BL 2010 Methodology

The measure is calculated by counting the number of mental health and mental retardation investigations for which an investigation completion date or investigation closure date is entered in IMPACT. The quarterly and annual counts are equal to the sum of the completed and closed investigations in each month of the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to track the number of investigations of abuse/neglect/exploitation of the elderly or disabled adults in MH and MR settings completed during the reporting period. This measure provides useful information for management purposes. The number of completed investigations and the promptness with which they are completed are important indicators of workload and performance in mental health and mental retardation investigations.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	3	MH and MR Investigations
Measure Type	OP	
Measure No.	2	Number of Confirmed Abuse Reports in MH and MR Settings

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-03 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of completed investigations in mental health or mental retardation settings, which may include state schools, state hospitals, state centers, community MHMR centers, and Medicaid waiver programs in which maltreatment of an individual or group of individuals was confirmed.

BL 2010 Data Limitations

None

BL 2010 Data Source

'Confirmed reports' refers to those investigations in Output Measure “Number of Completed Investigations-Mental Health and Mental Retardation” in which the overall disposition is confirmed at the end of the investigation. Confirmed investigations are coded as 'CON' at the completion of the investigation stage in

BL 2010 Methodology

The measure is calculated by totaling the sum of confirmed mental health and mental retardation investigations each month of the reporting period.

BL 2010 Purpose

The purpose of this measure is to track the number of completed investigations of abuse/neglect/exploitation of the elderly or disabled adults in MH and MR settings for which the allegations of abuse/neglect/exploitation have been substantiated. The measure is useful for internal management purposes. The number of confirmed reports is an indicator of the quality of care being provided to persons served by or through mental health or mental retardation programs.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	4	Protect Elder/Disabled Adults Through a Comprehensive System
Objective No.	1	Reduce Adult Maltreatment and Investigate MH and MR Reports
Strategy No.	3	MH and MR Investigations
Measure Type	OP	
Measure No.	3	Number of Victims in Confirmed Abuse Reports in MH and MR Settings

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-03-03 OP

Fall/Annual: N

BL 2010 Definition

This measure is an unduplicated count of victims in confirmed incidents of maltreatment occurring in mental health or mental retardation settings, which may include state schools, state hospitals, state centers, community MHMR centers, and Medicaid waiver programs.

BL 2010 Data Limitations

None

BL 2010 Data Source

Count the number of confirmed victims when the investigation completion date is during the reporting period and the overall disposition is confirmed. Confirmed victims are unduplicated by reporting period.

BL 2010 Methodology

The calculation consists of the sum of confirmed victims during the reporting period.

BL 2010 Purpose

The purpose of this measure is to track the number of elderly or disabled adults identified as confirmed victims in completed investigations. This information is useful for internal management purposes.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EF	
Measure No.	1	Average Cost per Inspection

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure gives an average cost for FPS to inspect a child care operation.

BL 2010 Data Limitations

None

BL 2010 Data Source

Data on inspections is from the Child-care Licensing Automation Support System (CLASS) , where a record is kept by operation of the number and date of all inspections conducted. Total program cost is from HHSAS-FS and an internal budget document (OOELEDGER.xls) for PACs 600 (Licensing Prog Admin), 602 (Licensing Training), 603 (Licensing Regional Program Administration and Support), 607 (CLASS Maintenance), 610 (Day Care Licensing), 620 (24 Hr Care Licensing), 698 (Licensing Cost Pool Staff), 699 (Licensing Training Cost Pool Staff), and related CPS Reform PACs. The Work Measurement Study (WMS) is used to factor in a workload percentage for this activity. A workload percentage for inspections is derived from WMS hours and reporting period's cases for all activities associated with each PAC listed above. This percentage is applied to each PAC's total dollars to determine expenditures for inspections.

BL 2010 Methodology

Data Source cont:
Due to modifications in the FPS fiscal system, PACs may change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

Methodology:
Annual expenditure projections for PACs 600, 602, 603, 607, 610, 620, 698, 699, and related CPS Reform PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, the annual expenditure projections are multiplied by the percent of the year elapsed for the reporting period and then are reduced by the previous quarter(s) dollars to get the estimated expenditures attributable to the quarter being reported. To these amounts, the workload percentage from the WMS representing this activity is applied. These amounts are totaled to get the expenditure amount for the reporting period, the numerator

BL 2010 Purpose

Methodology cont:
The denominator is the number of inspections for the reporting period.

Divide the numerator by the denominator to calculate the average cost per inspection. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is useful as a benchmark, and may be used along with other data to evaluate the value of on-site inspections in promoting compliance with minimum standards.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EF	
Measure No.	2	Average Monthly Day Care Caseload per Worker

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EF 04

Fall/Annual: N

BL 2010 Definition

This measure provides the average monthly caseload handled by a day care licensing worker. The day care caseload is made up of licensed or certified day care operations and registered child-care homes. Investigations are part of the regulation process and are usually assigned to specially trained staff who do not have caseloads of operations to monitor. For this calculation, those trained investigators are included in the worker count.

BL 2010 Data Limitations

None

BL 2010 Data Source

The average caseload (numerator) is the number of licensed day care operations and registered child-care home open on the last day of each month during the reporting period as obtained from the Child-care Licensing Automation Support System (CLASS), divided by the number of months in the reporting period. The average number of workers (denominator) is the number of workers (FTEs) active on the last day of each month during the reporting period charged in HHSAS-HR to PAC 610 (Day Care Licensing) and divided by the number of months in the reporting period.

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

BL 2010 Methodology

Divide the numerator by the denominator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

This measure is an indicator of an average amount of work handled by day care licensing workers, and is useful for determining and comparing staffing levels based on workload.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EF	
Measure No.	3	Average Monthly Residential Caseload per Worker

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EF 05

Fall/Annual: N

BL 2010 Definition

This measure provides the average monthly caseload handled by a residential child care licensing worker. The residential child care caseload is made up of licensed residential facilities, maternity homes, child-placing agencies, branch offices of child–placing agencies, foster homes that are verified by the child-placing agencies and CPS-approved foster and adoptive homes. Investigations are part of the regulation process and are usually assigned to specially trained staff who do not have caseloads of facilities to monitor. For this calculation, those trained investigators are included in the worker count.

BL 2010 Data Limitations

None

BL 2010 Data Source

The number of licensed and verified facilities is in the Child-care Licensing Automation Support System (CLASS). CPS-approved foster and adoptive homes are maintained in IMPACT by CPS staff. The actual number of workers in the calculation is the number of worker classifications charged in HHSAS-HR to PAC 620 (24 Hour Residential Care Licensing), and related CPS Reform PACs.

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

BL 2010 Methodology

To determine average caseload (numerator), calculate the number of residential child care facilities open on the last day of each month during the reporting period divided by the number of months in the reporting period. Residential child care facilities requiring routine monitoring visits are calculated as follows: from CLASS, add the number of residential facilities, child placing agencies including a count of the branch offices of the child placing agencies, to five percent of the agency homes, and from IMPACT, add five percent of CPS-approved foster and adoptive (FAD) homes. Count the actual number of workers (FTEs) active on the last day of the each month during the reporting period charged to PAC 620 and related CPS Reform PACs during the reporting period and divide by the number of reporting period months to determine the average number of workers (denominator).

BL 2010 Purpose

Methodology cont:
Divide the numerator by the denominator to get the average caseload per worker. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Purpose:
This measure is an indicator of an average amount of work handled by residential child care licensing workers, and is useful for determining and comparing staffing levels based on workload.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	1	Number of Licenses, Certifications, Registrations, and Listings

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 01

Fall/Annual: N

BL 2010 Definition

This includes the operating and/or licensed day care and residential child care operations, registered and listed family homes, child placing agencies, and licensed child care and child-placing agency administrators. CPS-approved Foster and Adoptive homes are a subset of residential care operations.

BL 2010 Data Limitations

None

BL 2010 Data Source

When an operation is licensed or registered, licensing staff enter this information into the Child-care Licensing Automation Support System (CLASS). CPS-approved foster and adoptive homes are maintained in IMPACT by CPS workers. Licensed child-care and child-placing agency administrators are maintained in an ACCESS database.

BL 2010 Methodology

Add together the totals from Explanatory Measures “Number of Licensed Day Care Operations,” “Number of Licensed Residential Child Care Operations,” “Number of Registered Family Homes,” “Number of Listed Family Homes,” “Number of Child Placing Agencies,” “Number of Child Care Administrators,” and “Number of Child-Placing Agency Adminstrators.”

BL 2010 Purpose

The purpose of this measure is to state the total number of operations, family homes and administrators that are regulated by the agency. This is important data in planning for adequate resources within the program.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	2	Number of Licensed Day Care Operations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 02

Fall/Annual: N

BL 2010 Definition

Day care operations are those which provide a part-day care for children under the age of 14 years. They are categorized as licensed child-care center, registered child-care home, or licensed child-care home depending upon their size, the program offered and/or the ages of the children they serve.

BL 2010 Data Limitations

None

BL 2010 Data Source

When operations are licensed, licensing staff enters the issuance into the Child-care Licensing Automation Support System (CLASS).

BL 2010 Methodology

On the last day of the reporting period, from CLASS calculate the number of provisionally and permanently licensed day care operations in an active status as of the end of the month.

BL 2010 Purpose

The purpose of this measure is to state the total number of day care operations that are regulated by the agency. It is a subset of the Explanatory Measure “Number of Licenses, Certifications, Registrations and Listings.” This is important data in planning for adequate resources in staffing for this activity.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	3	Number of Licensed Residential Child Care Facilities

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 03

Fall/Annual: N

BL 2010 Definition

Residential operations provide 24-hour care for children. The operation types are: Residential Treatment Center (provides services to children who are emotionally disturbed), Child Placing Agency (an operation that verifies foster and adoptive homes and places children in those homes), Residential Operations (includes institution providing basic care, emergency shelter, halfway house, institution serving mentally retarded children, and therapeutic camp), Maternity Home, Independent Foster Family Home, and Independent Foster Group Home.

BL 2010 Data Limitations

None

BL 2010 Data Source

When a residential operation is licensed, residential licensing staff enters the date of issuance into the Child-care Licensing Automation Support System (CLASS). Data for CPS-approved foster and adoptive homes is captured in IMPACT.

BL 2010 Methodology

On the last day of the reporting period, from CLASS count the number of provisionally and permanently licensed residential child care operations including the approved homes of Child Agencies, but not the child placing agencies as children do not reside in the Chold Placing Agencies. The facilities counted must have an active status as of the end of the month. The number of CPS approved foster and adoptive homes active on the last day of the month are pulled from

BL 2010 Purpose

The purpose of this measure is to state the total number of residential child care operations that are regulated or reviewed by the agency. It is a subset of the Explanatory Measure “Number of Licenses, Certifications, Registrations and Listings.” This is important data in planning for adequate resources in staffing this

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	4	Number of Registered Family Homes

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 04

Fall/Annual: N

BL 2010 Definition

A registered child-care home is one in which the primary caregiver provides care in the caregiver's own residence for not more than six children from birth through 13 years, and may provide care after-school for not more than six additional elementary school children. The total number of children in care at any given time, including the children related to the caregiver, must not exceed 12.

BL 2010 Data Limitations

None

BL 2010 Data Source

When an operation is registered, licensing staff enters the date of issuance into the Child-care Licensing Automation Support System (CLASS).

BL 2010 Methodology

On the last day of the reporting period, from CLASS calculate the number of permanently registered family homes in an active status as of the end of the

BL 2010 Purpose

The purpose of this measure is to state the total number of registered child-care homes that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this activity.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	5	Number of Listed Family Homes

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 05

Fall/Annual: N

BL 2010 Definition

A listed family home is one in which the caregiver cares for no more than three unrelated children. There are no minimum standards for this type of care. No inspections are made by licensing staff unless there is a complaint of child abuse/neglect.

BL 2010 Data Limitations

None

BL 2010 Data Source

When a home is listed, this information is entered into the Child-care Licensing Automation Support System (CLASS) by regional licensing staff.

BL 2010 Methodology

On the last day of the reporting period, from CLASS calculate the number of listed family homes in full status as of the end of the month.

BL 2010 Purpose

The purpose of this measure is to count the number of listed family homes. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This data is important in determining what resources should be allocated to this function.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	6	Number of Child Placing Agencies

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 06

Fall/Annual: N

BL 2010 Definition

A child-placing agency is licensed by the agency and may then verify foster and adoptive homes by assuring that they meet applicable minimum standards.

BL 2010 Data Limitations

None

BL 2010 Data Source

When a facility is licensed, residential licensing staff enter the date of issuance into the Child-care Licensing Automation Support System (CLASS).

BL 2010 Methodology

On the last day of the reporting period, from CLASS calculate the number of child placing agencies in active status as of the end of the month.

BL 2010 Purpose

The purpose of this measure is to state the total number of child-placing agencies that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this activity.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	7	Number of Child Care Administrators

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 07

Fall/Annual: N

BL 2010 Definition

Licensed child care administrators administer residential child care operations. They must meet certain qualifications, pass a written examination and pay an

BL 2010 Data Limitations

None

BL 2010 Data Source

A list of licensed administrators is maintained in an ACCESS database that is viewable in CLASS.

BL 2010 Methodology

On the last day of the reporting period, from the ACCESS database, count the number of administrators' licenses in effect as of the end of the month.

BL 2010 Purpose

The purpose of this measure is to state the total number of child care administrators that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this activity.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	8	Number of Criminal Record Checks

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 08

Fall/Annual: N

BL 2010 Definition

Criminal record checks are conducted on residential and child day care directors, owners, operators, administrators, employees (including those the operation intends to hire), persons applying to adopt or foster children through any licensed child placing agency, persons under contract with operations who have unsupervised contact with children in care on a regular or frequent basis, applicants for child care administrator's licenses and other persons age 14 years or older who reside at the facility or home or who will regularly or frequently be at the facility or home while children are in care, including volunteers. Persons are checked upon being hired or when they apply for a license, certification, registration or listing and every two years thereafter.

BL 2010 Data Limitations

None

BL 2010 Data Source

Data for both types of criminal records checks are entered into the Child-care Licensing Automation Support System (CLASS) by licensing staff. Checks against the DPS database are sent and received via a batch process. FBI checks are submitted electronically through the DPS (Department of Public Safety)

BL 2010 Methodology

Count the number of criminal history checks processed during the reporting period.

BL 2010 Purpose

The purpose of this measure is to determine the workload associated with the Legislative mandate to conduct criminal history checks on persons working in child care. It measures compliance with the statute and provides valuable information on the resources required for this function. The checks themselves help determine whether or not a person's presence at a facility is a violation of minimum standards, the licensing statute, licensing rules and/or would present a risk to the health and safety of children in care.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	9	Number of Child Placing Agency Administrators

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 09

Fall/Annual: N

BL 2010 Definition

Licensed child-placing agency administrators administer residential child care operations. They must meet certain qualifications, pass a written examination and pay an annual fee.

BL 2010 Data Limitations

None

BL 2010 Data Source

A list of licensed child-placing agency administrators is maintained in the Child-care Licensing Automation Support System (CLASS) or its predecessor.

BL 2010 Methodology

On the last day of the reporting period, from CLASS count the number of active child-placing agency administrators' licenses.

BL 2010 Purpose

The purpose of this measure is to count the total number of child-placing agency administrators that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	10	Percent of Child Care Licensing Workers: Two or More Years of Service

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 10

Fall/Annual: N

BL 2010 Definition

CCL direct delivery caseworkers are identified as CCL Specialist II-V (5701X, 5702X, 5703X, 5704X), CCI Specialist I -III (5024V, 5025V, 5026V), RCCL Specialist (5704D, 5705D, 5706D) and RCCL Investigator I-II (5026D, 5027D). Staff tenure is calculated from date of hire.

BL 2010 Data Limitations

None

BL 2010 Data Source

The total number of CCL direct delivery caseworkers with two or more years of service is the numerator. The total number of CCL direct delivery caseworkers is the denominator. Information for this measure is taken from HHSAS-HR.

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

BL 2010 Methodology

Divide the numerator by the denominator and multiply by 100 to achieve a percentage.

BL 2010 Purpose

This measure is a useful indicator of staff competencies and a general reflection of staff satisfaction.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	EX	
Measure No.	11	Number of Central Registry Checks

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 530 080-R-S70-1 01-04-01 EX 11

Fall/Annual: N

BL 2010 Definition

The central registry (CR) contains persons who have been found to have abused or neglected a child. Licensing staff check the names of persons in child care to determine whether they have a history of confirmed child abuse. Checks are conducted for residential and child day care applicants, owners, operators, employees and other persons age 14 years or older (non-clients) who reside at the facility or home or who will regularly or frequently be at the facility or home while children are in care, including volunteers. Persons are checked upon being hired or when they apply for a license, certification, registration or listing, and every two years thereafter.

BL 2010 Data Limitations

None

BL 2010 Data Source

Data for CR checks are obtained from the Child-care Licensing Automation Support System (CLASS).

BL 2010 Methodology

Count the number of CR checks processed during the reporting period.

BL 2010 Purpose

The purpose of this measure is to count the CR conducted by licensing staff.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	OP	
Measure No.	1	Number of New Licenses, Certifications, Registrations & Listings

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

A new license is defined as the issuance of a provisional or full license for a licensed operation or a child-care administrator, and a permanent registration for a Registered Child-Care Home (RCCH). A provisional license is valid for six months and may be renewed for an additional six months. When an operation has successfully completed the provisional period, a non-expiring license is issued. There is no provisional period for registered home, certified operations and listed homes. A non-expiring registration is issued when inspection(s) by licensing staff during the application period show that the home is meeting standards.

BL 2010 Data Limitations

The number of facilities and persons that apply is market-driven and is outside the agency's control.

BL 2010 Data Source

When licensing staff issue a license or registration, they enter the date of the issuance into the Child-care Licensing Automation Support System (CLASS) and note whether it is a provisional or non-expiring (permanent) issuance. Information is obtained from CLASS or its predecessor.

BL 2010 Methodology

For the reporting period, sum the number of provisional licenses issued to licensed day care and residential child care operations (including child placing agencies but excluding child placing agency homes), the number of new permanently-registered child-care homes, newly-listed family homes, and the number of newly licensed child care administrators. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to track the entrance of facilities into the child care system as a predictor of workload. It is important in projecting the need for regulatory resources.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	OP	
Measure No.	2	Number of Inspections

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

An inspection is an on-site visit to an operating or non-operating operation or family home for the purposes of determining whether it is in compliance with the law and minimum standards. Inspections may be made in the following circumstances: routine monitoring, licensing receives an allegation that an operation is operating illegally; a person submits an application to become licensed or registered, an operation reports to licensing that there has been a serious incident at the facility, such as a fire, injury to a child, etc., licensing receives a complaint alleging violations of the law or minimum standards.

BL 2010 Data Limitations

None

BL 2010 Data Source

When a licensing representative inspects an operation, the date of the inspection is entered into the Child-care Licensing Automation Support System (CLASS) and lists the standards, if any, that were in noncompliance. A record is kept by facility of the number and the date of all inspections that are conducted. The inspections are coded based upon the purpose as monitoring, investigation, follow-up or other. Information is counted from CLASS.

BL 2010 Methodology

From CLASS, add together the total number of inspections made by licensing representatives of all regulated child care facilities within the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to assess the involvement of licensing staff in monitoring regulated facilities. It is an indicator of workload. Regulated facilities would include facilities subject to regulation, licensed or certified for day care and residential care, registered and listed family homes, foster and adoptive homes verified by Child Placing Agencies and maternity homes.

Agency Code: **530** Agency: **Family and Protective Services, Department of**

Goal No.	5	Regulate Child Day Care and Residential Child Care
Objective No.	1	Reduce Occurrences of Serious Risk in Child Care Facilities
Strategy No.	1	Child Care Regulation
Measure Type	OP	
Measure No.	3	Number of Complaints Resolved

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

A complaint is any report received that alleges a violation of law, licensing minimum standards. This would include the following types of operations: those which are subject to regulation, licensed or certified for day care and residential care, registered and listed family homes, maternity homes and foster and adoptive homes verified by Child Placing Agencies. Licensing staff conduct investigations into these complaints. This is a count of all complaints resolved

BL 2010 Data Limitations

None

BL 2010 Data Source

When licensing staff receives a complaint, the date it was received is entered into the Child-care Licensing Automation Support System (CLASS). When the investigation is completed, staff enters their findings and a completion date. All complaints received by the agency are resolved in some manner, but the number of complaints received is outside the agency's control. Information is obtained from CLASS.

BL 2010 Methodology

Sum the total number of complaints resolved within the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

BL 2010 Purpose

The purpose of this measure is to track the number of times that Licensing staff responds to complaints from the public about the quality of child care.

Agency Code: 530 **Agency: State Health Services, Department of**

Goal No.	1	5	Prepare Lines and Prevention Services
Objective No.	2	1	Infection Disease Control, Prevention and Treatment
Outcome No.	1	1	Vaccination Coverage Levels among Children Aged 19 to 35 Months
Measure Type		OP	
Measure No.		4	Number of Validated Child Abuse/Neglect Reports

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 01-02 OC 01

BL 2010 Definition

This measure uses data collected from the National Immunization Survey (NIS) to estimate the percentage of 19 to 35 month old children who are vaccinated with the routine childhood vaccines (four doses of diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccines, one dose of measles-mumps-rubella vaccine, three doses of Haemophilus influenzae type b, three doses of hepatitis B vaccine, and one dose of varicella

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 530 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Data Limitations

Data are based on a telephone survey that is statistically weighted to adjust for nonresponse and households without telephones. NIS relies on provider-verified vaccination histories and incomplete records could result in underestimates of coverage. The estimate also assumes that coverage among children whose providers do respond is similar to that among children whose providers do not respond. The Texas coverage level estimates should be interpreted carefully due to the wide confidence interval range applied to the reported estimated vaccination coverage level (percentage).

BL 2010 Data Definition

This measure counts the number of completed child abuse/neglect investigations in which the disposition of at least one allegation was validated. These investigations are done by licensing staff using a preponderance of evidence rule. Completion is determined by the investigation stage closure date. This date cannot be null and must occur during the reporting period.

BL 2010 Data Source

The NIS is coordinated by the CDC National Immunization Program (NIP) and data is collected by a company under contract with NIP. The NIS contractor calls randomly generated telephone numbers to find households that contain children 19 to 35 months of age and then interviews the child's parent or guardian. The NIS uses the 19-35 month age group based on sampling methodology and data analysis needs. Vaccination dates are verified by the child's

BL 2010 Data Source

Using IMPACT, identify completed licensing abuse/neglect investigations where the investigation stage closure date is during the reporting period and the overall disposition is “RTB.”

BL 2010 Methodology

The percentage of 19 to 35 month old children who are vaccinated is estimated based on the data collected in the NIS. The NIS is conducted on a quarterly basis utilizing a random digit dial survey and results are reported annually to look at trends at the state level.

BL 2010 Methodology

Count the number of child abuse/neglect investigations with an overall disposition of "RTB" completed by licensing investigators within the reporting period.

BL 2010 Purpose

The purpose of this measure is to determine the number of validated abuse/neglect investigations in child care operations that were completed by licensing staff during the reporting period. This measure provides useful information for management purposes. It is helpful for noting variances and determining

BL 2010 Purpose

Data are based on a telephone survey that is statistically weighted to adjust for nonresponse and households without telephones. NIS relies on provider-verified vaccination histories and incomplete records could result in underestimates of coverage. The estimate also assumes that coverage among children whose providers do respond is similar to that among children whose providers do not respond. The Texas coverage level estimates should be interpreted carefully due to the wide confidence interval range applied to the reported estimated vaccination coverage level (percentage).

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Outcome No.	2	Incidence Rate of TB Among Texas Residents

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 01-02 OC 02

BL 2010 Definition

This measures indicates the degree to which tuberculosis (TB) is occurring in the Texas population.

BL 2010 Data Limitations

A study conducted in the early 1990's to determine how well the reporting system was functioning found that the total percentage of cases reported was in excess of 95%.

BL 2010 Data Source

TB is a reportable disease in Texas. The number of TB cases is available through the case register maintained by DSHS. The population estimates are obtained from the Texas State Data.

BL 2010 Methodology

The number of TB cases in the fiscal year is divided by the mid-year population estimate of Texas times 100,000.

BL 2010 Purpose

This measure reflects how successful TB elimination efforts are in Texas.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Outcome No.	3	% of 1995 Epizootic Zone that is Free From Domestic Dog-Coyote Rabies

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 01-02 OC 03

BL 2010 Definition

The percentage of square miles in the original epizootic area free of cases of the specific rabies variant.

BL 2010 Data Limitations

The surveillance data are a combination of active and passive sample submissions.

BL 2010 Data Source

Texas Department of State Health Services Laboratory reports. The requisite data are communicated to the Zoonosis Control Branch as specimens are submitted and tested by DSHS and as test results from other laboratories are received by DSHS laboratory.

BL 2010 Methodology

The area of the epizootic zone that has been treated once or has never been treated will be combined with the home range area of any rabid animal found within the original zone during the year. The resultant sum (A) will serve as the numerator with the original epizootic area (B) as the denominator in the formula:C = (1- A/B) x100. “C” will represent the percentage of the original epizootic zone considered free of the specified rabies variant.

BL 2010 Purpose

This is a measure of the effectiveness of the oral vaccination efforts for the targeted wildlife in the epizootic zones.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Outcome No.	4	% of 1996 Epizootic Zone that is Free From Texas Fox Rabies

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 01-02 OC 04

BL 2010 Definition

The percentage of square miles in the original epizootic area free of cases of the specific rabies variant.

BL 2010 Data Limitations

The surveillance data are a combination of active and passive sample submissions.

BL 2010 Data Source

Texas Department of State Health Services Laboratory reports. The requisite data are communicated to the Zoonosis Control Branch as specimens are submitted and tested by DSHS and as test results from other laboratories are received by DSHS laboratory.

BL 2010 Methodology

The area of the epizootic zone that has been treated once or has never been treated will be combined with the home range area of any rabid animal found within the original zone during the year. The resultant sum (A) will serve as the numerator with the original epizootic area (B) as the denominator in the formula:C = (1- A/B) x100. “C” will represent the percentage of the original epizootic zone considered free of the specified rabies variant.

BL 2010 Purpose

This is a measure of the effectiveness of the oral vaccination efforts for the targeted wildlife in the epizootic zones.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	4	Laboratory Operations
Outcome No.	1	% High Volume Tests Completed within Established Turnaround Times

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 01-04 OC 01

BL 2010 Definition

The outcome measure is completion of 95% of the high volume tests within established turnaround times. High volume tests are defined as tests conducted on more than 10,000 specimens per year. The turnaround time includes the pre-analytical, analytical, and post-analytical procedural steps that are taken from the time a sample arrives at the laboratory until the test result is validated and released for reporting.

BL 2010 Data Limitations

There is no widely accepted standard for sample turnaround time because of the diversity of test protocols from laboratory to laboratory. However, the Laboratory Services Section has established reasonable turnaround times for its testing procedures. These turnaround times are based on procedure complexity and the time required to complete the procedure using good laboratory practices. The performance measure will include the high volume procedures done in each of the three testing areas: Biochemistry and Genetics, Environmental Sciences, and Microbiological Sciences.

BL 2010 Data Source

The Laboratory Services Section information management systems include specimen tracking features which log the date and time a sample is received and the date and time the analysis is completed. These dates will be used to determine turnaround time.

BL 2010 Methodology

In most cases, these data are captured by the Laboratory Services Section information management systems and the calculations of turnaround times are completed during preparation of management reports. In the cases where computer data are not available, staff will manually determine the turnaround time. The turnaround time for each test will be calculated by subtracting the received date from the report date and will be compared with the established target turnaround time for the test procedure. The performance measure will be the percentage of test results that are completed within the target turnaround times.

BL 2010 Purpose

This performance measure demonstrates the efficiency and reliability of laboratory operations in prompt completion of testing procedures and is an important measure of customer service. Test results are used to determine client health status or to indicate environmental quality. Prompt completion of testing procedures allows the Laboratory Services Section customers to reach conclusions about client health status or environmental quality in a timely

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Outcome No.	1	Percentage of Eligible WIC Population Served

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-01 OC 01

BL 2010 Definition

This measure represents the percent of potentially eligible clients that are provided services during the most recent month for which data are available. To be certified and participate in the WIC program, infants, children, and pregnant, postpartum, and breast-feeding women shall reside within the jurisdiction of the state, meet certain income criteria, and meet nutritional risk criteria.

BL 2010 Data Limitations

Data Limitations:
Any updates to this performance will not attempt to update the estimated potential eligibles counts due to more recently revised potential eligible estimates. Estimates may be used at reporting deadlines. This calculation is based on a federal fiscal year.

BL 2010 Data Source

Participation is reported in the output measure "Number of WIC Participants Provided Food Supplements per Month". For number of WIC participants, see the measure "Number of WIC Participants Provided Food Supplements". Potential eligibles come from the Texas WIC Program County Potential Eligible Estimates Report, which is produced by the Texas Department of State Health Services. Potential eligibles are an estimate of the number of pregnant, postpartum or breast-feeding women, as well as children up to the age of 5 whose family incomes are at or below 185% of the Federal Poverty Level.

BL 2010 Methodology

The percentage is calculated by dividing the most recent month's number of WIC participants by the estimated number of persons eligible for WIC services at the time the report is due.

BL 2010 Purpose

Measures the percentage of eligible WIC population served.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Outcome No.	2	# of Infant Deaths Per Thousand Live Births (Infant Mortality Rate)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 537 080-R-S70-1 02-01 OC 02

BL 2010 Definition

This measure reports the infant mortality rate (per thousand live births) of Texas resident infants (under 1 year of age) in a given calendar year.

BL 2010 Data Limitations

Information to calculate the infant mortality rate is collected from birth and death certificates by DSHS' Vital Statistics department. The data has a two-year time lag (i.e., the number is calculated by using data from a calendar year two years prior).

BL 2010 Data Source

The data source is the Texas Vital Statistics Annual Report, Texas Department of State Health Services (DSHS).

BL 2010 Methodology

The number of deaths of Texas resident infants (under 1 year of age) in a given calendar year divided by the number of live births to Texas residents during the same period. This figure is then multiplied by 1000 to give the number of infant deaths per 1000 live births.

BL 2010 Purpose

This measure reports the infant mortality rate (per thousand live births) of Texas resident infants (under 1 year of age) in a given calendar year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Outcome No.	3	Percentage of Low Birth Weight Births

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 537 080-R-S70-1 02-01 OC 03

BL 2010 Definition

This measure reports the number of Texas resident live births in a given calendar year with a birth weight less than 5lbs., 9oz.

BL 2010 Data Limitations

The data has a two-year time lag (i.e., the percentage is calculated by using data from a calendar year two years prior).

BL 2010 Data Source

The data source is the Texas Vital Statistics Annual Report, Texas Department of State Health Services. Information to calculate the percentage is collected from birth certificates by DSHS' department of Vital Statistics.

BL 2010 Methodology

The number of Texas resident live births in a given calendar year with a birth weight less than 5lbs., 9oz., divided by the number of live births to Texas residents during the same period. This figure is then multiplied by 100.

BL 2010 Purpose

Measures the number of Texas resident live births in a given calendar year with a birth weight less than 5lbs., 9oz.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Outcome No.	4	# Pregnant Females Age 13-19 Per Thousand (Adolescent Pregnancy Rate)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 537 080-R-S70-1 02-01 OC 04

BL 2010 Definition

Number of pregnant females age 13-19 per thousand (adolescent pregnancy rate).

BL 2010 Data Limitations

The data has a two-year time lag (i.e., the number is calculated by using data from a calendar year two years prior).

BL 2010 Data Source

Information to calculate the number of pregnancies is collected and compiled from birth certificates, fetal death certificates, and reports of induced terminations of pregnancies by DSHS' department of Vital Statistics. The population data originates from the State Data Center, Department of Rural Sociology, Texas A&M University and are provided by DSHS' Office of Health Information and Analysis.

BL 2010 Methodology

The number of pregnancies (fetal deaths + induced terminations of pregnancy + live births) to Texas female residents aged 13-19 in a given calendar year divided by the total female population aged 13-19 during the same period. This figure is then multiplied by 1000 to give the number of pregnancies per 1000 women aged 13 to 19.

BL 2010 Purpose

Indicates the adolescent pregnancy rate in the state.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Outcome No.	5	% of Eligible Indigent Patients Provided Access to PHC

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-01 OC 05

BL 2010 Definition

This measure reports the percent of DSHS Primary Health Care (PHC) eligible indigent patients provided access to primary care services.

BL 2010 Data Limitations

The primary data limitation for this measure is the inclusion of multiple estimates and the assumptions underlying the estimates used to calculate the target population (calculation of denominator). This methodology includes five data sources, each with data limitations. Complete data may not be available for the reporting period at the time the report is due; therefore, estimates or projections may be included based on available data.

BL 2010 Data Source

The sources for this measure are the contractor quarterly and annual reports, and the Primary Health Care Program annual report from the previous fiscal

BL 2010 Methodology

The percent of Primary Health Care (PHC) eligible indigent patients provided access to primary care services is the unduplicated number of patients who are screened and found eligible for PHC divided by the target population of the PHC program (calculation methodology is published in the Primary Health Care Program's annual report). Eligibleindigent patients are Texas residents who are at or below 150% of poverty and are not eligible or potentially eligible for other programs that provide the same services.

BL 2010 Purpose

To report and monitor the percentage of PHC eligible clients provided access to primary health care.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	1	Prevalence of Tobacco Use among Middle & HS Youth Target Areas

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 01

BL 2010 Definition

This is a measure of the prevalence of tobacco use among middle and high school (6th - 12th grade) students in the targeted area of Texas. The targeted area consists of the population served by 6 community grantees that serves 17 zip codes within the city of Austin as well as Bexar, Fort Bend, Smith, Rusk, Gregg, Midland, Ector, Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn and Terry Counties.

BL 2010 Data Limitations

None

BL 2010 Data Source

The measurement is based on the Texas Youth Tobacco Survey, which is a school based survey relating to tobacco use behaviors.

BL 2010 Methodology

Percentage of current tobacco use among middle and high school (6th - 12th grade) youth in the targeted areas equals the number of target area middle and high school (6th – 12th grade). Texas Youth Tobacco Survey respondents who reported having used cigarettes, cigars, pipe or smokeless tobacco on one of the thirty days preceding the survey divided by the total number of valid middle and high school survey respondents in the target area and multiplied by 100. Data are weighted to the student population composition in the target area.

BL 2010 Purpose

Measures the prevalence of tobacco use among middle and high school (6th-12th grade) students in the targeted areas of Texas.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	2	Statewide Prevalence of Tobacco Use among Middle and High School Youth

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 02

BL 2010 Definition

This is a measure of the prevalence of tobacco use among middle and high school (6th-12th grade) students in Texas.

BL 2010 Data Limitations

None

BL 2010 Data Source

Texas Youth Tobacco Survey, a school-based survey relating to tobacco use behaviors.

BL 2010 Methodology

Statewide percentage of current tobacco use among middle and high school (6th -12th grade) youth equals the number of statewide middle and high school (6th– 12th grade) Texas Youth Tobacco Survey respondents who reported having used cigarettes, cigars, pipes or smokeless tobacco on one of the thirty days preceding the survey divided by the total number of valid middle and high school survey respondents in Texas and multiplied by 100. Data are weighted to the statewide student population composition.

BL 2010 Purpose

Measures the statewide prevalence of tobacco use among middle and high school (6th-12th grade) youth.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	3	Prevalence of Smoking among Adult Texans

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 03

BL 2010 Definition

This is a measure of the prevalence of smoking among adult Texans, based on the Behavioral Risk Factor Survey, which is a telephone survey relating to selected life style behaviors, conducted on randomly selected residents on a monthly basis.

BL 2010 Data Limitations

None

BL 2010 Data Source

Behavioral Risk Factor Surveillance Survey, a telephone survey relating to selected life style behaviors, conducted on randomly selected residents on a monthly basis and Texas population data received from the State Data Center, University of Texas at San Antonio.

BL 2010 Methodology

This is a measure of the prevalence of smoking among adult Texans based on the number of adults who smoke divided by population of adult Texans times 100, statistically adjusted. “Adults who smoke” is defined as someone who has smoked 100 cigarettes and now smokes every day or some days.

BL 2010 Purpose

This is a measure of the prevalence of smoking among adult Texans.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	4	% Youth Enrolled in Substance Abuse Prevention Programs

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 04

BL 2010 Definition

This measures the percent of youth in substance abuse prevention curricula who reduced identified risk and/or increased protective characteristics that minimize their probabilities of getting involved in the use of alcohol, tobacco and other drugs.

BL 2010 Data Limitations

The success rate will be limited by the number of program participants that were tested. Although a high rate of participation in testing is expected, circumstances beyond the providers' control may affect this rate (e.g., school regulations disallowing testing, low participation in voluntary testing). DSHS will also monitor and measure the number of clients who complete programs.

BL 2010 Data Source

Using the Prevention Outcome Report in the Behavioral Integrated Provider System (BHIPS) providers will report the number of youth who are enrolled, the number of youth who are pre- and post-tested, and the number of youth who complete the program successfully.

BL 2010 Methodology

The number of participants who scored in the desired direction and/or maintained scores at established score levels divided by the total number of participants who completed program activities and were post-tested.

BL 2010 Purpose

This is a measure of program effectiveness in reducing substance abuse risk factors and increasing protective factors.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	5	Percent of Adults Engaged in Substance Abuse Treatment for 90 Days

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 05

BL 2010 Definition

This measures the percent of discharged adult clients, age 18 or above, who were engaged in a course of substance abuse treatment for at least 90 days.

BL 2010 Data Limitations

This measure will be limited to adult clients in substance abuse treatment and does not take into consideration intervening variables, such as motivational stage, severity of the addiction, client satisfaction with services, array of services offered by the provider, medical status of the client, etc.

BL 2010 Data Source

Discharge information reported by providers via the Behavioral Health Integrated Provider System (BHIPS).

BL 2010 Methodology

Total number of unduplicated adults who were retained in substance abuse treatment for at least 90 days at one or more levels of service by the total number of unduplicated clients who were admitted to substance abuse treatment services during a period of time.

BL 2010 Purpose

Clients who are retained in substance abuse treatment for a period of time considered sufficient will demonstrate positive treatment outcomes.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	6	Percent of Youth Completing Treatment Programs Who Report Abstinence

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 06

BL 2010 Definition

The percent of youth, age 17 or below, who complete a treatment program for substance abuse and report no past month substance use when contacted 60 days after discharge.

BL 2010 Data Limitations

This only reflects clients from DSHS funded programs. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service.

BL 2010 Data Source

Provider staff contact youth clients 60 days after discharge to request client self-report on abstinence during past 30 days. Provider records information in Youth Follow-up Report. Data is entered directly into the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

Total number of youth, age 17 or below, who complete a treatment program for substance abuse and report no past month use of alcohol or drugs at the time of follow-up divided by the total number of youth who complete a treatment program for substance abuse and are contacted at follow-up.

BL 2010 Purpose

Abstinence is an objective of ongoing recovery for addiction.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	7	Percent of Adults Completing Treatment Programs Who Report Abstinence

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 07

BL 2010 Definition

The percent of adults, age 18 or above, who complete a treatment program for substance abuse and report no past month substance use when contacted 60 days after discharge.

BL 2010 Data Limitations

This only reflects clients from DSHS funded programs. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service.

BL 2010 Data Source

Provider staff contact adult clients 60 days after discharge to request client self-report on abstinence during past 30 days. Provider records information in Adult Follow-up Report. Data is entered by client ID number directly into the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

Total number of adults, age 18 or above, who complete a treatment program for substance abuse and report no past month substance use at the time of follow-up divided by the total number of adults who complete a treatment program and are contacted at follow-up.

BL 2010 Purpose

Abstinence is an objective of ongoing recovery for addiction.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	8	Percent of Youth Completing Treatment w/ Reduction in Absenteeism

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 08

BL 2010 Definition

The percent of youth, age 17 or below, who complete a treatment program for substance abuse and report improvement in school attendance when contacted 60 days after discharge.

BL 2010 Data Limitations

This only reflects clients from DSHS funded programs. Does not consider youth, age 16 or 17, who have dropped out of school. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service.

BL 2010 Data Source

Provider staff contact clients 60 days after discharge to request self-report on school attendance. Provider records information in Youth Follow-up Report by client ID number directly into the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

The number of youth clients, age 17 or below, who completed a treatment program for substacne abuse and whose total number of days suspended and absent during the 6 week period prior to follow-up was less than the total number of days suspended and absent during the 6-week period prior to admission, divided by the number of youth completing a treatment program for substance abuse and contacted at follow-up.

BL 2010 Purpose

Reduction in absenteeism is highly correlated to recovery from substance abuse.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	9	State MH Hospital and Center Re-admission Rate

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 09

BL 2010 Definition

This measure is the percent of all persons discharged from state mental health facilities to the community during the fiscal year who are readmitted to any mental health facility in the same fiscal year. A person may be counted more than once during a fiscal year if the person has multiple admissions during the

BL 2010 Data Limitations

This measure does not capture information regarding readmissions for persons discharged during any previous fiscal year.

BL 2010 Data Source

State mental health facility personnel enter information about the individual into the department's data warehouse upon admission to and discharge from a state mental health facility.

BL 2010 Methodology

The numerator is the number of persons admitted to state mental health facilities from the community that have had a previous discharge from a state mental health facility during the same state fiscal year. The denominator is the number of persons discharged from state mental health facilities during the state fiscal year. Readmission does not include persons that are transferred from one facility to another without an intervening stay in the community. The formula is the numerator/denominator * 100.

BL 2010 Purpose

When an individual returns to the community from a state mental health facility, the individual's community support system that existed prior to the inpatient admission must often be reestablished. Local authorities endeavor to minimize any disruption in the person's life that occurs as a result of transitioning back into the community. Readmission rates are an indicator of the effectiveness of the community reintegration process. High rates are indicative of discharge before the customer is ready for reintegration into the community and/or insufficient local services to facilitate reintegration.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	10	% Community MH Adults Admitted to a Level of Care (Service Package)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 10

BL 2010 Definition

Persons who receive assessment services may or may not be eligible for mental health community services. This measure provides information about the percentage of adults who seek mental health community services and following assessment are found to qualify for services.

BL 2010 Data Limitations

Collection of data is dependent upon the completion of the Uniform Assessment for Resiliency & Disease Management as prescribed.

BL 2010 Data Source

The consumer Data Warehouse stores all assessment and service information for a consumer. Local authority staff submit data monthly to the consumer Data Warehouse. Persons are assigned a level of care (service package) of 1,2,3 or 4 after being assessed and found to be eligible for services. This measure is computed quarterly and year-to-date.

BL 2010 Methodology

The numerator is the number of priority-population adults who were admitted to a level of care (service package) of 1, 2, 3 or 4 following assessment. The denominator is the number of priority-population adults who were assessed and found eligible for services. The formula is numerator/denominator *

BL 2010 Purpose

Prior to receiving mental health community services (except crisis services), persons are assessed to determine their current level of functioning and which service package appropriately addresses their needs. This information is collected on the Uniform Assessment for Resiliency & Disease Management.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	11	% Community MH Adults Stabilized or Improved

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 11

BL 2010 Definition

One goal of community mental health services is to maintain or improve the consumer's level of functioning in the community. The desired outcome of community mental health services is to improve level of functioning to the highest level of independence possible. This measure provides information about this outcome for adults receiving community mental health services through an authorized level of care as determined by the Adult Texas Recommended Assessment Guidelines (Adult-TRAG).

BL 2010 Data Limitations

Collection of data is dependent upon completion of the Uniform Assessment for Resiliency & Disease Management as prescribed.

BL 2010 Data Source

Level of functioning is measured by Dimension 4 of the Adult Texas Recommended Assessment Guidelines (Adult-TRAG), which measures an individual's lack of ability to function in various community settings over the past three months. This scale is used for persons with severe and persistent mental illnesses. Clinical staff are expected to administer the Adult-TRAG at admission to community services, every 90 days and at planned discharges. Greater functional impairment scores reflect greater problems functioning in the community. The results of this assessment are located on the Uniform Assessment for Resiliency & Disease Management and are entered into the department's data warehouse by staff at the local authority.

BL 2010 Methodology

For this calculation, the first Uniform Assessment for Resiliency & Disease Management (UA) upon admission and the latest UA which must have been completed at least 90 days after the initial UA are utilized. Dimension 4 of the Adult-TRAG is a five-point scale. A decrease of 1 or more points is labeled improvement.

The numerator is the number of adult consumers over the fiscal year with a minimum of two Uniform Assessments for Resiliency & Disease Management with a decrease of 1 or more points in the second Uniform Assessment score.

The denominator is the total number of adult consumers over the fiscal year with a minimum of two Uniform Assessments for Resiliency & Disease

BL 2010 Purpose

Improved functioning in the community is an important indication that treatment is effective in reducing the functional deterioration associated with mental illness. There are four levels of care a mental health consumer may be assigned, level of care 1, 2, 3, or 4. Each level of care has a designated service package that the mental health consumer may receive. Persons receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	12	% Community MH Children Admitted to a Level of Care (Service Package)

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 12

BL 2010 Definition

Persons who receive assessment services may or may not be eligible for mental health community services. This measure provides information about the percentage of children who seek mental health community services and following assessment are found to qualify for services.

BL 2010 Data Limitations

Collection of data is dependent upon the completion of the Child & Adolescent Evaluation Assessment for Resiliency & Disease Management as prescribed.

BL 2010 Data Source

The consumer Data Warehouse stores all assessment and service information for a consumer. Local authority staff submit data monthly to the consumer Data Warehouse. Persons are assigned a level of care (service package) of 1,2,3 or 4 after being assessed and found to be eligible for services. This measure is computed quarterly and year-to-date.

BL 2010 Methodology

The numerator is the number of priority-population children who were admitted to a level of care (service package) of 1, 2, 3 or 4 following assessment. The denominator is the number of priority-population children who were assessed and found eligible for services. The formula is numerator/denominator *

BL 2010 Purpose

Prior to receiving mental health community services (except crisis services), persons are assessed to determine their current level of functioning and which service package appropriately addresses their needs. This information is collected on the Child & Adolescent Evaluation Assessment for Resiliency & Disease Management.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	13	% Community MH Children Stabilized or Improved

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 13

BL 2010 Definition

One goal of community mental health services is to maintain or improve the consumer's level of functioning in the community. The desired outcome of community mental health services is to improve level of functioning to the highest level of independence possible. This measure provides information about this outcome for children as measured by the Child & Adolescent Texas Recommended Assessment Guidelines (CA-TRAG) during the fiscal year.

BL 2010 Data Limitations

Collection of data is dependent upon completion of the Child & Adolescent Evaluation Assessment for Resiliency & Disease Management as prescribed.

BL 2010 Data Source

Level of functioning is measured by the Ohio Youth Functioning Scale (OYFS), which measures an individual's functioning in various community settings over the past three months. This scale is used for children with severe emotional disturbance. Parents/guardians or clinical staff are expected to administer the OYFS at admission to community services, every 90 days and at termination of services. The results of this assessment are located on the Child & Adolescent Evaluation Assessment for Resiliency & Disease Management and are entered into the department's data warehouse by staff at the local authority.

For this calculation,the first CA-R&DM upon admission and the latest CA-R&DM, completed at least 90 days after the initial CA-R&DM, are utilized. Higher scores indicate worse functioning and lower scores indicate better functioning. DSHS reversed the endpoints relative to the original instrument.

BL 2010 Methodology

The SED will be used to measure change in scores.Based on preliminary data the SED for the OYFS is estimated to be 9 points.Stabilized functioning is defined as the second score being within (+)or(-)8 points of the first score.Improved functioning is defined as a decrease in the total score of at least 9 points.

The numerator is the number of children receiving mh services with a minimum of two OYFS assessments in the fiscal year whose update assessment score stabilized or improved.

The denominator is the total number of consumers with a minimum of two OYFS assessments in the fiscal year.The formula is the numerator/ denominator *

BL 2010 Purpose

Stabilized or improved functioning in the community is an important indication that treatment is effective in reducing the functional deterioration associated with mental illness. There are four levels of care a mental health consumer may be assigned, level of care 1, 2, 3, or 4. Each level of care has a designated service package that the consumer may receive. There may be children whose authorized level of care does not match the CA-TRAG, however these exceptions are usually due to clinical judgement, resource issues, continuity of care per UM guidelines and/or consumer choice. Children receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	14	Percent MH Children with a History of Arrest Who Avoid Rearrest

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 02-02 OC 14

BL 2010 Definition

This measure is an indication of the effectiveness of treatment strategies with children and adolescents who have a history of arrest involvement with the juvenile justice system.

BL 2010 Data Limitations

Collection of data is dependent upon the completion of the Child & Adolescent Evaluation Assessment for Resiliency & Disease Management as prescribed.

BL 2010 Data Source

The evaluation instrument for this measure is the Child & Adolescent Texas Recommended Authorization Guidelines (CA-TRAG) which is part of the Child & Adolescent Evaluation Assessment for Benefit Design completed for all children at admission,every 90 days and at termination of services.Staff at the local authorities enter this assessment data into the department's data warehouse. The CA-TRAG has ten dimensions for assessment and number eight is juvenile justice involvement.The ratings are from lowest to highest juvenile justice involvement with 1 (no involvement with the juvenile justice system in the past 90 days and not currently on probation or parole) to 5 (rearrested within the past 90 days). Children whose initial CA-BD has been rated 3 or 4 on this dimension are included in this calculation.Recidivism is defined as a "5" rating on any quarterly CA-TRAG following the initial intake CA-TRAG.Children who received services for one quarter or more are included in this measure.

BL 2010 Methodology

For this calculation, the first CA-TRAG on the Child & Adolescent Evaluation Assessment for Resiliency & Disease Management upon admission with a rating of "3" or "4", and any subsequent CA-TRAG during the fiscal year which does not have a rating of "5" (i.e., rearrested) on this dimension are utilized.

The numerator is the number of children with juvenile justice involvement receiving mental health services whose initial assessment indicates a rating of "3" or "4" on the juvenile justice dimension of CA-R&DM, but whose update assessment does not indicate a rating of "5" on the juvenile justice dimension of the CA-R&DM.

The denominator is the number of children with juvenile justice involvement receiving mental health services whose initial assessment indicates a rating of "3" or "4" on the juvenile justice dimension of CA-R&DM.

BL 2010 Purpose

Children receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs. Juvenile justice involvement is often related to severe emotional disturbance. This measure will provide information on the department's efforts to provide treatment to children involved with the juvenile justice system in order to prevent further involvement with the juvenile justice system.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	15	% Medicaid Receiving Crisis Services Followed by ER Visit

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

BL 2010 Definition

This measure reports the percent of persons (regardless of age) with a crisis episode who have an emergency room (ER) service within 30 days of the first day of each crisis episode. A crisis episode is defined as all crisis services received from Community Mental Health Centers including NorthSTAR with no break longer than 7 days. A crisis service occurring after another crisis service by 8+ days is considered a separate crisis episode. The crisis services include both residential and outpatient.

BL 2010 Data Limitations

The accuracy of the Department's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. The accuracy of the Health and Human Services Commission's Medicaid database is dependent upon accurate and timely submission of claims and encounters to the State. Only ER services for Sep-Dec of each Fiscal Year can be used to compute this measure in time for Quarter 4 reporting due to the inherent time lag in Medicaid claims processing.

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse(MBOW)and NorthSTAR data warehouse.
Medicaid claims and encounters are submitted by Health Management Organizations (HMOs)and providers participating with the State Medicaid program and are processed by the Texas Medicaid and Healthcare Partnership(TMHP).

BL 2010 Methodology

The numerator is the number of persons with Medicaid with a crisis episode who had an ER visit within 30 days of the first day of each crisis episode.
The denominator is the number of persons with one or more crisis episodes.
The formula is numerator/denominator * 100.

BL 2010 Purpose

Providing less restrictive and more appropriate mental health crisis services in the community is an important function of Crisis Redesign. Appropriate interventions for persons in mental health crisis should reduce their need to access ER services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	16	% Receiving Crisis Services Followed by Psychiatric Hospitalization

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

BL 2010 Definition

This measure reports the percent of persons (regardless of age) with a crisis episode who have a psychiatric hospitalization at a State or Community psychiatric hospital within 30 days of the first day of each crisis episode. A crisis episode is defined as all crisis services received from Community Mental Health Centers including NorthSTAR with no break longer than 7 days. A crisis service occurring after another crisis service by 8+ days is considered a separate crisis episode. The crisis services include both residential and outpatient.

BL 2010 Data Limitations

The accuracy of the Department's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse.
The State and Community hospitalization information is entered into the DSHS Client Assignment and Registration System (CARE).

BL 2010 Methodology

The numerator is the number of persons with a crisis episode who have a State or Community psychiatric hospitalization within 30 days of the first day of each crisis episode.
The denominator is the number of persons with one or more crisis episodes.
The formula is numerator/denominator * 100.

BL 2010 Purpose

Providing less restrictive and more appropriate mental health crisis services in the community is an important function of Crisis Redesign. Appropriate interventions for persons in mental health crisis should reduce their need to access State or Community psychiatric hospitals.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Outcome No.	17	% Receiving Crisis Services Followed by Jail Booking

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

BL 2010 Definition

This measure reports the percent of persons (regardless of age) receiving a residential or outpatient crisis service from Community Mental Health Centers including NorthSTAR who had a jail booking within 7 days of a crisis service. The same crisis service lasting more than one day is considered a separate

BL 2010 Data Limitations

This measure is dependent upon timely compliance to Texas Senate Bill 839, passed during the 80th Legislative Session, that requires DSHS and the Texas Department of Public Safety's (DPS) Bureau of Identification and Records to establish a contemporaneous identification system that cross-references persons booked into jails with persons in the DSHS Client Assignment and Registration (CARE) System. Thus, DSHS is not able to propose a target for this measure until compliance with Texas Senate Bill 839 is achieved.

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse.
Jail booking information is from local and county jails statewide and will be cross-referenced with the DSHS CARE system.

BL 2010 Methodology

The numerator is the number of persons with a crisis service that have a jail booking within 7 days of a crisis service.
The denominator is the number of persons with one or more crisis services.
The formula is numerator/denominator * 100.

BL 2010 Purpose

Providing less restrictive and more appropriate mental health crisis services in the community is an important function of Crisis Redesign. Appropriate interventions for persons in mental health crisis should prevent persons from being placed in jail settings.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Outcome No.	1	% Cases of TB Treated at TCID as Inpatients - Patients Treated to Cure

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 03-01 OC 01

BL 2010 Definition

Percent of cases of tuberculosis treated at TCID as inpatients in which the patients are treated to cure.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Discharge summary prepared to document physician authorization to discharge patient from hospitalization at TCID is logged and data is compiled for the reporting period. “Treatment to cure” is defined as the organism being completely eradicated in those patients who must be more expensively hospitalized to complete their treatment.

BL 2010 Methodology

Ratio of total TCID discharged patients who have completed treatment to cure to total number of patients admitted to TCID for the reporting period.

BL 2010 Purpose

Measures the controllable outcome expected by HSC13.031 for TCID services

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Outcome No.	2	% of State Mental Health Facility Patients Stabilized or Improved

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 03-01 OC 02

BL 2010 Definition

Mental health campus services are utilized when an individual's behavior and/or functioning level necessitates a structured environment. These services are intended to stabilize or improve the consumer's level of functioning so that the individual may return to his/her community. Campus services are provided at state mental health facilities and state centers. Campus services are provided to children and adults.

BL 2010 Data Limitations

None

BL 2010 Data Source

The instrument used to assess level of functioning in state mental health facilities is the Global Assessment of Functioning (GAF) Scale. Clinical staff completes the assessment during admission evaluation and at the time of discharge. The Global Assessment of Functioning scale measures the individual's functioning in global terms with respect only to psychological, social and occupational functioning on a 90 point scale.

BL 2010 Methodology

The calculation of this measure counts the number of persons discharged from state hospitals during the current fiscal year who have 2 functioning level scores during the inpatient episode. A significant decrease in functioning level is defined as a decrease of 10 or more points on the Global Assessment of Functioning (GAF) scale.The numerator is the number of patients discharged who were evaluated for level of functioning and whose functioning score did not decrease by 10 or more points on the Global Assessment of Functioning (GAF) scale.The denominator is the number of discharged patients with two usable level of functioning scores. The formula is the numerator/denominator * 100.

BL 2010 Purpose

Stabilized or improved functioning indicates that treatment in general is effective in stopping the deterioration due to the mental illness, increasing the consumer's ability to deal with the symptoms. The higher the percent improved or stabilized, the more effective the treatment provided by the facilities

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Outcome No.	3	Patient Satisfaction with State Mental Health Facility Treatment

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 03-01 OC 03

BL 2010 Definition

A primary goal for inpatient treatment is to assure that quality psychiatric services are provided that meet or exceed the needs and expectations of consumers and their families. This measure is obtained from the consumers (and family members as appropriate) and provides consumer self-report information as an indication of satisfaction

BL 2010 Data Limitations

The MHSIP is a voluntary survey. The collection of data from survey questionnaires is dependent upon the consumers' completion and submission of the survey. Since not all consumers will complete the survey, this measurement of satisfaction is not able to fully reveal consumer satisfaction.

BL 2010 Data Source

All adults and adolescents (13 years of age and older) are offered the Mental Health Statistical Improvement Project (MHSIP) Inpatient Consumer Survey at discharge, but participation is strictly voluntary. The survey instrument asks for agreement/disagreement ratings along a five-point scale for 28 statements. The survey results are entered into the stand-alone, non-proprietary database by staff of the facilities then e-mailed to State Mental Health Facilty staff. Staff analyzes the data and prepares monthly reports.

BL 2010 Methodology

The measure is calculated by averaging the items scored for all adolescent and adult patients combined who completed the MHSIP during the current fiscal

BL 2010 Purpose

A positive degree of satisfaction is one indicator reflecting success in addressing consumer needs and preferences. This includes achieving desired outcomes and is associated with compliance with treatment.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Outcome No.	1	Percentage of Inspected Entities in Compliance with Statutes/Rules

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 04-01 OC 01

BL 2010 Definition

Percentage of entities in compliance with statutes and/or rules is a measure identified during surveillance and enforcement activities. An inspected entity is a fixed or mobile site (usually a place of business) that the Department is directed to inspect by statute or rule. Includes routine and compliance inspections and investigations, and may be randomly selected or complaint initiated. An inspected entity is determined to be in compliance when serious conditions, as defined by programmatic area, are not identified upon inspection

BL 2010 Data Limitations

None

BL 2010 Data Source

The data is calculated from information submitted monthly by program staff. The measure is obtained manually and from automated databases. The programs (food [meat] and drug safety, environmental health, and radiation control) collect the data. The categories of data include surveillance, inspection, investigation and compliance. Documentation identifies the manual and automated databases stored in each program.

BL 2010 Methodology

The number of inspected entities in compliance and the total number of inspected entities are reported by each strategy. Each strategy's number in compliance is added together and divided by the total number of inspected entities for each strategy to arrive at this percentage.

BL 2010 Purpose

Measures the percentage of entities in compliance with statutes and/or rules identified during surveillance and enforcement activities.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Outcome No.	2	Avg # Inspections/Investigations/Surveys Per Compliance Field Staff

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 04-01 OC 02

BL 2010 Definition

This is the average number of inspections, investigations, and surveys conducted per compliance field staff member. Compliance field staff is defined as inspectors, surveyors, and investigators who conduct field activities.

BL 2010 Data Limitations

None

BL 2010 Data Source

Compliance records and automated databases.

BL 2010 Methodology

This measure reflects the average number of inspections, investigations, and surveys conducted per compliance field staff member based on program specific criteria. Calculated as the total number of inspections, investigations, and surveys conducted per compliance field staff divided by the total number of inspectors, investigators and surveyors.

BL 2010 Purpose

Ensures efficient use of compliance field staff resources.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Outcome No.	3	Percentage of Licenses Issued within Regulatory Timeframe

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 04-01 OC 03

BL 2010 Definition

Percentage of individuals credentialed and entities licensed within regulatory timeframes (mandated by statute and listed in specific program rules).

BL 2010 Data Limitations

None

BL 2010 Data Source

Application records and automated databases.

BL 2010 Methodology

This efficiency measure reflects the annual percentage of individuals credentialed and entities licensed within regulatory timeframes. Calculated using the total number of individuals and entities licensed/credentialed within the established timeframes divided by the total number of individuals and entities licensed/credentialed during the reporting period.

BL 2010 Purpose

Measures the efficiency of licensing activities to ensure compliance with regulatory timeframes.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Outcome No.	4	Percent of Licensed/Certified Professionals with No Recent Violations

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 04-01 OC 04

BL 2010 Definition

Percent of the total licensed, certified, registered, permitted or documented professionals at the end of the reporting period who have not incurred a violation within the current and preceding two years (three years total).

BL 2010 Data Limitations

The numbers of violations are dependent on the number of complaints filed and the nature of those violations investigated. The agency has no control over either of these two factors. The agency also has no control over the number of individuals who meet the requirements for professional credentialing and/or professionals who choose to renew their licenses.

BL 2010 Data Source

The total number of professionals is obtained from electronic databases. The professional licensing program collects the data. The number of professionals who received sanctions is obtained from electronic complaint tracking systems. Documentation identifies the electronic databases stored in

BL 2010 Methodology

The percentage is calculated by dividing the total number of individuals currently licensed, registered, permitted, certified, or documented who have not incurred a violation within the current and preceding two years by the total number of individuals currently licensed, registered, permitted, certified, or documented by the agency.

BL 2010 Purpose

Licensing, certifying, registering, permitting, and documenting individuals helps ensure that practitioners meet legal standards for professional education and practice, which is a primary program goal. This measure is an indication of the percentage of individuals who have not committed violations of the laws, and/or rules governing the profession. This measure is important because it indicates how effectively the agency's activities deter violations of professional standards established by statute and rule.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Outcome No.	5	% of Licensed/Certified AHCF Meeting St/Fed Regulations at Survey

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** **Cross Reference:** Agy 537 080-R-S70-1 04-01 OC 05

BL 2010 Definition

With the outcome measure of percentage of licensed/certified acute health care facilities (AHCF) meeting state/federal regulation at survey, the comparison will be made on a yearly basis between the number of acute care facility surveys conducted and the number of those surveys which found the facilities to be in compliance with state/federal regulations.

BL 2010 Data Limitations

The number of compliance surveys is provided through manual computation.

BL 2010 Data Source

The number of compliance surveys is provided through manual computation. The facilities found to be out of compliance are maintained in a database file in an automated computer system, the Integrated System, of the enforcement (health facility) program.

BL 2010 Methodology

The percentage is calculated by dividing the number of acute care facilities found out of compliance with state and federal regulations during surveys by the total number of compliance surveys conducted. This number is subtracted from 1 and then multiplied by 100%.

BL 2010 Purpose

The goal is to demonstrate an increase in the compliance rate being an indicator of improved health care delivery to the citizens of Texas by DSHS regulated health care facilities.

Agency Code: 537 Agency: **State Health Services, Department of**

Goal No.	4	1	Consumer Protection Services
Objective No.	1	1	Provide Licensing and Regulatory Compliance
Strategy No.	6	1	Percent of Facilities with No Recent Violations
Measure Type		EX	
Measure No.		1	Number of Local Health Agencies Connected to Health Alert Network

Calculation Method: N Key Measure: N New Measure: N Target Attainment: H Priority: H Cross Reference: Agy 537 080-R-S70-1 04-01 OC 06

BL 2010 Definition

Percent of all DSHS funded substance abuse programs that reached or exceeded their contractually required performance targets.

Calculation Method: C Key Measure: N New Measure: N Target Attainment: H Priority: H Cross Reference: Agy 537 080-R-S70-1 01-01-01 EX 01

Fall Annual: N

BL 2010 Data Limitations

As DSHS raises standards for performance targets to make them more challenging, fewer numbers of programs may meet or exceed these targets.

BL 2010 Data Source

Performance measure information entered by the providers directly into the DSHS Behavioral Health Integrated Provider System.

BL 2010 Definition

The measure defines the availability and use of telecommunications infrastructure for rapid public health emergency response. A local public health service provider is defined as an entity involved in the monitoring of local public health events and/or the provision of local public health services (i. e., city or county health departments, health districts, public and private hospitals, school health nurses, veterinarians, EMS providers).

BL 2010 Methodology

Total DSHS funded programs that reached or exceeded the majority of their contractually required performance targets divided by the total number of DSHS funded programs. A single target is considered reached if performance is within 10% of the target.

BL 2010 Data Limitations

The Texas Department of State Health Services is working through local public health departments to gather data to estimate the total number of local public health service providers in Texas.

BL 2010 Purpose

Information is used in contracting process.

BL 2010 Data Source

Quarterly reports on the number and type of local public health service providers (i. e.: city or county health departments, health districts, public and private hospitals, school health nurses, veterinarians, EMS providers) connected to the Health Alert Network. This data is compiled in the Prevention and Preparedness Division in Austin. This is a measure of the preparedness of Texas health officials to detect and rapidly respond to bioterrorism events. The Health Alert Network provides technology to rapidly notify public health and emergency management officials if such an event occurs.

BL 2010 Methodology

The total number of local public health service providers (i.e., city or county health departments, health districts, public and private hospitals, school health nurses, veterinarians, EMS providers) connected to the Health Alert Network.

BL 2010 Purpose

This is a measure of the preparedness of Texas health officials to detect and rapidly respond to bioterrorism events. The Health Alert Network provides technology to rapidly notify public health and emergency management officials if such an event occurs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	1	Public Health Preparedness and Coordinated Services
Measure Type	OP	
Measure No.	1	Number of LHD Contractors Carrying Out Essential Public Health Plans

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the number of Local Health Department contractors carrying out plans to provide the ten essential public health services within communities. Strategies utilized in these plans demonstrate cost-effective methods for providing the essential public health services at the local level.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data on contracts awarded to Local Health Departments will be collected by DSHS.

BL 2010 Methodology

DSHS will manually count the number of contracts awarded to Local Health Departments on an annual basis.

BL 2010 Purpose

The purpose of this measure is to capture the number of contracts awarded to Local Health Departments for implementing plans for providing the ten essential public health services. These plans will help the Local Health Departments develop and demonstrate cost-effective prevention and intervention strategies for improving public health outcomes, and address disparities in health in minority populations. DSHS intends to renew these contracts on an annual basis.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	1	Public Health Preparedness and Coordinated Services
Measure Type	OP	
Measure No.	2	Number of Educational Hours Provided on Bioterrorism & Preparedness

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

Educational hours provided through DSHS sponsored presentations, courses, conference, and workshops. The focus of this information/ education activity is the overall public health workforce. One (1) educational hour is equivalent to one (1) person being given one (1) hour of instruction.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Quarterly Bioterrorism Education Summary Report. Regional and Central Bioterrorism Educational staff generate this report.

BL 2010 Methodology

Number of educational hours provided quarterly. Multiply the number of hours times the number of people to determine educational hours.

BL 2010 Purpose

Measure DSHS sponsored educational hours provided on bioterrorism and public health preparedness-related topics.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	1	Public Health Preparedness and Coordinated Services
Measure Type	OP	
Measure No.	3	# of Essential Public Health Services Provided to Border Residents

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-01 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the number of essential public health services provided to border residents. Strategies utilized are defined in annual workplans from funders (number of services, timelines, outcomes).

BL 2010 Data Limitations

None.

BL 2010 Data Source

Border County Health Profiles.

BL 2010 Methodology

The number of border essential public health services will be manually counted and documented by monthly outcome reports provided by border offices (Austin, El Paso, Uvalde, Laredo and Harlingen).

BL 2010 Purpose

The main purpose is to demonstrate progress toward the established US-Mexico Health Border 2010 objectives, by assuming the 10 Essential Public Health Services are provided in Texas border counties.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	2	Health Registries, Information, and Vital Records
Measure Type	EF	
Measure No.	1	Average Number of Days to Certify or Verify Vital Statistics Records

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

An average number of days to complete fee-related requests from the day the requests are received until the day of completion.

BL 2010 Data Limitations

None.

BL 2010 Data Source

All requests are tracked in the automated Texas Electronic Registrar (TER) system. A Microsoft Access monthly query is used to extract the data on resolved

BL 2010 Methodology

Using the Texas Electronic Registrar (TER) databases, the number of days between when requests are received and when they are closed is average for requests closed during the quarter. For some requests, such as those for walk-in customers, the database close date does not reflect when the order was complete due to the system not closing the request until the money has been processed by the agency's fiscal department. In those areas affected by that problem, the average number of days requests are open is estimated.

BL 2010 Purpose

Identify the average time taken to fulfill fee-related requests during the reporting period. This information provides a measure of the Vital Statistics Unit's ability to meet customer needs using available resources.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	2	Health Registries, Information, and Vital Records
Measure Type	EF	
Measure No.	2	Avg # Working Days Required by Staff to Complete Customized Requests

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-02 EF 02

Fall/Annual: N

BL 2010 Definition

This measure tracks the average time required by staff of CHS to complete a customized data request, from receipt of the data request to completion and dissemination back to the customer.

BL 2010 Data Limitations

Dependent upon consistent use of tracking system by CHS employees in recording data requests. As standard reports and information become part of the website, more complex data requests will be handled by staff. This could increase the time required to complete requests.

BL 2010 Data Source

A record is kept for each request for data and information received. This includes requests for reports that may require special computer runs, standard reports, and technical assistance.

BL 2010 Methodology

Total time (hours, days, or greater unit of time) to respond to requests divided by the total number of requests.

BL 2010 Purpose

This measure monitors productivity and responsiveness to customer requests requiring customization to attain the data.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	2	Health Registries, Information, and Vital Records
Measure Type	OP	
Measure No.	1	Number of Requests for Records Services Completed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-02 OP

Fall/Annual: N

BL 2010 Definition

Vital Records receives fee-related requests for certified copies of birth, death and fetal death records. Services include marriage, divorce, birth and death verifications. In addition, Vital Records also files amendments to birth and death records and new records based on adoption and paternities.

BL 2010 Data Limitations

None.

BL 2010 Data Source

All requests are tracked in the automated Texas Electronic Registrar (TER) system. A Microsoft Access monthly query is used to extract the data on resolved

BL 2010 Methodology

Using the Texas Electronic Registrar (TER) database, the number of record services is found by counting record-related actions saved in TER for that quarter by Vital Statistics Unit processors for their customers. Record-related actions include activities such as issuing a birth certificate or filing an adoption.

BL 2010 Purpose

Identify the volume of fee-related services completed during the reporting month. This information reflects the demand for services and helps to identify the resources needed to meet that demand.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	2	Health Registries, Information, and Vital Records
Measure Type	OP	
Measure No.	2	Number of Abstracted Cases for Epidemiologic Study

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-01-02 OP

Fall/Annual: N

BL 2010 Definition

Surveillance systems have been established to determine the scope and magnitude of selected public health problems. The abstracted cases from these systems are analyzed for trends and are included in epidemiologic studies and investigations, leading to possible strategies for prevention and control. The number includes abstracted cases from routine surveillance activities, institutional case reporting, and case abstracts obtained as a result of special collection efforts for injuries, birth defects, cancer, childhood lead, occupational conditions, and hazardous substances emergency events (spills).

BL 2010 Data Limitations

None.

BL 2010 Data Source

ZIP1.SQL for birth defects; SANDCRAB database for cancer; STELLAR for childhood lead; PB, ASBESTOS.DBF, SILICOSIS.DBF, and SENSOR for occupational conditions;
AUSTIN. DBF and HOUSTON. DBF for hazardous substances emergency events surveillance.

BL 2010 Methodology

An abstracted case is information on a persons's disease or condition that is collected from a medical record. The number includes abstracted cases from routine surveillance activities, institutional case reporting, and case abstracts obtained as a result of special collection efforts for injuries, birth defects, cancer, childhood lead, occupational conditions, and hazardous substances emergency events (spills).

BL 2010 Purpose

Measures the number of abstracted cases that undergo epidemiologic analysis or study.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	1	Improve Health Status through Preparedness and Information
Strategy No.	2	Health Registries, Information, and Vital Records
Measure Type	OP	
Measure No.	3	Average Successful Requests - Pages per Day

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

Fall/Annual: N

BL 2010 Definition

This measure tracks the daily average of times that Center for Health Statistics (CHS) web pages on the DSHS Internet website are accessed for data or health-related information.

BL 2010 Data Limitations

We can count the number of pages retrieved from the server, but we do not know how, or if, CHS customers use the information being made available. Some variation can be expected because of seasonal effects and availability of new data.

BL 2010 Data Source

Web Server Log Files.

BL 2010 Methodology

The statistic used will be “Average successful requests for pages from the CHS website per day”. The total number of successful requests for pages, extracted from the server logs, will be divided by the number of days in the quarter. This measures access to complete web pages and excludes graphics and other

BL 2010 Purpose

This measure monitors the use of Center for Health Statistics (CHS) web-based products by customers.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	1	Immunize Children and Adults in Texas
Measure Type	EF	
Measure No.	1	Average Cost Per Dose of Vaccine Purchased with State Funds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reflects the dollar amount expended to purchase childhood vaccines, state purchased adult vaccines, and emergency biologicals. Vaccines are defined as: vaccines, toxoids, and biologicals.

BL 2010 Data Limitations

Vaccine amounts are based on population estimates. CDC will utilize a computer program (VOFA) to determine Texas' share of vaccine purchases. CDC instructs Texas on what vaccine is needed to replenish the federal inventory at its distribution contractor facility. Texas will purchase the vaccine (or vaccines) as instructed by CDC with general revenue funds. Dollar amounts are based on CDC invoices to Texas and will be used for the vaccines that CDC assigns to

BL 2010 Data Source

Data is derived from records of purchases with State funds of vaccines, toxoids, and biologicals.

BL 2010 Methodology

The total dollar value of vaccines purchased with state funds is divided by the total number of doses purchased with state funds to give the average cost per

BL 2010 Purpose

To gauge the cost to purchase one dose of vaccine. Rates above or below the average indicate that vaccine prices are fluctuating or that the state has purchased higher or lower priced products during that quarter.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	1	Immunize Children and Adults in Texas
Measure Type	EX	
Measure No.	1	Dollar Value (in Millions) of Vaccine Provided by the Federal Govt

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-02-01 EX 01

Fall/Annual: N

BL 2010 Definition

The Centers for Disease Control and Prevention (CDC) provides two sources of direct assistance funding for the purchase of childhood and adult vaccines/toxoids/biologicals --The Childhood Immunization Grant (317 Grant) and the Vaccines for Children (VFC) Program.

BL 2010 Data Limitations

None

BL 2010 Data Source

These direct assistance awards are in the form of actual vaccine products in lieu of cash awards. At the beginning of each calendar year the Centers for Disease Control and Prevention (CDC) estimates the amount of 317 and VFC vaccine awards that the Texas Department of State Health Services will receive during that grant period. CDC sends the Immunization Branch a monthly report of the number of doses shipped to Texas providers, and the dollar value of

BL 2010 Methodology

The quarterly performance measure data is based on the monthly reports from CDC on the number and dollar amount of vaccines shipped. Data for each month is provided to the Immunization Branch at the end of the following month, so data for each quarter is partially estimated until it can be updated after

BL 2010 Purpose

Dollar value (in millions) of vaccine provided by the federal government.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	1	Immunize Children and Adults in Texas
Measure Type	EX	
Measure No.	2	# of Sites Authorized to Access State Immunization Registry System

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 01-02-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure will count the number of providers (public and private) insurance companies, schools, and day care centers authorized to access the statewide immunization registry.

BL 2010 Data Limitations

The Program Specialist will be responsible for providing instruction and education to providers. The Program Specialist will be responsible for processing the provider registration applications and training provider staff. Limited funding for education and training, and limited or reduced staffing will impact the rate of provider participation and the processing of provider applications.

BL 2010 Data Source

Following processing of the ImmTrac provider registration application, the ImmTrac Program Specialist will enter the provider site name, contact person, address and phone number in customer support database. The customer support database can produce quarterly reports documenting the number of sites authorized to access the registry.

BL 2010 Methodology

For the purposes of this definition, sites are defined as the facility or office authorized to access the registry and not the individual workstation. This will be a frequency or simple count of the number of registered sites authorized to access to the immunization registry that have accessed the registry (logged in) during the previous two years.

BL 2010 Purpose

An increase in the number of sites participating in the registry is important for the growth of the number of children's records contained in the database and immunization histories stored in the registry.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	1	Immunize Children and Adults in Texas
Measure Type	OP	
Measure No.	1	# Vaccine Doses Administered - Children

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

Fall/Annual: N

BL 2010 Definition

Doses administered means the number of antigens administered. “Antigen” refers to each component of childhood vaccines/toxoids/biologicals administered including new vaccines and combination vaccines.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data are submitted in either automated or written format (C-33 form) from providers of state-supplied vaccines, including regional public health clinics, local health departments/districts, Women, Infants and Children (WIC) offices, community and rural health centers, and private providers. The data are reported monthly by each provider, and maintained in an automated database. The databases are as follows: Statewide Immunization Tracking Software (ImmTrac), Vaccine Management Software (VACMAN), Pharmacy Inventory Control System (PICS), and Texas-Wide Integrated Client Encounter System (TWICES).

BL 2010 Methodology

A report is produced based on aggregated data. Data is cumulative.

BL 2010 Purpose

Measures the total number of doses administered to children.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	1	Immunize Children and Adults in Texas
Measure Type	OP	
Measure No.	2	# Vaccine Doses Administered - Adults

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

Fall/Annual: N

BL 2010 Definition

Doses administered means the number of antigens administered. “Antigen” refers to each component of adult vaccines/toxoids/biologicals administered including new vaccines and combination vaccines.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data are submitted in either automated or written format (C-33 form) from providers of state-supplied vaccines, including regional public health clinics, local health departments/districts, Women, Infants and Children (WIC) offices, community and rural health centers, and private providers. The data are reported monthly by each provider, and maintained in an automated database. The databases are as follows: Statewide Immunization Tracking Software (ImmTrac), Vaccine Management Software (VACMAN), Pharmacy Inventory Control System (PICS), and Texas-Wide Integrated Client Encounter System (TWICES).

BL 2010 Methodology

A report is produced based on aggregated data. Data is cumulative.

BL 2010 Purpose

Measures the total number of doses administered to adults.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	1	Immunize Children and Adults in Texas
Measure Type	OP	
Measure No.	3	Number of Vaccine Doses Purchased with State Funds

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 01-02-01 OP

Fall/Annual: N

BL 2010 Definition

The number of vaccine doses purchased with state funds. The term "vaccine" is defined as: vaccines/toxoids/biologicals.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The source of the data used for this measure is provided from accounting ledgers maintained in an automated system in the Immunization Branch. The data may also be retrieved from the department's automated purchasing system. Each time an order for vaccines is placed, the automated systems will be updated. Each quarterly measure report will be based on all doses of vaccines purchased with state funds during that period.

BL 2010 Methodology

All vaccines will be counted by doses indicated by the manufacturer with the exception of immune globulin products. For this report, 2ml will be counted as one dose. The branch will cross-check the automated accounting system with the department's purchasing system to verify accuracy of the purchased made.

BL 2010 Purpose

Measures the number of vaccine doses purchased with state funds. The term "vaccine" is defined as: vaccines/toxoids/biologicals.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	2	HIV/STD Prevention
Measure Type	EF	
Measure No.	1	Proportion of HIV Positive Persons who Receive their Test Results

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 537 080-R-S70-1 01-02-02 EF 01

Fall/Annual: N

BL 2010 Definition

The proportion of clients testing HIV positive through DSHS HIV prevention programs who receive their HIV test results.

BL 2010 Data Limitations

This does not reflect all HIV testing in the state, only the testing that is completed by DSHS contractors funded for HIV prevention counseling and testing

BL 2010 Data Source

Program data systems maintained by the HIV/STD program (HIV/STD Comprehensive Services Branch). Both HIV test results and whether or not the test results were delivered to clients are reported.

BL 2010 Methodology

The number of clients who received their HIV+ test result will be divided by the number of clients who had an HIV+ test result.

BL 2010 Purpose

To assess the performance of HIV prevention counseling and testing contractors on a key measure: the delivery of HIV+ test results. This measure is recognized as a key measure by the Centers for Disease Control and Prevention.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	2	HIV/STD Prevention
Measure Type	OP	
Measure No.	1	Number of Persons Served by the HIV Medication Program

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-02-02 OP

Fall/Annual: N

BL 2010 Definition

The number of income eligible HIV infected persons enrolled in the Texas HIV Medication Program who have received medication.

BL 2010 Data Limitations

None.

BL 2010 Data Source

This information is retrieved from the HIV medication Program databases maintained by the HIV/STD Medication Program staff.

BL 2010 Methodology

The number of HIV infected persons with qualifying income enrolled in the Texas HIV Medication Program who have received medication. This is the number of unduplicated individuals that have presented a prescription and received the medication within the designated time period (per quarter and fiscal year).

BL 2010 Purpose

The number of HIV infected persons enrolled in the Texas HIV Medication Program who have received medication.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	2	HIV/STD Prevention
Measure Type	OP	
Measure No.	2	# of Clients with HIV/AIDS Receiving Medical and Supportive Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority:** Cross Reference: Agy 537 080-R-S70-1 01-02-02 OP

Fall/Annual: N

BL 2010 Definition

The unduplicated number of clients receiving medical and supportive services from HIV service providers supported through Ryan White CARE Act funds or DSHS State Services funds. Services include outpatient medical care, case management, dental care, substance abuse treatment, mental health services, drug reimbursement, home health, insurance assistance, hospice care, client advocacy, respite and child care, food bank, home delivered meals, nutritional supplements, housing related services, transportation, legal services, and other supportive services allowed by the Health Resources & Services Administration.

BL 2010 Data Limitations

These data reflect care delivered by providers who receive Ryan White CARE Act funds (Parts A, B, C, and D) and DSHS State HIV Services funds. The measure does not reflect all medical and supportive services delivered to HIV infected persons in Texas, but only those delivered by providers who receive Ryan White CARE Act funds (Parts A, B, C, and D) or State HIV Services funds. However, the data do not solely reflect those services contracted by DSHS. The reported clients may be served with a mixture of state, federal and local funds, and the assignment of funds is arbitrary at a client level, regardless of funding source supporting the service. Therefore, our client count reflects all eligible clients receiving at least one eligible service from a provider receiving Ryan White or State HIV services funds.

BL 2010 Data Source

HIV service providers throughout the state report on medical and supportive services provided to eligible clients using the Uniform Reporting System (URS).

BL 2010 Methodology

The unduplicated number of clients receiving medical and psychosocial services is reported in the URS.

BL 2010 Purpose

To monitor the number of persons receiving medical and psychosocial services through funded providers and to measure progress on program objectives.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	3	Infectious Disease Prevention, Epidemiology and Surveillance
Measure Type	OP	
Measure No.	1	Number of Communicable Disease Investigations Conducted

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-02-03 OP

Fall/Annual: N

BL 2010 Definition

The number of communicable disease reports managed during the fiscal year.

BL 2010 Data Limitations

Data are limited to information entered into one of the infectious disease reporting systems.

BL 2010 Data Source

The Infectious Disease Surveillance and Epidemiology Branch (IDSE) captures data in the National Electronic Surveillance System (NEDSS), ArboNet, the Texas-Wide Integrated Client Encounter System Tuberculosis module (TWICES-TB), and the Tuberculosis Information Management System (TIMS).

BL 2010 Methodology

This measure is calculated by summing the number of reports entered into the NEDSS, ArboNet, TWICES-TB, and TIMS. For the purpose of identifying which NEDSS records to count in this performance measure, a NEDSS record is defined as one instance per patient of an investigation, a lab report, or a morbidity report. An ArboNet record is defined as a record entered into the ArboNet system. A TWICES TB record is defined as a case, contact, or suspect report; a laboratory report; a test results; or a report of a candidate for latent TB infection. A TIMS report is defined as a patient record entered into the system.

BL 2010 Purpose

Measures the number of disease reports.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	2	Infectious Disease Control, Prevention and Treatment
Strategy No.	3	Infectious Disease Prevention, Epidemiology and Surveillance
Measure Type	OP	
Measure No.	2	Number Zoonotic Disease Surveillance Activities Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-02-03 OP

Fall/Annual: N

BL 2010 Definition

Epidemiologic surveillance activities and field investigations that include surveillance or case-related zoonotic disease consultations, zoonotic samples collected, sites sampled, and disease case investigations. These activities and investigations are designed to discover the cause, extent, and impact of the

BL 2010 Data Limitations

None.

BL 2010 Data Source

Zoonosis Control Branch Workplan/Monthly Report is the report generated from the accumulation of all Zoonosis Control Regional offices including Central

BL 2010 Methodology

The number includes the sum of the number of surveillance or case-related zoonotic disease consultations, zoonotic samples collected, sites sampled, and disease case investigations.

BL 2010 Purpose

Measure the number of surveillance activities and field investigations conducted.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	1	Health Promotion & Chronic Disease Prevention
Measure Type	OP	
Measure No.	1	Number of Diabetes-related Prevention Activities

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-01 OP

Fall/Annual: N

BL 2010 Definition

The number of outreach and education activities provided on diabetes and the number of persons receiving diabetes services.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Summary report derived from monthly activity reports from grant-funded projects generated through Program Management and Tracking System database, eye disease program database, and staff tracking forms.

BL 2010 Methodology

The number of activities and services consists of the sum of: 1)outreach and educational presentations, 2)one-on-one education, 3)support groups 4)responses to requests for information and consultation, 5)diabetic eye exams, and 6)persons receiving education services.

BL 2010 Purpose

Measures the number of diabetes related prevention activities provided by providers.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	2	Abstinence Education
Measure Type	OP	
Measure No.	1	Number of Persons Served in Abstinence Education Programs

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-02 OP

Fall/Annual: N

BL 2010 Definition

Number of Persons receiving services delivered by any contracting entity receiving funds under Section 510 of Title V of the Social Security Act.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

BL 2010 Data Source

Summary report derived from monthly activity reports from grant-funded projects; numbers served will be totaled from the data reports from the Abstinence Education program.

BL 2010 Methodology

The total number of persons served will be the unduplicated count of individuals receiving services from each contracting entity during each state fiscal year.

BL 2010 Purpose

Measures the number of persons receiving services delivered by any contracting entity receiving funds under Section 510 of Title V of the Social Security Act.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	3	Kidney Health Care
Measure Type	EF	
Measure No.	1	Average Cost Per Chronic Disease Service - Kidney Health Care

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 01-03-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure includes Kidney Health allowable services, including medical, drug and transportation. This measure is the average amount paid per KHC recipient per fiscal year.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available.

BL 2010 Data Source

Data are derived from the Kidney Health Care (KHC) claims processing system.

BL 2010 Methodology

The average cost per chronic disease service will be determined per recipient served per fiscal year by dividing the total client services expenditures by the total number of unduplicated recipients.

BL 2010 Purpose

To measure the average amount paid per KHC recipient per fiscal year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	3	Kidney Health Care
Measure Type	OP	
Measure No.	1	Number of Kidney Health Clients Provided Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-03 OP

Fall/Annual: N

BL 2010 Definition

The measure is the total number of unduplicated recipients for whom DSHS Kidney Health Care (KHC) made payment or reimbursed for services received during the fiscal year.

BL 2010 Data Limitations

Due to retroactive benefits and extended filing, actual data may not be complete for six (6) months or more; therefore, projections may be included based on the data available.

BL 2010 Data Source

Data are derived from KHC claims payment system.

BL 2010 Methodology

The measure is the total number of unduplicated recipients for whom Kidney Health Care (KHC) made payment or reimbursed for services received during the fiscal year. Data are non-cumulative, and the reported values will be updated on a quarterly basis.

BL 2010 Purpose

The measure is the total number of unduplicated recipients for whom Kidney Health Care (KHC) made payment or reimbursed for services received during the fiscal year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EF	
Measure No.	1	Average Cost Per CSHCN Client Receiving Case Management

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost per client with special health care needs who receives case management. Case management provides assistance to clients and their families in gaining access to needed services. For purposes of this performance measure, "CSHCN clients" are children (or adults with Cystic Fibrosis) with special health care needs who receive case management but are not necessarily enrolled in the CSHCN program. A client is considered as receiving case management services when a case manager has been assigned to the client and his or her family, and services have been provided.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the data available.

BL 2010 Data Source

The number of clients receiving case management services is derived from the monthly regional reports provided to the Texas Department of State Health Services (DSHS) by Children With Special Health Care Needs (CSHCN) regional program directors and quarterly reports provided by agencies or entities contracted to provide case management. The amount spent on case management is derived from the monthly Medicaid and Other Reporting Requirement Legislative Rider report, which includes expenditures from the Texas Department of State Health Services accounting system.

BL 2010 Methodology

The average cost per client receiving case management is calculated by dividing the total expended for case management by the total number of clients who received case management services. Estimates may be used for quarters in which claims data is incomplete.

BL 2010 Purpose

This measure reports the average cost per CSHCN client who receives assistance to: gain access to necessary medical, social, educational and other services to reduce morbidity and mortality in clients; encourage cost-effective health and health related care; make referrals to appropriate providers and community resources; and discourage over utilization and duplication of services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EF	
Measure No.	2	Average Cost Per CSHCN Client Receiving Medical Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-04 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the average paid for eligible Children with Special Health Care Needs (CSHCN) clients receiving medical services. For purposes of this measure, "medical services" includes the following health care benefits; hospital (inpatient and outpatient); physician services; dental care; durable medical equipment and supplies; home health services; drugs and other medically necessary services.

BL 2010 Data Limitations

The paid claims data is reported based on the date of service. Providers have 90 days to file claims from the date of service and 180 days to submit appeals. Therefore, payment data for a given period may change through time. Due to the format of the data source report, the number of clients used for this measure may be duplicated.Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the

BL 2010 Data Source

The average cost per client receiving medical services is obtained from the monthly Medicaid and Other Reporting Requirement Legislative Rider report, which includes client data from the CSHCN database. Other reports/automated systems may replace the current report/system. The data from these new reports/systems may be combined with current report/system and/or replace the data from the current report/system. Specific data source used will be noted in

BL 2010 Methodology

The average cost per CSHCN client is calculated by dividing the amount paid for medical services by the number of CSHCN clients who received medical services. Estimates may be included based on the data available.

BL 2010 Purpose

This measure is used to monitor trends in the cost of care for the clients receiving medical services reimbursed by the CSHCN program and reflects the program's ability to meet some of the needs of clients.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EX	
Measure No.	1	Number of Clients Removed from Waiting List and Provided Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-04 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reports the number of clients removed from the Children with Special Health Care Needs (CSHCN) waiting list and made eligible to receive services in accordance with CSHCN Rules §38.16 AND who had health care benefits claims for a paid dollar amount for dates of service during the fiscal year being reported. Health care benefits as defined in rule include medical services, enabling services, and family supports services.

BL 2010 Data Limitations

The paid claims data is reported based on date of service. Providers have 90 days to file claims from the date of service and 180 days to submit appeals. Therefore, payment data for a given period may change through time. Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the data available.

BL 2010 Data Source

The number of clients removed from the waiting list who receive health benefits services is obtained from the CSHCN Management Information System (CMIS). Other report/automated systems may replace the current report/system. The data from these new reports/systems may be combined with current report/system and/or replace the data from the current report/system. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

The measure is calculated by identifying the clients who have been removed from the waiting list, based on the definition above, and by summing the number of those who have paid claims for medical, enabling, or family supports services.

BL 2010 Purpose

This measure is used to monitor the number of clients removed from the waiting list who receive health care benefits reimbursed by the CSHCN program

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EX	
Measure No.	2	Percentage of CSHCN Clients in Medicaid

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 01-03-04 EX 02

Fall/Annual: N

BL 2010 Definition

The measure represents the percentage of clients served in the Children with Special Health Care Needs (CSHCN) Services Program who are also enrolled in the Medicaid Program.

BL 2010 Data Limitations

The measure reflects the eligibility for benefits at the point in time that the data is gathered. Client eligibility information changes daily due to ongoing renewals and new applicants. Changes in income or other resources may affect program eligibility of individual clients. The percentage includes clients with Medicaid and any other health insurance. The rules for the CSHCN Services Program define eligible clients as those who meet all eligibility criteria for the program including those on the waiting list for health care benefits. Clients on the CSHCN waiting list may receive case management services.

BL 2010 Data Source

The data is gathered from the CSHCN Management Information System, which maintains data submitted by the applicants for the program and data that is imported from the Medicaid and Children's Health Insurance Program (CHIP).

BL 2010 Methodology

The Numerator is the number of CSHCN eligible clients with Medicaid and the denominator is the total number of CSHCN eligible clients.

BL 2010 Purpose

To identify the percentage of clients eligible for the CSHCN Services Program who have applied for and have been determined eligible for the Medicaid

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EX	
Measure No.	3	Percentage of CSHCN Clients in the Children's Health Insurance Program

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 01-03-04 EX 03

Fall/Annual: N

BL 2010 Definition

The measure represents the percentage of clients served in the Children with Special Health Care Needs (CSHCN) Services Program who are also enrolled in the Children's Health Insurance Program (CHIP).

BL 2010 Data Limitations

The measure reflects the eligibility for benefits at the point in time that the data is gathered. Client eligibility information changes daily due to ongoing renewals and new applicants. Changes in income or other resources may affect program eligibility of individual clients. The rules for the CSHCN Services Program define eligible clients as those who meet all eligibility criteria for the program including those on the waiting list for health care benefits. Clients on the CSHCN waiting list may receive case management services.

BL 2010 Data Source

The data is gathered from the CSHCN Management Information System, which maintains data submitted by the applicants for the program and data that is imported from the Medicaid and CHIP.

BL 2010 Methodology

The Numerator is the number of CSHCN eligible clients with CHIP and the denominator is the total number of CSHCN eligible clients.

BL 2010 Purpose

Purpose: To identify the percentage of clients eligible for the CSHCN Services Program who are enrolled in CHIP.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EX	
Measure No.	4	Percentage of CSHCN Clients with Private Insurance

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 01-03-04 EX 04

Fall/Annual: N

BL 2010 Definition

The measure represents the percentage of clients served in the Children with Special Health Care Needs (CSHCN) Services Program who have private

BL 2010 Data Limitations

The measure reflects the private insurance information reported on the application for CSHCN Services at the time of application or renewal. Private insurance information and client eligibility change daily due to ongoing renewals and new applicants. Changes in employment may affect eligibility for coverage of individual clients. The rules for the CSHCN Services Program define eligible clients as those who meet all eligibility criteria for the program including those on the waiting list for health care benefits. Clients on the CSHCN waiting list may receive case management services.

BL 2010 Data Source

The data is gathered from the CSHCN Management Information System, which maintains data submitted by the applicants for the program and data that is imported from the Medicaid and Children's Health Insurance Program (CHIP).

BL 2010 Methodology

The Numerator is the number of CSHCN eligible clients with comprehensive private insurance and the denominator is the total number of CSHCN eligible

BL 2010 Purpose

To identify the percentage of clients eligible for the CSHCN Services Program who have private insurance.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EX	
Measure No.	5	CSHCN Clients Provided Medical Services at End of Year

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

Fall/Annual: N

BL 2010 Definition

This measure reports the number of clients who, based upon claims data, received one or more medical services under comprehensive health care benefits, excluding transportation services, for the Children with Special Health Care Needs (CSHCN) Services Program during the last month of the fiscal year being

BL 2010 Data Limitations

Because claims may be submitted for payment up to 95 days past the date of service, the number of clients served derived from claims data cannot be considered complete for approximately 120 days from the end date of the service month. Therefore, the number of clients ultimately served must be estimated for months that have not past the 120 days for completion based on actual number of clients served for completed months plus any programmatic impacts, such as, removals from the waiting list to begin receiving health care benefits and attrition.

BL 2010 Data Source

The number of clients receiving one or more medical services during the last month of the fiscal year is obtained from a query of claims data from multiple sources, to include the claims benefit administrator, the Vendor Drug Program (Health and Human Services Commission) and the CSHCN Information

BL 2010 Methodology

This is a simple unduplicated count of persons who received one or more medical services under comprehensive health care benefits, excluding transportation services, for the Children with Special Health Care Needs (CSHCN) Services Program during the last month of the fiscal year being reported.

BL 2010 Purpose

Due to the high demand for these services, as indicated by the number of persons on the CSHCN waiting list who are eligible for services, it is critical for the department to monitor how many persons are receiving the service annually/at the end of the year in order to determine the service level that will be carried into the next fiscal year and/or biennium.

BL 2011 Data Limitations

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	EX	
Measure No.	6	CSHCN Clients Provided Case Management Services at End of Year

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

Fall/Annual: N

BL 2010 Definition

This measure reports the number of clients who, based upon contractor and regional data system estimates, received case management services for the Children with Special Health Care Needs (CSHCN) Services Program during the last month of the fiscal year being reported.

BL 2010 Data Limitations

A move to an automated data system may occur in the future, potentially impacting projections prepared for FY 09-11.

BL 2010 Data Source

The number of clients receiving case management services during the last month of the fiscal year is obtained from a compilation of the number provided by case management contractor reports and the regional data system.

BL 2010 Methodology

This is a simple unduplicated count of persons who received case management services for the Children with Special Health Care Needs (CSHCN) Services Program during the last month of the fiscal year being reported.

BL 2010 Purpose

Due to the high demand for these services, as indicated by the number of persons on the CSHCN waiting list who are eligible for services, it is critical for the department to monitor how many persons are receiving the service annually/at the end of the year in order to determine the service level that will be carried into the next fiscal year and/or biennium.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	OP	
Measure No.	1	# of CSHCN Clients Receiving Case Management

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-04 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of clients with special health care needs who receive case management. Case management provides a comprehensive service to assist clients and their families in gaining access to needed resources, including intake, assessment, coordination, advocacy and follow-up. Dually-eligible, Medicaid and CSHCN clients served are not reflected in this measure. For purposes of this performance measure, "CSHCN clients" are children (or adults with Cystic Fibrosis) with special health care needs who receive case management but are not necessarily enrolled in the CSHCN program. A client is considered as receiving case management services when a case manager has been assigned to the client and his or her family, and services has been provided services.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the data available.

BL 2010 Data Source

The number of clients receiving case management services is derived from the quarterly regional reports provided to the Texas Department of State Health Services (DSHS) central office by the Children With Special Health Care Needs (CSHCN) regional program directors and quarterly reports provided by agencies or entities contracted to provide case management.

BL 2010 Methodology

The number of clients with a case manager reported by the regional offices plus the number of clients served by contractors is summed to obtain the number of clients with special health care needs receiving case management services.

BL 2010 Purpose

This measure reports the number of clients with special health care needs who receives assistance to; gain access to necessary medical, social, educational and other services to reduce morbidity and mortality in clients; encourage cost-effective health and health related care; make referrals to appropriate providers and community resources; and discourage over utilization and duplication of services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	4	Children with Special Health Care Needs
Measure Type	OP	
Measure No.	2	Number of CSHCN Clients Receiving Medical Services

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-04 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of clients enrolled in the Children with Special Health Care Needs (CSHCN) program who receive medical services paid by the program. For purposes of this measure, "medical services" include hospital (inpatient and outpatient) and physician services; all drugs and supplies; durable medical supplies and home health services.

BL 2010 Data Limitations

The number of clients with paid claims is reported based on the date of service. Providers have 90 days to file claims from the date of service and 180 days to submit appeals.Therefore, payment data for a given period may change through time. This measure may be affected by factors such as the number of individuals enrolled in the program, the clients' needs, and the availability of other healthcare resources. Due to the format of the data source report, the number of clients used for this measure may be duplicated.Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the data available.

BL 2010 Data Source

The number of clients receiving services is obtained from the monthly Medicaid and Other Reporting Requirement Legislative Rider report, which includes client data from the CSHCN database. Other reports/automated systems may replace the current report/system. The data from these new reports/systems may be combined with current report/system and/or replace the data from the current report/system. Specific data source used will be noted in supporting

BL 2010 Methodology

This measure is calculated by summing the number of clients with paid claims for medical services. Estimates may be used for quarters in which claims data is incomplete.

BL 2010 Purpose

This measure is used to monitor the number of eligible clients receiving medical services reimbursed by the CSHCN program and reflects the program's ability to meet some of the needs of clients.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	5	Epilepsy Hemophilia Services
Measure Type	EX	
Measure No.	1	Number of Epilepsy Program Clients Provided Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-05 EX 01

Fall/Annual: N

BL 2010 Definition

Number of epilepsy program clients provided outreach activities, case management, and (direct) medical services by DSHS funded contractors.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Information is obtained from the Epilepsy Contractor Quarterly Reports.

BL 2010 Methodology

The number of persons receiving epilepsy services through funded programs is derived from a quarterly tabulation based on information obtained from the Epilepsy Contractor Quarterly Reports.

BL 2010 Purpose

Measures the number of epilepsy program clients provided services which include outreach activities, case management, and (direct) medical services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	3	Health Promotion, Chronic Disease Prevention, and Specialty Care
Strategy No.	5	Epilepsy Hemophilia Services
Measure Type	EX	
Measure No.	2	Number of Hemophilia Assistance Program Recipients

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-03-05 EX 02

Fall/Annual: N

BL 2010 Definition

Number of hemophilia assistance program recipients that receive financial assistance for blood factor products through DSHS approved providers.

BL 2010 Data Limitations

None.

BL 2010 Data Source

HAP (Hemophilia Assistance Program)history files.

BL 2010 Methodology

The measure is the total number of unduplicated recipients for whom the Hemophilia Assistance Program (HAP) made payment for services received during the fiscal year.

BL 2010 Purpose

Measures the number of hemophilia assistance program recipients that receive financial assistance for blood factor products through DSHS approved providers

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	4	Laboratory Operations
Strategy No.	1	Laboratory Services
Measure Type	EF	
Measure No.	1	Average Cost Per Laboratory Test Performed

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 01-04-01 EF 01

Fall/Annual: N

BL 2010 Definition

The average cost per test performed by the DSHS laboratory.

BL 2010 Data Limitations

The cost per test performed will be an average cost, with some tests costing less than $5.00 per test to perform, while others cost in excess of $100.00 to

BL 2010 Data Source

The data for this measure is obtained from two sources: 1)annual budget expenditures for Laboratories as reported by Financial Services and 2)the total tests

BL 2010 Methodology

Total laboratory expenditures divided by the total tests performed.

BL 2010 Purpose

To provide an indicator of the cost for producing laboratory test results.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	1	Preparedness and Prevention Services
Objective No.	4	Laboratory Operations
Strategy No.	1	Laboratory Services
Measure Type	OP	
Measure No.	1	Number of Laboratory Tests Performed

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 01-04-01 OP

Fall/Annual: N

BL 2010 Definition

The number of laboratory tests performed represents the number of specimens submitted to the laboratory multiplied by the number of tests performed on each specimen. The number of tests is defined by the actual tests requested by the individual or organization submitting the specimen.

BL 2010 Data Limitations

This measure will report only the total volume of tests performed by the laboratory and will not account for differences in the amount of work needed for various

BL 2010 Data Source

Summary reports from the laboratory information management systems.

BL 2010 Methodology

Count of number of individual tests performed on specimens submitted to the laboratory.

BL 2010 Purpose

To provide an indicator of the volume of testing performed by the Laboratory Services Section of DSHS.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	1	Provide WIC Services: Benefits, Nutrition Education & Counseling
Measure Type	EF	
Measure No.	1	Average Food Costs Per Person Receiving Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

The average food cost per person is the average cost of supplemental allowable foods purchased as part of the services to eligible WIC program participants. A low average food cost per participant enables the WIC Program to serve a greater percent of the potentially eligible population. Please refer to the see "Number of WIC participants provided food supplements" for the definition of participation.

BL 2010 Data Limitations

Estimates may be used at reporting deadline.

BL 2010 Data Source

Actual food costs are obtained from the DSHS automated accounting records, which aggregate payments made to vendors with food funds. Rebates are calculated within the WIC Information network (WIN) automated system using the effective contract rebate rates as specified in the respective contracts. In the future, another automated system may replace the current WIN automated system. The data from that new system may be combined with the current WIN automated system and/or replace the data from the current WIN automated system.

BL 2010 Methodology

Food costs are reported by issue/benefit month. Rebates, which are netted against total food costs, are calculated using rebates received for items purchased with food funds for that issue/benefit month. To calculate the post-rebate average cost per participant, the total food cost for the reporting period less the total rebate dollars for the reporting period is divided by the total number of participants served during the reporting period. This calculation is based on a federal

BL 2010 Purpose

Measures the average food costs per person receiving services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	1	Provide WIC Services: Benefits, Nutrition Education & Counseling
Measure Type	EX	
Measure No.	1	Incidence (Percent) of Low Birth Weight Babies Born to WIC Mothers

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-01 EX 01

Fall/Annual: N

BL 2010 Definition

This explanatory measure reflects the percentage of low birth weight babies born to WIC mothers. A low birth weight (LBW) infant is defined as an infant who weighs 5 1/2 lbs. or less at birth.

BL 2010 Data Limitations

Estimates may be used at reporting time. Nutrition risk codes are queried to calculate this measure, not actual birth weight of infant. These risk codes are not "required fields" in the automated system.

BL 2010 Data Source

Local WIC clinics transmit data into the WIC Information Network (WIN) automated system to the central WIC office at DSHS. In the future, another automated system may replace the current WIN automated system. The data from that new system may be combined with the current WIN automated system and/or replace the data from the current WIN automated system.

BL 2010 Methodology

To determine the percent of LBW infants born to WIC mothers, the total number of LBW infants born to WIC mothers during the reporting period is divided by the total number of all infants born to WIC mothers during the reporting period. This calculation is based on a federal fiscal year.

BL 2010 Purpose

Measures the incidence (percent) of low birth weight babies born to women, infants and children (WIC) program mothers.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	1	Provide WIC Services: Benefits, Nutrition Education & Counseling
Measure Type	OP	
Measure No.	1	Number of WIC Participants Provided Nutrition Education & Counseling

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

The total number of times WIC participants receive either group nutrition education or individual nutrition counseling during the reporting period. WIC participants are typically seen at the WIC clinic every 2 to 3 months and are offered group education or individual counseling during each of these visits. This is a duplicative count because participants may receive between 4 and 6 educational contacts per year.

BL 2010 Data Limitations

Estimates may be used at reporting deadlines.

BL 2010 Data Source

The WIC Information Network (WIN) automated data system is the data source. Local WIC agencies document nutrition education and counseling contacts on the system at the clinic level and transmit this data to the central WIC office at DSHS. In the future, another automated system may replace the current WIN automated system. The data from that new system may be combined with the current WIN automated system and/or replace the data from the current WIN

BL 2010 Methodology

The WIN system is queried at the central WIC office to derive this total for the reporting period. In the future, another automated system may replace the current WIN automated system. The data from that new system may be combined with the current WIN automated system and/or replace the data from the current WIN automated system.This calculation is based on a federal fiscal year.

BL 2010 Purpose

Measures the total number of times WIC participants receive either group nutrition education or individual nutrition counseling during the reporting period.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	1	Provide WIC Services: Benefits, Nutrition Education & Counseling
Measure Type	OP	
Measure No.	2	Percent of WIC Clients Participating in Electronic Benefits Transfer

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

To determine the percentage of WIC clients EBT participation to total WIC client participation.

BL 2010 Data Limitations

Preliminary participation counts and/or estimates for monthly participation may be used at reporting deadline.

BL 2010 Data Source

Participation counts are collected through the WIC Information Network (WIN) automated system.

BL 2010 Methodology

The most recent available monthly participation count at the time the report for the year-to-date performance. Sum of EBT Participants divided by Total WIC Participants served for the reporting period. [(EBT Participants) / (Total Participants)] x 100.

BL 2010 Purpose

This output measures actual statewide EBT participation determined by the number of WIC clients provided with food benefits loaded onto WIC EBT smart cards to the total number of WIC clients served for the reporting period.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	1	Provide WIC Services: Benefits, Nutrition Education & Counseling
Measure Type	OP	
Measure No.	3	Number of WIC Participants Provided Nutritious Food Supplements

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-01 OP

Fall/Annual: N

BL 2010 Definition

This output measures actual state-wide monthly participation determined by the number of WIC clients provided with food supplements for a particular month. The United States Department of Agriculture (USDA) and DSHS define WIC client participation as: the sum of the number of persons who have received supplemental foods or food instruments plus the number of totally breastfed infants (i.e., receiving no supplemental foods or food instruments) whose mothers were WIC participants and received food benefits during the reporting period.

BL 2010 Data Limitations

Preliminary participation counts and/or estimates for monthly participation may be used at reporting deadline.

BL 2010 Data Source

Participation counts are collected through the WIC Information Network (WIN) automated system. In the future, another automated system may replace the current WIN automated system. The data from that new system may be combined with the current WIN automated system and/or replace the data from the current WIN automated system.

BL 2010 Methodology

The most recent available monthly participation count at the time the report is due will be reported for both the quarterly and year-to-date performance. This calculation is based on a federal fiscal year.

BL 2010 Purpose

This output measures actual state-wide monthly participation determined by the number of WIC clients provided with food supplements for a particular month.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	2	Women and Children's Health Services
Measure Type	OP	
Measure No.	1	Number of Newborns Receiving Hearing Screens (All Funding Sources)

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of newborns receiving a newborn hearing screen (NBHS), as mandated under Section 1, Subtitle B, Title 2, Health and Safety Code, Chapter 47, at a fully certified NBHS birthing facility.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Birthing facilities licensed under Chapters 241 or 244, H&SC, that are located in counties with populations under 50,000 are exempt under the law but may elect to participate in the NBHS program. Exempt facilities electing to participate must also report. The volume of screens performed by exempt facilities may

BL 2010 Data Source

The data source is the DSHS Newborn Hearing Screening System (NBHSS) provided by the contractor. Certified birth facilities have licenses to utilize the NBHSS web-based system to report Newborn Hearing data as rrequired. Reports generated by NBHSS are used to report the data in thes measure.

BL 2010 Methodology

Newborns receiving a newborn hearing screen from a birth facility certified by DSHS will be counted. Certified birth facilities electronically data enter newborn hearing screen information as soon as testing occurs using the NBHSS.

BL 2010 Purpose

To report the number of newborns receiving a newborn hearing screen (NBHS), as mandated under Section 1, Subtitle B, Title 2, Health and Safety Code, Chapter 47, at a fully certified NBHS birthing facility.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	2	Women and Children's Health Services
Measure Type	OP	
Measure No.	2	Number of Infants <1 and Children Age 1-21 Years Provided Services

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of infants <1 and children (ages 1 through 21) receiving prenatal, dysplasia, genetics, newborn hearing and metabolic screenings, vision and hearing screening among school children, spinal screening, dental and child health services through regional clinics and contracting agencies funded with Title V and/or related general revenue.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available. Estimates are updated in the subsequent reporting periods.

BL 2010 Data Source

TWICES (Texas Wide Client Encounter System), SDI (Service Delivery Integration), Newborn Screening, Vision and Hearing Screening, Spinal Screening, School-based Clinics, Birth Defects and Genetics systems and the Title V System report for the contracting agencies. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

Reported data is calculated by adding the number of clients reported on the TWICES (Texas Wide Integrated Client Encounter System) reporting system for regional clinics, SDI (Service Delivery Integration), Newborn Hearing, Vision and Hearing Screening, Spinal Screening, School-based clinics, Birth Defects and Genetics reporting systems and the Title V System reports for the contracting agencies.

BL 2010 Purpose

This measure reports the unduplicated number of infants <1 and children (ages 1 through 21) receiving prenatal, dysplasia, genetics, newborn hearing and metabolic screenings, vision and hearing screening among school children, spinal screening, dental and child health services through regional clinics and contracting agencies funded with Title V and/or related general revenue.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	2	Women and Children's Health Services
Measure Type	OP	
Measure No.	3	Number of Women Over 21 Provided Title V Services

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the unduplicated number of women over 21 receiving prenatal, dysplasia, and genetics, and laboratory services through regional clinics and contracting agencies funded with Title V and/or related general revenue.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available. Estimates are updated in the subsequent reporting periods.

BL 2010 Data Source

TWICES (Texas Wide Integrated Client Encounter System), SDI (Service Delivery Integration), Genetics reporting system, and the Title V System reports for the contracting agencies. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

Reported data is calculated by adding the number of clients reported on the TWICES (Texas Wide Integrated Client Encounter System) reporting system for regional clinics, SDI (Service Delivery Integration), Genetics reporting system, and the Title V System reports for the contracting agencies.

BL 2010 Purpose

This measure reports the unduplicated number of women aged 21 and over receiving prenatal, dysplasia, and genetics,and laboratory services through regional clinics and contracting agencies funded with Title V and/or related general revenue.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	2	Women and Children's Health Services
Measure Type	OP	
Measure No.	4	Number of Children Receiving Preventive Dental Services

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-02 OP

Fall/Annual: N

BL 2010 Definition

This is an unduplicated count of children who receive preventive dental services (topical fluoride application and/or dental pit and fissure sealants) provided by the Oral Health Services Program in accordance with Chapter 43 of the Health and Safety Code

BL 2010 Data Limitations

None

BL 2010 Data Source

Patient treatment information is reported by regional dental teams through collaborative projects with community-based organizations, school districts, day cares, Head Starts, faith-based organizations, and local professionals.

BL 2010 Methodology

This is an unduplicated count of children who receive preventive dental services (topical fluoride application and/or dental pit and fissure sealants) provided by the Oral Health Services Program in accordance with Chapter 43 of the Health and Safety Code.

BL 2010 Purpose

To more clearly articulate all oral health preventive services provided under this strategy.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	3	Family Planning Services
Measure Type	EF	
Measure No.	1	Average Annual Cost Per Family Planning Client

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost of providing family planning services to eligible clients with funds from Texas Titles V, X, and XX.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Data sources are Compass 21 data and billing system. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Estimates are updated in subsequent reporting periods. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

The average annual cost is total funds expended for family planning claims (Titles V, X, and XX) divided by the unduplicated number of clients receiving family planning services from contracting and/or enrolled entities.

BL 2010 Purpose

This measure reports the average cost of providing family planning services for eligible clients with funds from Titles V, X, and XX.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	3	Family Planning Services
Measure Type	OP	
Measure No.	1	Number of Adults & Adolescents Receiving Family Planning Services

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-03 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the number of persons receiving a family planning services by any contracting and/or enrolled entity funded through Titles V, X, and XX Family Planning Program.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the available data. Estimates are updated in subsequent reporting periods.

BL 2010 Data Source

Compass 21 data and billing system. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

BL 2010 Methodology

The total number of persons receiving a family planning services will be the unduplicated count of individuals whose claims were paid for with Family Planning funds from Titles V, X, and XX.

BL 2010 Purpose

This measure reports the number of persons receiving a family planning service by any contracting and/or enrolled entity funded through Titles V, X, and XX Family Planning Program.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	4	Community Primary Care Services
Measure Type	EF	
Measure No.	1	Average Cost Per Primary Health Care Eligible Patient

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-01-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average cost per Primary Health Care (PHC) eligible patient provided access to primary care services. The cost includes service and administrative dollars spent by PHC contractors.

BL 2010 Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available. Estimates are updated in the subsequent reporting periods.

BL 2010 Data Source

The source of this measure is the contractor quarterly and annual reports.

BL 2010 Methodology

Average cost per Primary Health Care eligible patient provided access to primary care services per year is calculated by dividing the unduplicated number of patients who are screened and found eligible for PHC services into the available contract funding for the fiscal year.

BL 2010 Purpose

Measures average cost per Primary Health Care eligible patients provided access to primary care services per year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	1	Provide Primary Care and Nutrition Services
Strategy No.	4	Community Primary Care Services
Measure Type	OP	
Measure No.	1	# of Primary Hlth Care Eligible Patients Provided Primary Care Svcs

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-01-04 OP

Fall/Annual: N

BL 2010 Definition

This measure is the unduplicated number of Primary Health Care (PHC) clients provided primary care services.

BL 2010 Data Limitations

Complete data may not available for the reporting period at the time the report is due; therefore, projections may be included based on the data available. Estimates are updated in the subsequent reporting periods.

BL 2010 Data Source

The source of this measure is the contractor quarterly and annual reports.

BL 2010 Methodology

This is the unduplicated number of Primary Health Care clients receiving services as reported by (PHC) contractors.

BL 2010 Purpose

Measures the number of Primary Health Care Program clients provided primary health care services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Adult: Community Mental Health Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs the state each month, on average, to provide community mental health services to each adult consumer who is assigned to any of the Resiliency & Disease Management service packages (levels of care 1-4). It measures the DSHS appropriation authority cost per consumer per service package as defined by the companion output measure.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

DSHS appropriation authority funds include all general revenue and federal funds allocated through the performance contract. Also included are administrative claiming funds that the local authority receives following the submission of quarterly cost reports and Medicaid Service Coordination and Rehabilitation funds that the local authorities receive based on the submission of claims. The number of months in the reporting period are 3 for each quarter and either 3, 6, 9, or 12 for year to date.

The numerator is the total DSHS appropriation authority funds utilized to fund adult MH community services as reported in the data warehouse / the number of months in the reporting period.

The denominator is the average monthly number of adults receiving mental health community services that are served with DSHS appropriation authority funds.

The formula is numerator/denominator.

BL 2010 Purpose

This measure captures DSHS appropriation authority cost per person for adult community mental health services provided through the Resiliency & Disease Management service packages (levels of care 1-4).

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	EF	
Measure No.	2	Average Monthly Cost Per Person: Front Door Crisis Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-01 EF 02

Fall/Annual: N

BL 2010 Definition

This measure reports the actual average cost per person (regardless of age) provided community mental health crisis services when that person does not currently receive mental health services from the local authority (a consumer who is assigned to the Resiliency & Disease Management level of care “0”). Individuals who receive front-door community mental health crisis services may or may not be priority population.

BL 2010 Data Limitations

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

BL 2010 Data Source

At the end of each quarter, staff of the local authorities input expenditure information into the data warehouse system. The local authority indicates the fund sources used to finance the expenditures. The method of finance includes funds that are part of the DSHS appropriation authority as well as local funds, grant funds and earned revenues. Persons who present for community mental health services are assessed and may be determined in need of crisis services. The results of this assessment (level of care “0”) are located on the Uniform Assessment for Resiliency & Disease Management and are entered into the department's data warehouse by staff at the local authority.

BL 2010 Methodology

DSHS appropriation authority funds include all general revenue and federal funds allocated through the performance contract. Other funding sources for the local authorities are grant funds, local funds and earned revenues. The number of months in the reporting period are 3 for each quarter and either 3, 6, 9, or 12 for year to date.

The numerator is the total funds utilized to fund front-door crisis services as reported in the data warehouse system/the number of months in the reporting period.

The denominator is the average monthly number of persons (regardless of age) receiving front-door crisis services as determined by an adult or children and

BL 2010 Purpose

: Providing mental health crisis services in the community is an important function of the local authorities. Appropriate interventions for persons in mental health crisis offer an alternative to more costly sources of intervention, such as county jails. Persons who receive front-door community mental health crisis services are assisted in locating viable resources in their respective communities to access those services appropriately addressing their identified needs. Persons may choose to access other community mental health services after their crisis has abated, choose other community options for treatment, or refuse further services. This measure will provide information on the average monthly cost per person accessing front-door community mental health crisis services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	EF	
Measure No.	3	Average Monthly Cost Per Person: New Gen Meds

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-01 EF 03

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs the state each month, on average, to provide New Generation Medications services to each adult and child mental health consumer who is assigned to this service. It measures the DSHS appropriation authority cost per consumer as defined by the

BL 2010 Data Limitations

Due to the 30-45 day lag in reporting the expenditure and number of consumers served data in the data warehouse, each current quarter reported in ABEST will be equal to the prior quarter's actual updated value, and then updated the following quarter to reflect the actual average cost per consumer for that quarter.

BL 2010 Data Source

This measure is derived from expenditures and number of consumers served. The number of consumers, both children and adults, that receive a New Generation Medication (NGM) where the funding source was DSHS state funds allocated for NGM is reported monthly from the data warehouse. Expenditures (includes both children and adults) for NGM where the funding source was DSHS state funds allocated for NGM are reported quarterly from the data warehouse. Due to timing requirements at the local level to gather the information and input it into the data warehouse, monthly and quarterly NGM data in the data warehouse is considered final 30-45 days after the month or quarter ends.

BL 2010 Methodology

The quarterly expenditures are divided by the number of months in the reporting period to get the average monthly expenditures for the reporting period. The number of consumers served for each month in the reporting period is averaged to get the average monthly number of consumers served for the reporting period. The average monthly expenditures are divided by the average monthly number of consumers served to get the average monthly cost of NGM per

BL 2010 Purpose

This measure captures DSHS appropriation authority cost per person for New Generation Medications provided to mental health community consumers regardless of age.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	EX	
Measure No.	1	Number of Adults Receiving Community Mental Health Services Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 02-02-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority population eligible adults who receive mental health community services through one of the four service packages (levels of care 1-4) in Resiliency & Disease Management during one fiscal year. Mental health community services include a wide range of activities that are provided in the communities where the consumers live. The specific services include, but are not limited to, assessment and/or service coordination, psychiatric rehabilitation services (assertive community treatment, supported housing, supported employment), counseling services and medication services.

BL 2010 Data Limitations

Data collection will depend on the completion of the Uniform Assessment as prescribed.

BL 2010 Data Source

Every adult mental health consumer receives a Uniform Assessment for Resiliency & Disease Management upon admission to the local authority and two to four times per year thereafter. The assessment includes the Adult-TRAG level of care and the authorized level of care. Local authority staff enters this information into the CARE database system. Consumers are only counted once for this measure.

BL 2010 Methodology

The total unduplicated number of priority population adults that receive a service package under Resiliency & Disease Management for mental health community services during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

BL 2010 Purpose

This measure provides the actual number of adults who receive community services through Resiliency & Disease Management service packages (levels of care 1-4 during one fiscal year. It is a number used to compare system activity over a period of two or more fiscal years.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	EX	
Measure No.	2	Number of Persons Receiving Front Door MH Crisis Services Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-01 EX 02

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority and non-priority population eligible persons (regardless of age) not receiving ongoing community mental health services who receive front-door crisis services during one fiscal year (a consumer who is assigned to the Resiliency & Disease Management level of care “0”). Community mental health services include a wide range of activities that are provided in the communities where the consumers live. Crisis services are one of those required activities.

BL 2010 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the data warehouse by the local mental health authorities.

BL 2010 Data Source

Through an individual's initial Uniform Assessment for R&DM, the need for crisis services (emergent or urgent mental health community services)is determined. That individual will immediately receive crisis intervention and/or monitoring (observation) of the person until the crisis is resolved or the consumer is placed in a clinically appropriate environment, receiving a LOC"0". This information is entered into the data warehouse by local mental health authority staff. Production reports of consumers served are issued quarterly based on the information in the data warehouse. The total number of persons assigned to receive this service each quarter represents the unduplicated Number of Persons Receiving Front Door MH Crisis Services year-to date.

BL 2010 Methodology

A mental health diagnosis is not required for crisis services. Therefore, the people who receive front-door crisis services may or may not be members of the priority population for mental health community services. Persons who are currently receiving community mental health services through Resiliency & Disease Management may receive services through a variety of service packages (levels of care 1-4). These service packages all offer crisis intervention as needed. These persons are not included in this measure.
The total unduplicated number of persons (regardless of age) during the fiscal year that receive a crisis service (level of care “0”), who are not receiving other community mental health services at the time of crisis, regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

BL 2010 Purpose

Providing mental health crisis services in the community is an important function of the local authorities. Persons who receive front-door community mental health crisis services are assisted in locating viable resources in their respective communities to access those services appropriately addressing their identified needs. Persons may choose to access community mental health services after their crisis has abated, choose other options for treatment, or refuse further services. This measure provides an unduplicated count of the number of individuals receiving no other community mental health service who utilize front-door crisis services in the community over a fiscal year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	EX	
Measure No.	3	Number of Persons Receiving Community MH New Gen Meds Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-01 EX 03

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority population eligible adults and children who receive mental health New Generation Medication services during one fiscal year.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

The total unduplicated number of adults and children that receive a mental health New Generation Medication service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

BL 2010 Purpose

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

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	OP	
Measure No.	1	Average Monthly Number of Adults Receiving Community MH Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated count of priority population eligible adults whose services are funded with DSHS appropriation authority funds and who receive mental health community services through a service package (levels of care 1-4) as part of Resiliency & Disease Management. These services may be provided on a monthly or quarterly basis depending upon the service. The service packages include a wide range of activities that are provided in the communities where the consumers live. The specific services include, but are not limited to, assessment and/or service coordination, psychiatric rehabilitation services (assertive community treatment, supported housing, supported employment), counseling services and medication services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

BL 2010 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the data warehouse by the local mental health authorities.

BL 2010 Data Source

There are four levels of care a mental health consumer may be assigned. Each LOC has a designated service package that the MH consumer may receive. Persons receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs. There may be persons whose authorized level of care does not match the recommended level of care as determined by the Adult-TRAG. These exceptions are usually due to clinical judgement, resource limitations, continuity of care per UM guidelines and/or consumer choice.
The total unduplicated number of persons assigned to receive these MH community services each month is calculated. For each quarter of the fiscal year,the unduplicated number of persons served in each month of the quarter is averaged. The production report lists total number of adults assigned to a particular service each month regardless of funding source.

BL 2010 Methodology

To obtain the # of adults served with DSHS appropriation authority funds,the percentage of total expenditures that were funded through the department's appropriation authority is calculated.(See Method of Calculation for the companion efficiency measure for details of calculating DSHS authority funding.) This (%) is applied to the average monthly numbers served for the specified quarter and for YTD to yield the average monthly number served for the specified quarter with DSHS appropriation authority funds.
The numerator is the sum of the number of persons receiving any adult MH community service, as determined by a service package or LOC 1-4, each month of the reporting period *state funded percentage.The state funded percentage is the expenditures financed through the DSHS appropriation authority for any adult MH community service/Total expenditures for any adult MH community service *100.
The denominator is the number of months in the period.The formula is numerator/denominator.

BL 2010 Purpose

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

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	OP	
Measure No.	2	Average Monthly Number Persons Receiving Community MH Crisis Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority and non-priority population eligible persons (regardless of age) not receiving ongoing community mental health services who receive crisis services on a monthly basis (level of care “0”). Community mental health services include a wide range of activities that are provided in the communities where the consumers live. Crisis services are one of those required activities. Quarterly and year to date performance is stated as the average of the months in the reporting period.

BL 2010 Data Limitations

The accuracy of the department's client database is dependent upon accurate and timely information being entered into the data warehouse by the local mental health authorities.

BL 2010 Data Source

When an individual is determined through an initial Uniform Assessment for Resiliency & Disease Management to be in need of crisis services (emergent or urgent mental health community services), as designated by a level of care “0”, that individual will immediately receive crisis intervention and/or monitoring (observation) of the person until the crisis is resolved or the consumer is placed in a clinically appropriate environment. This information is entered into the data warehouse by staff of the local mental health authority. Production reports of consumers served are issued quarterly based on the information in the data warehouse. The production report lists total number of persons assigned to a particular service each month regardless of how the services for the individuals were funded.

BL 2010 Methodology

A mental health diagnosis is not required for crisis services. Therefore, the people who receive crisis services may or may not be members of the priority population for mental health community services. Persons who are currently receiving community mental health services through Resiliency & Disease Management may receive services through a variety of service packages (1-4). These service packages all offer crisis intervention as needed. These persons are not included in this measure. Persons may access front-door community mental health crisis services more than once over a quarter or fiscal year. These persons will be included in the count each time they receive a level of care “0” through a Uniform Assessment.
The total number of persons (regardless of age) assigned a level of care “0” each month is calculated. A persons may be counted more than once each period. For each quarter of the fiscal year, the number of persons served in each month of the quarter is averaged.

BL 2010 Purpose

Providing mental health crisis services in the community is an important function of the local authorities. Persons who receive front-door community mental health crisis services are assisted in locating viable resources in their respective communities to access those services appropriately addressing their identified needs. Persons may choose to access community mental health services after their crisis has abated, choose other options for treatment, or refuse further services. This measure provides a count of the average monthly number of individuals receiving front-door crisis services in the community reflecting system-wide activity over time and allows the agency to associate this activity with related costs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	1	Mental Health Services for Adults
Measure Type	OP	
Measure No.	3	Average Monthly Number Persons Receiving Community MH New Gen Meds

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-01 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with DSHS appropriation authority funds and who receive new generation medications on a monthly basis. Quarterly and year-to-date performance is stated as the average of the months in the

BL 2010 Data Limitations

Data must be current and accurate in the department's data warehouse as of the date reports are produced. Accurate data is available about 45 days after the end of the quarter due to reporting requirements at the local authorities. Therefore, the values reported in ABEST will be updated regularly and when the appropriation year closes.

BL 2010 Data Source

As persons enter the community programs, registration information is entered into the department's data warehouse by staff of the local mental health authority. For the new generation medications, the data warehouse tracks the type of medication and its start/end dates, the funding source for the medications and reasons for discontinuing the medications. To be counted as served in any month, the individual's clinical record must contain documentation of a prescription (including refill orders) for a new generation medication for each month of the period.

BL 2010 Methodology

The total number of persons that receive a new generation medication where the source of funding was DSHS authority funds each month is calculated by the department's financial division utilizing the data warehouse. For each quarter of the fiscal year, the number of persons served with DSHS authority funds in each month of the quarter is averaged. For the second, third and fourth quarters, year-to-date calculations are also obtained.
The numerator is the sum of the monthly unduplicated number of persons receiving new generation medications with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate use of the new drugs with related costs and outcomes. New generation medications provide consumers the opportunity to receive the newer, more effective medications for the treatment of mental illnesses including, but not limited to schizophrenia, bipolar disorders, and major depression. Among the most important developments in recent years is the availability of a "new generation" of medications for mental illnesses. For many people these medications are producing very positive outcomes.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	2	Mental Health Services for Children
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Child Receiving Community MH Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-02 EF 01

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs the state each month, on average, to provide community services to children and adolescents who are assigned to any of the Resiliency & Disease Management service packages (levels of care 1-4). It measures the DSHS appropriation authority cost per consumer per service package as defined by the companion output measure.

BL 2010 Data Limitations

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

BL 2010 Data Source

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

BL 2010 Methodology

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

BL 2010 Purpose

This measure captures DSHS appropriation authority cost per child receiving mental health services in the community provided through the Resiliency & Disease Management service packages (levels of care 1-4).

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	2	Mental Health Services for Children
Measure Type	EX	
Measure No.	1	Number of Children Receiving Community MH Services Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-02 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority population eligible children and adolescents receiving mental health community services through Resiliency & Disease Management (service packages or levels of care 1-4). Community services available to children include, but are not limited to, assessment and/or service coordination, counseling, medication services, day treatment services, family support services, and therapeutic foster care services, and other residential services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

BL 2010 Data Limitations

The accuracy of the department's data is dependent upon accurate and timely information being entered into data warehouse system by the local mental health authorities.

BL 2010 Data Source

There are four levels of care a mental health consumer may be assigned.Each level of care has a designated service package that the mental health consumer may receive. Persons achieve optimal benefit from those services appropriately addressing their identified needs. There may be children whose authorized level of care does not match the recommended level of care as determined by the CA-TRAG, however these exceptions are usually due to clinical judgement, resource limitations, continuity of care per UM guidelines and/or consumer choice.As persons enter community programs, registration information and assignment to a specific service package is entered into the department's data warehouse by local mental health authority staff. Production reports of consumers served are issued quarterly based on the information in the data warehouse system. If a child receives more than one community service during the year, the child is counted only once.

BL 2010 Methodology

The total unduplicated number of children and adolescents that receive a mental health community service package 1-4 (through Resiliency & Disease Management) during the fiscal year is tallied for each local authority and system-wide. The production report lists total number of different children served each month and unduplicated number served year-to-date.

BL 2010 Purpose

This measure provides the actual number of children and adolescents who receive services through Resiliency & Disease Management (service packages or levels of care 1-4) and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	2	Mental Health Services for Children
Measure Type	EX	
Measure No.	2	Children Served at End of Year

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

Fall/Annual: N

BL 2010 Definition

This measure reports the number of children who received one or more services under the Resiliency & Disease Management (RDM) service packages or are in a level of care 1.1-4 during the last month of the fiscal year being reported (i.e., August).

BL 2010 Data Limitations

Because it takes 37 days for data to be finalized within DSHS Mental Retardation and Behavioral Outpatient Warehouse (MBOW), the number of clients ultimately served may not be complete at the time of reporting.

BL 2010 Data Source

The number of clients receiving one or more RDM services during the last month of the fiscal year is obtained from DSHS MBOW.

BL 2010 Methodology

This is a simple unduplicated count of persons who received RDM services during the last month of the fiscal year being reported.

BL 2010 Purpose

Due to the high demand for these services, as indicated by the number of persons waiting for RDM services, it is critical for the department to monitor how many persons are receiving service in the month of August/at the end of the year in order to determine the service level that will be carried into the next fiscal year and/or biennium.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	2	Mental Health Services for Children
Measure Type	OP	
Measure No.	1	Average Monthly Number of Children Receiving Community MH Services

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-02 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated count of priority population eligible children (under age 18) whose services are funded with DSHS appropriation authority funds and who receive mental health community services through Resiliency & Disease Management (service packages or levels of care 1-4). on a monthly basis. The mental health services in the service packages may be provided on a monthly or quarterly basis depending upon the service. Community services available to children include, but are not limited to, assessment and/or service coordination, counseling, medication services, day treatment services, family support services, therapeutic foster care services, and other residential services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

BL 2010 Data Limitations

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

BL 2010 Data Source

When a child is assigned to a specific service package, this information is entered into the data warehouse. Production reports of children served regardless of funding are issued quarterly based on the information in the data warehouse. The total unduplicated # of children assigned to receive any MH community service each month is calculated. To obtain an unduplicated # of children, each child is counted only once each period regardless of the number of different community services to which assigned. For each quarter of the fiscal year, the unduplicated # of children served in each month of the quarter is averaged.

BL 2010 Methodology

To obtain the number of children served with DSHS appropriation authority funds, the percentage of total expenditures that were funded through the department's appropriation authority is calculated.(See Method of Calculation for the companion efficiency measure for details of calculating DSHS authority funding.) This (%) is applied to the average monthly # served for the specified quarter and for year to date to yield the average monthly number served for the specified quarter with DSHS appropriation authority funds.
The numerator is the sum of the # of children receiving community MH services through R&DM (service packages or levels of care 1-4) each month of the reporting period * state funded percentage. The state funded (%) is expenditures financed through the DSHS appropriation authority for children's community MH services / Total expenditures for children's community MH services *100.
The denominator is the number of months in the period.The formula is numerator/denominator.

BL 2010 Purpose

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

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	3	Community Mental Health Crisis Services
Measure Type	EF	
Measure No.	1	Avg GR Spent Per Person for Crisis Residential Services

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

Fall/Annual: N

BL 2010 Definition

This measure captures the average amount of General Revenue (GR) spent per person for a crisis residential service (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) and including competitive funding for crisis residential options from Community Mental Health Centers including NorthSTAR during the fiscal year.

BL 2010 Data Limitations

The accuracy of the Department's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Report III to DSHS by Community Mental Health Centers and Value Options.

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse.

BL 2010 Methodology

The numerator is the total GR expenditures for crisis residential services as in Report III submitted to DSHS by Community Mental Health Centers and Value Options.
The denominator is the unduplicated year-to-date number of persons who receive a crisis residential service funded by GR.

BL 2010 Purpose

Providing mental health crisis residential services as alternatives to service in more restrictive and less appropriate settings (e.g., ER, psychiatric hospital, jail) is an important function of Crisis Redesign. This measure provides the average amount of GR spent per person served in residential crisis services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	3	Community Mental Health Crisis Services
Measure Type	EF	
Measure No.	2	Avg GR Spent Per Person for Crisis Outpatient Services

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

Fall/Annual: N

BL 2010 Definition

This measure captures the average amount of General Revenue (GR) spent per person for a crisis outpatient service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year.

BL 2010 Data Limitations

The accuracy of the Department's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Report III to DSHS by Community Mental Health Centers and Value Options.

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse.

BL 2010 Methodology

The numerator is the total GR expenditures for crisis outpatient services as in Report III submitted to DSHS by Community Mental Health Centers and Value Options.
The denominator is the unduplicated year-to-date number of persons who receive a crisis outpatient service funded by GR.

BL 2010 Purpose

Providing mental health crisis outpatient services as alternatives to service in more restrictive and less appropriate settings (e.g., ER, psychiatric hospital, jail) is an important function of Crisis Redesign. This measure provides the average amount of GR spent per person served in outpatient crisis services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	3	Community Mental Health Crisis Services
Measure Type	OP	
Measure No.	1	# Persons Receiving Crisis Residential Services Per Year Funded by GR

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

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis residential service (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by General Revenue (GR).

BL 2010 Data Limitations

The accuracy of the Department's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of the Crisis Redesign Budget Category Survey to DSHS by Community Mental Health Centers and ValueOptions.

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse.

BL 2010 Methodology

The unduplicated number of persons who receive a residential crisis service from Community Mental Health Centers including NorthSTAR, where the source of funding was GR, is summed for the fiscal year.

BL 2010 Purpose

Providing mental health crisis residential services as alternatives to service in more restrictive and less appropriate settings (e.g., ER, psychiatric hospital, jail) is an important function of Crisis Redesign. This measure provides an unduplicated count of the number of individuals served in residential crisis services as less restrictive and more appropriate alternatives per year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	3	Community Mental Health Crisis Services
Measure Type	OP	
Measure No.	2	# Persons Receiving Crisis Outpatient Services Per Year Funded by GR

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

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis outpatient service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by General Revenue (GR).

BL 2010 Data Limitations

The accuracy of the Department's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Crisis Redesign Budget Category Survey to DSHS by Community Mental Health Centers and ValueOptions.

BL 2010 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse.

BL 2010 Methodology

The unduplicated number of persons who receive an outpatient crisis service from Community Mental Health Centers including NorthSTAR, where the source of funding was GR, is summed for the fiscal year.

BL 2010 Purpose

Providing mental health crisis outpatient services as alternatives to service in more restrictive and less appropriate settings (e.g., ER, psychiatric hospital, jail) is an important function of Crisis Redesign. This measure provides an unduplicated count of the number of individuals served in outpatient crisis services as less restrictive and more appropriate alternatives per year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	4	NorthSTAR Behavioral Health Waiver
Measure Type	EF	
Measure No.	1	Average Monthly Cost Per Person Served by NorthSTAR

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-04 EF 01

Fall/Annual: N

BL 2010 Definition

The average monthly cost for behavioral health (mental health and substance abuse) services per person served in the Dallas area under the NorthSTAR managed care program.

BL 2010 Data Limitations

The persons served count used in the calculation is extracted from the claims data submitted by the managed care organization, and therefore is a reflection of the quality of data submitted by them. Lags in claims submission by service providers could make the most recent reporting periods understated in numbers of persons served, and thus make the cost per person look larger than the final calculations. In addition, the payments are adjusted for seven months after the initial payment to reflect Medicaid eligibility retroactive adjustments, and will modify the performance reported in previous periods.

BL 2010 Data Source

The funding excludes the state hospital bed day allocation. The number of persons served is extracted from the NorthSTAR data warehouse as unduplicated count of claimants for each month.

BL 2010 Methodology

The calculation is ((Sum of Premiums paid for each month in the reporting period)/(Sum of unduplicated count of claimants for each month in the reporting period))/(number of months in the reporting period).

BL 2010 Purpose

This measure captures the average cost per person for behavioral health services in the NorthSTAR program regardless of age, and allows a mechanism for the managed care program to be compared to traditional methods of service delivery.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	4	NorthSTAR Behavioral Health Waiver
Measure Type	EX	
Measure No.	1	Average Monthly Number of Persons Covered by NorthSTAR

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-04 EX 01

Fall/Annual: N

BL 2010 Definition

This measure captures the unduplicated count of persons (adults and children) who are eligible for mental health and/or substance abuse services through the NorthSTAR Behavioral Health Services Waiver. This number is estimated based on poverty, population and eligibility criteria.

BL 2010 Data Limitations

This measure uses a combination of population and poverty estimates and actual Medicaid recipient numbers. It is only as accurate as the estimation.

BL 2010 Data Source

The number of covered lives in the seven county region served by NorthSTAR is based on Medicaid eligibility, population and poverty statistics. There are two basic eligibility groups (persons eligible for Medicaid and all other indigent persons). Persons eligible for Medicaid are divided into five smaller groups: SSI recipients under age 21, SSI recipients ages 21 - 64, SSI recipients age 65 and over, TANF and related groups under age 21, and TANF and related groups age 21 and over. The two indigent eligibility groups are: non-Medicaid children under age 21 and non-Medicaid persons age 21 and over below 200% of poverty. The data sources are the SAVERR data system or its successor for Medicaid eligibility, population statistics from the State Data Center, and poverty statistics from the HHSC.

BL 2010 Methodology

The number of covered lives for NorthSTAR is derived by first estimating the population numbers of children 0 through 20 years of age and of adults under 200% of poverty in the NorthSTAR region. Individuals under 200% of poverty is an estimate of the number of individuals who have no behavioral health insurance or who have exhausted their behavioral health insurance benefits. All persons eligible for Medicaid are included in the population counts for children and adults. To determine the number of covered lives, the total number of persons estimated from population projections is reduced by the number of persons who are eligible for Medicaid who are in nursing homes, ICF/MR residences, or a CPS Foster Care placement, those who are Medicaid eligible solely due to a temporary medical emergency and children enrolled in CHIP.

BL 2010 Purpose

Monthly number of covered lives reflects the highest level of activity that may occur and allows the agency to associate this activity with related costs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	4	NorthSTAR Behavioral Health Waiver
Measure Type	OP	
Measure No.	1	Number of Persons Served by NorthSTAR Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 537 080-R-S70-1 02-02-04 OP

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of persons receiving mental health or substance abuse community services through the NorthSTAR Behavioral Health Services Waiver regardless of age.

BL 2010 Data Limitations

While the majority of paid records are available within 30 days of service, some information lags up to 120 days. For reporting purposes, the lag for posting of paid bills is estimated and added to the most recent four months of information. The lag factors by month will updated at least quarterly until the are stable. Once the lag factors are stable (within 18 to 24 months), they will be updated annually. Values in ABEST will be updated the quarter following the initial entry to insure the most accurate data are available.

BL 2010 Data Source

Data are from encounter records in the NorthSTAR data warehouse. These data are collected on a paid basis. That is, for each service received by an individual, the provider submits a claim to the Behavioral Health Organization that authorized the service. The collection of data is based on payment of these claims. Claims information includes the client identifying information needed to count number of persons served.

BL 2010 Methodology

The total unduplicated number of persons that receive a behavioral health service through NorthSTAR program during the fiscal year is counted.

BL 2010 Purpose

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

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EF	
Measure No.	1	Average Mo Cost Per Adult for Substance Abuse Prevention Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EF 01

Fall/Annual: N

BL 2010 Definition

This measures the average cost per adult, age 18 or above, receiving authorized prevention services.

BL 2010 Data Limitations

Average cost of services is effected by quality and intensity of service. This measure only reflects DSHS funded cost. Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count of numbers

BL 2010 Data Source

Contractually-required prevention activities/services (key performance measures) are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Expenditures for direct services from providers, along with the DSHS non-service expenditures are maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

The sum of direct service expenditures and the DSHS non-service expenditures for the prevention programs reporting services by age category and serving adults, age 18 or above, divided by the total number of adults served. The the DSHS non-service expenditures are pro-rated based on the percent of total direct service expenditures attributed to youth and adults. Number served is the total number of adults, age 18 or above, receiving prevention services, as reported by providers in Performance Activity Reports. This includes all key performance measures related to information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Purpose

Intended to measure average cost to serve one client. Useful in determining efficiency over time.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EF	
Measure No.	2	Average Mo Cost Per Youth for Substance Abuse Prevention Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EF 02

Fall/Annual: N

BL 2010 Definition

This measures the average cost per youth, aged 17 or below, receiving authorized prevention services for substance abuse.

BL 2010 Data Limitations

Average cost of services is effected by quality and intensity of service. This measure only reflects DSHS funded cost. Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count of numbers

BL 2010 Data Source

Contractually-required prevention activities/services (key performance measures) are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Expenditures for direct services from providers, along with DSHS non-service expenditures are maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

The sum of direct service expenditures and DSHS non-service expenditures for the prevention programs for substance abuse reporting services by age category and serving youth, age 17 or below, divided by the total number of youth served. The DSHS non-service expenditures are pro-rated based on the percent of total direct service expenditures attributed to youth and adults. Number served is the total number of youth, age 17 or below, receiving prevention services, as reported by providers in Performance Activity Reports.This includes all key performance measures related to information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Purpose

Useful in determining efficiency over time

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EF	
Measure No.	3	Average Mo Cost Per Adult for Substance Abuse Intervention Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EF 03

Fall/Annual: N

BL 2010 Definition

This measures the average cost per adult, age 18 or above, receiving intervention services for substance abuse.

BL 2010 Data Limitations

Average cost of services is affected by quality and intensity of service. This measure only reflects DSHS -funded cost. Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count of numbers

BL 2010 Data Source

Contractually-required intervention activities/services (key performance measures) are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Expenditures for direct services from providers, along with DSHS non-service expenditures are maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

The sum of direct service expenditures and DSHS non-service expenditures for the intervention programs reporting services by age category and serving adults, age 18 or above, divided by the total number of adults served. The DSHS non-service expenditures are pro-rated based on the percent of total direct service expenditures attributed to youth and adults. Number served is the total number of adults, age 18 or above, receiving intervention services, as reported by providers in Performance Activity Reports. This includes all key performance measures related to information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Purpose

Useful in determining efficiency over time.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EF	
Measure No.	4	Average Mo Cost Per Youth for Substance Abuse Intervention Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EF 04

Fall/Annual: N

BL 2010 Definition

This measures the average cost per youth, age 17 or below, receiving intervention services for substance abuse.

BL 2010 Data Limitations

Average cost of services is affected by quality and intensity of service. This measure only reflects DSHS -funded cost. Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count of numbers

BL 2010 Data Source

Contractually-required intervention activities/services (key performance measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Expenditures for direct services from providers, along with DSHS non-service expenditures are maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

The sum of direct service expenditures and DSHS non-service expenditures for the intervention programs reporting services by age category and serving youth, age 17 or below, divided by the total number of youth served. The DSHS non-service expenditures are pro-rated based on the percent of total direct service expenditures attributed to youth and adults. Number served is the total number of youth, age 17 or below, receiving intervention services, as reported by providers in Performance Activity Reports. This includes all key performance measures related to information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Purpose

Useful in determining efficiency over time.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EF	
Measure No.	5	Average Mo Cost Per Adult Served in Treatment Programs for SA

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EF 05

Fall/Annual: N

BL 2010 Definition

This measures the average cost per adult, age 18 or above, who completes a prescribed treatment program for substance abuse.

BL 2010 Data Limitations

Cost of completion may cross fiscal years. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider for the DSHS substance abuse program. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and

BL 2010 Data Source

Discharge and completion information and client billings are submitted by providers via the DSHS Behavioral Health Integrated Provider System. Direct client expenditures, along with DSHS substance abuse program non-service expenditures, are maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

The sum of direct client and non-service expenditures associated with adult clients, age 18 or above, who have completed a level of service during the reporting period divided by the number of adult clients who completed a level of service during the reporting period. (Calculation for non-service expenditures for completers: Of the total adult service expenditures, the percent expended for adult completers is multiplied times the total portion of non-service expenditures attributed to adults. Total non-service expenditures for adults are based on the portion of direct service expenditures for adults.) Excluded from the calculation are clients who: have been reassessed as inappropriate for the treatment service level or program; have left due to loss of DSHS substance abuse program funding; or have died.

BL 2010 Purpose

Useful in evaluating program efficiency over time.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EF	
Measure No.	6	Average Mo Cost Per Youth Served in Treatment Programs for SA

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EF 06

Fall/Annual: N

BL 2010 Definition

This measures the average cost per youth, age 17 or below, who completes a prescribed treatment program for substance abuse.

BL 2010 Data Limitations

Cost of completion may cross fiscal years. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider for the DSHS substance abuse program. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and

BL 2010 Data Source

Discharge and completion information and client billings are submitted by providers via the DSHS Behavioral Health Integrated Provider System. Direct client expenditures, along with DSHS substance abuse program non-service expenditures, are maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

The sum of direct client and non-service expenditures associated with youth clients, age 17 or below, who have completed a level of service during the reporting period divided by the number of youth clients who completed a level of service during the reporting period. (Calculation for non-service expenditures for completers. Of the total youth service expenditures, the percent expended for youth completers is multiplied times the total portion of non-service expenditures attributed to youth. Total non-service expenditures for youth are based on the portion of direct service expenditures for youth.) Excluded from the calculation are clients who: have been reassessed as inappropriate for the treatment service level or program; have left due to loss of DSHS substance abuse program funding; or have died.

BL 2010 Purpose

Useful in evaluating program efficiency over time.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EX	
Measure No.	1	% of Adults Completing Treatment Programs for Substance Abuse

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EX 01

Fall/Annual: N

BL 2010 Definition

This measures the percent of adults, age 18 or above, completing treatment programs monthly for substance abuse as reported by providers.

BL 2010 Data Limitations

This only reflects clients in DSHS substance abuse funded programs. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service.

BL 2010 Data Source

Discharge and completion information reported by providers via the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

The total adults, age 18 or above, who completed a treatment program for substance abuse during the reporting period divided by the total number of adult clients discharged during the reporting period. Excluded from the calculation are adults who have been re-assessed as inappropriate for the treatment service level or program; have left due to loss of DSHS funding; or have died.

BL 2010 Purpose

Intended to identify adults who completed treatment.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EX	
Measure No.	2	% of Youth Completing Treatment Programs for SA

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EX 02

Fall/Annual: N

BL 2010 Definition

This measures the percent of youth, age 17 or below, completing treatment programs quarterly for substance abuse as reported by providers.

BL 2010 Data Limitations

This only reflects clients in DSHS substance abuse funded programs. Completion of treatment in this measure refers only to the completion of a level of care at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service.

BL 2010 Data Source

Discharge and completion information reported by providers via the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

The total youth, age 17 or below, who completed a treatment program for substance abuse during the reporting period divided by the total number of youth clients discharged during the reporting period. Excluded from the calculation are youth who: have been re-assessed as inappropriate for the treatment service level or program; have left due to loss of DSHS funding; or have died.

BL 2010 Purpose

Intended to identify youth who completed treatment.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	EX	
Measure No.	3	# of Co-Occuring Psychiatric SA Disorder Clients Served

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 EX 03

Fall/Annual: N

BL 2010 Definition

The indicator measures the number of clients admitted and served in a co-occurring psychiatric substance abuse disorder program.

BL 2010 Data Limitations

Data as it is currently collected do not present a challenge to measure the indicator. Each client has a unique identification number.

BL 2010 Data Source

Admissions and billing information reported by providers via the DSHS's Behavioral Integrated Provider System. Expenditure data is maintained in the Uniform Statewide Accounting System.

BL 2010 Methodology

Clients in COPSD services are identifiable by provider of services, billing categories, and program identification number. A count of the number of unduplicated clients served in a co-occuring psychiatric substance abuse disorder program will be calculated using SAS, a statistical software program.

BL 2010 Purpose

This information is used in the strategic planning and budget allocation processes.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	1	Avg Mo Number of Adults Served in Substance Abuse Prevention Programs

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measures the average monthly number of adults, ages 18 or above, served in prevention programs for substance abuse as reported by providers.

BL 2010 Data Limitations

Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count.

BL 2010 Data Source

Contractually-required prevention activities/services (key performance measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Key measures include information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Methodology

The numerator is the sum of the monthly unduplicated number of adults receiving SA prevention services with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

Useful in determining relative proportion of adults receiving prevention services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	2	Avg Mo Number of Youth Served in Substance Abuse Prevention Programs

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measures the average monthly number of youth, age 17 and below, served in prevention programs for substance abuse as reported by providers.

BL 2010 Data Limitations

For individuals who receive more than one service, there is a chance of duplication in the total count.

BL 2010 Data Source

Contractually-required prevention activities/services (key performance measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Key performance measures include information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Methodology

For each cquarter of the fiscal year, the number of youth served with DSHS SA Prevention funds in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of youth receiving SA prevention services with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

Useful in determining relative proportion of youth receiving prevention services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	3	Avg Mo Number of Adults Served in SA Intervention Programs

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of adults, age 18 or above, served in intervention services for substance abuse as reported by providers.

BL 2010 Data Limitations

For individuals who receive more than one service, there is a chance of duplication in the total count.

BL 2010 Data Source

Contractually-required intervention activities/services (key performance measures) and age categories are submitted by the providers in the monthly Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Key performance measures include information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Methodology

For each quarter of the fiscal year, the number of adults served with DSHS SA intervention services in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of adults receiving SA intervention services with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

Useful in determining relative proportion of adults receiving intervention services for substance abuse.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	4	Avg Mo Number of Youth Served in SA Intervention Programs

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of youth, age 17 or below, served in intervention services for substance abuse as reported by providers.

BL 2010 Data Limitations

For individuals who receive more than one service, there is a chance of duplication in the total count.

BL 2010 Data Source

Contractually-required intervention activities/services (key performance measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the DSHS Behavioral Health Integrated Provider System. Key measures include information dissemination, education, alternatives, problem identification and referral, community-based processes, and environment.

BL 2010 Methodology

For each quarter of the fiscal year, the number of youths served with DSHS SA intervention services in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of youth receiving SA intervention services with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

Useful in determining relative proportion of youth receiving intervention services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	5	Avg Mo Number of Adults Served in Treatment Programs for SA

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of adults, ages 18 or above, served in treatment programs for substance abuse as reported by providers.

BL 2010 Data Limitations

This shows only clients treated in DSHS funded programs.

BL 2010 Data Source

Billing information is reported by providers via the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

For each quarter of the fiscal year, the number of adults in DSHS SA treatment programs in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of adults receiving SA treatment services with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

This information is used in the strategic planning and budget allocation processes.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	6	Avg Mo Number of Youth Served in Treatment Programs for SA

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of youth served quarterly, ages 17 or below, in treatment programs for substance abuse as reported by providers.

BL 2010 Data Limitations

This shows only clients treated in DSHS substance abuse funded programs.

BL 2010 Data Source

Billing information is reported by providers via the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

For each quarter of the fiscal year, the number of youths served in DSHS SA treatment programs in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of youth in SA treatment programs with DSHS appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2010 Purpose

This information is used in the strategic planning and budget allocation processes.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	5	Substance Abuse Prevention, Intervention and Treatment
Measure Type	OP	
Measure No.	7	% of DSHS-funded Programs Meeting Performance Targets

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority:** Cross Reference: Agy 537 080-R-S70-1 02-02-05 OP

Fall/Annual: N

BL 2010 Definition

Percent of all DSHS funded substance abuse programs that reached or exceeded their contractually required performance targets.

BL 2010 Data Limitations

As the Commission raises standards for performance targets to make them more challenging, fewer numbers of programs may meet or exceed these targets.

BL 2010 Data Source

Performance measure information entered by the providers directly into the DSHS Behavioral Health Integrated Provider System.

BL 2010 Methodology

Total DSHS funded programs that reached or exceeded the majority of their contractually required performance targets divided by the total number of DSHS - funded programs. A single target is considered reached if performance is within 10% of the target.

BL 2010 Purpose

Information is used in contracting process.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	6	Develop a Statewide Program to Reduce the Use of Tobacco Products
Measure Type	EF	
Measure No.	1	Average Cost Per Capita for Populations Served in Target Areas

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-06 EF 01

Fall/Annual: N

BL 2010 Definition

This measures the average cost per capita in the targeted area for comprehensive tobacco prevention and control. Population served is defined as the number of people reached with comprehensive tobacco prevention and control exposure in the targeted community grant project area.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Expenditures for appropriated tobacco program funds in HHSAS and population data for the targeted area.

BL 2010 Methodology

The average cost per capita for populations served equals the total expenditures of the targeted area divided by the total population served in the target areas.

BL 2010 Purpose

The Texas Department of State Health Services (DSHS) received funding from Article XII Tobacco Settlement Receipts for reduction of use of tobacco products. This efficiency measure captures the impact of DSHS' implementation of a statewide comprehensive prevention community grant program in Texas. The targeted area consists of the population served by 6 community grantees that serves 17 zip codes within the city of Austin as well as Bexar, Fort Bend, Smith, Rusk, Gregg, Midland, Ector, Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn and Terry Counties.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	6	Develop a Statewide Program to Reduce the Use of Tobacco Products
Measure Type	OP	
Measure No.	1	Number of People Served in Targeted Area

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-06 OP

Fall/Annual: N

BL 2010 Definition

This measures the number of people served in the targeted area for comprehensive tobacco prevention and control. People served are defined as the number of people reached with comprehensive tobacco prevention and control exposure in the targeted community grant project area.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Texas State Population Census data in the targeted area.

BL 2010 Methodology

The total population in the targeted area.

BL 2010 Purpose

The Texas Department of State Health Services (DSHS) received funding from Article XII Tobacco Settlement Receipts for reduction of use of tobacco products. This output measure captures the impact of DSHS' implementation of a statewide comprehensive prevention community grant program in Texas. The target pilot project areas consists of 17 zip codes within the city of Austin and Bexar, Fort Bend, Smith, Rusk, Gregg, Midland, Ector, Lubbock, Crosby, Dickens, Gaines, Hale, Hockley, Lynn and Terry Counties.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	2	Provide Behavioral Health Services
Strategy No.	6	Develop a Statewide Program to Reduce the Use of Tobacco Products
Measure Type	OP	
Measure No.	2	# Of TX Communities Implementing Comprehensive Tobacco Prevention Pgms

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-02-06 OP

Fall/Annual: N

BL 2010 Definition

This is a measure of the number of Texas communities implementing a comprehensive tobacco prevention program.

BL 2010 Data Limitations

Texas communities that implement comprehensive tobacco prevention and control programs using other methods of finance, such as a local foundation or hospital district funding are not required to submit data to DSHS.

BL 2010 Data Source

DSHS Tobacco Prevention and Control Program contracts will be the data source for the number of community grantees funded for implementation of comprehensive tobacco prevention and control programs in local communities. Communities using other methods of finance will be identified by regional DSHS tobacco program staff who work in local communities.

BL 2010 Methodology

This is a measure of the no. of communities who implement comprehensive tobacco prevention & control programs. A comprehensive tobacco prevention & control program is a multi-faceted effort to reach all segments of the community. The goal of comprehensive tobacco control programs is to reduce disease, disability, & death related to tobacco use by:

- Preventing the initiation of tobacco use among young people.
- Promoting quitting among young people & adults.
- Eliminating nonsmokers' exposure to secondhand smoke.
- Identifying the disparities related to tobacco use & its effects among different population groups & reducing tobacco use among populations with the highest burden of tobacco related disparities.

Comprehensive programs, as defined by the Centers for Disease Control, include 5 basic components including 1) State & community interventions, 2) health communications interventions, 3) cessation interventions, 4) surveillance & evaluation and 5) administration & management

BL 2010 Purpose

This is a measure of the number of Texas communities implementing comprehensive tobacco prevention and control programs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	3	Build Community Capacity
Strategy No.	1	EMS and Trauma Care Systems
Measure Type	EX	
Measure No.	1	Number of Trauma Facilities

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-03-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure is defined as the number of hospitals designated as trauma facilities. Levels designate trauma facilities. Each trauma facility designation is documented in applications filed and by survey reports filed by staff or the applicant hospital. Each designation survey is documented in files established by staff for each designated facility.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The emergency management program's database of designated trauma facilities and trauma designation files is the data source.

BL 2010 Methodology

The number is determined by adding the number of designated trauma facilities at each level and then summing those.

BL 2010 Purpose

This measure provides a way to determine the level of department regulatory activities within this strategy. Significant staff resources are required to designate trauma facilities. This measure provides a way to track those resources.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	3	Build Community Capacity
Strategy No.	1	EMS and Trauma Care Systems
Measure Type	OP	
Measure No.	1	Number of Providers Funded: EMS/Trauma

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 02-03-01 OP

Fall/Annual: N

BL 2010 Definition

This measure tracks emergency health care providers who are provided funding through one or more of the EMS/trauma systems development funding

BL 2010 Data Limitations

None.

BL 2010 Data Source

Emergency Management database of contractors and files.

BL 2010 Methodology

The number is determined by counting the providers who are funded. Data is obtained from contract files.

BL 2010 Purpose

This measure is an indicator of how well the department handles the distribution of funds intended for emergency healthcare system's development.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	3	Build Community Capacity
Strategy No.	3	Indigent Health Care Reimbursement (UTMB)
Measure Type	EX	
Measure No.	1	Average Monthly # of Indigents Receiving Health Care Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 02-03-03 EX 01

Fall/Annual: N

BL 2010 Definition

This measure reflects the average monthly number of indigent patients receiving health care services through the University of Texas Medical Branch (UTMB), which pays for services with funds from the State-Owned Multi-Categorical Teaching Hospital Account.

BL 2010 Data Limitations

The Texas Department of State Health Services depends on UTMB to provide the documentation of voucher billing.

BL 2010 Data Source

Data are submitted to DSHS as documentation of voucher billing from UTMB.

BL 2010 Methodology

Sum the number of indigent patients per month and divide by the number of months summed. NOTE: House Bill 1799 (76th Legislature) allots $40 million each biennium to this program. When the limit has been reached, no further reimbursements are made to UTMB. When computing the measure for fiscal years that have exceeded the limit before the end of the year, include only those months that had sufficient funds to pay for all of the patients. Exclude any months from the calculation process that involve partially paid or non-paid months.

BL 2010 Purpose

Measures the average monthly number of indigent patients receiving health care services through UTMB. These services are funded through the State-Owned Multi-Categorical Teaching Hospital Account.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	3	Build Community Capacity
Strategy No.	3	Indigent Health Care Reimbursement (UTMB)
Measure Type	EX	
Measure No.	2	Average Monthly Cost Per Indigent Receiving Health Care Services

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 02-03-03 EX 02

Fall/Annual: N

BL 2010 Definition

This measure reflects the average cost per indigent patient receiving services from the University of Texas Medical Branch (UTMB).

BL 2010 Data Limitations

DSHS depends on UTMB to provide the documentation of voucher billing.

BL 2010 Data Source

Data are submitted to the Texas Department of State Health Services as documentation of voucher billing from UTMB.

BL 2010 Methodology

The average monthly cost equals the sum of dollars spent by UTMB from the State-Owned Multi-Categorical Teaching Hospital Account for indigent health care services divided by the sum of indigent patients receiving health care services.

BL 2010 Purpose

Measures the average cost per indigent patient receiving services from UTMB. These services are funded through the State-Owned Multi-Categorical Teaching Hospital Account.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	3	Build Community Capacity
Strategy No.	4	County Indigent Health Care Services
Measure Type	EF	
Measure No.	1	Average State Expenditure Per County

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-03-04 EF 01

Fall/Annual: N

BL 2010 Definition

This measure reports the average state expenditure per County Indigent Health Care Program (CIHCP) participating eligible.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Reports submitted by CIHCP participating eligible counties and the DSHS accounting system.

BL 2010 Methodology

The total amount reimbursed by the CIHCP as reported by the DSHS accounting system divided by the number of unduplicated participating eligible counties for state assistance funds

BL 2010 Purpose

Measures the average state expenditure per participating eligible County for the CIHCP.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	2	Community Health Services
Objective No.	3	Build Community Capacity
Strategy No.	4	County Indigent Health Care Services
Measure Type	OP	
Measure No.	1	Counties Receiving State Assistance Funds from CIHCP

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 02-03-04 OP

Fall/Annual: N

BL 2010 Definition

This measure reports the actual number of participating eligible counties spending over eight percent (8%) of the county's general revenue tax levy and receiving reimbursement from the County Indigent Health Care Program (CIHCP) state assistance fund.

BL 2010 Data Limitations

CIHCP relies on data received from participating eligible counties.

BL 2010 Data Source

Data are derived from reports (CIHCP Form 105) submitted by CICHP participating eligible counties.

BL 2010 Methodology

This measure is the number of unduplicated counties, which CIHCP reimbursed for services paid during the fiscal year. Data is cumulative.

BL 2010 Purpose

This measure reports the actual number of unduplicated eligible counties spending over eight percent (8%) of the county's general revenue tax levy and receiving reimbursement from the CIHCP state assistance fund.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	1	Texas Center for Infectious Disease (TCID)
Measure Type	EF	
Measure No.	1	Average Length of Stay, Texas Center for Infectious Disease

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

The average duration of inpatient treatment for all patients admitted during a reporting period.

BL 2010 Data Limitations

Patients may have left TCID grounds without medical advice or with an authorized pass, will not have returned at midnight, and when the patient returns, the daily census must be updated.

BL 2010 Data Source

Total daily census is aggregated in the Hospital Information System at midnight. The measure's numerator is computed by summing the data for the reporting

BL 2010 Methodology

Summation of daily patient census counts. Numerator is the number of days of inpatient care, taken from each day's census of occupied patient beds, for the reporting period. Denominator is equal to the number of discharges during the reporting period. The formula is numerator/denominator x 100.

BL 2010 Purpose

Although length of stay is a function of antibiotic effectiveness to cure TB, length of stay is a common measure of disease management of chronic disease with other inpatient facilities.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	1	Texas Center for Infectious Disease (TCID)
Measure Type	EF	
Measure No.	2	Average Cost Per Inpatient Day, Texas Center for Infectious Disease

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-01 EF 02

Fall/Annual: N

BL 2010 Definition

Calculated monthly, this measure reflects the total operating cost per day of inpatient care provided.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Monthly accounting reports, medical records system, and billing system.

BL 2010 Methodology

It is calculated by dividing the total expenses for inpatient services for a given period by the total number of patient days for the same period.

BL 2010 Purpose

Measures the average cost per patient day at the Texas Center for Infectious Disease.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	1	Texas Center for Infectious Disease (TCID)
Measure Type	OP	
Measure No.	1	Number of Inpatient Days, Texas Center for Infectious Disease

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-01 OP

Fall/Annual: N

BL 2010 Definition

The total number of days of care charged for occupied inpatient beds.

BL 2010 Data Limitations

Patients may have left TCID grounds without medical advice or with an authorized pass, will not have returned at midnight, and when the patient returns, the daily census must be updated. So, adjusted daily census reports are common and monthly reporting can be delayed.

BL 2010 Data Source

Total daily census is aggregated in the Hospital Information System at midnight.

BL 2010 Methodology

The measure is computed by summing the data for the reporting, period, daily, weekly, monthly, quarterly, and year-to-date.

BL 2010 Purpose

TCID is budgeted to operate two inpatient patient care units. The standard of treatment for TB is outpatient directly observed therapy (DOT). While admission to TCID is based on clinical conditions of patients requiring hospitalization, monitoring of total patient days regularly is a public health indicator both of acuity of patient conditions and complications in communities.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	1	Texas Center for Infectious Disease (TCID)
Measure Type	OP	
Measure No.	2	Number of Admissions: Total Number Patients Admitted to TCID

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-01 OP

Fall/Annual: N

BL 2010 Definition

Number of admissions for the reporting period.

BL 2010 Data Limitations

Data collection is dependent upon completion of admission documentation when a patient is admitted to TCID for inpatient treatment.

BL 2010 Data Source

Admission summary for each patient admitted to TCID is logged into patient accounting systems and data is compiled monthly, quarterly and annually.

BL 2010 Methodology

Whole number cumulated for the reporting period.

BL 2010 Purpose

Measures activity and utilization of more expensive TB inpatient treatment.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	2	South Texas Health Care System
Measure Type	EF	
Measure No.	1	Average Cost Per Outpatient Visit, South Texas Health Care System

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

Calculated monthly, this measure reflects the total direct operating cost per patient visit.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Monthly accounting reports and medical records.

BL 2010 Methodology

It is calculated by dividing the total expenses for outpatient services by the total number of outpatient visits.

BL 2010 Purpose

Measures the average cost per outpatient visit at the South Texas Health Care system.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	2	South Texas Health Care System
Measure Type	OP	
Measure No.	1	Number of Outpatient Visits, South Texas Health Care System

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-02 OP

Fall/Annual: N

BL 2010 Definition

An outpatient clinic visit is one in which a scheduled or unscheduled individual who is not an inpatient of the hospital is registered to receive non-emergency services. Each registration at the outpatient clinic is considered one outpatient visit. Services can include: 1) those provided by a member of the active medical staff or by a consultant who is paid from hospital funds, or 2) those which do not require a physician but which involve diagnosis and treatment, necessitating use of the administrative services of the outpatient clinic.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Daily log.

BL 2010 Methodology

Total number of outpatient visits.

BL 2010 Purpose

Measures the number of outpatient visits to the South Texas Health Care system.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	3	Mental Health State Hospitals
Measure Type	EF	
Measure No.	1	Average Daily Cost Per Occupied State Mental Health Facility Bed

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs DSHS,on average, per occupied state mental health facility bed.

BL 2010 Data Limitations

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

BL 2010 Data Source

The expenditures for facility operations are entered into the department's accounting system for each mental health facility.

BL 2010 Methodology

This is the average daily DSHS cost, averaged by quarter and year-to-date, for an occupied bed in the state mental health facility program. Costs include both facility administrative and residential operations. Excluded costs include depreciation and employee benefits paid by the Employee Retirement System. The numerator is the total expenditures (less exclusion as above) paid by DSHS for state mental health facilities in the reporting period / Number of days in the reporting period. The denominator is the average daily census of state mental health facilities for the reporting period. The formula is numerator / denominator.

BL 2010 Purpose

This measure allows the department to estimate the funding necessary to provide the number of state mental health facilities beds needed by its consumers.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	3	Mental Health State Hospitals
Measure Type	EF	
Measure No.	2	Average Monthly Cost Per SMHF Consumer Receiving New Gen Meds

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-03 EF 02

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs the state each month, on average, to provide the new generation of medications to state mental health facility consumers. Among the most important developments in recent years is the availability of a "new generation" of medications for the major mental illnesses including, but not limited to schizophrenia, bipolar disorders and major depression. These drugs are more expensive than many medications currently in widespread use, but for many people are producing very positive outcomes.

BL 2010 Data Limitations

Data must be current and accurate in the department's accounting system as of the date reports are produced. If the values reported in ABEST are determined to be inaccurate as a result of the Data Integrity Review process, the values will be updated when the errors are identified.

BL 2010 Data Source

Each time a physician at a state mental health facility prescribes a new generation medication, the consumer and the name of the medications are recorded in the electronic medical record by staff at state mental health facilities using pharmacy records. When the physician orders a discontinuation of one of these medications for a consumer, that information is also entered into the medical record.

BL 2010 Methodology

The numerator is the total state mental health facility expenditures for new generation medications for the reporting period divided by the number of months in the reporting period. The denominator is the average monthly number of mental health facility consumers receiving new generation medications. The formula is numerator/denominator.

BL 2010 Purpose

This measure allows the agency to track the cost of the new medications. These new medications should be used as first line treatment in the majority of cases in which the individual has a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. This measure allows the department to estimate the funding necessary to provide the new generation medications to its customers within the identified population.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	3	Mental Health State Hospitals
Measure Type	EX	
Measure No.	1	Number of Consumers Served by State Mental Health Facilities Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-03 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides a simple unduplicated count of all adults and children receiving services through the state mental health facilities during one fiscal year.

BL 2010 Data Limitations

None.

BL 2010 Data Source

As persons are admitted to and discharged from state mental health facilities, this movement activity is entered into the department's electronic medical record.

Production reports of consumer movement are issued monthly based on the information in the electronic medical record. Quarterly information is calculated based on these reports.

BL 2010 Methodology

This measure is a simple unduplicated count of individuals with one day or longer in residence at a state mental health facility during the state fiscal year.

BL 2010 Purpose

This measure provides the actual number of persons admitted to all state mental health facilities each year plus the number of persons in residence in all state mental health facilities at the beginning of the year.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	3	Mental Health State Hospitals
Measure Type	OP	
Measure No.	1	Average Daily Census of State Mental Health Facilities

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-03 OP

Fall/Annual: N

BL 2010 Definition

The state mental health facilities provide services to persons with severe mental illnesses for both acute episodes and longer-term care. The census of the facilities includes persons who have been admitted and not discharged. This measure provides information about the number of persons in state mental health facilities each day on average.

BL 2010 Data Limitations

Data is accurate to the extent that it is correctly entered into the data warehouse system.

BL 2010 Data Source

As persons are admitted to and discharged from state mental health facilities, this movement activity is entered into the department's electronic medical record.

Production reports of consumer movement are issued monthly based on the information in the electronic medical record. Quarterly information is calculated based on these monthly reports.

BL 2010 Methodology

This is an average daily census by quarter where census is defined as the total number of persons occupying a campus bed on any given day. Total bed days are obtained by multiplying the number of persons residing on campus during the reporting period by the number of days each person is on campus. The numerator is the total number of bed days for state mental health facilities for the reporting period. The denominator is the number of days in the reporting period. The formula is numerator/denominator.

BL 2010 Purpose

The census of state mental health facilities provides information about the utilization of these facilities. In order to ensure maximum occupancy and ensure availability of beds to meet needs, managers require information about current utilization and utilization trends over time.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	3	Mental Health State Hospitals
Measure Type	OP	
Measure No.	2	Average Monthly Number of SMHF Consumers Receiving New Generation Meds

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-03 OP

Fall/Annual: N

BL 2010 Definition

The average monthly number of unduplicated patients receiving new generation medications for the reporting period.

BL 2010 Data Limitations

The department has a Data Integrity Review process for state mental health facilities (SMHFs). This process includes on-site reviews of all SMHF measures matching CARE data data warehouse information to clinical records. Failure by a facility to demonstrate accurate data results in mandatory plans of

BL 2010 Data Source

All orders are done through the Order Entry Component of the Electronic Medical Record and stored in the CRS system.

BL 2010 Methodology

The unduplicated number of patients receiving NGMs for each month during the quarter are counted; the three monthly counts are then averaged and it is the average number that is reported.

BL 2010 Purpose

For many people these medications are producing very positive outcomes. The state and the department invest a significant level of funding to purchase these medications for those persons who may benefit from them.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	1	Provide State Owned Hospital Services and Facility Operations
Strategy No.	3	Mental Health State Hospitals
Measure Type	OP	
Measure No.	3	Number of Admissions to State Mental Health Facilities

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-01-03 OP

Fall/Annual: N

BL 2010 Definition

This measure captures the number of admissions to all State Mental Hospitals.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The electronic medical record. Whenever a person is admitted to a State Mental Hospital (by a physician's order) a new episode is created in the electronic medical record.

BL 2010 Methodology

The total number of new episodes created for all State Mental Hospitals each month is calculated.

BL 2010 Purpose

Admissions are one of the basic measures of service provided to the community and workload to the hospitals. Admissions represent the beginning of a new episode of treatment and there are specific tasks and costs associated with each new admission independent of the average bed day cost for an episode.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	2	Provide Privately Owned Hospital Services
Strategy No.	1	Mental Health Community Hospitals
Measure Type	EF	
Measure No.	1	Average Daily Cost Per Occupied MH Community Hospital Bed

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: L** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 03-02-01 EF 01

Fall/Annual: N

BL 2010 Definition

This measure captures information regarding what it costs the state each day, on average, to provide inpatient services in the Community Hospitals to each mental health consumers assigned to this service regardless of age. It measures the DSHS appropriation authority cost per consumer as defined by the companion output measure.

BL 2010 Data Limitations

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

BL 2010 Data Source

At the end of each quarter, staff of the local authorities input expenditure information into the data warehouse. The local authority indicates the fund sources used to finance the expenditures. The method of finance includes funds that are part of the DSHS appropriation authority as well as other local funds, grant funds, and earned revenues. For this strategy, only those dollars appropriated for Community Hospitals that are used for inpatient services at the hospitals are included in the cost calculation.

BL 2010 Methodology

The numerator is the total DSHS appropriation authority funds for Community Hospitals utilized to fund Community Hospital inpatient services as reported in the data warehouse / the number of days in the reporting period.The denominator is the average daily number of persons receiving Community Hospital inpatient services. The formula is numerator/denominator.

BL 2010 Purpose

This measure captures DSHS appropriation authority cost of Community Hospital inpatient services.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	2	Provide Privately Owned Hospital Services
Strategy No.	1	Mental Health Community Hospitals
Measure Type	EX	
Measure No.	1	Number of MH Consumers Served in MH Community Hospitals Per Year

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 03-02-01 EX 01

Fall/Annual: N

BL 2010 Definition

This measure provides an unduplicated workload count of priority population eligible adults and children who receive Community Hospital Inpatient services during one fiscal year.

BL 2010 Data Limitations

The accuracy of the department's data warehouse is dependent upon accurate and timely information being entered by the local mental health authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service. The expectation is for assignments to be ended when persons are discharged from the Community Hospital.

BL 2010 Data Source

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

BL 2010 Methodology

The total unduplicated number of adults and children that receive Community Hospital Inpatient service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

BL 2010 Purpose

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

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	2	Provide Privately Owned Hospital Services
Strategy No.	1	Mental Health Community Hospitals
Measure Type	OP	
Measure No.	1	Number of Admissions to MH Community Hospitals

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-02-01 OP

Fall/Annual: N

BL 2010 Definition

Community Hospital services are provided in three psychiatric hospitals. This measure captures the actual number of admissions to community hospitals on a quarterly and year-to-date basis. The number of admissions when viewed with the state mental health facilities companion measure demonstrates the system-wide level of activity for these services.

BL 2010 Data Limitations

The accuracy of the department's data warehouse system is dependent upon accurate and timely information being entered into the database by the local mental health authorities.

BL 2010 Data Source

As persons enter the community programs, registration information is entered into the department's data warehouse system by staff of the local mental health authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse system. Production reports of consumers served are issued quarterly based on the information in the data warehouse system. A person may be admitted and discharged more than once

BL 2010 Methodology

This measure is a simple count of admissions to mental health community hospitals for each month in the fiscal quarter and year-to-date.

BL 2010 Purpose

Community Hospital services are provided to adults and children in acute crisis situations where inpatient care is necessary. The service is usually of short duration and is used as an alternative to hospitalization in a state mental health facility.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	3	Hospital Facilities Management and Services
Objective No.	2	Provide Privately Owned Hospital Services
Strategy No.	1	Mental Health Community Hospitals
Measure Type	OP	
Measure No.	2	Average Daily Number of Occupied MH Community Hospital Beds

Calculation Method: N **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 03-02-01 OP

Fall/Annual: N

BL 2010 Definition

Community Hospital services are provided in three psychiatric hospitals. This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with DSHS appropriation authority funds and who occupy a Community Hospital bed on a daily basis. Quarterly and year-to-date performance is stated as the average of the days in the reporting period.

BL 2010 Data Limitations

The accuracy of the department's data warehouse is dependent upon accurate and timely information being entered into the database by the local mental health authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service. The expectation is for assignments to be ended when persons are discharged from the Community Hospital.

BL 2010 Data Source

As persons enter the community programs, registration information is entered into the department's data warehouse by staff of the local mental health authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse. Production reports of consumers served are issued quarterly based on the information in the data warehouse. The total number of bed days utilized by adults and children in Community Hospitals each quarter is calculated. The production report lists total bed days each quarter regardless of how the services for the individuals were funded

BL 2010 Methodology

This is an average daily count by quarter of the total number of persons who occupy a MH Community Hospital bed on any given day (as financed through the DSHS appropriation authority for Inpatient Community Hospital Service). The numerator is the total number of bed days utilized in MH Community Hospitals for the reporting period. The denominator is the number if days in the reporting period. The formula is numerator/denominator.

BL 2010 Purpose

Community Hospital services are provided to adults and children in acute crisis situations where inpatient care is necessary. The service is usually of short duration and is used as an alternative to hospitalization in a state mental health facility.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	1	Food (Meat) and Drug Safety
Measure Type	EF	
Measure No.	1	Average Cost Per Surveillance Activity

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-01 EF 01

Fall/Annual: N

BL 2010 Definition

The average cost per surveillance activity is defined as the average of all costs for the inspection and investigation programs relative to food and drug safety.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The costs are calculated from dollars expended for each program area, as indicated by departmental printouts or electronic downloads, and the number of surveillance activities is obtained from automated databases or activity reports. The numbers are compiled by designated program staff and verified by program managers as accurate.

BL 2010 Methodology

The year-to-date cost is calculated for each program area: manufactured food, retail foods, drugs and medical devices, meat safety, milk and dairy, and seafood safety. These costs are divided by the program area's year-to-date number of surveillance activities conducted. The quotients are then averaged by the weighted-average method to arrive at the average cost.

BL 2010 Purpose

Measures the average cost per surveillance activity.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	1	Food (Meat) and Drug Safety
Measure Type	OP	
Measure No.	1	Number of Surveillance Activities Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

The total number of surveillance activities inspections and investigations performed by staff that are documented by appropriate investigation and inspection reports.Includes: food, meat, drug and device routine, special, complaint, compliance, and enforcement inspections and investigations; seafood surveys; collection of samples; recall effectiveness checks and scheduling of drugs.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data is computed manually and from automated databases of activity reports submitted by staff. The programs (manufactured foods, milk and dairy, meat safety, seafood safety, drugs and medical devices, and retail foods) collect routine, special, complaint, compliance, and enforcement inspection and investigation data, as well as sample data and recall effectiveness data. The seafood safety program also collects the seafood survey data. The drugs and medical devices program also collects drug scheduling data. Source documentation identifies the manual and automated databases stored in each program.

BL 2010 Methodology

The number of surveillance activities performed by staff, which are documented by appropriate inspection and investigation reports, are totaled each quarter and are cumulative for the fiscal year.

BL 2010 Purpose

Measures the number of surveillance activities conducted.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	1	Food (Meat) and Drug Safety
Measure Type	OP	
Measure No.	2	Number of Enforcement Actions Initiated

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

The number of enforcement actions initiated is defined as the total number of enforcement related activities initiated.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The programs (seafood safety (SS), manufactured foods, retail foods, milk & dairy (M&D), drugs & medical devices, and meat safety) collect data regarding notices of violation that propose revocation, suspension and denial of licenses; administrative penalties (except for M&D) and orders; enforcement conferences; referrals to the AG and DA (except for M&D); repeated violation letters; detention, destruction, and recall of foods, drugs, devices or cosmetics; incident evaluations; collection letters; and inspection warrants obtained. SS also collects data on closing and opening of bays. Source documentation identifies the manual and automated databases stored in each program.

BL 2010 Methodology

The number of enforcement actions initiated is defined as the total number of enforcement related activities initiated.

BL 2010 Purpose

Measures the number of enforcement actions initiated.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	1	Food (Meat) and Drug Safety
Measure Type	OP	
Measure No.	3	Number of Licenses/Registrations Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 04-01-01 OP

Fall/Annual: N

BL 2010 Definition

The total number of licenses, permits, registrations, certifications and accreditations issued to food, milk, meat, drug, and device establishments, studios, manufacturers, wholesalers, brokers, educational programs, and individuals.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data is calculated manually and by automated databases. The programs (licensing and enforcement, seafood safety, milk and dairy, and meat safety collect data on licenses, permits, and registrations. Certification data is collected by the manufactured foods, milk and dairy, retail, and seafood safety programs. Accreditation data is collected by the retail foods and manufactured foods programs. Source documentation identifies the manual and automated

BL 2010 Methodology

The number of licenses, permits, registrations, certifications and accreditations issued is totaled quarterly and is cumulative for the fiscal year.

BL 2010 Purpose

Measures the number of licenses, permits, registrations, certifications and accreditations issued.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	2	Environmental Health
Measure Type	EF	
Measure No.	1	Average Cost Per Surveillance Activity

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-02 EF 01

Fall/Annual: N

BL 2010 Definition

The average cost per surveillance activity is defined as the average of all costs for the inspections and investigation programs (review of chemical inventory reports know as "Tier Two" reports is not considered a surveillance activity) relative to environmental health.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The cost numbers are calculated from dollars expended by these programs: toxic substances control, general sanitation, and product safety for surveillance activities. The number of surveillance activities is obtained from monthly activity reports. The numbers are verified by program managers and certified as

BL 2010 Methodology

The cost numbers are calculated from dollars expended by the toxic substances control, general sanitation, and product safety programs for surveillance activities. The number of surveillance activities is obtained from monthly activity reports.

BL 2010 Purpose

Measures the average cost per surveillance activity for environmental health.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	2	Environmental Health
Measure Type	OP	
Measure No.	1	Number of Surveillance Activities Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-02 OP

Fall/Annual: N

BL 2010 Definition

The total number of surveillance activities performed by staff that are documented appropriately in writing.Surveillance activities include routine and special inspections, complaint investigations, special compliance investigations, enforcement inspections, collection of samples, and any other type of investigation performed at a place of business, school, clinic, public building, temporary work place, or any other facility or location.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data is obtained manually and from automated databases. It is collected by the general sanitation, product safety and toxic substances control programs from staff activity reports. Documentation identifies the databases and files stored in the programs.

BL 2010 Methodology

The data is totaled quarterly and is cumulative for the fiscal year.

BL 2010 Purpose

Measures the number of surveillance activities conducted.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	2	Environmental Health
Measure Type	OP	
Measure No.	2	Number of Enforcement Actions Initiated

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-02 OP

Fall/Annual: N

BL 2010 Definition

The number of enforcement actions initiated is the total number of enforcement related activities initiated. Enforcement actions include notices of violation, license, permit, certificate, registration and accreditation revocations, suspensions and denials, enforcement conferences, administrative hearings, post inspection compliance letters, referral to the Attorney General or other appropriate authority for civil or criminal penalties seeking an injunction, and all other

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data is obtained manually and from automated databases. It is collected by the general sanitation, product safety and toxic substances control programs from staff activity reports. Documentation identifies the electronic databases stored in the programs.

BL 2010 Methodology

The data is totaled quarterly and is cumulative for the fiscal year.

BL 2010 Purpose

Measures the number of enforcement actions initiated.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	2	Environmental Health
Measure Type	OP	
Measure No.	3	Number of Licenses Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 04-01-02 OP

Fall/Annual: N

BL 2010 Definition

This measure includes the number of actions proposed on licenses, permits, registrations, certifications, and accreditations issued. For purposes of this output measure, "license" includes new and renewal licenses, permits, registrations, certifications, accreditations issued or initially denied. The types of "licenses" are: pesticide applicator, vector control, youth camp, bedding, volatile chemical, hazardous products, asbestos, and lead. Regulation of migrant labor camp licenses, formerly a part of this strategy, has transferred to the Texas Department of Housing and Community Affairs (TDHCA) per HB 1099, 79th Legislative session.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data is maintained in manual and automated databases. The license issued data is collected by the general sanitation, product safety and toxic substances control programs. Documentation identifies the manual and automated databases stored in each program.

BL 2010 Methodology

This measure is calculated from staff activity reports. The data is totaled quarterly and is cumulative for the fiscal year.

BL 2010 Purpose

Measures the number of licenses issued.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	3	Radiation Control
Measure Type	EF	
Measure No.	1	Average Cost Per Surveillance Activity

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-03 EF 01

Fall/Annual: N

BL 2010 Definition

The average cost per surveillance activity is defined as the average of all costs for the inspection and investigation programs relative to radiation control.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The cost for these activities is the actual year-to-date expended amount for surveillance activities. The number of surveillance activities performed is the actual year-to-date total surveillance activities conducted (another output measure number.

BL 2010 Methodology

The cost number is calculated from dollars expended as indicated by departmental printouts or electronic downloads, and the number of surveillance activities is obtained from monthly activity reports. This measure is non-cumulative. The program's average cost is determined by the weighted-average method. Total costs year-to-date are divided by the total number of surveillance activities. The numbers are compiled by designated program staff. The numbers are verified by program managers and certified as accurate.

BL 2010 Purpose

Measures the average cost per surveillance activity for radiation control.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	3	Radiation Control
Measure Type	OP	
Measure No.	1	Number of Surveillance Activities Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-03 OP

Fall/Annual: N

BL 2010 Definition

The number of surveillance activities conducted is defined as the total number of investigations/inspections of radiation performed by staff, which are documented by an appropriate investigation/inspection report.

BL 2010 Data Limitations

None.

BL 2010 Data Source

Source data are investigation/inspection reports submitted by staff, and if applicable, environmental monitoring results. Routine and special investigations/inspections are included in definition. Investigations include routine inspections, complaint investigations, special compliance investigations, enforcement inspections, collection of official samples, and any other type of investigation performed at place of business, school, clinic, public building, temporary work place, other facility, or area. Surveillance activities include investigations, inspections, laboratory analyses, and other activities completed. Telephone consultations and office visits are not included in this measure.

BL 2010 Methodology

The program's numbers are derived by summing the number of surveillance activities that are indicated on each employee's monthly activity sheet or taken from each public health region activity report to calculate a combined total. The activity reports are reviewed and the numbers compiled by designated program staff. The numbers are verified by program managers and certified as accurate.

BL 2010 Purpose

Measures the number of surveillance activities conducted.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	3	Radiation Control
Measure Type	OP	
Measure No.	2	Number of Enforcement Actions Initiated

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-03 OP

Fall/Annual: N

BL 2010 Definition

The number of enforcement actions initiated is defined as the total number of enforcement related activities initiated.Enforcement actions include a radioactive material license, x-ray or laser registration, industrial radiography certification, general license acknowledgment, mammography certification, or identification card revocation, enforcement conference, proposal of administrative penalties, administrative hearings, post inspection compliance letters, forwarding a case to the Attorney General or other appropriate authority for civil or criminal penalties or seeking an injunction for appropriate reason, and any other actions in courts of law.

BL 2010 Data Limitations

None.

BL 2010 Data Source

This measure is cumulative for a fiscal year and is calculated from monthly reports manually and/or from automated databases.

BL 2010 Methodology

This measure is cumulative for a fiscal year and is calculated from monthly reports manually and/or from automated databases. The program's numbers are derived by summing the number of actions that are indicated on each employee's monthly activity sheet. The activity reports are reviewed and the numbers compiled by designated program staff. The numbers are verified by program managers and certified as accurate.

BL 2010 Purpose

Measures the number of enforcement actions initiated.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	3	Radiation Control
Measure Type	OP	
Measure No.	3	Number of Licenses/Registrations Issued

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 04-01-03 OP

Fall/Annual: N

BL 2010 Definition

This is the measure of the total number of actions issued on radioactive material licenses, x-ray or laser registrations, industrial radiography certifications, general license acknowledgments, and mammography certifications (includes new permits, amendments, renewals, and terminations).

BL 2010 Data Limitations

None.

BL 2010 Data Source

The source data are the actual documents issued. The activity reports are reviewed and the numbers compiled by the designated program staff. The numbers are verified by program managers and certified as accurate

BL 2010 Methodology

The measure is calculated manually or using automated databases compiled from reports submitted by staff. The program's numbers are derived by summing the number of actions from monthly activity reports submitted by staff and by computer program. The program uses automated databases into which program staff have entered the actions completed. It totals the number of actions for the reporting period.

BL 2010 Purpose

Measures the number of licenses/registrations issues.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	4	Health Care Professionals
Measure Type	OP	
Measure No.	1	# Health Care Professionals & LCDCs Licensed, Permit, Cert, Registrd

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-04 OP

Fall/Annual: N

BL 2010 Definition

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a

BL 2010 Data Limitations

None.

BL 2010 Data Source

License application records maintained by the DSHS and information in the Integrated Management System, the Source.

BL 2010 Methodology

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a

BL 2010 Purpose

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	4	Health Care Professionals
Measure Type	OP	
Measure No.	2	Number of Professional Complaint Investigations Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: L** Cross Reference: Agy 537 080-R-S70-1 04-01-04 OP

Fall/Annual: N

BL 2010 Definition

The number of health care professional complaint investigations conducted is defined as the total number of investigations performed by staff which are documented by an appropriate investigative report. The investigations are initiated upon notification of possible violations of state laws or rules.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data are extracted from an automated regulatory system which has an enforcement module for tracking complaint investigations

BL 2010 Methodology

The complaint investigations are totaled quarterly and are cumulative for the fiscal year

BL 2010 Purpose

Investigating complaints against health care professionals is an element of regulation and public health protection.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	5	Health Care Facilities
Measure Type	OP	
Measure No.	1	Number of Health Care Facility Complaint Investigations Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-05 OP

Fall/Annual: N

BL 2010 Definition

. The number of complaint investigations conducted is defined as the total number of investigations performed by staff and the total number of self-investigated complaints by acute health facilities, which are documented by an appropriate investigative report. The professional licensing and certification and emergency management program's investigations are initiated upon notification of possible violations of state laws or rules.

BL 2010 Data Limitations

None.

BL 2010 Data Source

The data are computed manually and from computerized database information from survey and investigative documents submitted by staff and the acute health facilities. The professional licensing and certification program (PLCP), health facility licensing and compliance program (HFLCP), and the emergency management program (EMP) activities are tracked by using a computerized tracking system for complaints. They also collect complaint data on the entities regulated. The HFLCP also collects data on the acute health facility self-investigations and on the follow-up of these investigations. Documentation identifies the automated data bases stored in PLCP, HFLCP, and EMP.

BL 2010 Methodology

The complaint investigations are totaled quarterly and are cumulative for the fiscal year.

BL 2010 Purpose

A complaint investigation is based on allegations of potential violations of state and federal regulations. The investigative report, completed by the surveyor or the acute health facility who performs the investigation, shows the allegation(s) considered; the investigative process; the area(s) found to be deficient in meeting any relevant regulations; and the surveyor's or acute health facility findings(s) relating to the validity of the allegations(s).

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	5	Health Care Facilities
Measure Type	OP	
Measure No.	2	Number of Health Care Delivery Entity Surveys Conducted

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-05 OP

Fall/Annual: N

BL 2010 Definition

This measure is defined as the number of surveys pertaining to the quality of health care delivery and health-related educational programs under state and federal regulations conducted by staff, excluding complaint investigations. Health care delivery entities include: orthotic and prosthetic facilities, acute care facilities, and emergency medical services providers. Health-related educational program entities include massage therapist and emergency management

BL 2010 Data Limitations

None.

BL 2010 Data Source

Each survey is documented in a report provided by the surveyor(s) at the completion of the survey process. These reports are kept in files either in the central or regional offices depending on the surveyors' headquarters and some data is entered into databases, which are maintained in the professional licensing and the emergency management programs. Documentation identifies the databases and data stored in each regional office, the professional licensing and the emergency management programs.

BL 2010 Methodology

This measure is the total number of surveys pertaining to the quality of health care delivery and health-related educational programs conducted by staff for each quarter, excluding complaint investigations, and is cumulative for the fiscal year.

BL 2010 Purpose

This measure is the total number of surveys pertaining to the quality of health care delivery and health-related educational programs under state and federal regulations conducted by staff, excluding complaint investigations.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	5	Health Care Facilities
Measure Type	OP	
Measure No.	3	Number of Licenses Issued for Health Care Entities

Calculation Method: C **Key Measure: N** **New Measure: N** **Target Attainment: H** **Priority: M** Cross Reference: Agy 537 080-R-S70-1 04-01-05 OP

Fall/Annual: N

BL 2010 Definition

The number of licenses issued reflects the number of newly licensed entities, entities renewing licenses, changing ownership (i.e., entities bought and sold), changing address, name, and number of beds. Entities include: general, special, and private mental hospitals; crisis stabilization units; ambulatory surgical and birthing centers; special care, end stage, abortion, and orthotic/prosthetic facilities, massage therapy schools and establishments; and emergency medical

BL 2010 Data Limitations

This measure may be less than the actual workload due to applications received and reviewed where no license is issued (for various reasons). This measure does not reflect the number of licensed entities at any given time (i.e., a count of licensed entities) due to the fact that while initial licenses are being issued to new entities, a number of entities are closing or undergoing a change of ownership.

BL 2010 Data Source

After the receipt of a complete application and licensing fee and upon completion of the application review, a license is issued to the entity. All license data is entered into databases, which are maintained in the professional licensing, health facility licensing and compliance and the emergency management programs. Documentation in these three programs identifies the databases.

BL 2010 Methodology

The licenses issued are totaled each quarter and are cumulative for the fiscal year.

BL 2010 Purpose

These counts can be used for analyzing trends in the health care industry and in forecasting future trends, growths, and/or declines in the health care industry as well as showing the significant workload of the programs.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	7	Sex Offender Treatment and Supervision
Measure Type	EF	
Measure No.	1	Average Cost Per Sex Offender for Treatment and Supervision

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-07 EF 01

Fall/Annual: N

BL 2010 Definition

The average cost per civilly committed sex offender for treatment and supervision per reporting period, annualized, for all current, civilly committed sex

BL 2010 Data Limitations

The database provides point-in-time data only; it does not provide the actual amount of time during a reporting period that a civilly committed sex offender received service. Data does not discern that a sex offender was served for only part of a reporting period, rather than the entire reporting period.

BL 2010 Data Source

Civilly Committed Sex Offender database, DSHS financial system. Data is non-cumulative.

BL 2010 Methodology

The average cost per civilly committed sex offender is calculated by taking the expenditures from the DSHS financial system related to the civilly committed sex offenders program for the reporting period and annualizing them, and then dividing them by the number of current, civilly committed sex offenders (excluding those who were in prison for the entire reporting period) as of the last date of the reporting period.

BL 2010 Purpose

Provide the average annual cost of treatment and supervision provided per current, civilly committed sex offender not residing in prison, per reporting period

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	7	Sex Offender Treatment and Supervision
Measure Type	EX	
Measure No.	1	Number of New Civil Commitments

Calculation Method: C **Key Measure: Y** **New Measure: N** **Target Attainment: H** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-07 EX 01

Fall/Annual: N

BL 2010 Definition

The number of sex offenders who were civilly committed during the reporting period.

BL 2010 Data Limitations

None

BL 2010 Data Source

Civilly Committed Sex Offender database

BL 2010 Methodology

Program will run a report on CSS that identifies the number of sex offenders that were civilly committed during the reporting period.

BL 2010 Purpose

To determine the number of new civil commitment cases for the reporting period.

Agency Code: **537** Agency: **State Health Services, Department of**

Goal No.	4	Consumer Protection Services
Objective No.	1	Provide Licensing and Regulatory Compliance
Strategy No.	7	Sex Offender Treatment and Supervision
Measure Type	OP	
Measure No.	2	Number of Sex Offenders Provided Treatment and Supervision

Calculation Method: N **Key Measure: Y** **New Measure: N** **Target Attainment: L** **Priority: H** Cross Reference: Agy 537 080-R-S70-1 04-01-07 OP

Fall/Annual: N

BL 2010 Definition

The number of current sex offenders who have been civilly committed, receiving treatment and supervision, who have not been in prison for the entire reporting

BL 2010 Data Limitations

Available data is point-in-time data. Databases provide placement at the time of the query; they do not capture changes in civilly committed sex offender placement status across time (i.e., the databases do not track the movement of a civilly committed sex offender among community placements and locked

BL 2010 Data Source

Civilly Committed Sex Offender database

This is a measure of the effectiveness of OIG's efforts to maximize recoveries to HHSC programs.

BL 2010 Methodology

A report will be run to capture the total number of civilly committed sex offenders as of the last day of the reporting period. From the number of all current, civilly committed sex offenders, those who resided in prison for the entire reporting period will be subtracted. This number will be the number of sex offenders provided treatment and supervision. Data is non-cumulative.

To provide treatment and supervision, Data is non-cumulative. care domains that the Department and the Health and Human Services Commission have identified as statewide priorities.

BL 2010 Purpose

To determine the number of current sex offenders who have been civilly committed and are receiving treatment and supervision.

BL 2010 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy and indicates how many Quality Monitoring visits and technical assistance events are occurring in accordance with the requirements of Senate Bill 1839, 77th Legislature.

Appendix E

The 2007 State Strategic Plan for Information Resources Management: *The Texas Transformation*

This appendix responds to “Instructions for Preparing and Submitting Agency Strategic Plans” developed by the Legislative Budget Board and the Governor’s Office of Budget, Planning, and Policy.

The appendix includes the following items for each of the five health and human services agencies:

- A table listing the “Technology Initiative Alignment,” and
- Responses to the nine “Implementing the Texas Transformation” questions.

"Technology Initiative Alignment"

Department of Aging and Disability Services (DADS)

Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
Application Remediation Program	3.1	5-1	Current	Remediate several mission critical applications that reside in unsupported and outdated technologies to supported and current technologies.	
*Electronic and Information Resources (EIR)		5-1	Current	Procurement of tools and training for application and web developers to comply with Agency standards and provide accessible resources and services to DADS customers with disabilities.	
Data Center Transformation	3.1	1-1	Current	Consolidation of old end-of- life servers on new supported technology platforms. Achieving economies of scale for server administration across the agency and the standardization of hardware.	
Governance	3.1	4-3	Current	Governance is a prescribed method for the executive leadership of an organization to identify, select, and prioritize projects that comprise the organization's portfolio of projects using project proposals and business cases. Promotes efficient / economical use of limited staff resources, fiscal accountability, executive buy-in of IT project selections / priorities, achievement of mandated projects, alignment with agency strategic goals, and oversight of the selected portfolio to help ensure return on investment.	Best Practice
*Identity Management Initiatives	3.1	3-1	Current	Ensure agency standardization of access to the business applications and adhering to state federal standards to become compliant with state and federal security rules.	
Mainframe Migration	3.1.	1-2	Current	Migrate all legacy mainframe modules on new supported technology platforms, while, eliminating the cost of the legacy mainframe and aligning with an enterprise standard technical architecture.	

Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
Scalable Project Management Methodology	3.1.	4-3	Current	Standard operating policy, procedures, and re-usable templates aligned with the Texas Project Delivery Framework and approved by the agency Commissioner which scale the project management effort to magnitude of the project. Considerations for scalability include project cost, risk, technology, and interagency impact. Promotes standardized, sound project management practices and documentation in compliance with the Texas Project Delivery Framework and 1 TAC 216, so that projects are completed on time, within budget, scope, and quality expectations.	Best Practice
Software Engineering Methodology	3.1.	4-3	Current	Standard operating policy, procedures, and re-usable templates to standardize the agency's software development life cycle (SDLC): Initiate / Plan, Requirements, Design, Development, Testing (Unit, Integration, System, and User Acceptance), Deployment, Post Implementation Support, and Transition to Maintenance. Promotes sound system / software engineering techniques and documentation, economical use of resources (fiscal, staffing, technical, and time), inclusion of the customer from the outset, and improves probability of delivering products that meet customer needs and expectations.	Best Practice
Project Quality Assurance (QA) Program	3.1.	4-3	Current	Standard operating policy and procedures and a dedicated QA team to develop an annual QA Plan, conduct project portfolio assessments at regular intervals, and individual project compliance assessments. Promotes compliance with project management and software engineering policies and procedures, identifies strengths, weaknesses, and opportunities for continuous improvement in the portfolio and individual projects, and improves probability of delivering products that meet customer needs and expectations.	Best Practice

*Technology Initiative managed and led by the Health and Human Services Commission with DADS participation.

Department of Assistive and Rehabilitative Services (DARS)

Technology Initiative (Name of Project)	**Related Agency Objective**	**Related SSP Strategy**	**Status**	**Anticipated Benefit (s)**	**Innovation, Best Practice Benchmarking**
1. Data Center Services (DCS)	01 – 1 01 – 2 02 – 1 02 – 2 02 – 3 04 – 1 04 – 3 04 - 4	1 - 1	Current	The State of Texas spends approximately $1.8 billion annually on information and communications technologies. DCS leverages economies of scale, modernizes the technology infrastructure, enhances information security levels, improves disaster recovery capabilities, provides the flexibility and agility to meet changing business requirements and provides services and service levels that meet the unique needs of each agency.	Best Practice as DCS leverages economies of scale for DARS.
2. ReHabWorks	02 – 1 02 -- 3	4 – 1 5 -- 1	Current	Provides broader access to consumer information by establishing one enterprise database that is accessible by one application for both the Rehabilitative Services and Blind Services divisions. Streamlines common reporting	Innovation. The DARS ReHabWorks application follows accessibility guidelines as stated in Section 508, the Texas Administrative Code – Chapters 206 and 213, Texas Government Code

				processes by combining into an enterprise data warehouse one source of information – as opposed to merging from various reporting structures. Creates potential cost savings for IT cost of both hardware/ software and support of two systems.	2054.116 and Web Content Accessibility Guidelines 1.0. Additionally, one application will now support the Division of Rehabilitative Services as well as the Division of Blind Services.
3. Seat Management	01 – 1 01 – 2 02 – 1 02 – 2 02 – 3 04 – 1 04 – 3 04 -- 4	4 – 1 4 – 2 4 – 3 4 -- 4	Current	Maintains the reliability, efficiency and quality of business operations and improved delivery of consumer services. Meets the challenges of the ever changing technology including the migration of critical enterprise applications to web-based architecture. Eliminates the recycling costs of ownership to salvage.	Best Practice for reasons shown in the Anticipated Benefits column.
4. Infrastructure and Development Platform Refresh	All objectives	1 – 2 5 -- 1	Current	Miscellaneous hardware and software purchases and service contracts will keep software licenses current and replace hardware that will be at the end of its life, plus some additions	Best Practice for reasons shown in the Anticipated Benefits column.

				required by changing needs. In this way, DARS will be up-to-date on all software products critical to its enterprise operations. This project will also provide tools (which includes adaptive and accessibility software and hardware) agency personnel require for continued support of blind services, rehabilitation services, services for deaf and hard of hearing and services for children.	

Department of Family and Protective Services (DFPS)

Technology Initiative (Name of Project)	**Related Agency Objective**	**Related SSP Strategy**	**Status**	**Anticipated Benefit (s)**	**Innovation, Best Practice Benchmarking**
1. Data Center Services	Objectives 1,3	1-1	Current	Centralized, statewide project which ensures replacement of outdated servers in a timely manner, and availability of resources on a 24 X 7 basis, allowing access to data by DFPS caseworkers to deliver needed services to clients.	
2. IMPACT Operational Enhancements	Objectives 1,2,3	3-2 4-1 5-1	Current	Improve functionality, data sharing, usability, speed, and other aspects beyond the regular scope of IMPACT maintenance for efficient delivery of services to DFPS clients.	
3.Mobile Protective Solutions	Objectives 1,2,3	3-2 4-1 5-1	Current	The MPS project is designed to support quality casework through the use of tablet PCs, digital maps, and other technologies improving communication between caseworkers and supervisors providing timely services for DFPS clients.	DFPS remains on the cutting edge of providing services in timely efficient methods by enlisting the use of tablet PCs, wireless communications, and digital maps.
4.Enterprise Software Licensing	Objectives 1,3	1-4 2-1 4-2	Current	DFPS maintains current Microsoft software licenses using the HHSC Microsoft Enterprise Subscription Agreement (ESA) for greater savings than could be obtained outside the agreement. Standardizing Office across the agency and HHS agencies allows unimpeded communication between agencies providing better access to information and services for DFPS clients.	
5. Email	Objectives 1,3	1-4 2-1 4-2	Planned	This is a coordinated project by the HHS email messaging system. It allows dependable information sharing between DFPS agency staff, HHS staff and organizations, and clients of DFPS.	

Department of Sate Health Services (DSHS)

	TECHNOLOGY INITIATIVE	RELATED DSHS STRATEGIC PRIORITIES	RELATED SSP STRATEGY/(IES)	STATUS	ANTICIPATED BENEFITS	INNOVATION, BEST PRACTICE, BENCHMARKING
1	Data Center Consolidation	6-7, & 10	1-1	Current FY 08/09	Improved data center services and disaster recovery	
2	Clinical Management for Behavioral Health Services (CMBHS)		2-2, 3-2, 4-1, 4-2, 4-4, & 5-1	Current FY 08/09	Prompt identification public health issues; improved behavioral health outcomes	Project implements innovative approaches by connecting mental health and substance abuse treatment information; providing systems interoperability with information systems at Local Mental Health Authorities; and creating a tool that can be used to facilitate continuity of care and information exchange about behavioral health between state agencies. CMBHS will allow benchmarking of LMHA performance.
3	Public Health Laboratory Information Management System (PHLIMS) Enhancements	7-10	Statewide Partnerships (4-4)	Current FY 08/09	Combining several systems into one saving time/ & personnel and speeding lab results reporting.	Provides a Public Health Information Network-compliant solution using a distributed environment which enables remote access to test results by Laboratory Reporting Network facilities and other agencies across Texas.

4	Automated Medication Administration Record System (AMARS)	1, 4, & 7	4-2 5-1	Current FY 08/09	Improve patient medication safety	Innovation: • Wireless internet use (pilot) • Bluetooth use • Set agency policy & standards for wireless and Bluetooth use • Tablet PC use Best practice: Business process standardization of medication administration practices and reporting
5	Software & Website Remediation	6, 7, & 9	4-1 4-2 4-4	Current FY 08/09	1) Simplify the infrastructure by reducing the number of unsupported applications. 2) Provide compliance with accessibility for DSHS websites and applications. 3) Improved communication through implementation of web content management	Innovation: Established interagency collaboration with DIR by including SWR project requirements. into an existing RFO. Best Practice: Use Gartner Inc. to provide an independent strategic architecture recommendation. Best Practice: Use accessibility consultant to identify high-leverage accessibility activities.

					tool.	
6	Surveillance Systems (STD, HIV, Birth Defects)	1-4, 6-7, & 9	1-1, 3-2, 4-1, 5-1	Current FY 08/09	Prevention and control of disease and hazards	Innovation: Enhancements and upgrades to systems and data reporting capability allows faster identification of and response to disease patterns and trends, thus reducing illness and/or death in Texans through better prevention and control.
7	Web-enable Hospital Patient Discharge Data	7, 9-10	3-1 4-1 4-2 4-3 4-4 5-1	Current FY 08/09	Reduced costs, improved compliance with HIPAA, JCAHO and client confidentiality requirements.	Providing data collection best practices of well developed technology and following security standards. The project will be a benchmark in streamlining routine processes that will make data accessible to healthcare facilities throughout the state of Texas. This projects ultimate goal is to be innovative in collecting inpatient and outpatient data and provide it to the public in a reasonable amount of time. The project will follow DSHS IT Project governance guidelines.
8	Hospital Automated Medication Dispensing System (AMDS)	1, 4, & 7	4-2 5-1	Planned FY10/11	Improve patient medication safety	Implementing an AMDS is a best practice recommended by the Joint Commission on Accreditation of Healthcare Organizations (JACHO)
9	Wireless-Tablets for State Hospitals	3, 5-7	2-2, 3-2, 4-1, 4-2, 4-4, & 5-1	Planned FY10/11	Improve patient safety -- fragile or quarantined patients are able to receive	Wireless initiative for clinical care improvement in state hospitals to integrate critical information at the point-of-care, with the Client Record System, pharmacy system, electronic

					medications in their beds Reduces waste of resources by allowing direct, point of contact real time data entry into the medical record; reduces the likelihood of errors of forgotten information. Improves organization efficiency.	medication administration system, and other related applications.

Health and Human Services Commission (HHSC)

Agency Objective	Technology Initiative (Name of Project)	Related SSP Strategy	Status	Anticipated Benefit (s)	Innovation, Best Practice Benchmarking
Objective 1-1. Enterprise Oversight and Policy.	1. **Commission IT Executive Governance Program**: IT will formalize an executive governance program to review strategic alignment of service delivery initiatives and operations with the business requirements of HHSC. Develop methods to support executive prioritization of IT investment decisions and to monitor performance of the IT project portfolio. 2. **Formalize Commission IT Strategy:** Draw a strategic roadmap of activities for Commission IT that reflects the requirements of the business. The formal service delivery portfolio of Commission IT operations and initiatives will be compiled with appropriate metadata to support daily and strategic management. The portfolio will be mapped to the agency strategic budget and executive customer areas. High level objectives will be validated. 3. **Enhanced Eligibility Systems**	1. 4-3 2. 4-3 3. 5-1 4. 4-1 4-2	1. In Progress 2. Proposed 3. In Progress 4. Planned	1. Provide business leadership direction in the effective application of Commission IT resources and establish the basis for periodic performance assessment. Ability to close projects. Ability to prioritize projects. Improved alignment of work assignments with resource capacity. 2. Developing the high-level strategy and roadmap will enable us to prioritize our efforts. Will help with identity problem. 3. Enhancing the eligibility determination system to meet goals for better serving the public's needs. Conversion to TIERS and retirement of the SAVERR system; integration of eligibility determination for CHIP and MEPD into TIERS. 4. Provide a consolidated view of diverse data sources currently stored in a variety of formats and locations. (Medicaid, CHIP, food stamps and TANF. Detect fraud and abuse. Reduce overall costs to taxpayers, predicting the state's human services needs	1. Project will draw from best practices of the IT Governance Institute, Gartner Group, and others. 2. Project will use best practice of the Balanced Scorecard by Robert S. Kaplan of Harvard Business School and David P. Norton. 3. Provides innovative ways to get clients connected to services in addition to face-to-face, internet and telephone submissions. Also allows enhanced eligibility sharing of data with other government entities and providers. 4. The data warehouse system will consolidate and reconcile data from different business functions and systems into a single location

	(Includes TIERS) 4. **Enterprise Data Warehouse**			and priorities in the future, improve delivery of health care services.	that allows an organization to perform strategic decision making and operational analysis that could otherwise not be performed using the individual data sources.
Objective 1-2. Client and Provider Accountability.	**1. Enterprise Data Warehouse**	1. 4.1 4.2	1. Planned	1. Provide a consolidated view of diverse data sources currently stored in a variety of formats and locations. (Medicaid, CHIP, food stamps and TANF. Detect fraud and abuse. Reduce overall costs to taxpayers, predicting the state's human services needs and priorities in the future, improve delivery of health care services.	1. The data warehouse system will consolidate and reconcile data from different business functions and systems into a single location that allows an organization to perform strategic decision making and operational analysis that could otherwise not be performed using the individual data sources
Objective 1-3. HHS Consolidated System Support Services.	**1. Medicaid Information Technology Architecture (MITA) Initiatives:** Oversee the Texas Medicaid Management Information Systems (TMMIS) compliance with CMS' directives regarding MITA. Texas Medicaid Self Assessment, Tx Medicaid Future State and to-be road map, data governance and data modeling.	1. 4-1 2. 4-1 3. 1-1 4. 3-1 3-2 5. 1-2 6. 1-4	1. Proposed 2. Proposed 3. In Progress 4. In Progress 5. In Progress 6. Planned	1. Obtain 90/10 enhanced funding on MITA aligned projects; Ensure HHS IT projects conform with MITA direction to use standards-based technology including Service-oriented Architecture (SOA), Health Level 7, and X-12 transaction standards 2. HHS electronic information resources will be compliant with applicable state and federal	1. Innovation: MITA initiative seeks to move state Medicaid programs toward inter-operability through the use of standards based technology. 2. Project will draw from the best practices of the World Wide Web

	2. Monitor Compliance with Electronic Information Resource Accessibility Requirements: Assure all HHS delivered products meet HHS Accessibility Requirements. **3. Data Center Services** **4. Data User Identity Management** **5. Telecommunications** **6. Email**			laws. 3. Replacement of outdated mainframe computer; improved bulk print/mailing capability; enhanced disaster recover mechanism. 4. The Security and Identity Management initiative will improve access to, and security of, HHS information resources. It will be a primary repository of identity accounts for HHS employees, contractors and partner employees who access secured HHS applications, providing consistently high level of secure, auditable access. 5. The aging telephone systems in HHSC, DADS, DSHS and DFPS regional offices have reached end of life and need to be replaced. This solution will provide dial tone, voice mail, call routing, and ACD functions and enable all regional offices to be attached to. 6. Bring all HHS email messaging systems up to supported application and hardware lifecycles with periodic hardware and server software updates. Will keep the systems in supported lifecycles with relatively modern hardware and software. Consolidates email.	Consortium (W3C) which develops interoperable technologies (specifications, guidelines, software, and tools) to lead the Web to its full potential 3. N/A 4. Provide a primary repository of identity accounts for HHS employees, contractors and partner employees who access secured HHS applications. Providing a consistently high level of secure, auditable access. 5. Provides an integrated system throughout all locations. 6. Provides the migration of all HHS Agencies' current Exchange email systems to a consolidated Exchange System.

Objective 2-1. Medicaid Health Services.	1. **Medicaid Eligibility and Health Information Project:** Improve client service through improved eligibility verification and electronic health record information. Project components include: • Replace monthly paper Med-Id card with more permanent plastic swipe card. • Eligibility verified via HIPAA compliant transaction. • Electronic Health Record claims based information for client available via swipe card 2. **Integrated Case Management (ICM):** Create a new managed care model for SSI, deemed SSI and 1915c Nursing Waiver (Community Based Alternative) (CBA) recipients in the Dallas and Tarrant Service Areas (SAs). The model will provide acute-care and long-term care services and supports for Medicaid Only (MO) recipients and Long Term Services and Supports (LTSS) for dual eligible recipients (person covered by Medicaid and Medicare) in a non-capitated model. 3. **Enhanced Eligibility Systems (includes TIERS)** 4.	1. 4-2 2. 4-2 3. 5-1	1. Proposed 2. Proposed 3. In Progress	1. Eliminate cost of printing monthly Medicaid IDs and provide near real-time eligibility verification via a more permanent plastic magnetic stripe card. Additionally, the MINT Electronic Health Record will provide a rudimentary claims-based health history to providers that includes medical claims/encounters and prescription drug information. Providers accessing this information will be able to potentially eliminate duplicative services and harmful drug interactions because they have access to client health history. 2. Provides acute-care and long-term care services for Medicaid Only recipients and Long Term Services and Supports for dual eligible recipients in a non-capitated model. 3. Enhancing the eligibility determination system to meet goals for better serving the public's needs. Conversion to TIERS and retirement of the SAVERR system; integration of eligibility determination for CHIP and MEPD into TIERS.	1. Innovation: Texas would be the first state to provide an EHR to all Medicaid recipients. 2. N/A 3. Provides innovative ways to get clients connected to services in addition to face-to-face, internet and telephone submissions. Also allows enhanced eligibility sharing of data with other government entities and providers

Objective 2-2. Other Medicaid Services.					
Objective 2-3. Special Services for Children.	1. **Family Violence .NET Replacement:** Replace the current HHSC-ITS System for the Family Violence Program with a WebSphere system which will allow HHSC users to produce reports and extracts, and Customer Vendors to submit their monthly extracted data to HHSC via an internet browser.	1. 4-1	1. Planned	1. A browser-based application will lead to automation efficiency, efficient access to data, and reduce cost of implementing changes. This includes a single centralized database, real time data processing.	1. Innovative methods being used to re-write the current application using a Web front end for gathering information. The SOA environment will provide redundancy and failover that will reduce application dependency on a single server. The new application will greatly reduce the manual effort currently required by customer and Commission IT staff in order to produce both state and federal reports in a timely fashion.
Objective 2-4. Administrative Support.	1. **Claims Administrator Reprocurement Activities:** Reprocurement activities for the Claims Administrator (MMIS)/PCCM contract including vendor drug. 2. **Legislative Tracking System (HLTS) Enhancements and Session Support:** Enhancements planned for	1. 2-2 2. 4-1 3. 4-1 4. 4-1 5. 4-3 6. 4-1 7. 2-2 8. 4-1 9. 4-1 10. 4-1	1. In Progress 2. In Progress 3. In Progress 4. In Progress 5. Proposed 6. In Progress 7. In Progress 8. Proposed 9. In Progress 10. In Progress	1. Medical Claims will continue to be paid to Medicaid/CHIP Providers. 2. Centralized tracking of legislative efforts and sharing of analysis across agencies. 3. The Border Affairs organization will benefit from easier data collection and a significant increase in productivity. HHSC	1. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including

	FY08 are fiscal note, search and history features, and LTS reporting. 3. **Colonias Data Collection/Reporting Initiative:** Provide automation in the way of a new application and centralized database that supports entry and dissemination of Colonias related data to meet the requirements of SB827. Automate data extraction and tracking through development of a Web Based process/application. 4. **Policy Development Automated System (PDAS-MCD) Initiative:** Develop new application and centralized database that supports a document library and business workflows for Medicaid/CHIP Division related information. Automate document extraction and tracking through development of a Web Based process/application. 5. **Increase Commission IT Project Management Maturity:** Assess current state of Commission IT project management maturity across all areas, work with the Directors to customize plans to improve maturity in their areas, execute the plans.			will benefit due to a common point being established for the Colonias data and reporting options. Field Workers will benefit from all agencies as the data will then be requested in a consistent constructive format. 4. The Medicaid/CHIP Division will benefit from easy access of related documentation and a significant increase in productivity with their business flows. HHSC (programs) will benefit from having access to documents requiring their review and approval. Public will benefit from having access to the Texas State Plan and associated approved amendments. 5. Better understanding of our project management strengths and weaknesses, and the ability to target improvements. 6. Will provide expenditure information in a timely fashion in a suitable format, accessible to them on-line. 7. Current data maintained in Excel spreadsheets with limits on data capture and reporting; Oracle database will allow greater depth for reporting and amounts of data capture. Reduction in man hours to capture data. 8. Develop a web based agency application for tracking and reporting employee	(but not exclusively) such as those of the PMBOK (PMI). 2. The tracking enhancements will allow easier access to bill data after assignment. Reporting changes will allow more resolution of the bill data and greater reporting ability. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 3. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively)

	6. **Financial Services Support:** Support the CFO to modify existing systems/processes, and/or create new applications. 7. **HCATS - Medicaid/HHSC Deliverables Tracking:** Enhance HCATS to include ad hoc reporting, track procurements, contract renewals and contract amendments, routing/approvals, accessibility and elements defined by the Contract Council. Review, assess and consolidate the HCATS Rewrite and HCATS Phase 2 Requirements Project to improve management, control, coordination audit ability of HHS Contracts through the Contract Management Process Lifecycle. 8. **Separation Tracking/Initiation System:** Develop a web based agency application for tracking and reporting employee separation/transfer information for HHSC central and regional state office locations. 9. **411 Form Automated Replacement:** Develop a web-based application for tracking wireless telecommunications devices and subsequent reporting.			separation/transfer information for HHSC central and regional state office locations. 9. Reduce loss of wireless devices. 10. Eliminate the need for paper documents across the Commission and maintain the paper workflow.	such as those of the PMBOK (PMI). 4. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 5. Project will use best practices from the Project Management Institute and their publication *A Guide to the Project Management Body of Knowledge*, also known as PMBOK. 6. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI).

	10. **Correspondence Tracking System:** Migrate the TDH Correspondence Tracking System (CTS) from SQL Server to Oracle. Modify the presentation layer (VB). Provide ongoing support, maintenance, and changes as directed.				7. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 8. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 9. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively)

					such as those of the PMBOK (PMI). 10. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI).
Objective 3-1. CHIP Services.	**Enhanced Eligibility Systems (includes TIERS)**	1. 5-1	1. In Progress	1. Enhancing the eligibility determination system to meet goals for better serving the public's needs. Conversion to TIERS and retirement of the SAVERR system; integration of eligibility determination for CHIP and MEPD into TIERS	1. Provides innovative ways to get clients connected to services in addition to face-to-face, internet and telephone submissions. Also allows enhanced eligibility sharing of data with other government entities and providers.
Objective 4-1. Assistance Services.	**2-1-1 Enhancements:** Upgrade 2-1-1 to utilize the latest taxonomy code standard. Move the application from the single server Badger to the SOA UCE environment.	1. 4-1	1. In Progress	1. The new taxonomy will improve site searches to provide more accurate detailed information to the user. The move to the UCE environment will improve response time, availability and failover.	1. This taxonomy upgrade keeps the application current with the National AIRS taxonomy standards. The SOA environment will provide

					redundancy and failover in the event of a disaster. Improvements to the search screens were added to be more user friendly.
Objective 4-2. Other Support Services.	1. **Critical Sites Telecommunications Refresh, Phase 1.5:** Twenty-five IEE sites have been identified as critical to the success of the state roll out of TIERS. These sites have been prioritized for immediate refresh of their existing telecommunication systems. Standard services will be provided to 100% of the targeted remote sites including dial tone, in/outbound calling, and voicemail. 2. **Investigate Inventory Control Systems:** Investigate inventory control systems that meet agency requirements in tracking computer hardware and software movement. Potentially interface with HHSAS Asset Management system. This project differs from the Asset Control Deficiencies project in that it focuses on identifying an automated solution, whereas the Asset Control Deficiencies project focuses on identifying	1. 1-2 2. 4-1 3. 4-1 4. 4-1 5. 1-2	1. In Progress 2. Proposed 3. In Progress 4. Proposed 5. In Progress	1. Improved communication and improved service delivery to clients by decreased client wait time, decrease dropped calls. 2. The use of automated inventory control systems is expected to improve the accuracy of tracking hardware and software movement by 10% within 6 months after implementation. 3. Pre-project sample has an estimated 25% error. 6 months after the project ends the error rate will be reduced to 10%. 4. If PC equipment can be quickly deployed, there will be no, or minimal, delay in dispensing benefits to affected clients. 5. Clients will be able to reach key service delivery staff regarding benefits and other services; toll-bypass will allow HHS agency staff to call other HHS agency without incurring long distance fees. Will ensure consistent quality and cost of service throughout the agencies. Cost avoidance due to reduced equipment failures.	1. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 2. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 3. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals.

	root causes of the deficiencies. 3. **Identify Control Deficiencies in Management of PC Assets:** Improve accuracy of asset records by correcting the process steps that result in inaccuracies and errors. 4. **Commission IT Disaster Support Plan:** Establish a process to ensure that PC assets are available to be deployed to temporary remote locations in order to support the issuance of HHSC benefits to clients affected by disasters. 5. **HHS Enterprise Telecommunications Strategy (Telecommunications Phase 2):** Replace/refresh telecommunications systems at high priority HHS sites using a Seat Managed, enterprise-wide approach.				These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 4. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 5. Innovation: Communications methods used include SharePoint for documentation repository, distribution and controls. Conference call and web conferencing are also been used to ensure live communication within this project.
Objective 5-1. Program Support					
Objective 6-1. Information	1. **Identity Management - Oracle Connectivity and**	1. 3-1 2. 3-1	1. On Hold 2. In Progress	1. Cradle-to-grave management of identities to include the auditing	1. N/A 2. In accordance with

Technology Projects.	**Audit:** Establish Identity Vault (IDV) connectivity to Oracle and institute User-Level audit trails. 2. **Identity Management - Security Permission Process:** Create end-to-end identity-based, multi-step security access/request/approval process. 3. **GALSIGN link to Identity Vault (IDV):** Link IDV HHSAS Employee ID to GALSIGN process in order to create users on local office file servers. 4. **Intrusion Prevention System (IPS) Implementation:** Conduct Proventia desktop pilot and implement Proventia desktop on high risk laptops. 5. **HIPAA II:** Analyze and implement EDI requirements not originally implemented in HIPAA Phase I. 6. **Voltage Secure Email Roll Out:** Manage Voltage service delivery of secure email service for HHSC. 7. **Mainframe Migration – Multiple Systems:** Create programs in Java and Perl to replace the current Cobol programs on the Mainframe. Design the new system to be more efficient by using the	3. 3-1 4. 3-1 5. 3-2 6. 3-1 7. 5-1 8. 5-1 9. 1-1	3. On Hold 4. In Progress 5. On Hold 6. In Progress 7. In Progress 8. In Progress 9. In Progress	of all actions associated with this. 2. Single system to provision access requests; will speed up current paper-based/multi-layer process. 3. Remove dependency on Mainframe for user creation; allow for stronger password. 4. Ability to detect & prevent potential security events--malicious or otherwise. 5. HIPAA EDI modifications improve efficiency and ensure full and continued compliance with HIPAA regulations set forth in 45 CFR Parts 160 and 162 Health Insurance. 6. Today confidential information is at risk because it is being sent in an unsecure format. Voltage will provide secure solution with minimal impact to HHSC. 7. All of processing will be done in a client server environment saving the State thousands of dollars from quicker code changes and processing the data faster. 8. Significant re-engineering is expected to take best advantage of new technology. All of Medicaid ID's processing will be done in a client server environment saving the State thousands of dollars from quicker code changes and processing	Project Deliverables Standard, Systems Optimization. 3. N/A 4. In accordance with the policy in HHS Enterprise Security Standards and Guidelines, V2.00, Section 1.13. 5. Project will use best practices from the CMS Medicaid Information Technology Architecture (MITA) Standards. 6. N/A 7. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 8. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the

	lessons learned from the current systems. 8. **Mainframe Migration - Medical ID Cards:** Migrate MN from mainframe to Oracle server environment. 9. **Data Center Transformation:** Facilitate planning and execution of Team for Texas transformation of data center services to their two data centers.			the data faster. 9. There will be a coordinated, interruption-free transition to the new data center(s).	agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI). 9. Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These include, but are not limited to, alignment of platforms and architectures to the State of Texas Enterprise Technology Plan and use of ITIL-driven processes from the Data Center Services Policy and Procedures Manual.
Goal 7 Office of Inspector General Objective 7-1, Integrity and Accountability	1. **Reprocurement of the Medicaid Fraud and Abuse Detection System (MFADS)** 2. **ASOIG Phase II:** Add functionality and expand system attributes of the ASOIG application (released 9/2007).	1. 5-1 2. 5-1	1. In process: developing APD and RFP with projected publication date of September 30, 2008 2. In Progress	1. Continued compliance with Govt Code Sec. 531.106 and enhanced ability to identify provider, client and contractor fraud and abuse. 2. This effort will further ensure the proper handling of the investigations of fraud. In addition, the reporting and report	1. Competitive procurement should result in the selection of the proposed solution that best meets the needs of HHSC-OIG. 2. The application is applying new technologies and

				simplification will establish greater use of the application and its associated functionality.	coding practices that are easier to support and maintain. Innovative methods of data extraction are being applied (use of data views) and were implemented to save storage space (a massive amount of data is in the application). Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. ROI will be reviewed in the future related to the amount of dollars recovered and/or the case specifics such as the time from entry to closure, recovery or case handling. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI).

"Implementing the Texas Transformation"

Department of Aging and Disability Services (DADS)

Question	Answer
MANAGED SERVICE DELIVERY **Has the agency considered use of managed services in order to focus more on its business needs?**	**Yes** Team for Texas is an alliance of several vendors which collectively provide managed (Data Center) services for the agency infrastructure needs. As part of the Health and Human Services Enterprise, DADS actively collaborates and participates in jointly managed services initiatives such as Accessibility, Voltage Email Encryption, Managed Document Output and Telecommunication Services.
MANAGED IT SUPPLY CHAIN **2. Does the agency leverage and obtain additional value from the Information and Communications Technology (ICT) Cooperative Contracts program; for example, by further negotiating not-to-exceed pricing?**	The agency supplements this objective through the use of DIR Information Technology Staff Augmentation Contract. DADS also uses other contracts and services through the Cooperative Contracts program to meet the business needs of the agency such as software, and hardware purchases and acquisition for equipment and services.
SECURITY AND PRIVACY **3. Describe the agency's strategies to align with the State Enterprise Security Plan (http://www.dir.state. tx.us/pubs/securityplan2007/index.htm).**	Chapter 202 of Title 1 of the Texas Administrative Code (1 TAC 202) establishes information security standards for all Texas state agencies and universities. The State Enterprise Security Plan provides goals, objectives, and a plan of action to safeguard information resources assets of the State. Texas Health and Human Services (HHS) reinforced these requirements with the publication of HHS Circular C-021 HHS Enterprise Information Security Policy and the Publication of Enterprise Information Security Standards. HHS Agency Information Security Officers (ISOs), including DADS, are required to develop and implement an Information Security Program for their agency. Further, HHS agencies are required to develop and implement information security policies, standards, and guidelines that are consistent with and do not limit the effectiveness of the Enterprise Information Security Policy. In compliance with these requirements, DADS published an executive-approved Security Road Map outlining requirements of the DADS ISO including regular security training

	of DADS staff.
4. Describe the agency's policies, practices and programs, implemented or planned, that comply with relevant statutes and administrative rules to ensure the privacy of confidential data. Consider federal privacy requirements (e.g., the Health Insurance Portability and Accountability Act or the Family Educational Rights and Privacy Act) that apply to the agency. List the organizational units (program, offices, IT, legal, etc.) that manage privacy functions. Describe any future plans for improvement.	Listed below are the functions and tools that DADS has implemented to better the privacy of confidential data: • The agency is currently implementing a full disk encryption of all the agency desktops and mobile devises. This will fully encrypt the entire hard disk drive including the operating system. • DADS has a HIPAA privacy officer responsible for responding to customers questions and concerns regarding HIPAA statues, and policies. • Enhanced File Transfer File Transfer Protocol (FTP) is a secure network protocol used to transfer data from one computer to another through a network, such as over the Internet. Business Continuity Management Program **is a** program developed in accordance with requirements of the DADS Continuity of Operations Plan (COOP), Texas Administrative Code (TAC) 202, and Health and Human Services policies and procedures. It includes business impact analysis, business continuity planning, disaster recovery planning, and testing.
TECHNOLOGY POLICY, BEST PRACTICES, AND PARTNERSHIPS **5. What current practices or plans are in place to improve usability and search ability of the agency's Web content? (2007 SSP, Strategy 4 1)**	Several applications are in the process of being remediated to move to newer technology. The move to new technology will provide for the capability to more easily enhance and maintain these applications. As part of the Health and Human Services Enterprise, DADS actively participates in establishing goals and objectives for Electronic Information Resources to ensure Accessibility compliance. HHS also established an EIR Accessibility Policies and Resource website as a one stop center for accessibility standards, guidelines, policy and procedures relating to Electronic Information Resources. As additional projects are identified which will enhance the content on the Web, these are prioritized by the agency as needed to support the agency's goals and strategies.

6. What current practices or plans are in place to improve life cycle management of agency data and information? Include the agency's approach and ability to meet future open records and e-discovery requests. (2007 SSP, Strategy 4-1)	As applications are migrated to new technologies, the data and information in these applications is evaluated to ensure appropriate data management practices. Consistent data definitions will help the agency respond to open records and other e-discovery requests.
7. Describe agency methods and standards (federal, state, industry), implemented or planned, intended to enhance data sharing (i.e., improve interoperability) with other entities. (2007 SSP, Strategy 4-2)	Currently DADS has no strategy for implementing enhanced data sharing with entities outside the agency.
<u>CORE MISSIONS</u> **8. Does the agency have any plans to simplify or reduce the number of existing software platforms (e.g., operating systems, application development environments, database systems, office suites, other COTS applications)? If no, is the agency fully leveraging its technology to support both its current and future business environment?**	Yes. DADS is working to reduce the number of existing software platforms and in conjunction with this effort is ensuring the technology direction supports the current and future business environment. DADS Information Technology Department has developed an Information Technology Roadmap (ITR) to provide this foundation and direction.
9. Describe any current or planned activities targeted at reducing the environmental resource consumption of technology equipment (recycling, consolidating, virtualizing, buying energy efficient equipment, etc.).	As a participant in the Team for Texas Data Center Consolidation effort, DADS will work with IBM on the transformation efforts. Whenever possible, the transformation efforts will consolidate equipment needs of the agency. This consolidation should result in a reduction in resource needs.

Department of Assistive and Rehabilitative Services (DARS)

Question	Answer
1. Has the agency considered use of managed services in order to focus more on its business needs?	DARS recognizes the potential benefits associated with the selective use of managed services and takes advantage of such offerings where feasible. Some examples include desktop seat management, managed document output, data center services, and telephony services.
2. Does the agency leverage and obtain additional value from the Information and Communications Technology (ICT) Cooperative Contracts program; for example, by further negotiating not-to-exceed pricing?	DARS IR recognizes that DIR's ICT contracts are merely a basis from which agencies should negotiate better pricing and has begun actively negotiating from that starting point.
3. Describe the agency's strategies to align with the State Enterprise Security Plan (http://www.dir.state.tx.us/pubs/securityplan2007/index.htm).	DARS Security Management is committed to the Department of Information Resources Enterprise Security Plan (ESP). Specific strategies aligning with the plan are listed below: • Enhance current encryption practices, • Convert unsecured file transfers to secure encrypted transmissions, • Implement identity and access management systems, • Improve risk assessment processes by using the DIR Information Risk Assessment tool. • Conduct regular external and internal network vulnerability and penetration testing, • Introduce security methodology in systems development tools, practices, and training to ensure more effective security controls.
4. Describe the agency's policies, practices and programs, implemented or planned, that comply with relevant statues and administrative rules to ensure the privacy of confidential data. Consider federal privacy requirements (e.g., the Health Insurance Portability and Accountability Act or the Family Educational Rights and Privacy Act)	The Enterprise Security Policy is formally defined in HHS Circular C-021 - HHS ENTERPRISE INFORMATION SECURITY POLICY. The purpose of this policy is to establish an information resources security program for the health and human services (HHS) Enterprise that is consistent with Chapter 202 of Title 1 of the Texas Administrative Code (1 TAC 202), Information Security Standards. This policy is provided as a uniform measure to protect HHS Enterprise information resources against unauthorized access, disclosure, modification, or destruction, as well as to ensure the availability, integrity, utility, authenticity, non-repudiation, and confidentiality of information.

that apply to the agency. List the organizational units (program, offices, IT, legal, etc.) that manage privacy functions. Describe any future plans for improvement.	DARS has implemented four examples: (1) Microsoft Certificate issued and installed on the Outlook Client for secure e-mail and attachments; (2) DARS-wide distribution of WinZip version 11 enabling file encryption and secure archiving; (3) The issuance of secure volume USB flash drives for demonstrated business purposes; (4) Imminent deployment of whole disk encryption on all DARS laptops and desktops, plus a universal secure webmail capability with internal and external customers. The HHS Enterprise Information Security Standards and Guidelines, to achieve compliance with this policy, were last updated on December 31, 2007. These are organized within the following The policy, standards and guidelines apply to the information, information systems, applications, products, services, telecommunications networks, state personnel, all users, and related resources, which are sponsored by, operated on behalf of, or developed for the benefit of the Health and Human Services System. The accompanying security procedures, also published on December 31, 2007, were based upon review of and designed to ensure compliance with applicable state and federal laws, rules, and regulations, including: • Chapter 202 of Title 1 of the Texas Administrative Code (1 TAC 202), Information Security Standards. • Federal Information Processing Standards (FIPS). • Federal Information Security Management Act (FISMA). • Internal Revenue Service Publication 1075, Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities. • National Institute of Standards and Technology (NIST) Special Publications. • Social Security Administration's Information System Security Guidelines for Federal, State, and Local Agencies Receiving Electronic Information from the Social Security Administration. • Centers for Medicare and Medicaid Services (CMS) Policy for Information Security for Medicaid and the State Children's Program. • The Health Insurance Portability and Accountability Act (HIPAA).

5. What current practices or plans are in place to improve usability and search ability of the agency's Web content?	DARS designs web pages that conform to the World Wide Web Consortium (W3C) XHTML 1.0 Strict and Cascading Style Sheets (CSS) version 1.0 guidelines. By following these standards, DARS hopes to reduce website maintenance costs, improve accessibility for users with disabilities, and take advantage of technological trends. Regarding security, DARS has an internal vulnerability scan capability that is embedded in the application development process.
6. What current practices or plans are in place to improve life cycle management of agency data and information? Include the agency's approach and ability to meet future open records and e-discovery request.	DARS adheres to the approved electronic data retention plan with the Texas State Library. DARS is investigating tools to enhance the agency storage of e-mails to improve retention times and make them more searchable. Within an application, DARS is capturing originator of actions. The "Who – when – and what" of these actions is being captured and available for current and future Open Records requests.
7. Describe Agency methods and standards (federal, state, industry), implemented or planned, intended to enhance data sharing (i.e., improve interoperability) with other entities.	DARS will adhere to the standards established by HB921. This bill establishes a process for creating and implementing data sharing standards for agencies which provide social services, mental health services, substance abuse services, or health services. These standards will be established by the Texas Health Care Policy Council. DARS has identified a representative to participate on the Council.
8. Does the agency have any plans to simplify or reduce the number of existing software platforms (e.g., operating systems, application development environments, database systems, office suites, other COTS applications)? If no, is the agency fully leveraging its technology to support both its current and future business environment?	Yes, DARS has already established agency standard software platforms to improve IR support, user maintenance, and interoperability. Standards include, but are not limited to: OS = Microsoft Windows and UNIX; Application development = BEA WebLogic and Microsoft.NET; Office Suite = Microsoft Office 2007; Database = Primarily Informix and MS SQL Server. The ReHabWorks project is going to decrease the complexity of our environment by eliminating two application systems – one UNIX based and one Windows based – and replacing them with one UNIX based system. Additionally, DARS IR is staffed with the required skill sets to support our current application development environment.

9. Describe any current or planned activities targeted at reducing the environmental resource consumption of technology equipment (recycling, consolidating, virtualizing, buying energy efficient equipment, etc.	For the past two years, DARS has been virtualizing Windows based servers to decrease the number of physical servers in our data center – which in turns reduces the power consumption. With the desktop rollout which is now in progress, the agency will be able to power desktops up and down for upgrades and patches at night, whereas previously all the desktops had to be left powered-up continuously.

Department of Family and Protective Services (DFPS)

Question	Answer
1. Has the agency considered use of managed services in order to focus more on its business needs?	DFPS currently utilizes managed services for all desktop, notebook, and tablet computers. DFPS also uses managed services for all server and print services, as well as e-mail services. In addition, DFPS participates in the HHS Enterprise licensing programs for applications and software.
2. Does the agency leverage and obtain additional value from the Information and Communications Technology (ICT) Cooperative Contracts program; for example, by further negotiating not-to-exceed pricing?	DFPS utilizes the ICT program as a beginning point in negotiating best pricing practices.
3. Describe the agency's strategies to align with the State Enterprise Security Plan.	DFPS conducts regular external network vulnerability and penetration testing and assessments as outlined in the State Enterprise Security Plan.
Goal 1: Prevent Cyber Attacks and Incidents against Critical Infrastructure	DFPS participates in: current and ongoing statewide assessment activities; statewide cyber security risk, vulnerability, and equipment assessments, which track strengths, weaknesses, and remediation activities; and technical cyber security training, security forums, seminars, and conferences.
Goal 2: Reduce Vulnerability to Cyber Attacks and Other Disruptions	DFPS: promotes cyber security awareness, training, education, and certification programs; periodically tests and exercises cyber security plans; includes cyber security participation in emergency response exercises; and continues to participate in current and ongoing statewide assessment activities.
Goal 3: Respond and Recover to Minimize the Impact of Successful Cyber Attacks and Disruptions	DIR chose a DFPS staff member to attend the three week training program for developing a state Computer Security Incident Response Team (CSIRT). Through this effort, DFPS actively participates in the state Computer Security Incident Response Team to rapidly identify, contain, and recover from any attack or attempt to disrupt the state's critical IT infrastructure.

4. Describe the agency's policies, practices and programs, implemented or planned, that comply with relevant statues and administrative rules to ensure the privacy of confidential data. Consider federal privacy requirements (e.g., the Health Insurance Portability and Accountability Act or the Family Educational Rights and Privacy Act) that apply to the agency. List the organizational units (program, offices, IT, legal, etc.) that manage privacy functions. Describe any future plans for improvement.	Confidentiality and non-disclosure agreements are required of all staff, contractors, vendors and business partners. Access to data is controlled by login permissions, and is provided based on job classification and the categorization of data. Information Security Awareness Training is provided to all users of Information Resources. HIPAA training is available to all users. All computers are scheduled to blank after a period of inactivity preventing unauthorized use or viewing of sensitive materials. DFPS organizational units involved in privacy functions include the Information Resources Security Officer, Chief Operating Officer, Internal Audit, Legal Services/ General Counsel, and the Director of Information Resources. DFPS is planning a method for encrypting all hard drives, e-mails, data, and backups.
5. What current practices or plans are in place to improve usability and search ability of the agency's Web content?	DFPS provides skip links on the top of all Web pages with different styles of sheet selection options for larger font and higher contrast. The DFPS Web site includes an "Accessibility" link to a Web page that contains the DFPS accessibility policy, contact information for the DFPS accessibility coordinator, and a link to the Governor's Committee on People with Disabilities Web site. DFPS tests any new or changed web page designs for usability. In addition to Intranet and Internet searches, the DFPS web site also provides links to the DADS Internet and Intranet, DARS Internet and Intranet, DSHS Internet and Intranet, and the HHSC Internet, Intranet, and Extranet. DFPS has a strong presence on the HHS Electronic Information Resource workgroup and works in close relationship with DARS to ensure the accessibility of Web pages.
6. What current practices or plans are in place to improve life cycle management of agency data and information? Include the agency's approach and ability to meet future open records and e-discovery request.	DFPS follows an established Records Retention Schedule approved on May 31, 2007 by the Texas State Library and Archives Commission that meets the requirements of the TAC. DFPS follows standards and guidelines as outlined by the DIR Standards Review and Recommendations Publications for State Web sites. DFPS manages electronic records according to the Electronic Records Standards and Procedures adopted by the TSLAC.

7. Describe Agency methods and standards (federal, state, industry), implemented or planned, intended to enhance data sharing (i.e., improve interoperability) with other entities.	DFPS interfaces with: Health and Human Services (HHS) Children's Bureau of Administration of Children & Families through Foster Care and Adoption Reporting Information (AFCARS), and the Voluntary reporting of National Child Abuse and Neglect Data System (NCANDS). Health and Human Services Commission (HHSC): Foster Care SAVERR Medicaid sends files to HHSC to verify Medicaid information. Data from the APS and CPS case reviews is collected and the results are available to HHSC. Title XIX Eligibility communicates to match DFPS clients on SAVERR. Child Care Licensing Automated Support System (CLASS) interfaces for Fee Notices for facilities. Observance Reports for the HHSC Food Program, and the report of Facility Changes is used by HHSC in determining facilities that qualify for the HHSC Food Program. Comptroller of Public Accounts (CPA): Reports which originate at CPA send employee data extracts for employee and mail code information. Department of Public Safety (DPS): DFPS interfaces with DPS for Criminal History checks Texas Department of Aged and Disabled Services (DADS): DFPS and DADS share information on facility investigations completed during the prior month. Texas Attorney General (AG): IMPACT receives reports of court ordered child support for children in foster care. Texas Youth Commission (TYC): IMPACT sends and receives data to TYC to recoup IV-E eligibility federal money for TYC. Texas Juvenile Probation Commission (JPC): IMPACT sends and receives data to JPC to recoup IV-E eligibility federal money for JPC.

	Third Party Reviewer Interface: IMPACT sends and receives information from Youth for Tomorrow regarding children in foster care whose level of care needs to be established or reviewed. Judicial System: Judicial Web Page/Count Improvement Project (CIP) shares information with the judicial system. Texas Education Agency: TEA sends electronic files updating school district and school information once a year to the DFPS interface in IMPACT.
8. Does the agency have any plans to simplify or reduce the number of existing software platforms (e.g., operating systems, application development environments, database systems, office suites, other COTS applications)? If no, is the agency fully leveraging its technology to support both its current and future business environment?	DFPS is participating in the Data Center Consolidation transformation process to simplify and reduce the number of hardware and software platforms in use.
9. Describe any current or planned activities targeted at reducing the environmental resource consumption of technology equipment (recycling, consolidating, virtualizing, buying energy efficient equipment, etc.	Through partnerships with computer vendors, DFPS recycles old equipment for newer more efficient equipment. DFPS has been innovative in the use of leased instead of purchased computer resources. As applications become more complex requiring greater computer resources, DFPS will continue to provide those resources for the caseworkers who protect the children and adults of Texas.

Department of State Health Services (DSHS)

1. Has the agency considered use of managed services in order to focus more on its business needs? Outline major accomplishments and challenges that are anticipated.	Current: • Seat managed PCs & laptops • Microsoft Enterprise Subscription Agreement (standard desktop software) Future: • HHSC is considering a new seat managed phone system. • HHSC is negotiating for an enterprise-wide email system • DSHS is considering wireless seat managed services (state hospitals) • HHSC is negotiating for enterprise-wide managed print services (printing/copying/faxing/scanning)
2. Does the agency leverage and obtain additional value from the Information and Communications Technology (ICT) Cooperative Contracts program; for example, by further negotiating not-to-exceed pricing? Outline major accomplishments and challenges that are anticipated	DSHS does negotiate with the ICT Cooperative Contracts vendors but afterwards HHSC Enterprise Contracting & Procurement Services may negotiate further. One challenge might be to discover ways to include value-add opportunities (training vouchers, consulting hours, etc.) into the procurement process. The ICT Cooperative Contracts program has greatly improved our end-of-year purchasing experience.
3. Describe the agency's strategies to align with the State Enterprise Security Plan (http://www.dir.state. tx.us/pubs/securityplan2007/index.htm).	DSHS Information Security Program and Information Security Architecture Strategy incorporate goals and objectives outlined in the State Enterprise Security Plan. **Goal 1 – Prevent Cyber Attacks and Incidents Against Critical Infrastructure** **Objective 1** – DSHS IT uses various tools to monitor and analyze network traffic for security threats and incidents, IDS, anti-virus, anti-spyware, etc. System logs are reviewed regularly for

	abnormal and suspicious activity. Monthly incident reports are provided to DIR and HHS Enterprise Security Management. **Objective 2** – DSHS IT staff participates in security training provided through vendors and DIR sponsored security training. **Objective 3** – Information Security is integrated into the procurement process and the project management process. **Goal 2 – Reduce Vulnerability to Cyber Attacks and Other Disruptions** **Objective 4** – Assessments are performed annually and when new systems are developed. Controlled Penetration Test, Information Security Assessment, Awareness and Compliance, Web Application Vulnerability Scan. Systems are also audited by DSHS Internal Audit. **Objective 5** – IT Operations and Information Security receive and distribute security alerts and notices. These alerts and notices are receive from numerous sources; HHS Enterprise CIRT, TX-S/NOC, CERT, SANS, Multi-State-ISAC and vendor SOCs. **Objective 6** – DSHS Information Security policies, standards and guidelines are reviewed and updated periodically. System Security Plans and developed and reviewed annually. **Goal 3 – Respond and Recover to Minimize the Impact of Successful Cyber Attacks and Disruptions** **Objective 7** – DSHS has implemented a Computer Incident Response Plan and Computer Incident Response Team. DSHS participates in the HHS Enterprise CIRT. DSHS is involved in the development of the state Computer Security Incident Response Team. **Objective 8** – Information Security provides input to the DSHS COOP
4. Describe the agency's policies, practices and programs, implemented or planned, that	Information Security policies, practices and program are reviewed and updated to align with T.A.C., HIPAA, CMS, NIST, FIPS and HHS

comply with relevant statutes and administrative rules to ensure the privacy of confidential data. Consider federal privacy requirements (e.g., the Health Insurance Portability and Accountability Act or the Family Educational Rights and Privacy Act) that apply to the agency.	Enterprise Information Security Policies, Standards and Guidelines. Confidentiality and Non-disclosure agreements are required of staff, contractors, vendors and business partners. MOUs are executed with governmental agencies. Access to data is controlled and provided based on job functions for least- privilege and need-to-know. Information Security Awareness Training is provided to all users of Information Resources. HIPAA training is provided to all users with access to data within all HIPAA covered entities. **List the organizational units (program, offices, IT, legal, etc.) that manage privacy functions.** Information Security Officer, Information Security Team, OGC, HIPAA Privacy Officer, HIPAA Project Manager, Internal Audit, business units with confidential data. **Describe any future plans for improvement.** Encryption technologies for • data storage • data in transit • email Network Access Control Improve Risk Management Process **Regarding Security and privacy, outline major accomplishments and challenges that are anticipated.** **Major Accomplishments** 1. Addition of two assessments

	• Information Security Assessment, Awareness and Compliance • Web Application Vulnerability Scan 2. Integration of Information Security into Project Management process 3. Increased Management's focus on Information Security 4. Increased Information Security training **Challenges** 1. Acquisition of network and data protection tools (funding) 2. Remediation of discovered vulnerabilities (staffing, training)
5.What current practices or plans are in place to improve usability and searchability of the agency's Web content? (2007 SSP, Strategy 4 1)	1. An HHSC Enterprise policy on accessibility is in place. 2. DSHS has an IT Web Office Change Control Board that enforces the DIR accessibility standards. 3. DSHS has an FY08/09 project in progress that includes accessibility consulting, system remediation, and web content management. 4. DSHS has a proposed FY10/11 exceptional item to fund the next steps in becoming fully compliant including maintaining compliance.
6.What current practices or plans are in place to improve life cycle management of agency data and information? Include the agency's approach and ability to meet future open records and e-discovery requests. (2007 SSP, Strategy 4-1)	1. DSHS IT is working jointly with the DCS Team for Texas to ensure data backups are successfully completed, logged, and tracked. 2. DSHS IT is working jointly with the DSHS Records Management Office to provide agency-wide awareness regarding records retention policy and guidelines. 3. DSHS IT is reviewing e-discovery products as a future planning effort.
7.Describe agency methods and standards (federal, state, industry), implemented or planned, intended to enhance data sharing (i.e., improve interoperability) with other entities. (2007 SSP, Strategy 4-2)	1. State Evacuation Tracking System all hazards application, Special Needs Evacuation Tracking System and Web EOC (Emergency Operations Center– DSHS, Governor's Division of Emergency Management, UT Space Research, Governor's Office 2. CMBHS shares data with DPS and is based on Service Oriented Architecture designed for data sharing 3. Public Health Information Network – State and Federal data sharing system

	4. Planned Real ID for VSU/Social Security Administration 5. Videoconferencing – City and County Judicial systems
8.Does the agency have any plans to simplify or reduce the number of existing software platforms (e.g., operating systems, application development environments, database systems, office suites, other COTS applications)? If no, is the agency fully leveraging its technology to support both its current and future business environment?	1. DSHS was funded for a software remediation project in FY08/09. The purpose is to upgrade software that is no longer supported by the vendor and to ensure accessibility. This project is now underway. DSHS is leveraging the DIR IT Services RFO in support of this project. 2. DSHS has plans to migrate from a Novell platform to a Windows platform.
9.Describe any current or planned activities targeted at reducing the environmental resource consumption of technology equipment (recycling, consolidating, virtualizing, buying energy efficient equipment, etc.).	DSHS is preparing for DCS transformation to a virtual server environment. DSHS is driving out old technology and refreshing with more energy-efficient technology

Health and Human Services Commission (HHSC)

Question	Answer
1. Has the agency considered use of managed services in order to focus more on its business	HHSC recognizes the potential benefits associated with the selective use of managed services and takes advantage of such offerings where feasible.

needs?	Some examples include desktop seat management, and telephony services.
2. Does the agency leverage and obtain additional value from the Information and Communications Technology (ICT) Cooperative Contracts program; for example, by further negotiating not-to-exceed pricing?	HHSC Enterprise IT recognizes that DIR's ICT contracts are merely a basis from which agencies should negotiate better pricing and has begun actively negotiating from that starting point.
3. Describe the agency's strategies to align with the State Enterprise Security Plan (http://www.dir.state.tx.us/pubs/securityplan2007/index.htm).	HHS Enterprise Security Management is committed to the Department of Information Resources Enterprise Security Plan (ESP). Specific strategies aligning with the plan are listed below: – Enhance current encryption practices, – Convert manual tape processing to secure encrypted transmissions, – Implement identity and access management systems, – Improve risk assessment processes by using the DIR Information Risk Assessment tool. – Conduct regular external network vulnerability and penetration testing, – Improve data classification processes, – Improve systems development tools, practices, and training to ensure more effective security controls.
4. Describe the agency's policies, practices and programs, implemented or planned, that comply with relevant statues and administrative rules to ensure the privacy of confidential data. Consider federal privacy requirements (e.g., the Health Insurance Portability and Accountability Act or the Family Educational Rights and Privacy Act) that apply to the agency. List the organizational units (program, offices, IT, legal, etc.) that manage privacy functions. Describe any future plans for improvement.	The Enterprise Security Policy is formally defined in HHS Circular C-021 - HHS ENTERPRISE INFORMATION SECURITY POLICY. The purpose of this policy is to establish an information resources security program for the health and human services (HHS) Enterprise that is consistent with Chapter 202 of Title 1 of the Texas Administrative Code (1 TAC 202), Information Security Standards. This policy is provided as a measure to protect HHS Enterprise information resources against unauthorized access, disclosure, modification, or destruction, as well as to ensure the availability, integrity, utility, authenticity, non-repudiation, and confidentiality of information. The HHS Enterprise Information Security Standards and Guidelines to achieve compliance with this policy were last updated on December 31, 2007. These are organized within the following The policy, standards and guidelines apply

	to the information, information systems, applications, products, services, telecommunications networks, state personnel, all users, and related resources, which are sponsored by, operated on behalf of, or developed for the benefit of the Health and Human Services System. The accompanying security procedures, also published on December 31, 2007, were based upon review of and designed to ensure compliance with applicable state and federal laws, rules, and regulations, including: • Chapter 202 of Title 1 of the Texas Administrative Code (1 TAC 202), Information Security Standards. • Federal Information Processing Standards (FIPS). • Federal Information Security Management Act (FISMA). • Internal Revenue Service Publication 1075, Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities. • National Institute of Standards and Technology (NIST) Special Publications. • Social Security Administration's Information System Security Guidelines for Federal, State, and Local Agencies Receiving Electronic Information from the Social Security Administration. • Centers for Medicare and Medicaid Services (CMS) Policy for Information Security for Medicaid and the State Children's Program. • The Health Insurance Portability and Accountability Act (HIPAA). Implementation of this policy is addressed by each project. In addition HHSC has implemented an Enterprise class Identify and Access Management solution and is actively working to use this centralized resource as a method to help ensure data privacy.The following HHSC documents/policies address privacy and the confidentiality of data: **HHSC IT Security Handbook; HIPAA Privacy Policies and Procedures Handbook; Texas Works Handbook; Medicaid Eligibility Handbook and HHS Human Resources Manual.** Security policies and requirements are also found in the HHSE Computer Use Agreement (HR0314), HHS EASM Security and Privacy Agreement; HHSC Computer Resources Use Agreement (HHSC740), and HHSC Non-Disclosure Agreement. The Information Security Office has developed the HHSC

	"Information Security Plan" which is based on ISO 17799 information security standards and establishes the security plan for information systems supporting HHSC and is the foundation for protecting HHSC information systems. HHSC has implemented an IPS (Intrusion Prevention System) and firewalls at the network core to protect agency data. HHSC initiated a HIPAA vulnerability assessment and CPT (Controlled Penetration Test) to assess the security of HIPAA data. The HIPAA Privacy Office ensures compliance with HIPAA regulations, state, federal and agency privacy requirements. Privacy policies and procedures are integrated into program handbooks. Examples of topics are verification protocols, authorization forms, minimum necessary, alternate address policy, health information amendment procedures, access rights, and HHSC privacy notice. Other office activities include review of research protocols and requests for PHI data, de-identification standards, complaint investigations (State and Federal), business associate assessments, and review of privacy incidents (paper and electronic). HHSC requires new employees to take online privacy and security training with refresher courses required of all staff and contractors. Volunteers are required to complete privacy training and security training, if granted access to automation systems. **Future plans:** HHSC is beginning risk assessment activities of HIPAA applications with plans to implement as an ongoing process for all applications. HHSC plans to upgrade their IT Security Handbook with a revised Security Standards and Guidelines document which incorporated IRS and SSA requirements for PII and PHI. HHSC plans to implement Web Application Scanning as a tool to identify web application vulnerabilities. HHSC has two additional IPS boxes which are in place in monitor mode with plans to activate soon. HHSC is working with DIR to schedule an agency wide CPT (Controlled Penetration Test) prior to the end of August 2008 with a follow-up CPT to be performed in 2009. Implement revised HIPAA Privacy Course by September

	1, 2008. Implement encryption to protect data at rest. **List the organizational units (program, offices, IT, legal, etc.) that manage privacy functions:** HIPAA Project Office;Commission IT; Office of Chief Counsel.
5. What current practices or plans are in place to improve usability and search ability of the agency's Web content?	HHSC is in the process of redesigning its primary public website to make consumer information easier to find. The redesigned site will include a Google search engine that is much more effective than the agency's previous search tool. It also includes prominent links to many resources for clients of HHSC services. This includes links to tools to help Medicaid clients find a doctor or get a ride to a medical appointment, instructions on how to replace a Lone Star Card, details on how to pay a CHIP enrollment fee online and other information that previously was difficult to find or not located on the HHSC website. The site also includes streamlined information for Texans seeking assistance with clear program descriptions written in plain language and instructions on how to apply for services.
6. What current practices or plans are in place to improve life cycle management of agency data and information? Include the agency's approach and ability to meet future open records and e-discovery request.	**Open records** – HHSC Commission IT is researching enterprise e-discovery solutions. We plan to meet with multiple vendors and have met with one vendor already. Funding is a concern since e-discovery costs are anticipated to be a half million dollars or more. Currently HHSC is using multiple tools to manually perform e-discovery. (Encase, Active Folders, DT Search and ISYS desktop). In addition the current tools require the data to be captured from desktops, servers and consolidated before using the tools. The current process is labor intensive. An enterprise class solution can eliminate a large percentage of the labor and provide the search results quickly.
7. Describe Agency methods and standards (federal, state, industry), implemented or planned, intended to enhance data sharing (i.e., improve interoperability) with other entities.	HHSC IT is standardizing on a single platform. Each request for development is reviewed to leverage reuse of code and reduce development time. HHSC will undertake the Medicaid Information Technology Architecture (MITA) state self-assessment in FY08 and FY09. MITA is a CMS directed initiative that asks Medicaid agencies to use standards based technology to improve interoperability among states. MITA promotes standards based technology including X12 transaction standards, Service Oriented Architecture (SOA) messaging standards, and Health Level 7 (HL7) clinical data exchange

	standards. The state self-assessment will be the first step in cataloguing the use of standards based technology for all Texas Medicaid programs. Once the self-assessment has been completed, HHSC will develop a “to-be” MITA roadmap that describes the HHSC vision, the gap between the current processes and systems and the future vision of MITA compliance, and a long range plan for movement toward the vision.
8. Does the agency have any plans to simplify or reduce the number of existing software platforms (e.g., operating systems, application development environments, database systems, office suites, other COTS applications)? If no, is the agency fully leveraging its technology to support both its current and future business environment?	As an agency participating in the data center services program, HHSC will consolidate operations to the state data centers in Austin and San Angelo in the next 18-24 months. The consolidation includes migration to the DCS standard software platforms and tools for greater consistency across the state. Additionally, HHSC submits new infrastructure technology purchases through the DCS solution request process. The solution request process uses the DCS standard configurations and includes enterprise-level reviews of solutions to ensure alignment with the state’s direction for data center services.
9. Describe any current or planned activities targeted at reducing the environmental resource consumption of technology equipment (recycling, consolidating, virtualizing, buying energy efficient equipment, etc.	As an agency participating in the data center services program, HHSC will consolidate operations to the state data centers in Austin and San Angelo in the next 18-24 months. The state data centers us highly efficient energy management systems, including double-conversion technology for the uninterruptible power supply (UPS) direct current (DC) units and specialized lighting design that utilizes 23 percent less electricity than the state energy allowance. In addition to migrating operations to the more efficient environment, HHSC will simplify, and improve systems management by combining distributed systems into virtual systems, replace older, less efficient technology, and employ other remerging technology strategies to reduce HHSC’s technology footprint. The technology Plan delivered as part of the Data Center Services contract describes HHSC’s consolidation and virtualization plans in detail.

Health and Human Services System Strategic Plan
for the Planning Period 2009–13

APPENDIX F

Health and Human Services System Workforce Plan for Human Capital Management

Planning Period 2009–13

Executive Summary

The Health and Human Services (HHS) System Workforce Plan is an integral part of the agency's staffing plan. With constraints on funding, an increased demand for HHS services, an aging workforce resulting in fewer, less experienced workers available as replacements and increased competition for highly skilled employees, workforce planning is not optional; it is a business necessity. HHS agencies are proactively addressing this challenge by preparing for the future and reducing risks. Designed for flexibility, the HHS System Workforce Plan allows HHS executive management to make staffing adjustments according to the changing needs of HHS agencies.

State leaders in Texas recognize the importance of workforce planning. As part of their strategic plans, state agencies are required under the Texas Government Code, Section 2056.0021, to develop a workforce plan in accordance with the guidelines developed by the State Auditor's Office (SAO). To meet these requirements, this Appendix to the HHS System Strategic Plan for the Fiscal Years 2009–2013 analyzes the following key elements for the entire HHS System and each individual HHS agency:

- **Current Workforce Demographics** – Describes how many employees work for the agency, where they work, what they are paid, how many of them are return-to-work retirees, how many have left the agency, how many are expected to retire, and whether or not minority groups are underutilized when compared to the state Civilian Labor Force (CLF) for Equal Employment Opportunity (EEO) job categories. The workforce is examined by gender, race, age and length of state service.

- **Expected Workforce Challenges** – Describes anticipated staffing needs based on population trends, projected job growth and other demographic trends. A detailed examination of each of identified shortage occupation jobs was conducted to identify and understand retention and recruitment problems.

- **Strategies to Meet Workforce Needs** – Describes recruitment and retention strategies that address expected workforce challenges for shortage occupation jobs.

The following is the detailed HHS System Workforce Plan.

HEALTH AND HUMAN SERVICES SYSTEM WORKFORCE PLAN

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Prepared by: Consumer Support & Workforce Services
Human Resources Office

HEALTH AND HUMAN SERVICES SYSTEM

OVERVIEW

The 78th Legislature (Regular Session, 2003) transformed the Health and Human Services (HHS) agencies listed in Article II of the General Appropriations Act by creating an integrated, effective and accessible HHS System that protects public health and brings high-quality services and support to Texans in need.

The HHS System consists of the following five agencies:

- **Health and Human Services Commission (HHSC).** Includes providing leadership to all HHS agencies, administering programs previously administered by the Texas Department of Human Services and oversight of HHS agencies. Began services in 1991.

- **Department of Family and Protective Services (DFPS).** Includes all programs previously administered by the Department of Protective and Regulatory Services. Began services on February 1, 2004.

- **Department of Assistive and Rehabilitative Services (DARS).** Includes programs previously administered by the Texas Rehabilitation Commission, Commission for the Blind, Commission for the Deaf and Hard of Hearing and Interagency Council on Early Childhood Intervention. Began services on March 1, 2004.

- **Department of Aging and Disability Services (DADS).** Includes mental retardation and state school programs previously administered by the Department of Mental Health and Mental Retardation, community care and nursing home services and long-term care regulatory programs of the Department of Human Services and aging services programs of the Texas Department of Aging. Began services on September 1, 2004.

- **Department of State Health Services (DSHS).** Includes programs previously administered by the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, the Health Care Information Council and mental-health community services and state hospital programs from the Department of Mental Health and Mental Retardation. Began services on September 1, 2004.

VISION

Albert Hawkins, Executive Commissioner for Health and Human Services, articulated the following vision for the HHS System:

> We envision a health and human services enterprise that works better and costs less. Toward this goal, we will seek input and build partnerships with local communities, advocacy groups and the private and not-for-profit sectors to put in place solutions that emphasize program efficacy and personal responsibility. We also envision a highly coordinated Health and Human Services (HHS) system driven by motivated and talented workers focused not only on sound processes and procedure, but also on results.

MISSION

The mission of HHS agencies in Texas is to develop and administer an accessible, effective and efficient health and human services delivery system that is beneficial and responsive to the people of Texas.

PHILOSOPHY

Every Texan should be able to access and utilize available health and human services provided by state agencies in the most integrated, cost-effective setting possible. The HHS System is dedicated to developing client-focused program and policy initiatives that are relevant, timely and within the means of the taxpayers of the state of Texas. The HHS System will advocate for client-choice, appropriate funding and streamlined service delivery. Additionally, we hold to these guiding principles:

- Every person, regardless of income, race, ethnicity, physical or mental limitation, gender, religion, or age, is entitled to dignity, independence and respect.

- Texans deserve openness, fairness and the highest ethical standards from us, their public servants.

- Taxpayers and their elected representatives, deserve conscientious stewardship of public resources and the highest level of accountability.

- As agency representatives, we work in partnership with lawmakers, customers, service providers and the public to continually improve the quality of our service.

WORKFORCE DEMOGRAPHICS

Between August 31, 2004 and August 31, 2007, the HHS workforce has increased by about seven percent (adding 3,111 workers, for a total of 48,203 full-time and part-time employees).[1]

Figure 1: HHS System Workforce for FY 05 - FY 07

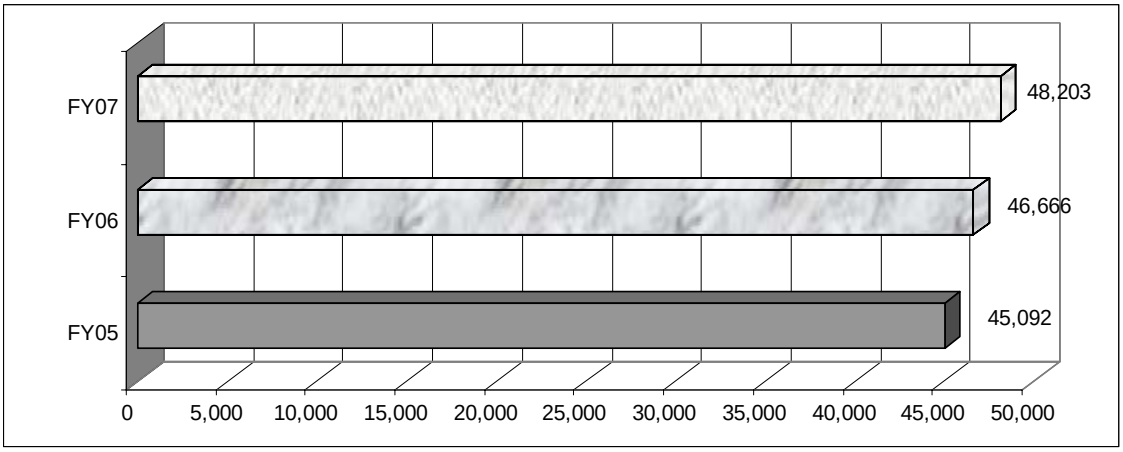
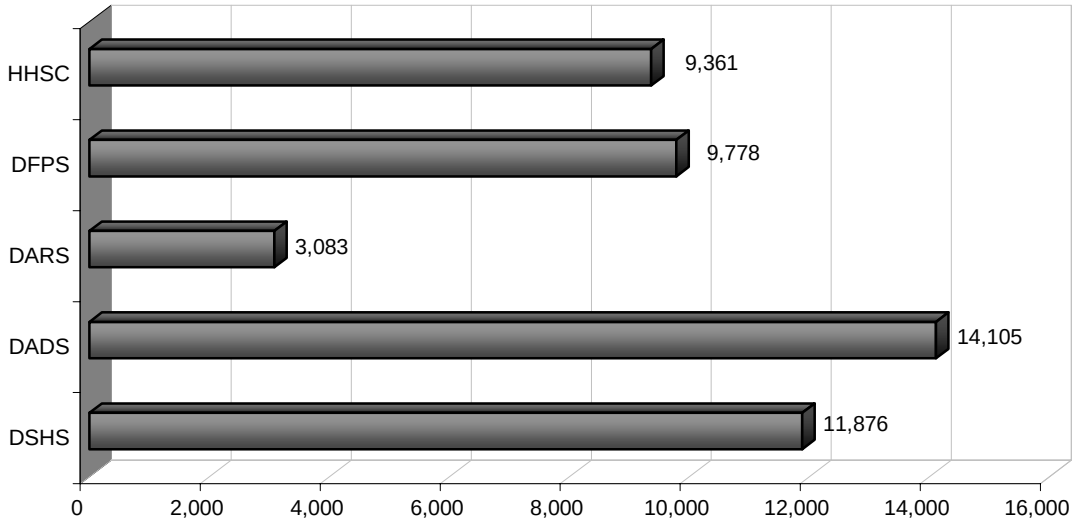


Figure 2: HHS System Workforce for FY 07



[1] HHSAS Database, as of 8/31/07.

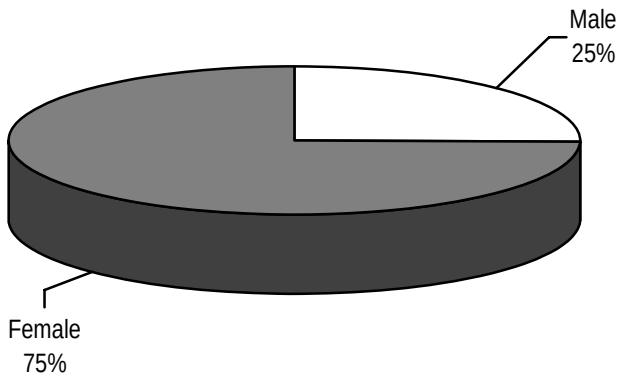
Gender

Most HHS employees are female, making up about 75 percent of the HHS workforce.[2]

Table 1: HHS System Workforce Gender for FY 05 – FY 07

Gender	FY 05	FY 06	FY 07
Male	26.0%	26.1%	25.4%
Female	74.0%	73.9%	74.6%

Figure 3: HHS System Workforce by Gender for FY 07



Race

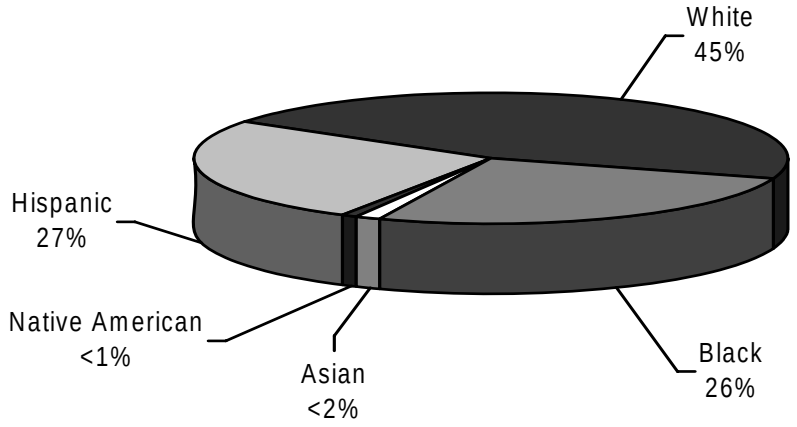
The workforce is diverse, with approximately 45 percent White, 26 percent Black and 27 percent Hispanic.[3]

Table 2: HHS System Workforce Race for FY 05 – FY 07

Race	FY 05	FY 06	FY 07
White	46.7%	45.7%	45.1%
Black	24.7%	25.5%	25.7%
Hispanic	26.2%	26.5%	27.0%
Native American	.8%	.8%	.7%
Asian	1.5%	1.6%	1.6%

[2] HHSAS Database, as of 8/31/07.
[3] Ibid.

Figure 4: HHS System Workforce by Race for FY 07



Age

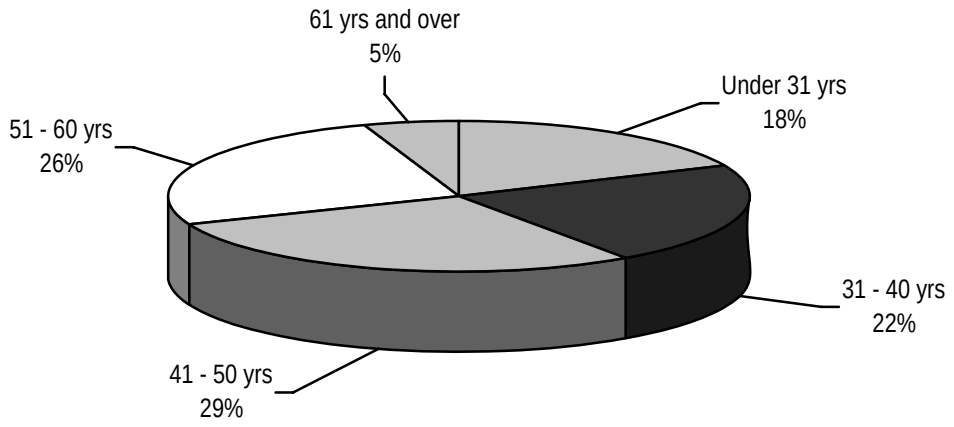
The average age of an HHS worker is 44 years of age.[4]

Table 3: HHS System Workforce Age for FY 05 – FY 07

Age	FY 05	FY 06	FY 07
Under 31	16.3%	17.2%	18.2%
31-40	23.3%	22.7%	22.1%
41-50	30.7%	29.5%	28.5%
51-60	25.4%	25.7%	26.0%
Over 61	4.3%	4.8%	5.2%

[4] HHSAS Database, as of 8/31/07.

Figure 5: HHS System Workforce by Age for FY 07



Average age: 44 yrs

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and Females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

The utilization analysis was conducted for the HHS System and for each individual agency using the Two Standard Deviation Rule. This rule compares the actual number of employees to the expected number of employees based on the available state CLF for Black, Hispanic and Female employees. Differences greater than two standard deviations are considered statistically significant. For purposes of this analysis, a group is considered underutilized when the actual representation in the workforce is more than two standard deviations below what the expected number would be based on the CLF. In cases where the analysis identified underutilization, the minimum number of additional employees needed to bring that group within two standard deviations has been identified.

The HHS Civil Rights Office (CRO) reviewed and conducted analyses for each individual agency's workforce to determine where underutilization was identified.

An analysis of the HHS System workforce indicates underutilization in the following areas:

- Black, Hispanic and Female employees in the Skilled Craft job category; and

- Hispanic employees in the Service Maintenance job category.[5] [6] [7]

Table 4: HHS System Utilization Analysis Results

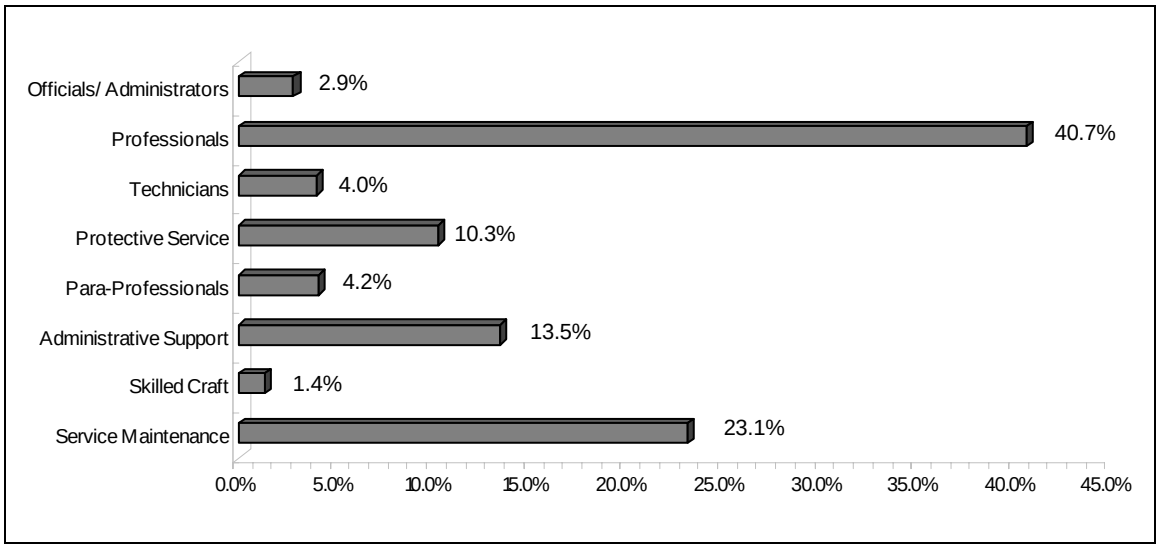
Job Category	Black			Hispanic			Female		
	HHS %	CLF %	Underutilization (If Yes, # needed)	HHS %	CLF %	Underutilization (If Yes, # Needed)	HHS %	CLF %	Underutilization (If Yes, # Needed)
Officials/ Administrators	12.8%	7.2%	No	14.5%	12.3%	No	57.9%	32.6%	No
Professionals	19.0%	9.4%	No	25.9%	11.6%	No	73.5%	49.0%	No
Technicians	19.1%	13.9%	No	24.0%	19.7%	No	77.4%	42.1%	No
Protective Service	28.4%	18.0%	No	24.0%	23.1%	No	80.8%	21.6%	No
Para-Professionals	27.4%	14.3%	No	31.1%	25.7%	No	85.4%	56.3%	No
Administrative Support	21.8%	19.4%	No	35.9%	26.8%	No	90.3%	78.8%	No
Skilled Craft	6.0%	14.7%	39	25.1%	35.2%	41	4.7%	16.5%	58
Service Maintenance	41.9%	20.4%	No	26.6%	43.7%	1,808	68.3%	44.4%	No

Although underutilization was identified in the Skilled Craft job category, it should also be noted that this job category comprises only 1.4 percent of the HHS System workforce. In addition, this group also has the lowest attrition rate compared to other job categories analyzed.

The other job category showing underutilization is Service Maintenance. This Equal Employment Opportunity (EEO) job category represents 23.1 percent of the HHS System workforce and has a higher attrition rate than other job categories. DADS and DSHS employ most of the staff in this EEO job category. The Service Maintenance EEO job category is discussed in greater detail under the individual agency data.

[5] HHSAS Database, as of 8/31/07.
[6] CLF data – EEOC publications, "Job Patterns for Minorities and Women in State and Local Government, 2003" for Texas and "Job Patterns for Minorities and Women in Private Industry, 2003" for Texas. Modified 06/08/2005.
[7] Percentage Totals may not equal 100% due to rounding; TCC (Texas Cancer Council) Totals (6 employees) included in Statewide – therefore, Agency Totals are not equal to State Wide.

Figure 6: HHS System – Percent of Employees by EEO Category



State Service

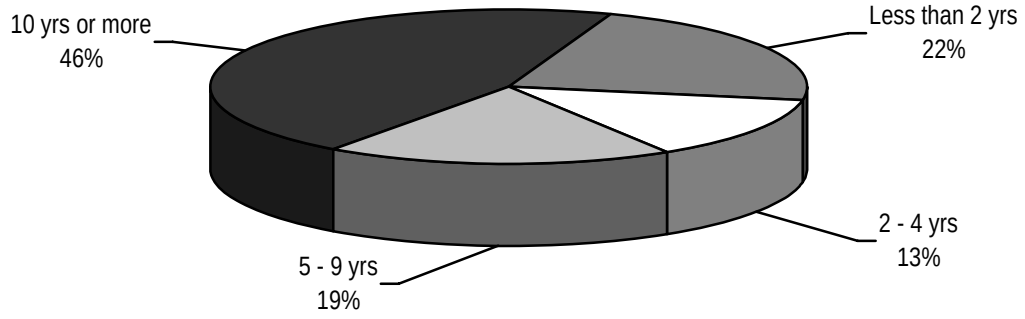
About half of the workforce has 10 or more years of state service. Only one in five workers has been with the state for less than two years.[8]

Table 5: HHS System Workforce Length of State Service for FY 05 – FY 07

State Service	FY 05	FY 06	FY 07
less than 2 yrs	17.0%	20.0%	22.1%
2-4 yrs	15.5%	13.3%	13.4%
5-9 yrs	19.9%	20.3%	18.9%
10 yrs or more	47.6%	46.3%	45.5%

[8] HHSAS Database, as of 8/31/07.

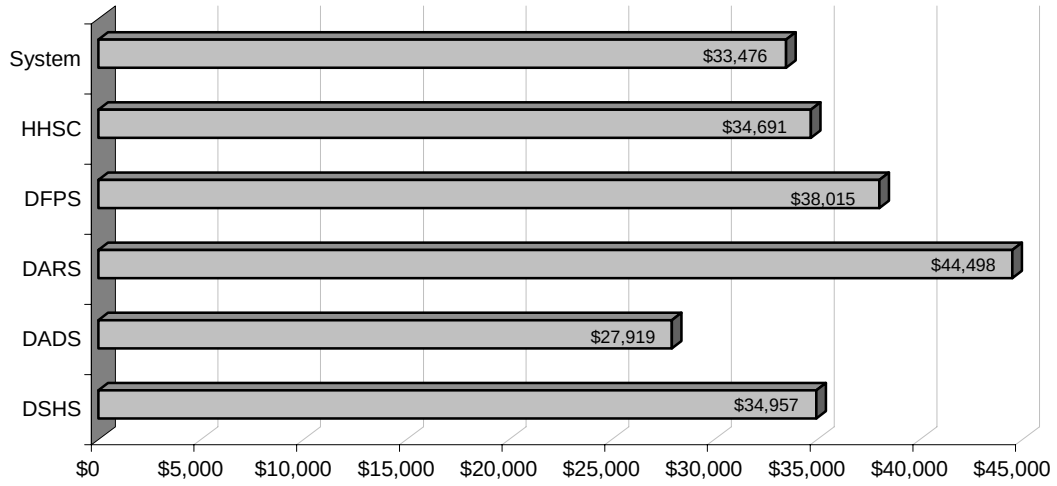
Figure 7: HHS System Workforce by Length of State Service



Average Annual Employee Salary

On average, the annual salary for an HHS System employee is $33,476. DARS has the highest average annual salary at $44,498 and DADS has the lowest at $27,919.[9]

Figure 8: HHS Average Annual Salary by Agency

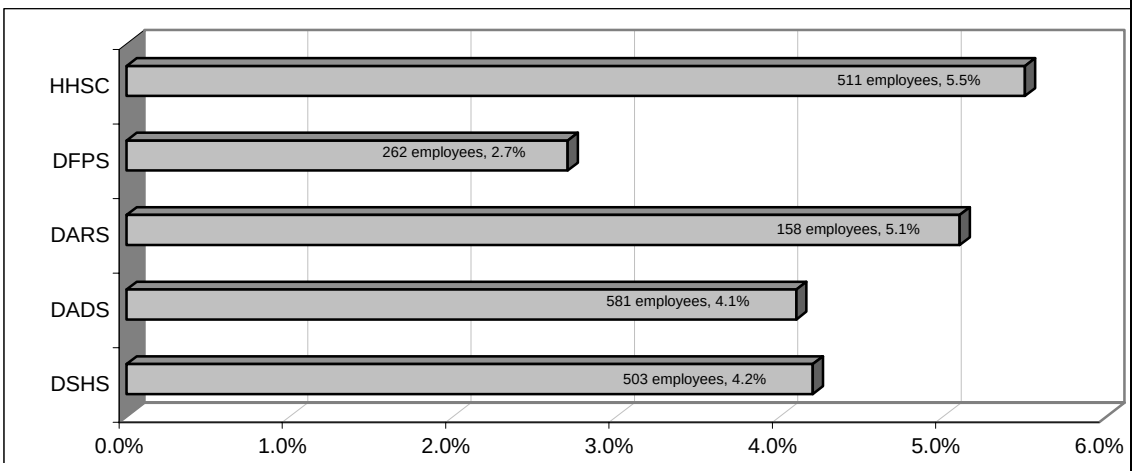


[9] HHSAS Database, as of 8/31/07.

Return-to-Work Retirees

HHS agencies routinely hire retirees to support both ongoing operational needs and to assist in implementing new initiatives. When recruiting for shortage occupations, special skill required positions or for special projects, retirees provide a good source of relevant program-specific knowledge. Rehired retirees constitute about 4.2 percent of the total HHS workforce. [10]

Figure 9: HHS Return-to-Work Retirees by Percent of Agency Workforce



Agency management understands that demographic trends over the next decade will increasingly impact recruitment from typical sources. As turnover continues to be high for core jobs across the HHS System, the loss of experienced workers will demand a concentrated focus on hiring retired workers to fill these needs. Retired workers who have institutional knowledge will be needed to pass their expertise to others.

Dealing with this “graying” workforce will require HHS agencies to attract more people to apply for work, encourage them to work longer and help make them more productive. Creative strategies will need to be devised to keep older workers on the job, such as hiring retirees as temps; letting employees phase into retirement by working part time; having experienced workers mentor younger employees; promoting telecommuting, flexible hours and job-sharing; urging retirement-ready workers to take sabbaticals instead of stepping down; and/or offering bonuses to forestall retirement.

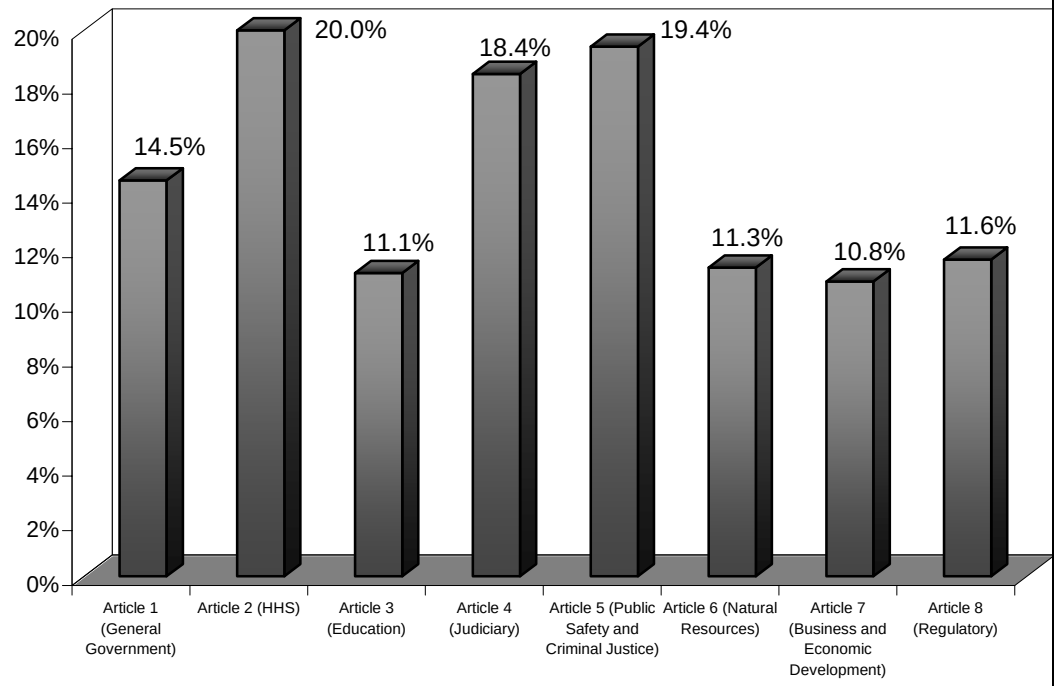
TURNOVER

The Article II (HHS agencies) employee turnover rate during fiscal year 2007 was 20 percent, as identified by the State Auditor’s Office (SAO). When compared to

[10] HHSAS Database, as of 8/31/07.

the turnover rates of other General Appropriations Act articles, HHS agencies had the highest turnover rate.[11]

Figure 10: Turnover Rate by Article for FY 07 (excludes inter-HHS agency transfers)



Note: The SAO does not consider it a loss when employees transfer between HHS agencies.

Table 6: HHS System Workforce - Turnover for FY 05 – FY 07 (excludes inter-HHS agency transfers)

	FY 05	FY 06	FY 07
HHS System	19.2%	17.0%	20.0%

DADS experienced the highest turnover rate (30.2 percent), with the lowest turnover rate at DARS (10.7 percent).[12]

The SAO does not consider transfers between agencies as a loss to the state and therefore does not include this turnover in their calculations. However, when transfers between HHS agencies are taken into account, the HHS turnover rate increases from 20 percent to almost 23 percent. This additional turnover is significant because replacement costs are incurred by the agencies to process

[11] State Auditor's Office (SAO) FY 2007 Turnover Statistics.
[12] Ibid.

terminations and hires, to train new staff for different jobs and to recruit staff to replace those who have moved to another agency.[13]

Table 7: Turnover by HHS Agency (includes inter-HHS agency transfers)			
Agency	**Average Annual Headcount**	**Total Separations**	**Turnover Rate**
HHSC	7,951.75	1,120	14.1%
DFPS	9,841.00	2,284	23.2%
DARS	3,193.25	343	10.7%
DADS	15,178.75	4,581	30.2%
DSHS	12,393.75	2,637	21.3%
Grand Total	**48,558.50**	**10,965**	**22.6%**

Certain job families have significantly higher turnover than other occupational series, including MHMR Workers (Mental Retardation Assistants and Psychiatric Nursing Assistants) at 41.3 percent, Child Protective Services Workers at 39.5 percent, Licensed Vocational Nurses at 27.9 percent, Adult Protective Services Workers at 24.9 percent and Registered Nurses at 22.4 percent.[14]

[13] HHSAS Database, as of 8/31/07.
[14] HHSAS Database for FY 2007.

Table 8: FY 07 Turnover for Significant Job Families		
Job Title	Average Annual Headcount	Turnover Rate
MHMR Workers	9,917.5	41.3%
Child Protective Services Workers	1,853.8	39.5%
Licensed Vocational Nurses	1,148.0	27.9%
Auditors	152.0	25.0%
Adult Protective Services Workers	666.8	24.9%
Registered Nurses	1,718.0	22.4%
Pharmacists	83.5	18.0%
Rehabilitation Therapy Technicians	991.3	16.4%
Accountants	479.3	16.3%
Child Care License Workers	459.0	16.3%
Contract Specialists	257.5	16.3%
Psychologists	207.8	14.4%
Rehabilitation Services Technicians	408.8	14.4%
Vocational Rehabilitation Counselors	673.5	13.7%
Clinical Social Workers	187.5	13.9%
Directors	362.5	12.4%
Attorneys	179.3	12.3%
Psychiatrists	121.5	11.5%
Chemists	61.5	11.4%
Physicians	118.5	11.0%
Claims Examiners	505.3	9.5%

Of the total losses during fiscal year 2007, 76.2 percent were voluntary separations and 23.8 percent were agency-directed. Agency-directed includes reduction in force, dismissal for cause, resignation in lieu of separation and separation at will.[15]

[15] State Auditor's Office (SAO) Reports "Employee Turnover by State Agency during Fiscal Year 2007."

Figure 11: Turnover Rate by Length of Service for FY 07

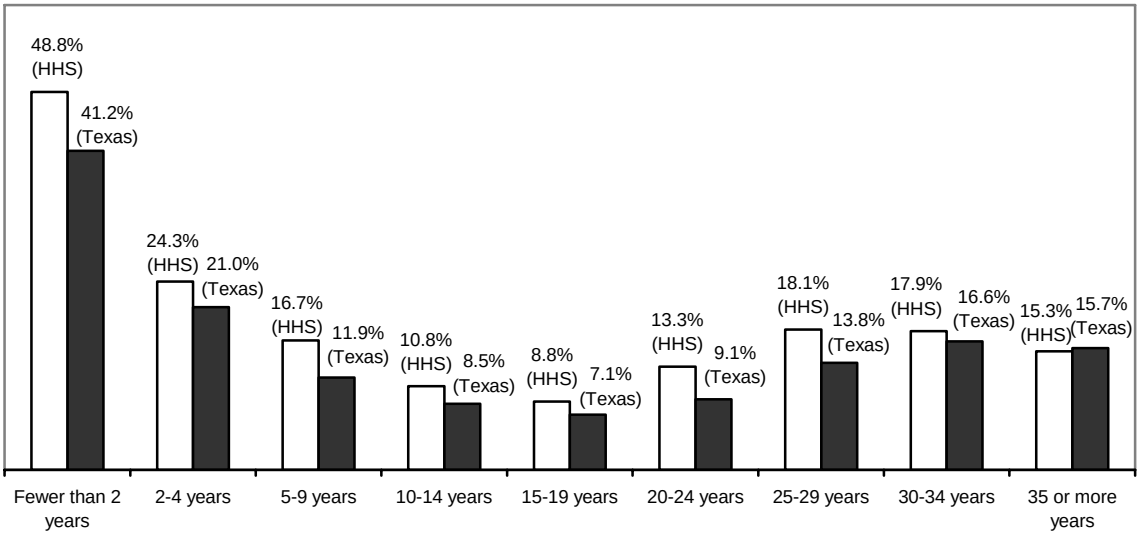
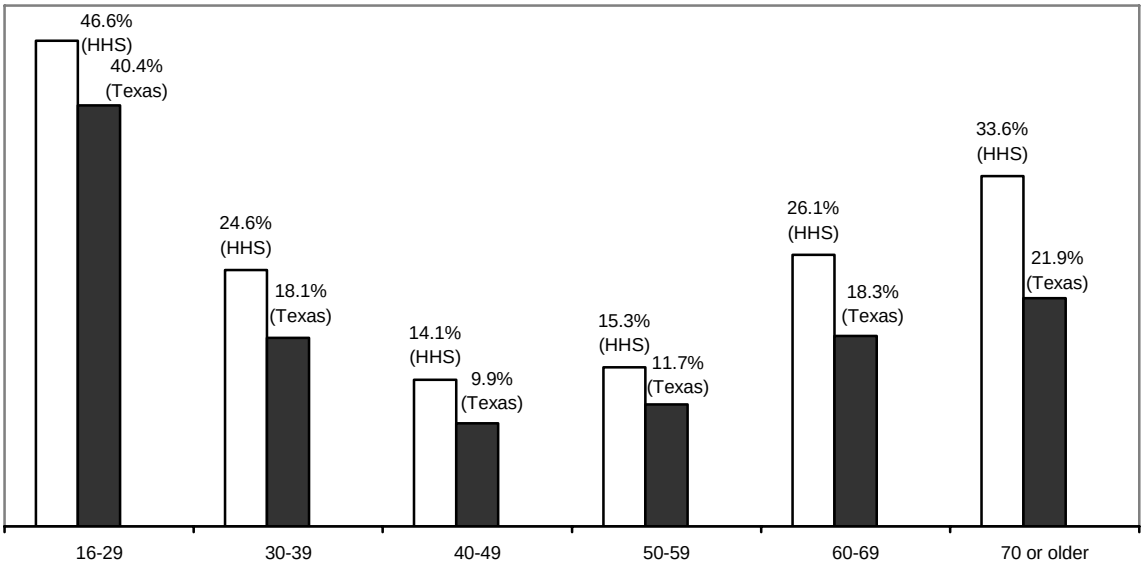


Figure 12: Turnover Rate by Age for FY 07



RETIREMENT PROJECTIONS

Today, almost 10 percent of the HHS workforce is eligible to retire. Within the next five years, the number of eligible employees will increase to about 24 percent.[16]

Table 9: HHS System Projected Retirement Eligibility through Rule of 80 (FY 07 – FY 12)

Agency	FY 07		FY 08		FY 09		FY 10		FY 11		FY 12	
HHSC	1,020	10.9%	1,343	14.3%	1,676	17.9%	2,024	21.6%	2,374	25.4%	2,740	29.3%
DFPS	512	5.2%	655	6.7%	839	8.6%	1,026	10.5%	1,204	12.3%	1,418	14.5%
DARS	472	15.3%	573	18.6%	691	22.4%	812	26.3%	927	30.1%	1,051	34.1%
DADS	1,349	9.6%	1,715	12.2%	2,121	15.0%	2,534	18.0%	3,002	21.3%	3,454	24.5%
DSHS	1,174	9.9%	1,536	12.9%	1,905	16.0%	2,284	19.2%	2,716	22.9%	3,159	26.6%
Grand Total	4,527	9.4%	5,822	12.1%	7,232	15.0%	8,680	18.0%	10,223	21.2%	11,822	24.5%

The steady increase in the number of employees eligible to retire means the HHS agencies will lose some of their most knowledgeable workers, including many employees in key positions. Effective succession planning and employee development will be critical in ensuring there are qualified individuals who can replace those leaving state service.

CRITICAL WORKFORCE SKILLS

The current climate of the information age, advances in technology, increasing population for the state, consolidation of services, right-sizing and outsourcing will continue to place increased emphasis on the demand for well trained and skilled staff.

The outsourcing and self-service automation of major HR functions, such as employee selection, have made it critical for HHS managers and employees to improve and commit to a continual learning of human resource policy, employee development, conflict resolution, time management, project management and automation skills.

It is important for HHS agencies to employ professionals who have the skills necessary for the development, implementation and evaluation of the health and human services programs. These skills include:

- analytic/assessment skills;
- policy development/program planning skills;

[16] HHSAS Database, as of 8/31/07. * Projections include current return-to-work retirees.

- communication skills;
- cultural competency skills;
- community dimensions of practice skills;
- basic public health sciences skills;
- financial planning and management skills;
- contract management skills; and
- leadership and systems thinking skills.

Most management positions require agency program knowledge and the majority of these jobs are filled through the promotion of current employees. As HHS agencies continue to lose tenured staff, effective training will be needed to ensure that current employees develop the skills necessary to transfer into management positions.

In addition, as the Spanish speaking population in Texas increases, there will be an increased need for employees with bi-lingual skills, especially Spanish-English proficiency.

ENVIRONMENTAL ASSESSMENT

The Texas Economy

The Texas economy continues to be strong. Texas employment growth exceeded the national employment growth rate for calendar year 2007. According to the latest employment estimates from the Texas Workforce Commission, the state gained 220,100 nonagricultural jobs in 2007, for an annual growth rate of 2.2 percent.[17]

The January 2008 statewide seasonally adjusted unemployment rate was 4.3 percent, down from 4.5 percent a year ago.[18]

[17] "Texas Labor Market Review," dated January 2008 (web page: http://www.tracer2.com/admin/uploadedPublications/1857_TLMR-Jan08.pdf), last accessed on April 2, 2008.
[18] Texas Workforce Press Release, dated March 6, 2008 (web page http://www.twc.state.tx.us/news/press/2008/030608epress.pdf), last accessed on March 11, 2008.

With the increase in fuel costs and the continuing downturn in the nation's economy, whether the Texas economy can remain strong is a question that could have a profound impact on the recruitment and retention challenges facing HHS agencies.

Poverty in Texas

As the number of families living in poverty increases for the state, the demand for services provided by the HHS System will also increase.

The U.S. Department of Health and Human Services defined the poverty level for 2008 according to household/family size as follows:

- $21,200 or less for a family of four;
- $17,600 or less for a family of three;
- $14,000 or less for a family of two; and
- $10,400 or less for individuals.[19]

It is projected that in 2009 approximately 4.1 million Texas residents, 16.8 percent of the population, will live in families with annual incomes falling below the federal poverty level. For 2013, it is projected that 4.6 million Texas residents, or 17.3 percent of the population, will live in families with annual incomes below the poverty level.[20] For children under the age of 18, the projected poverty rates are 22.1 percent for 2009 and 22.6 percent for 2013.

Unemployment

Another factor that directly impacts the demand for HHS System services is unemployment. In Texas, unemployment remains low compared to most other states. In January 2008, the Texas unemployment rate was 4.3 percent, down from 6.4 percent in January 2004.[21]

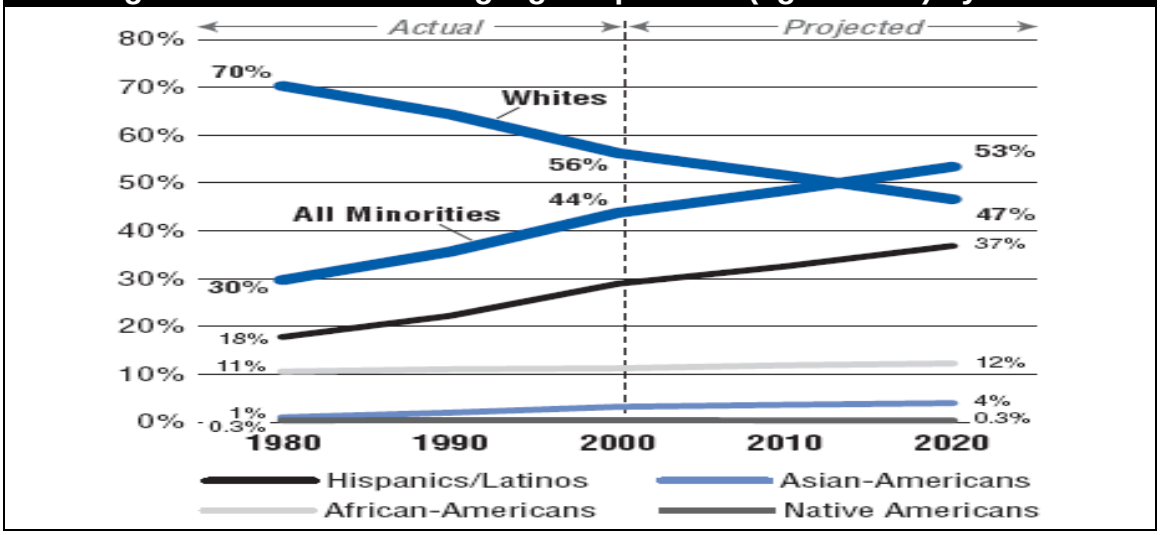
[19] "The 2008 HHS Poverty Guidelines: One Version of the [U.S.] Federal Poverty Measure," US Department of Health and Human Services, web page (http://aspe.hhs.gov/poverty/08poverty.shtml), last accessed on April 2, 2008. Note: Guidelines apply to the 48 Contiguous States and D.C.
[20] U.S. Census Bureau, March 2007 Current Population Survey (CPS), 2007, for Texas; Texas State Data Center Population Migration Growth Scenario 2002-2004, v. 10/06; HHSC Strategic Decision Support.
[21] Office of the Comptroller, State of Texas.

Other Significant Factors

With over 23 million residents, Texas is one of the faster growing states in the nation. In just a one year period, July 1, 2006 to July 1 2007, the population of Texas increased by almost half a million, the largest population increase in the country.[22] The Texas population is expected to continue to increase. By 2020, the Texas population is expected to reach 30 million residents.[23]

The Texas population will become increasingly diverse over the next 10 years, as the overall percentage of Whites continues to decline. By the year 2020, Hispanics, African-Americans/Blacks, Asian/Pacific Islanders and American Indians/Alaskan Natives are projected to make up 53 percent of the state population. The largest increase is Hispanic, representing 37 of the state's population by 2020.[24]

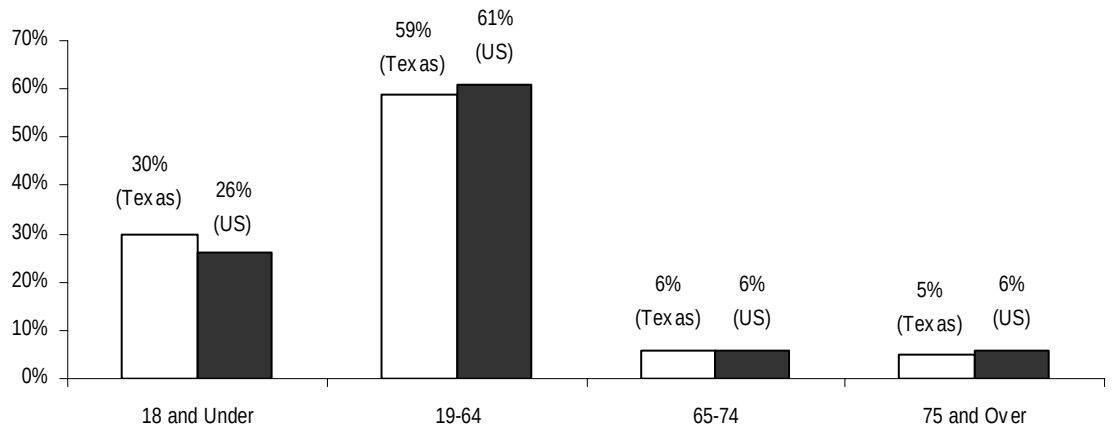
Figure 13: Texas' Working-Age Population (ages 25-64) by Race



The distribution of age groups in Texas closely mirrors that of the nation, with the largest percentage of Texas residents (59 percent) being between age 19 to 64, followed by those 18 and under (30 percent) and those 65 and over (11 percent).[25] [26]

[22] U.S. Census Bureau, December 27, 2007, web page http://www.census.gov/Press-Release/www/releases/archives/population/011109.html, last accessed on March 11, 2008.
[23] Office of the State Demographer, Texas State Data Center.
[24] Policy Alert Supplement, November 2005, The National Center for Public Policy and Higher Education, web page http://www.highereducation.org/reports/pa_decline/states/TX.pdf, last accessed on January 12, 2006.
[25] The Kaiser Family Foundation, Texas: At-A-Glance, web page http://www.statehealthfacts.org, last accessed on February 26, 2008.
[26] Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

Figure 14: Population Distribution by Age



Population projections through 2010 show that the number of Texas residents aged 18 and under will increase by 200,000; the number of adults ages 18 through 64 will increase by about 1,200,000; and the number of adults over 64 will increase by about 284,000.[27] In the longer term, the Texas State Data Center estimates that by 2040, the number of persons older than age 65 will increase by 295 percent.[28]

EXPECTED WORKFORCE CHALLENGES

HHS agencies will need to continue to recruit and retain health and human services professionals, such as Physicians, Dentists, Registered Nurses, Pharmacists, Laboratory Workers, Vocational Rehabilitation Counselors, Epidemiologists, Sanitarians, Auditors and other professions. Additionally, core jobs will continue to be essential to the delivery of services throughout the HHS System. Many of the jobs are low paying, highly stressful and experience higher than normal turnover, such as Protective Services Workers (Adult and Children), MHMR Workers (Mental Retardation Assistants and Psychiatric Nursing Assistants) and Food Service Workers.

[27] The Kaiser Family Foundation, Texas: At-A-Glance, web page http://www.statehealthfacts.org, last accessed on January 12, 2006.
[28] New Texas State Data Center Population Projections from The University of Texas at San Antonio, web page http://txsdc.utsa.edu/tpepp/2006projections/summary/, last accessed on April 4, 2008.

Registered Nurses and Licensed Vocational Nurses

Nationwide, the nursing shortage is reaching crisis proportions. The federal government is projecting a shortfall of one million Registered Nurses (RNs) by the year 2012.[29] RNs constitute the largest healthcare occupation, with 2.5 million jobs in the US. Job opportunities for RNs are expected to grow faster than the average for all occupations.[30] In addition, it is projected that there will be 587,000 new RN jobs by 2016.[31] With this level of job growth, it is projected that there will not be enough qualified applicants to meet the demand.

Texas is also experiencing a critical shortage in RNs. Although numbers vary from study to study, most concur that the nursing shortage is the most severe health workforce shortage currently facing both the nation and Texas.[32] Texas is far below the national average of the nurse-to-population ratio (782 Nurses per 100,000 people), with the state ratio being 609 Nurses per 100,000 people. By some estimates, Texas will need an additional 138,000 Nurses in the next 10 years.[33]

Factors contributing to the current shortage include the steep population growth (resulting in a growing need for health care services), an aging nursing workforce, an overall aging and service-demanding population and an increased need for specialized nursing skills. This crisis is emerging just as skilled nurses are retiring and job opportunities in health care are expanding. The projected rates of growth in the youth, elderly and minority populations in Texas will result in an increased demand for health services from HHS System agencies.

Together, DADS and DSHS employ approximately 2,600 RNs and Licensed Vocational Nurses (LVNs).[34] As the demand for nursing services increases and the supply decreases, the recruitment and retention of Nurses becomes more difficult and the need for competitive salaries will become more critical.

Currently, the average annual salary for RNs in HHS agencies during fiscal year 2007 was $48,260 and $30,346 for LVNs during the same time period. These

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[29] MedicineWorld.org, 'Lack of Resources, Not Lack of Students, Cause Nurse Shortage," web page http://medicineworld.org/cancer/lead/12-2005/lack-of-resources-not-lack-of-students-cause-nurse-shortage.html, last accessed on 1/17/06.
[30] US Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *2008-09 Edition*, web page http://www.bls.gov/oco/ocos083.htm, last accessed on 3/10/08.
[31] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[32] State of Nursing Workforce in Texas – Statewide Health Workforce Symposium Policy Brief, March 2005.
[33] MedicineWorld.org, 'Lack of Resources, Not Lack of Students, Cause Nurse Shortage," web page http://medicineworld.org/cancer/lead/12-2005/lack-of-resources-not-lack-of-students-cause-nurse-shortage.html, last accessed on 1/17/06.
[34] HHSAS Database, as of 8/31/07.

salaries fall below both national and state averages for these occupations.[35] Nationally, the average annual earnings for RNs in 2006 was $59,730 and $37,530 for Licensed Practical Nurses and LVNs.[36] In Texas, the average annual earnings for RNs in 2006 was $57,180 and $35,920 for Licensed Practical Nurses and LVNs.[37] Many private hospitals are further widening the salary gap by offering signing bonuses. The non-competitive salaries offered by HHS agencies are directly contributing to the HHS System's difficulties recruiting qualified applicants. Posted vacant positions are currently taking several months to fill. The System is also losing existing staff to these higher paying private health care jobs at an alarming rate (turnover of approximately 22 percent for RNs and 28 percent for LVNs).[38]

As the nursing workforce shortage continues and as a significant portion of System nurses approach retirement, it is expected that recruitment and retention of Nurses will continue to be a problem for the System.

Pharmacists

Pharmacists represent the third largest health professional group in the US, with approximately 243,000 active Pharmacists as of November 2006.[39] While the overall supply of Pharmacists has increased in the past decade, there has been an unprecedented demand for Pharmacists and for pharmaceutical care services. This need is expected to grow faster than the average for all occupations due to the increased pharmaceutical needs of a growing elderly population and increased use of medications. It is projected that there will be a need for 53,000 new Pharmacists by 2016, or a 22 percent increase.[40] However, the number of available Pharmacists is expected to grow only modestly.

HHS agencies employ 76 Pharmacists, with an average annual salary of $79,748.[41] This salary falls significantly below the market rate. The average annual salary for Pharmacists nationally is $93,500 and $96,290 in Texas.[42] This

[35] HHSAS Database, as of 8/31/07.
[36] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[37] Ibid.
[38] HHSAS Database, FY 2007 data.
[39] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[40] Ibid.
[41] HHSAS Database, as of 8/31/07.
[42] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.

disparity is affecting the System's ability to recruit qualified applicants for open positions. Pharmacist positions often remain unfilled for several months.[43]

With Pharmacist turnover at 18 percent, HHS agencies have often used contract Pharmacists to meet program needs. These contracted Pharmacists are paid at rates that are well above the amount it would cost to hire Pharmacists at state salaries. With a significant number of Pharmacists nearing retirement age (or have already retired and returned to work), recruitment and retention will continue to be a problem for the System.

Protective Services Workers

As of November 2006, there were 282,000 Protective Service Worker jobs in the U.S., with a projected job growth of 19.1 percent by 2016.[44] [45]

There are approximately 5,300 Protective Services Workers employed by DFPS as Child Protective Service Specialists, Child Protective Service Investigators, Adult Protective Service Workers, State Wide Intake Workers and Child Care License Workers.[46] The average annual salary for these Workers is $32,609, a salary below both the national and state average annual salary. Nationally, Protective Services Workers earn $40,640 annually.[47] In Texas, Protective Service Occupations earn, on the average, $34,460 annually.[48]

Senate Bill 6, which passed during the 79th Legislative session, mandated sweeping reform within DFPS, including increased hiring of skilled Protective Services Workers throughout the state. The 80th Legislature (Regular Session, 2007) approved additional funding to increase child protective services throughout the state and to build on CPS reforms initiated by the 79th Legislature (Regular Session, 2005).

In fiscal year 2007, the turnover rate for these jobs was 24.9 percent, with turnover averaging about 21.7 percent over the past three years.[49] During the next decade, the significant increase in the Texas population, especially the

[43] HHSAS Database, FY 2007 data.
[44] Occupational title used is Child, Family and School Social Workers.
[45] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[46] HHSAS Database, as of 8/31/07.
[47] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[48] Ibid. Note: The Employees are listed under the Occupational title of Child, Family and School Social Workers.
[49] State Auditor's Office (SAO Electronic Classification Analysis System).

aging population, will require additional Adult Protective Services Workers, which could further exacerbate the high turnover rate.

Vocational Rehabilitation Counselors

As of November 2006, there were 141,000 Rehabilitation Counselor jobs in the U.S., with a projected job growth of 23 percent by 2016.[50] Nationally, there is a shortage of qualified vocational rehabilitation counselors.

DARS employs 649 Vocational Rehabilitation Counselors, with an average annual salary of $43,720.[51]

The federal requirements for Vocational Rehabilitation Counselors to have a master's degree in rehabilitation counseling and/or to be eligible to take the Certified Rehabilitation Counselor certification exam have made it increasingly difficult to fill vacancies with qualified individuals. As a result, the agency has established incentive programs to assist current employees in obtaining the appropriate credentials.

Epidemiologists

DSHS employs 82 full-time Epidemiologists who are responsible for monitoring health status, investigating health hazards, evaluating the effectiveness of health services and monitoring and responding to health emergencies.

Although epidemiology is known as the core science of public health, Epidemiologists comprise less than one percent of all public health professionals.[52] As of November 2006, there were approximately 5,000 Epidemiologist jobs in the U.S., with a projected job growth rate of 13.6 percent by 2016.[53]

The shortage of Epidemiologists may be partly explained by the high level of education required for this profession. DSHS Epidemiologists earn an average

[50] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[51] HHSAS Database, as of 8/31/07.
[52] Melissa Taylor Bell and Irakli Khodeli. "Public Health Worker Shortages.," The Council of State Governments, November 2004.
[53] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).

annual salary of $49,675, significantly below the average wage paid nationally ($60,290), but higher than the Texas average of $44,250.[54] Barriers to recruiting and retaining Epidemiologists in the public health field include noncompetitive salaries and a general shortage of professionals.

Though the overall turnover rate for Epidemiologists is low at only about 12 percent, DSHS has had difficulty filling vacant positions. With a high vacancy rate for these positions (almost 16 percent), Epidemiologist positions are remaining open for months before filled.[55]

Sanitarians

The System employs 106 Sanitarians across the state.[56] Registered Sanitarians at DSHS inspect all food manufacturers, wholesale food distributors and food salvagers in Texas, as well as all retail establishments in the 188 counties not covered by local health jurisdictions. They conduct a multitude of environmental inspections, such as children's camps, asbestos abatement, hazardous chemicals/products and many others. Sanitarians are instrumental in protecting the citizens of Texas from food-borne illness and many dangerous environmental situations and consumer products, including imported foods, drugs and consumer products. The U.S. Food and Drug Administration (FDA) and the Consumer Products Safety Commission (CPSC) have little manpower and therefore depend on the state programs to protect citizens. DSHS Sanitarians also respond to a variety of emergencies, including truck wrecks, fires, tornados, floods and hurricanes and are the first line of defense against a bioterrorist attack on the food supply.

Higher starting salaries offered by local health jurisdictions, federal counterparts (U.S. Food and Drug Administration, USDA and the Consumer Product Safety Commission) and private industry, have made it extremely difficult for the DSHS to hire Sanitarians to fill vacant positions. In addition, these organizations have been hiring many of the agency's highly trained staff, leaving even more positions vacant.

Turnover for DSHS Sanitarians is currently low, at only eight percent. However, due to the shortage of qualified applicants, vacant positions go unfilled for months.[57] Historically, some of these vacancies posted have remained unfilled for over two years.

[54] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[55] HHSAS Database, as of 8/31/07.
[56] Ibid.
[57] HHSAS Database, FY 2007 data.

Architects/Engineers

As of November 2006, there were approximately 2.6 million jobs in architectural and engineering occupations nationally, with a projected job growth rate of 10.4 percent by 2016.[58]

HHS employs 30 Architects and Engineers across the state. These positions are responsible for licensing decisions on hospitals, ambulatory surgical centers, end stage renal disease facilities, special care facilities and psychiatric facilities.

It is anticipated that the System will experience a shortage of Architects/ Engineers in the next few years. This is a result of retirements and current vacancy trends.

HHS Architects earn an average annual salary of $52,678 and HHS Engineers earn $52,850 annually. These salaries are lower than the national and state average salaries for Architecture and Engineering occupations ($66,190 nationally and $67,750 for Texas).[59]

MHMR Workers (Mental Retardation Assistants and Psychiatric Nursing Assistants)

There are approximately 9,000 MHMR Workers employed in DSHS state mental health hospitals and in DADS state mental retardation facilities. These positions require no formal education to perform the work, but employees are required to develop people skills to effectively interact with consumers. The physical requirements of the position are difficult and challenging due to the nature of the work.

The pay is low, with an average hourly rate of $9.96.[60] The overall turnover rate for employees in this group is high, at 41.3 percent annually. [61] Taking into account these factors, state hospitals and schools have historically experienced difficulty in both recruiting and retaining these workers. Little change is expected.

[58] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[59] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[60] HHSAS Database, as of 8/31/07.
[61] Ibid.

Vital Statistics Staff

DSHS employs approximately 154 employees in the Vital Statistics Bureau (VSB) in Austin. New federal legislation has increased the demand for services. For example, there has been a 50 percent increase in demand for passport processing services over the last two years due in part to the Western Hemisphere Travel Initiative of the United States Department of State, Passport Services Office.

In addition, DSHS anticipates new business demands will be placed on VSB employees due to the acceptance of faxed credit card requests, by advertising at hospitals where babies are born and from accepting third party requests from private organizations.

The overall turnover rate for Vital Statistics Staff is high at almost 20 percent. Staff earn an average annual salary of about $30,439.[62]

Food Service Workers

There are approximately 1,000 Food Service Workers employed across Texas in state mental health hospitals and state mental retardation facilities.[63]

The physical requirements are very demanding and there are no formal education requirements. Since meals are prepared seven days a week, some of these employees are required to work on night and weekend shifts.

The average hourly rate paid to Food Service Workers is $9.12. Turnover in Food Service Worker positions was extremely high, at 32 percent during fiscal year 2007.[64]

Auditors

HHS employs approximately 150 Auditors who are responsible for performing audits to ensure compliance with state and federal laws, rules and regulations. Employees in these classifications prepare audit reports outlining discrepancies, recommending corrective actions, improving accounting or management operation systems and advising on the requirements for compliance and liabilities and penalties of noncompliance.

[62] HHSAS Database, as of 8/31/07.
[63] Ibid.
[64] Ibid.

The overall turnover rate for Auditors is about 25 percent, with an average annual salary of $53,628.[65]

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

Recruitment Strategies

Gap	HHS agencies do not attract enough qualified applicants for critical and/or difficult to fill jobs.
Goal	Establish efficient and effective recruiting initiatives to attract qualified applicants.
Rationale	If HHS agencies are going to recruit effectively, the agencies must recognize that attracting and assessing applicants from outside traditional pools and resources will be a necessity.
Strategies	♦ Implement an HHS internship program to attract future employees in hard to fill job classes. ♦ Provide summer and co-op placements for high school and college students. ♦ Provide college tuition reimbursement or scholarships for high potential high school graduates in exchange for a certain number of years of service. ♦ Create customized recruitment strategies based on managers' staffing goals, current/future program priorities and specific job vacancies. ♦ Increase recruitment efforts for 'critical' occupations, such as: o Protective Services Workers; o MHMR Workers (Mental Retardation Assistants and Psychiatric Nursing Assistants); o Physicians and Psychiatrists; o Dentists; o Nurses; o Pharmacists; o Vocational Rehabilitation Counselors; o Epidemiologists; and o Sanitarians.

[65] HHSAS Database, as of 8/31/07.

	♦ Provide assessment tools to identify applicants who have an aptitude for the position for which they apply. ♦ Prepare and implement targeted recruitment plans. ♦ Use aggressive recruiting efforts, such as extensive internet recruiting, attendance at technical job fairs and same day hiring at job fairs. ♦ Develop media presentations to assist in recruiting efforts. ♦ Post jobs using the full salary range or market comparable salaries to attract qualified applicants. ♦ Rehire skilled retirees. ♦ Use recruitment and retention bonuses to attract applicants for high turnover and critical positions. ♦ Offer alternative work schedules to attract applicants, such as telecommuting, job sharing and part-time work. ♦ Provide incentives for employee referrals that result in successful hiring of qualified applicants. ♦ Offer jobs placements for people exiting the military (i.e., Military Outplacement Services). ♦ Concentrate efforts to recruit older workers and individuals seeking a second career.

Retention Strategies

Gap	There is a high rate of attrition for younger employees, less tenured employees and employees performing stressful jobs.
Goal	Create an environment whereby employees and applicants will view their HHS agency as an employer of choice.
Rationale	If HHS agencies are to be successful in retaining good employees, employees need to be treated well and rewarded for outstanding job performance.
Strategies	♦ Obtain funding and implement a compensation program intended to attract, retain and reward employees and to make salaries more competitive. Compensation strategies might include the use of: o salary equity adjustments; o promotions; o merit raises, including one-time merit awards;

	o retention bonuses; and o hiring above the salary minimum at comparable market rates. ♦ Develop strategies to address turnover, including: o ensure sufficient FTEs are available for the volume of work to be accomplished; o provide a realistic preview of the job during the interview process; o provide adequate training to ensure success of the employee in completing assignments and duties o ensure that supervisors set clear expectations of the new hire (and all employees); o assign a current employee as a peer mentor in the same job to assist the new employee in acclimating to the new position and ensure support from a lead worker; and o have the supervisor hold frequent meetings with the new employee to provide immediate feedback and information on how to improve within the position. ♦ Ensure separating employees participate in exiting surveys available through the SAO Exit Survey process and analyze the Survey Responses to determine appropriate actions for improving retention. ♦ Grant administrative leave for outstanding performance. ♦ Establish flexible work schedules to retain staff and meet the needs of HHS agencies, using: o telecommuting; o job sharing; o regular, instead of rotating, shift work for employees who desire a more regular and predictable schedule; o part-time jobs; and o flex hours. ♦ Audit HHS agency positions to ensure salary and FLSA parity among job classes that perform like and similar duties across all HHS agencies. ♦ Create career ladders, where job duties are clearly differentiated within the levels of a job series, to counter the lack of advancement opportunities and the impact of management/supervisory restrictions. ♦ Obtain funding and provide professional development training in the employee's career field for all employees in the System. ♦ Obtain funding and provide personal development training that will benefit both the employee and the System for all

	employees in the System. ♦ Expand the HHS Wellness Program to promote organizational satisfaction, reduce employee stress and reduce turnover. ♦ Ensure that the EAP provider makes regular presentations to large employee groups on topics of interest, such as stress in the work place, employee burnout and prevention strategies. ♦ Implement an HHS employee recognition program to ensure that employees know that their work is valued and appreciated by: o providing non-monetary incentive awards and recognition to high-performing employees; o having senior management routinely visit employees in their job areas and thank them for being a part of the team; and o having agency heads and executive staff send notes, memos and emails, thanking and congratulating employees who perform exceptionally well on special projects and provide exceptional customer service to internal and external consumers. ♦ Recognize supervisors and managers who have decreased employee turnover. ♦ Recognize supervisors and managers who receive high praise from their employees and who get the job done with a high degree of excellence. ♦ Recognize employees who align and support the vision and mission of the HHS System. ♦ Provide training for supervisors and managers – and require attendance and successful completion – on topics of agency policy and positive performance to ensure that new employees receive better on-the-job training, coaching, recognition and supervision. ♦ Fund and encourage managers to use educational leave, stipends and scholarships to prepare employees for future employment in ‘critical’ or ‘hard to fill positions.’ ♦ Develop “grow your own” employee training programs to ensure adequate staffing and reduce the overburden for employees in shortage occupations ♦ Implement strategies to hire “soon to be qualified” individuals - even if they have not completed required certifications. ♦ Seek additional pay for employees who handle difficult consumers or who are routinely placed in difficult situations.

	♦ Explore opportunities for job rotation, job sharing, etc. for employees in extremely difficult and stressful jobs. ♦ Expand the practice allowing retirees to return to positions within the HHS System to ease recruiting and retention issues. ♦ Communicate to employees the value of their employee benefits as part of their total compensation package. (During fiscal year 2007, the total benefits package, according to the State Auditor's Office, was 67 percent salary and 33 percent benefits). ♦ Remind employees that the HHS System allows FLSA exempt employees to bank compensatory time, which is often not done in the private sector. ♦ Remind employees that the HHS System provides some benefits that other employers and some state agencies don't provide, such as Sick Leave Bonus Days. ♦ Invest funds to "upgrade" the physical facilities in which employees work.

HEALTH AND HUMAN SERVICES COMMISSION

MISSION

The mission of the Health and Human Services Commission (HHSC) is to provide leadership and direction and foster the spirit of innovation needed to achieve an efficient and effective health and human services system for Texans.

SCOPE

HHSC was created in 1991 to provide strategic leadership to HHS agencies. HHSC oversees the consolidated operation of the HHS system in Texas. HHSC has responsibility for strategic leadership, administrative oversight of Texas health and human services programs and provides direct administration of some programs, including:

- Texas Medicaid;
- Children's Health Insurance Program (CHIP);
- Temporary Assistance for Needy Families (TANF);
- Food Stamps and Nutritional Programs;
- Family Violence Services;
- Refugee Services;
- Integrated Eligibility Services;
- Disaster Assistance;
- Border Affairs; and
- Fraud and Abuse Prevention and Detection.

The agency is accountable to Texans, ensuring that the other four HHS agencies provide quality services in the most efficient and effective manner possible.

HHSC has approximately 9,300 employees who work throughout Texas, supporting the agency, the other HHS agencies and Texans in need.[66]

[66] HHSAS Database, as of 8/31/07.

CORE BUSINESS FUNCTIONS

The core functions of HHSC include the following:

- Health and Human Services Administrative System Oversight. The HHSC oversight function is critical to the successful delivery of effective and efficient health and human services in Texas. Within HHSC, employees performing these functions work together to provide support and direction to the HHS agencies in implementing legislation, streamlining services and facilitating cross-agency innovation. HHSC divisions listed below are key to the Health and Human Services System oversight function:
  - Office of Inspector General;
  - Ombudsman/Consumer Affairs;
  - Consolidated Financial Services, including Strategic Planning and Evaluation, Forecast and Rate Setting;
  - Consolidated Information Technology Support;
  - Consolidated Human Resources, Time, Labor and Leave and Payroll;
  - Consolidated Civil Rights Services;
  - Consolidated Contracts and Procurement Services;
  - Consolidated Facilities Support Services for State Schools and Hospitals;
  - Consolidated Risk Management; and
  - Consolidated Regional Administrative Services;

- Medicaid Program Administration. HHSC employees performing this function administer the statewide Medicaid program using a comprehensive approach to integrate Medicaid client health services with other direct service delivery programs. Medicaid administration includes the following programs:
  - Aged and Disabled Financial Eligibility Determinations;
  - Pregnant Women;
  - Children and Medically Needy;
  - Medicare Savings Programs;
  - Integrated Managed Care (STAR+PLUS);
  - Medicaid Vendor Drug Program;
  - Medical Transportation;
  - Health Steps – Medical and Dental;
  - Family Planning;
  - Health Care Delivery Models for Aged, Blind and Disabled Recipients;
  - Comprehensive Health Care for Children in Foster Care;
  - Medicaid Buy-In Program;
  - Medicaid Access Card Project;
  - Women's Health Program;
  - Medicaid for Breast and Cervical Cancer;
  - Refugee Medical Assistance; and
  - Medicaid for Transitional Foster Care Youth.

- Children's Health Insurance Program (CHIP) Administration. HHSC employees performing this function are responsible for ensuring health insurance coverage for eligible children in Texas. CHIP Services Administration includes the following programs:
  - Immigrant Health Insurance;
  - School Employee Children's Health Insurance Program (CHIP);
  - CHIP Vendor Drug Program;
  - CHIP Perinatal; and
  - State Employee Children's Insurance (SKIP).

- Social and Eligibility Services Program Administration. Currently, the administration of Eligibility Services is the largest program function within HHSC. Employees performing this function support programs that provide families in need with assistance. These programs also encourage and promote self-sufficiency, safety and long-term independence for families. Programs within Social Services Administration include:
  - Temporary Assistance for Needy Families (TANF);
  - Food Stamps, Nutrition Education and Outreach;
  - Family Violence Services;
  - Refugee Affairs;
  - Healthy Marriage Services;
  - Alternatives to Abortion; and
  - Disaster Assistance.

WORKFORCE DEMOGRAPHICS

On August 31, 2007, HHSC employed 9,361 full and part-time employees. The majority of the employees (6,420 employees or 69 percent) work in the Office of Eligibility Services (OES) and are located in offices throughout the state.[67]

[67] HHSAS Database, as of 8/31/07.

Job Families

Approximately 92 percent of HHSC employees (8,587 employees) work in 10 job classifications.[68]

Table 10: Largest Program Job Classes and Average Salaries

Job Title	Number of Employees	Average Salary
Human Services Specialists	4,638	$34,522
Clerical Workers	1,873	$23,976
Program Specialists	800	$49,058
System Analysts	305	$53,972
Managers	249	$61,739
Investigators	214	$39,601
Human Services Technicians	173	$22,964
Directors	122	$92,687
Auditors	113	$52,162
Network Specialists	100	$39,788

Salary

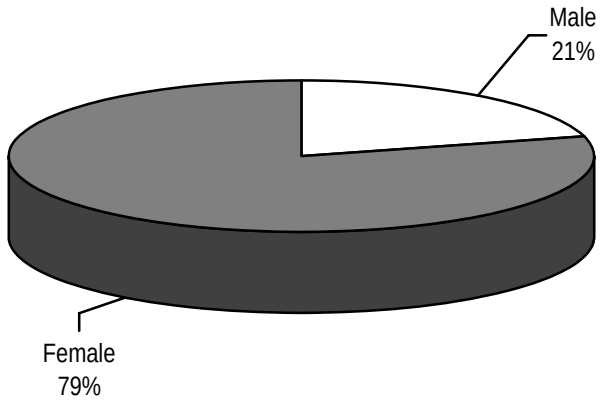
HHSC employees earn an average annual salary of $34,691.[69]

[68] HHSAS Database, as of 8/31/07.
[69] Ibid.

Gender

The HHSC workforce is primarily female, representing approximately 79 percent of all agency employees.[70]

Figure 15: HHSC Workforce by Gender

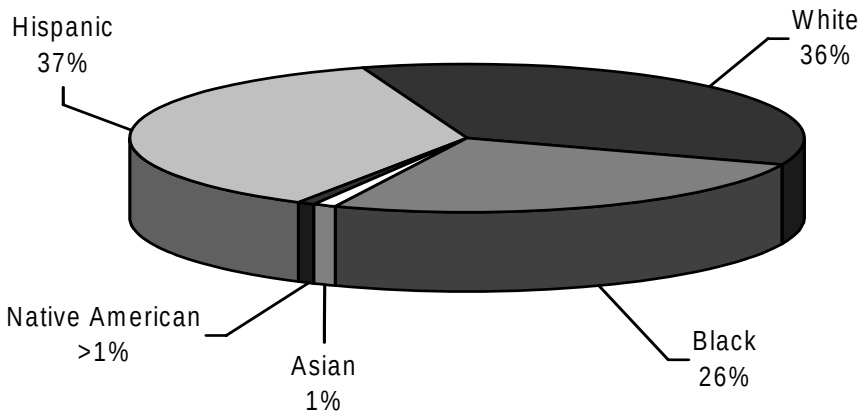


[70] HHSAS Database, as of 8/31/07.

Race

The largest racial group in the HHSC workforce is Hispanic. This group makes up approximately 37 percent of all agency employees, followed by White employees at approximately 36 percent and Black employees at approximately 26 percent.[71]

Figure 16: HHSC Workforce by Race

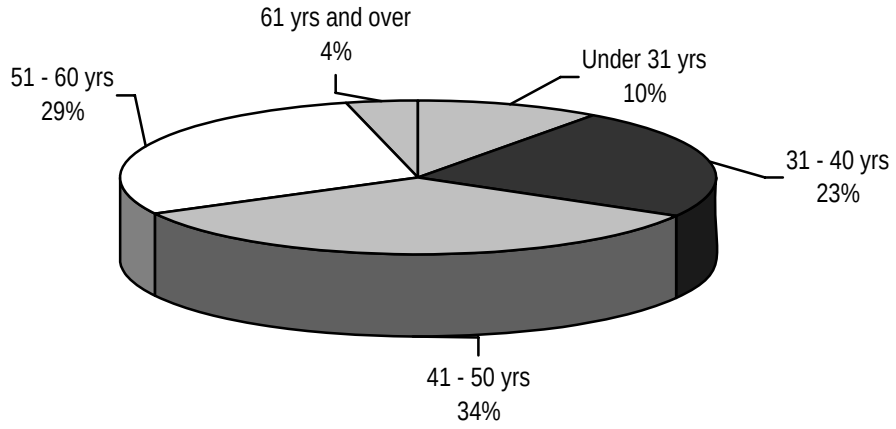


[71] HHSAS Database, as of 8/31/07.

Age

The average age of an HHSC employee is 45 years. About 67 percent of the HHSC workforce are 41 years or older.[72]

Figure 17: HHSC Workforce by Age



Average age: 45 yrs

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and Females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

The utilization analysis of the HHSC workforce does not reflect underutilization.[73] [74]

[72] HHSAS Database, as of 8/31/07.
[73] HHSC workforce data – report prepared from the Human Resources/PeopleSoft, 08/31/2007.
[74] CLF data – EEOC publications, "Job Patterns for Minorities and Women in State and Local Government, 2003" for Texas and "Job Patterns for Minorities and Women in Private Industry, 2003" for Texas. Modified 06/08/2005.

Table 11: HHSC Utilization Analysis Results

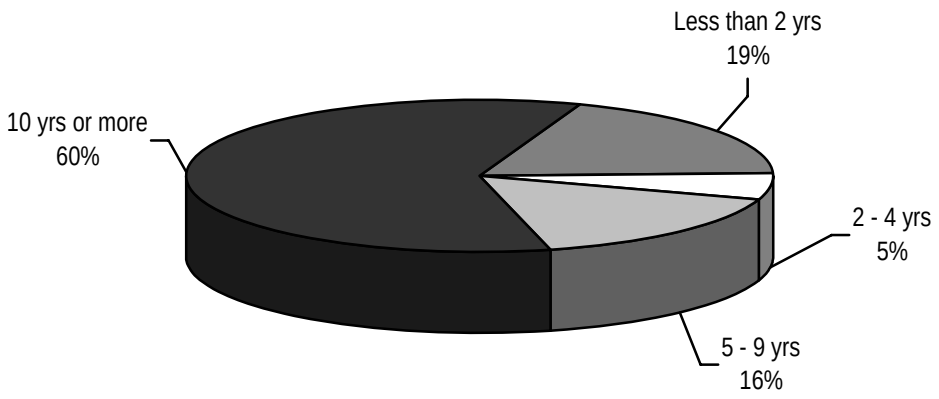
Job Category	Black			Hispanic			Female		
	HHSC %	CLF %	Underutilization (If Yes, # needed)	HHSC %	CLF %	Underutilization (If Yes, # Needed)	HHSC %	CLF %	Underutilization (If Yes, # Needed)
Officials/ Administrators	18.3%	7.2%	No	16.4%	12.3%	No	55.3%	32.6%	No
Professionals	24.7%	9.4%	No	35.6%	11.6%	No	77.6%	49.0%	No
Technicians	23.4%	13.9%	No	33.8%	19.7%	No	76.6%	42.1%	No
Protective Service	0.0%	18.0%	N/A	0.0%	23.1%	N/A	0.0%	21.6%	N/A
Para-Professionals	47.2%	14.3%	No	27.1%	25.7%	No	89.2%	56.3%	No
Administrative Support	27.0%	19.4%	No	45.2%	26.8%	No	88.5%	78.8%	No
Skilled Craft	25.0%	14.7%	N/A	50.0%	35.2%	N/A	0.0%	16.5%	N/A
Service Maintenance	66.7%	20.4%	N/A	0.0%	43.7%	N/A	0.0%	44.4%	N/A

Note: "N/A" indicates that the number of employees in this category was too small (less than thirty) to test any differences for statistical significance.

State Service

HHSC has a tenured workforce, with approximately 60 percent of the employees having 10 or more years of state service. Only 19 percent have less than two years of state service.[75]

Figure 18: HHSC Workforce by Length of State Service

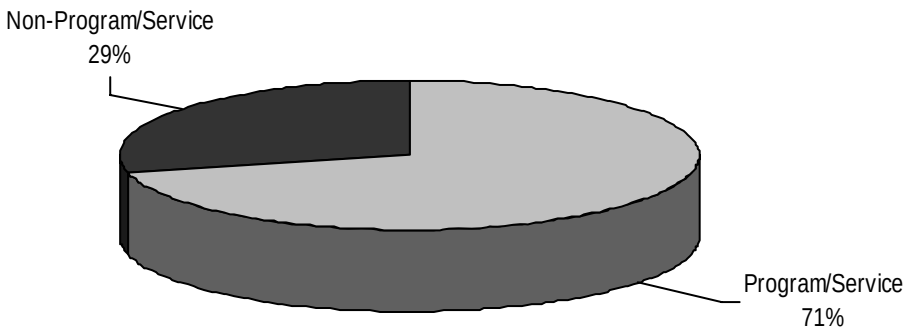


Return-to-Work Retirees

HHSC employs 511 return-to-work retirees. The majority of rehired retirees work in program/service areas.[76]

[75] HHSAS Database, as of 8/31/07.

Figure 19: HHSC Return-to-Work Retirees



[76] HHSAS Database, as of 8/31/07.

TURNOVER

The turnover rate during fiscal year 2007 was 14.1 percent. This rate is slightly lower than the statewide turnover rate of 17.4 percent for all agencies.[77] The majority of these separations (approximately 88 percent) were voluntary separations from state employment.[78]

Table 12: Reason for Separation

Reason	Percentage[79]
Voluntary Separations	
Personal reasons	44.6%
Transfer to another agency	24.6%
Retirement	18.5%
Involuntary Separations	
Termination at Will	1.0%
Resignation in Lieu	0.7%
Dismissal for Cause	9.2%
Reduction in Force	0.0%

Employees in Computer Operator positions had the highest turnover rate during fiscal year 2007 (with 16 losses or a 136.2 percent turnover rate), followed by Database Administrators (with 7 losses or a 60.9 percent turnover rate) and System Support Specialists (with18 losses or a 32.7 percent turnover rate). These losses are primarily attributed to the Department of Information Resources data center consolidation project for Information Technology.[80]

[77] State Auditor's Office (SAO) FY 2007 Turnover Statistics.
[78] Ibid.
[79] Death accounted for 1.4% of separations.
[80] HHSAS Database, FY 2007 data.

Table 13: FY 2007 Turnover for Significant Job Classes		
Job Title	Average Annual Headcount	Turnover Rate
Computer Operators	11.8	136.2%
Database Administrators	11.5	60.9%
System Support Specialists	55.0	32.7%
Human Services Techs	149.5	32.1%
Auditors	114.3	25.4%
System Analysts	314.0	24.5%
Contract Specialists	51.5	19.4%
Registered Nurses	57.8	19.0%
Network Specialists	104.8	18.1%
Architects	5.8	17.4%
Budget Analysts	26.3	15.2%
Clerical Workers	1452.5	15.2%
Accountants	87.0	14.9%
Purchasers	92.5	14.1%
Human Services Specialists	1005.3	13.2%
Investigators	218.5	12.8%

RETIREMENT PROJECTIONS

Currently, about 11 percent of the agency's workforce is eligible to retire from state employment. Over 29 percent of the HHSC workforce will reach retirement eligibility by the year 2012.[81]

Table 14: HHSC Projected Retirement Eligibility through Rule of 80 (FY 07 – FY 12)		
Fiscal Year	Cumulative Number of Eligible Employees	Percent of Workforce
2007	1,020	10.9%
2008	1,343	14.3%
2009	1,676	17.9%
2010	2,024	21.6%
2011	2,374	25.4%
2012	2,740	29.3%

EXPECTED WORKFORCE CHALLENGES

HHSC was created to provide leadership and innovation necessary to administer an efficient and effective HHS system for Texas. The agency oversees the

[81] HHSAS Database, as of 8/31/07.

consolidated HHS system, provides centralized support services for all HHS agencies and administers critical state programs, such as Medicaid, CHIP and eligibility determination. With this array of programs and services, it is essential for HHSC to recruit and maintain a skilled workforce to meet the diverse needs of the agency.

The Legislature appropriated approximately $31.3 billion to HHSC for the fiscal year 2008 - 2009 biennium, about a five percent increase over appropriated funds for the previous biennium.

The major workforce challenge for the agency continues to be the recruitment and retention of Eligibility Determination staff in the Office of Eligibility Services (OES). The 78th Legislature (Regular Session, 2003) directed HHSC to evaluate the cost effectiveness of call centers as a methodology for determining eligibility for Medicaid, food stamps and other state assistance programs. HHSC determined in 2005 that privately managed call centers would be more cost effective than having state-operated call centers. Based on this analysis, in June of 2005, a private-sector contractor, Accenture, was awarded a contract to assist in performing certain eligibility determination activities utilizing a recognized call center methodology. The new business model called for only 2,600 OES employees. In June of 2005, OES had about 6,400 eligibility determination staff, with a turnover rate of 22 percent. By the end of the third quarter of fiscal year 2006 (May 2006), staffing levels had decreased to about 5,500 employees, with an increasing number of temporary staff hired. In addition, the turnover rate had risen to 38 percent.

In March of 2007, when specific contract terms could not be reached, HHSC terminated the contract with Accenture. In the wake of the contract termination, the 80th Legislature (Regular Session, 2007) appropriated sufficient funds for modernizing the eligibility system without a reduction in force or the closing of local offices. To allow OES to perform the full scope of operations, the agency is expected to increase staffing levels to approximately 8,000 employees in fiscal year 2009. To facilitate this re-staffing, OES has implemented a number of strategies to assist in recruitment and retention efforts, including:

- “hiring ahead” to reduce job vacancies;
- assigning regional hiring coordinators to expedite the recruitment process;
- awarding retention bonuses for eligibility staff;
- increasing pay for supervisors;
- hiring retirees and former eligibility staff; and

- staffing centralized benefits centers with state employees to help reduce the workload on local offices.

The effect of these strategies can be measured by the reduction in the turnover rate of eligibility employees during the period of December 2007 through February 2008.

To build upon these improvements, the agency will be introducing a new compensation plan for OES staff in June 2008. This plan will increase entry-level salaries for new workers and provide existing workers with promotions or merit salary increases.

Another challenge is the legislatively mandated transfer of staff to the agency. Senate Bill 10, 80th Legislature (Regular Session, 2007) transferred the administration and operation of the Medical Transportation Program (MTP) from the Texas Department of Transportation (TxDOT) to HHSC. The MTP consists of approximately 180 employees responsible for arranging non-emergency transportation for certain Medicaid recipients. A significant amount of HHSC support staff time has been spent ensuring these new employees receive all required orientation and training and that their records, insurance benefits and payroll information were appropriately transferred. The transition was effective on May 1, 2008. Many of the staff will not be physically moved into HHSC space until after the beginning of fiscal year 2009.

In addition to the growth of OES and the transfer of the MTP program, the agency is increasing staffing and services in the HHSC Office of Inspector General (OIG). Created by the 78th Legislature (Regular Session, 2003), OIG works to prevent and reduce waste, abuse and fraud within the HHS System. The 79th Legislature (Regular Session, 2005) approved an increase in OIG positions for fiscal year 2006. Sixteen new FTE's were allocated to the OIG Medicaid Provider Integrity (MPI) section, which is primarily devoted to investigating provider fraud in the Texas Medicaid Program. This staffing increase allowed MPI to place investigators in key areas of the state to more efficiently investigate issues related to Medicaid fraud, waste and abuse. The 80th Legislature (Regular Session, 2007) continued this expansion of FTEs for fiscal year 2008 and fiscal year 2009.

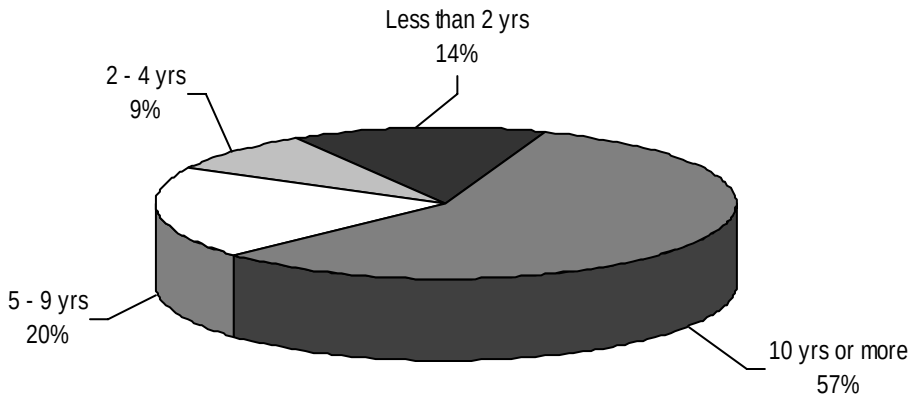
HHSC has a diverse workforce, consisting of over 77 different job classifications. Many of these jobs, particularly professional jobs that require degrees, licenses or certifications, are difficult to fill and historically experience a higher than average annual turnover rate. Most of these classifications relate to the regulatory and oversight functions performed by the agency. As an example, the Auditor job classification series had one of the highest turnover rates (25 percent) during fiscal year 2007. High turnover also occurred in the job series for Human Services Technicians (32 percent), Human Services Specialists (13 percent),

Texas Works Advisors (12 percent), Medical Eligibility Specialists (11 percent) and Hospital Based Workers (10 percent).[82]

Auditors

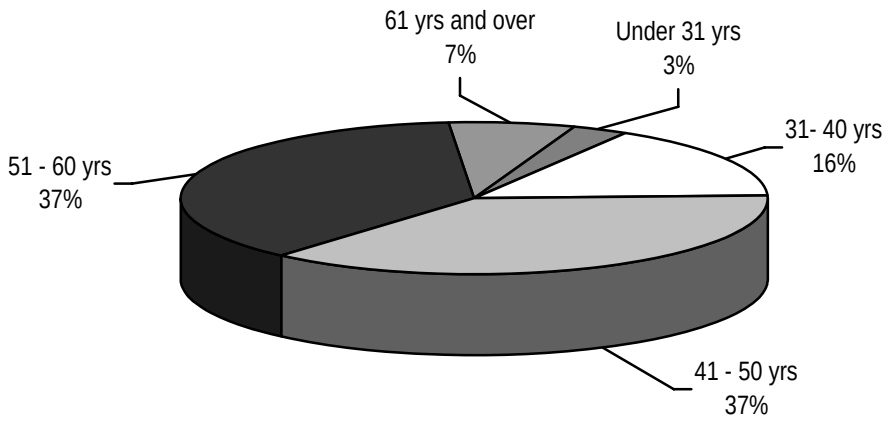
There are approximately 113 auditor positions with HHSC, divided among numerous program areas, including Internal Audit, Medicaid, Quality Review Consolidated, Hospital Audits and Audit Consolidated. The typical Auditor is about 49 years old and has an average of 13 years of state service.[83]

Figure 20: HHSC Auditors – Length of Service



[82] HHSAS Database, as of 8/31/07.
[83] Ibid.

Figure 21: HHSC Auditors – Distribution of Age



Turnover for Auditors is one of the highest at the agency, at 24 percent. Strong retention efforts are needed to reduce the already high turnover rate for this employment group.[84]

Office of Eligibility Services Workers

Across the state, there are 6,420 OES Workers positions with the agency. These Workers include Eligibility Workers (Texas Works Advisors, Medical Eligibility Specialists, Hospital Based Workers and Human Service Specialists), Clerical Workers, Human Services Technicians, Program Specialists, Unit Supervisors, Managers and Directors. Nearly a quarter of these employees have less than two years of state service, though a little over half of these employees are tenured staff, with 55 percent having 10 or more years of state service. Seventy-one percent (71%) are age 50 and younger, with an average age of 44.[85]

[84] HHSAS Database, FY 2007 data.
[85] HHSAS Database, as of 8/31/07.

Figure 22: OES Workers – Length of Service

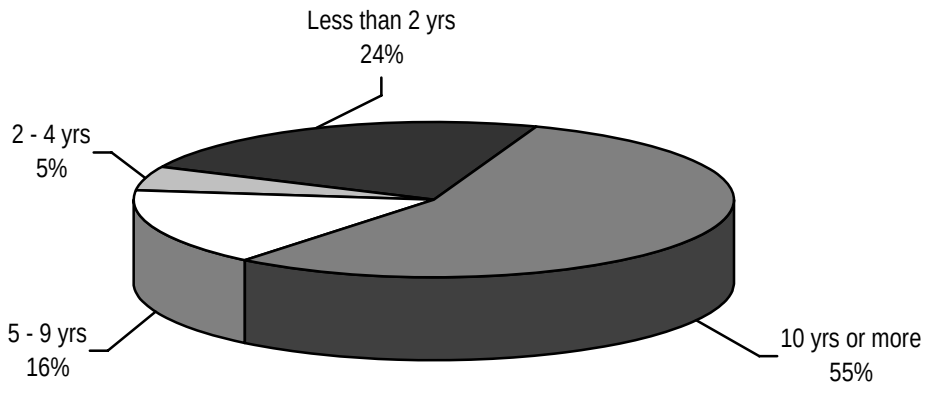
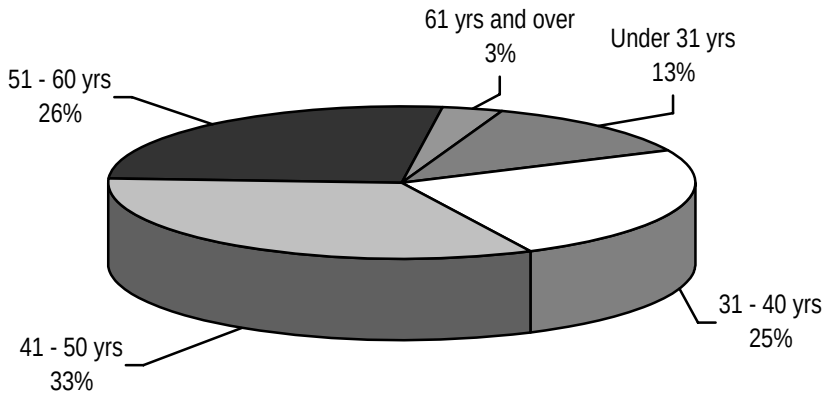


Figure 23: HHSC OES Workers – Distribution of Age



Though turnover for this group of employees is low at only about 13 percent for fiscal year 2007, certain positions within this group are experiencing much higher turnover. Medical Eligibility Specialists are experiencing a 19 percent turnover rate, with 27 percent of these workers having less than two years of state service. Human Services Technicians are experiencing the highest turnover, at a rate of 32 percent, with nearly 64 percent of these workers having less than two years of state service.[86] Special retention strategies have been used to address this high turnover. As a result, OES turnover has been significantly reduced from fiscal year 2006 levels.

[86] State Auditor's Office (SAO) FY2007 Turnover Statistics.

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

The HHSC workforce will continue to require a wide variety of skilled professional staff. It is expected the consolidation of programs and outsourcing may result in a realignment of existing jobs, requiring employees to acquire new skills. The knowledge, skills and abilities necessary to perform mission essential tasks within the agency will require a more highly skilled and educated workforce. Critical competencies essential to meet the mission and goals of the agency are:

- automation skills;
- business acumen;
- ability to interpret and implement state and federal statutes;
- communication and negotiation skills;
- contract management skills;
- management and supervisory skills;
- ability to create and interpret policy;
- analytical and conceptual skills such as planning, evaluation and problem solving;
- oversight and performance monitoring skills; and
- increased administrative skills to ensure the efficiency, quality and effective management of services to the consumer populations.

Recruitment Strategies

HHSC faces a challenge in recruiting and retaining a diverse workforce. HHSC must aggressively recruit qualified employees for all jobs. Strategies the agency can use to address recruitment of qualified employees include:

- recruitment bonus payments;
- competitive salaries utilizing the full salary group range;
- raising entry-level salaries;
- professional development and education assistance;

- defined career progression programs;
- intern programs; and
- partnering with colleges and universities to recruit hard to fill jobs.

The agency has many recruitment opportunities available. Recruitment programs, such as attendance at job fairs and college recruitment fairs and participation in intern programs, professional organizations and Internet recruitment venues may be used.

Retention Strategies

Competency gaps identified for existing staff can be addressed through internal and external training, electronic training initiatives, education programs offered through colleges and agency mentoring programs. Other retention strategies the agency may use include:

- retention bonus payments;
- one-time merit awards;
- salary equity adjustments;
- performance recognition;
- defined career progression;
- mentoring programs;
- professional development and education assistance;
- basic and advanced computer training;
- continued use of the new compensation plan for OES staff, which includes the raising of entry-level salaries and provided existing workers with promotions or merits; and
- management skills training.

DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

MISSION

The mission of the Department of Family and Protective Services (DFPS) is to protect children, the elderly and people with disabilities from abuse, neglect and exploitation by involving clients, families and communities.

SCOPE

DFPS was created with the passage of H.B. 2292 by the 78th Legislature, (Regular Session, 2003). Previously called the Department of Protective and Regulatory Services, DFPS is responsible for protecting children, adults who are elderly or have disabilities living at home or in state facilities; and licensing group day-care homes, day-care centers and registered family homes. The agency is also charged with managing community-based programs that prevent delinquency, abuse, neglect and exploitation of Texas children, elderly and disabled adults.

Every day, almost 10,000 DFPS employees in more than 249 offices across the state, protect the physical safety and emotional well-being of the most vulnerable citizens of Texas.[87]

CORE BUSINESS FUNCTIONS

DFPS has the following four major programs areas that deliver client services to Texans in need:

- The Child Protective Services (CPS) Division:
  - investigates reports of abuse and neglect of children;
  - provides services to children and families in their own homes;
  - contracts with others to provide clients with specialized services;
  - places children in foster care;
  - provides services to help youth in foster care make the transition to adulthood; and
  - places children in adoptive homes.

[87] HHSAS Database, as of 8/31/07.

- The Adult Protective Services (APS) Division investigates:
  - reports of abuse, neglect and/or exploitation of elderly adults (defined as 65 years and older) and adults with disabilities who reside in the community and if appropriate, provides or arranges for protective services, which may include referral to other programs, referral for guardianship, emergency assistance with food, shelter and medical care, transportation, counseling, or other remedies; and
  - reports of abuse, neglect and/or exploitation of clients receiving services in state operated mental health and mental retardation facilities and/or state contracted settings that serve adults with mental illness or mental retardation.

- The Child Care Licensing (CCL) Division safeguards the basic health, safety and well-being of Texas children. Employees in this program:
  - develop and enforce minimum standards for child-caring facilities and child-placing agencies;
  - investigate complaints and serious incidents involving day care and residential-care facilities and, if necessary, take corrective or adverse action; and
  - license group day care homes, day care centers, registered family homes, child-placing agencies and private and publicly owned residential child-care facilities.

- The Statewide Intake (SWI) Division is the agency's automated call center. It receives information from the general public who want to report suspicions of abuse/neglect of children or abuse/neglect/exploitation of adults with disabilities and persons 65 years or older. This call center remains open 24 hours a day, 7 days a week.

WORKFORCE DEMOGRAPHICS

DFPS is the third largest agency in the HHS System. DFPS currently employs approximately 9,700 employees, with the majority of the workforce located in offices throughout the state.[88] The DFPS workforce is diverse. To better illustrate this diversity, the following demographic categories are examined:

[88] HHSAS Database, as of 8/31/07.

Job Families

The majority of DFPS employees work in Protective Services Worker job classifications, with the largest number of employees in Child Protective Services Worker positions.

About 92 percent of DFPS employees (9,009 employees) work in only 10 job families.[89]

Table 15: Largest Program Job Classes and Average Salaries

Job Title	Number of Employees	Average Salary
Child Protective Service Specialists	2,138	$33,368
Child Protective Service Investigators	1,758	$32,095
Program Specialists	1,644	$44,257
Clerical Workers	1,147	$24,810
Human Services Technicians	735	$24,546
Adult Protective Service Workers	656	$33,345
State Wide Intake Workers	295	$34,284
Child Care License Workers	456	$35,856
System Analysts	98	$54,073
Accountants	82	$34,737

Salary

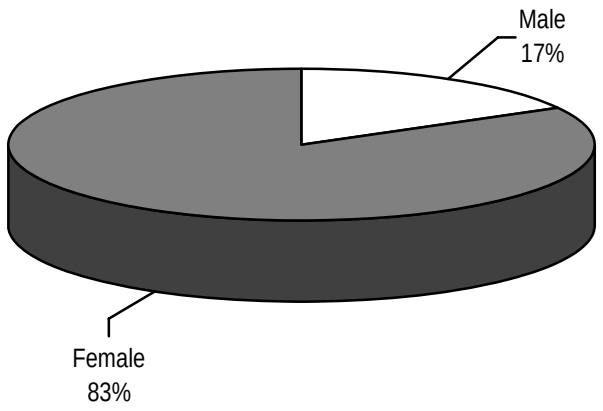
DFPS employees are, on the average, the second highest paid employees in the HHS System, earning an average annual salary of $38,015.[90]

[89] HHSAS Database, as of 8/31/07. Note: The HHS HR Facts book for FY 2007 uses the job family title of "CPS Workers," which only included CPS Investigators. References to "CPS Workers" in this document refer to both CPS Investigators and CPS Specialists.
[90] Ibid.

Gender

Females make up 83 percent of the agency workforce.[91]

Figure 24: DFPS Workforce by Gender

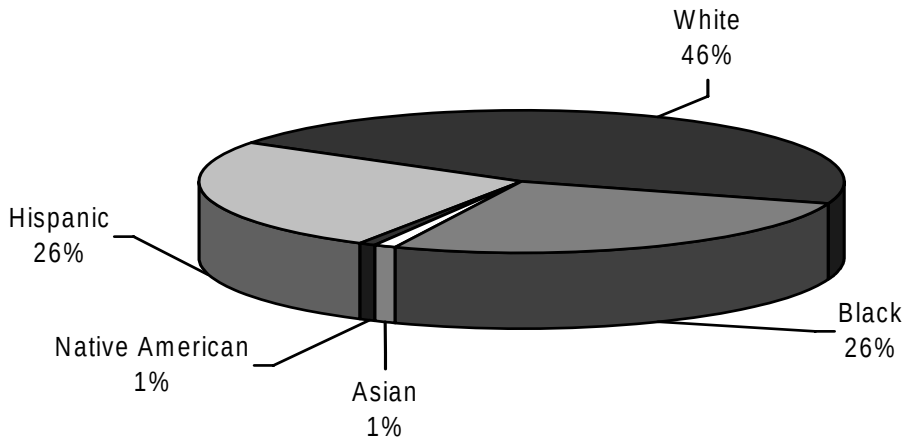


[91] HHSAS Database, as of 8/31/07.

Race

White employees represent the largest racial group at 46 percent, followed by Black employees at 26 percent and Hispanic employees at 26 percent. [92] The agency encourages diversity in its workforce, which is supported by its hiring practices.

Figure 25: DFPS Workforce by Race

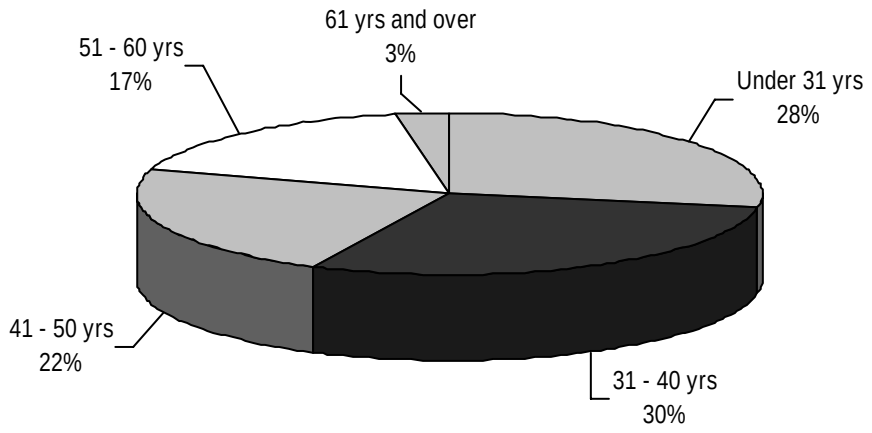


[92] HHSAS Database, as of 8/31/07.

Age

Of all HHS agencies, DFPS has the youngest workforce. Approximately 28 percent of the DFPS workforce are 30 years or younger. The average age of a DFPS employee is 40 years.[93]

Figure 26: DFPS Workforce by Age



Average age: 40 yrs

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and Females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

The utilization analysis of the DFPS workforce does not reflect underutilization.[94] [95]

[93] HHSAS Database, as of 8/31/07.
[94] DFPS workforce data – HHSAS Database, as of 8/31/07.
[95] CLF data – EEOC publications, "Job Patterns for Minorities and Women in State and Local Government, 2003" for Texas and "Job Patterns for Minorities and Women in Private Industry, 2003" for Texas. Modified 06/08/2005.

Table 16: DFPS Utilization Analysis Results

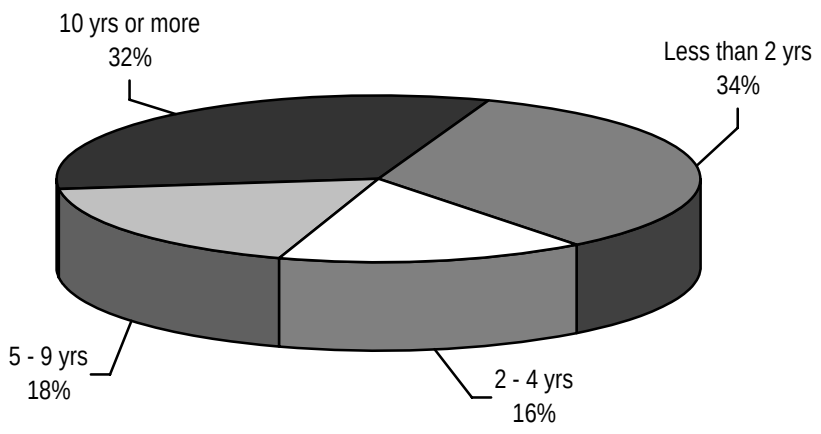
Job Category	Black			Hispanic			Female		
	DFPS %	CLF %	Underutilization (If Yes, # needed)	DFPS %	CLF %	Underutilization (If Yes, # Needed)	DFPS %	CLF %	Underutilization (If Yes, # Needed)
Officials/ Administrators	12.6%	7.2%	No	17.0%	12.3%	No	71.9%	32.6%	No
Professionals	21.3%	9.4%	No	21.4%	11.6%	No	76.3%	49.0%	No
Technicians	26.2%	13.9%	No	27.7%	19.7%	No	52.3%	42.1%	No
Protective Service	29.2%	18.0%	No	24.3%	23.1%	No	83.1%	21.6%	No
Para-Professionals	30.9%	14.3%	No	36.8%	25.7%	No	91.6%	56.3%	No
Administrative Support	25.0%	19.4%	No	35.9%	26.8%	No	95.5%	78.8%	No
Skilled Craft	0.0%	14.7%	N/A	0.0%	35.2%	N/A	100.0%	16.5%	N/A
Service Maintenance	0.0%	20.4%	N/A	0.0%	43.7%	N/A	0.0%	44.4%	N/A

Note: "N/A" indicates that the number of employees in this category was too small (less than thirty) to test any differences for statistical significance.

State Service

Not only does DFPS have the youngest workers, it also has the least tenured. About 34 percent have less than two years of state service.[96]

Figure 27: DFPS Workforce by Length of State Service

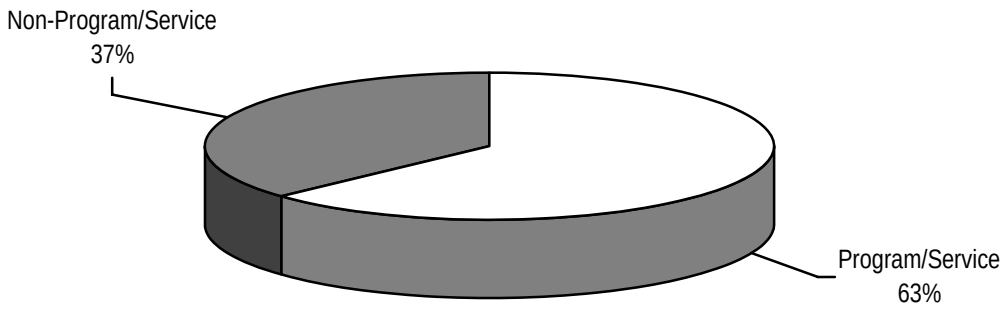


[96] HHSAS Database, as of 8/31/07.

Return-to-Work Retirees

DFPS employs 262 return-to-work retirees. The majority of these retirees (191 employees or 63 percent) work in the program/service related areas.[97]

Figure 28: DFPS Return-to-Work Retirees



[97] HHSAS Database, as of 8/31/07.

TURNOVER

The turnover rate during fiscal year 2007 was 23.2 percent, the third highest of all HHS agencies. This rate is significantly higher than the statewide turnover rate of 17.4 percent.[98] The majority of these separations (approximately 90 percent) were voluntary separations from state employment.[99]

Table 17: Reason for Separation

Reason	Percentage[100]
Voluntary Separations	
Personal reasons	73.1%
Transfer to another agency	12.0%
Retirement	5.1%
Involuntary Separations	
Termination at Will	1.3%
Resignation in Lieu	3.6%
Dismissal for Cause	4.5%
Reduction in Force	0.0%

Employees performing core agency duties in CPS positions (CPS Specialists and CPS Investigators) experienced the highest combined turnover during fiscal year 2007 with 34.3 percent, followed by SWI Workers at 27.9 percent, APS Workers at 17.8 percent and CCL Workers at 16.7 percent.[101]

[98] State Auditor's Office (SAO) FY 2007 Turnover Statistics.
[99] Ibid.
[100] Death accounted for .4% of separations.
[101] HHSAS Database, as of 8/31/07.

Table 18: FY 07 Turnover for Significant Job Classes		
Job Title	Average Annual Headcount	Turnover Rate
CPS Investigators	1,853.8	39.5%
Auditors	3.3	30.8%
CPS Specialists	2,223.3	29.9%
SWI Workers	318.8	27.9%
Contract Specialists	90.0	23.3%
System Support Specialists	60.3	19.9%
Attorneys	75.8	18.5%
APS Workers	343.0	17.8%
Network Specialists	11.3	17.8%
Clerical Workers	1127.8	17.5%
Budget Analysts	23.3	17.2%
CCL Workers	449.0	16.7%
System Analysts	102.5	16.6%
Quality Assurance Specialists	30.5	16.4%
Human Services Technicians	678.5	16.4%
Human Services Specialists	67.3	16.4%
Director / Managers	141.3	13.5%

RETIREMENT PROJECTIONS

Currently, over five percent of the DFPS workforce is eligible to retire from state employment. Over the next five years, approximately 14.5 percent of the DFPS workforce will reach retirement eligibility. This is the lowest projected percentage of all HHS agencies.[102]

Table 19: DFPS Projected Retirement Eligibility through Rule of 80 (FY 07 – FY 12)

Fiscal Year	Cumulative Number of Eligible Employees	Percent of Workforce
2007	512	5.2%
2008	655	6.7%
2009	839	8.6%
2010	1,026	10.5%
2011	1,204	12.3%
2012	1,418	14.5%

EXPECTED WORKFORCE CHALLENGES

There are almost 300,000 Child, Family and School Social Workers in the US, with a projected 19.1 percent increase in job openings by the year 2016.[103]

Following two years of comprehensive agency reform, the 80th Legislature (Regular Session, 2007) continued its support of ongoing improvements of DFPS. The Legislature appropriated approximately $2.6 billion to DFPS for the fiscal year 2008-09 biennium operating budget, an 18.3 percent increase over appropriated funds from the previous biennium. In addition, the Legislature authorized funds to allow the agency to continue to provide the salary retention supplement of $5,000 established by the 79th Legislature (Regular Session, 2005) for Child Protective Services Investigation Caseworkers and Supervisors.

DFPS was provided with many new resources to continue agency reform, lower caseloads and make other improvements. The agency will hire an additional 1,335 staff, with the vast majority to be hired during fiscal year 2008. The agency was allocated 985 new positions during fiscal year 2008 and another 350 during fiscal year 2009. Hired staff will include:

- 501 Conservatorship staff (including 372 Conservatorship caseworkers);

[102] HHSAS Database, as of 8/31/07.
[103] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).

- 348 Family Based Safety Services staff (including 212 caseworkers);
- 84 Family Group Decision Making staff;
- 89 Kinship staff (including 69 Kinship workers);
- 86 Residential Child Care Licensing staff (including 40 workers);
- 34 Legal staff; and
- 21 contracting staff.

Retaining these workers remains a difficult challenge for the agency. The work is face to face, emotional, difficult and often crisis driven. It requires staff to interact regularly with vulnerable children and adults in dire need and with those who may be or are maltreating them.

To retain trained, competent staff while providing the highest quality services for DFPS consumers over the next five years, the agency must:

- competitively recruit, retain and train quality staff to adequately manage increasing caseloads and provide quality services to clients;
- meet the training demands of new staff, explore innovative ways to improve skills and provide policy refresher training for supervisors and caseworkers; and
- continue intensive hiring efforts for new staffing positions and fill Protective Services Worker positions that are experiencing high turnover.

For agency reforms to succeed, DFPS will need to aggressively recruit and retain their Protective Services Workers.

Child Protective Service (CPS) Workers

There are 3,896 filled CPS Worker positions (1,758 CPS Investigators and 2,138 CPS Specialists). Turnover with this group of employees is the highest of all job categories, at approximately 34 percent. With an average age of 35 years, CPS Workers are young (nearly half are under 31 years of age) and

have an average of four years of state service.[104] It is difficult to recruit an employee with an aptitude for CPS casework and equally hard to retain them.

Figure 29: CPS Investigators at DFPS – Distribution of Age

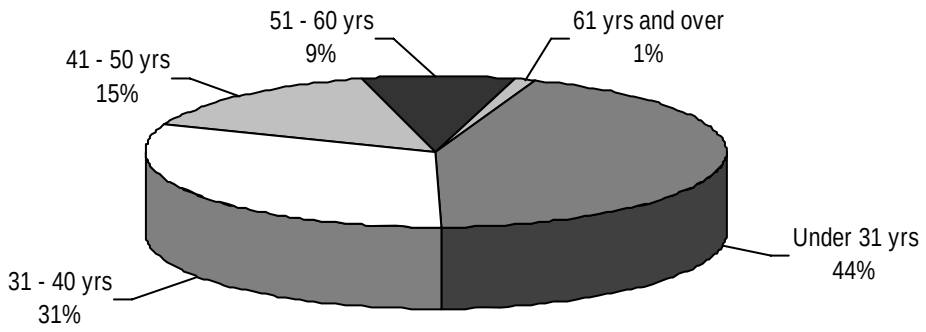
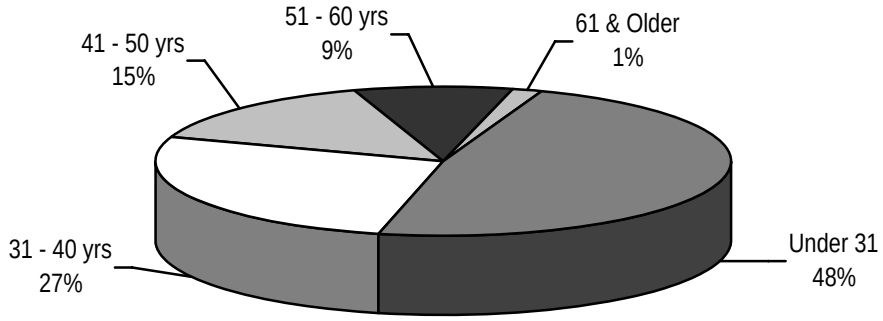


Figure 30: CPS Specialists at DFPS – Distribution of Age



[104] HHSAS Database for FY 2007.

Figure 31: CPS Investigators at DFPS – Length of Service

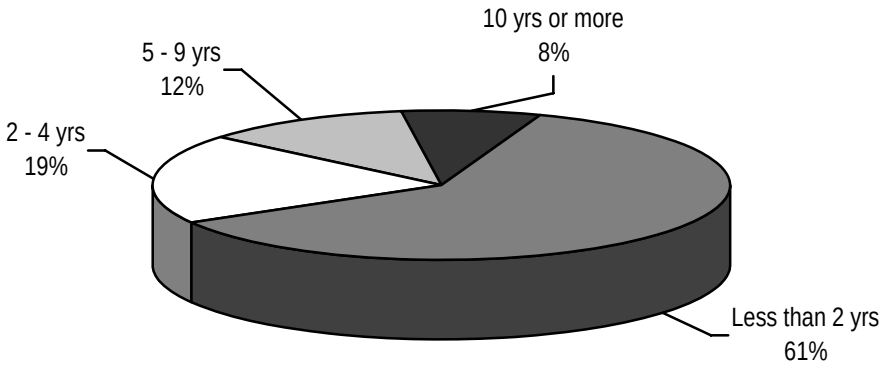
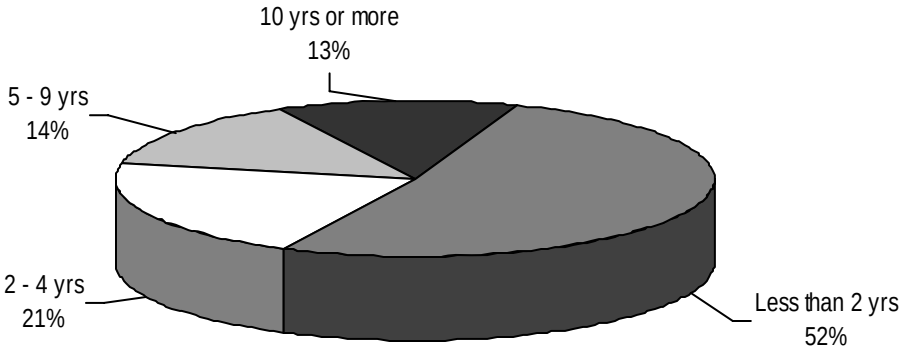


Figure 32: CPS Specialists at DFPS – Length of Service



Statewide Intake Workers (SWIs)

There are approximately 295 SWI Workers with DFPS. With an average age of about 39, approximately 35 percent are under 31 years of age. SWI Workers have an average of 7.3 years of state service, with approximately 31 percent having less than two years of state service.

Turnover for SWI Workers is considered high at approximately 28 percent.[105]

[105] HHSAS Database, as of 8/31/07.

Figure 33: SWI Workers at DFPS – Distribution of Age

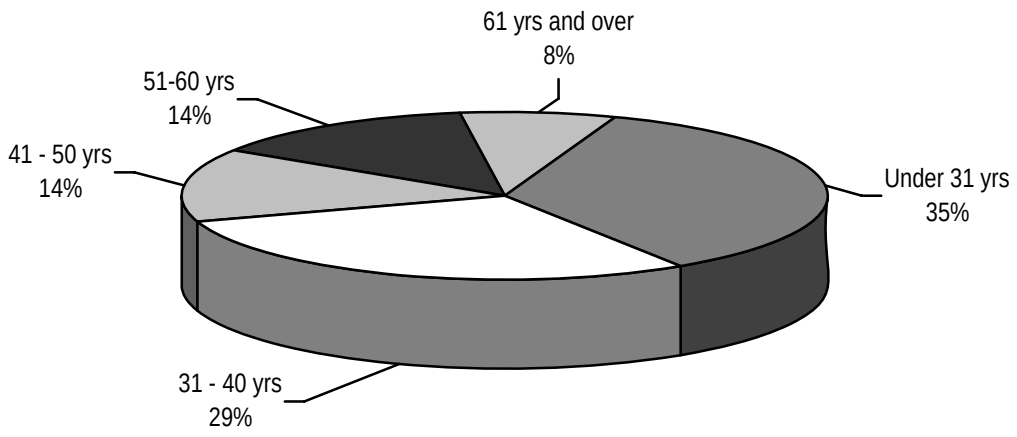
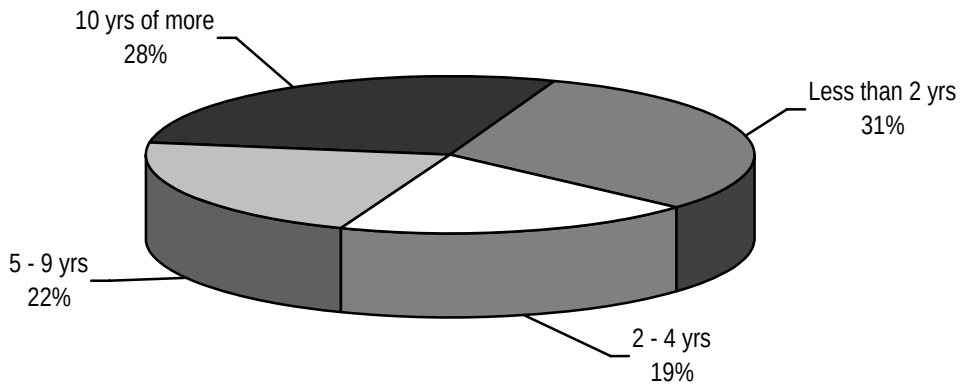


Figure 34: SWI Workers at DFPS -- Length of State Service



Child Care Licensing (CCL) Workers

There are over 450 CCL Workers with DFPS. The typical employee in the job is 41 years old and has an average of 10 years of state service.[106]

During fiscal year 2007, turnover for CCL Workers was 16.3 percent, slightly under the state average of 17.4 percent.[107] [108]

[106] Ibid.
[107] HHSAS Database, as of 8/31/07.
[108] State Auditor's Office (SAO) FY 2007 Turnover Statistics.

Figure 35: CCL Workers at DFPS – Distribution of Age

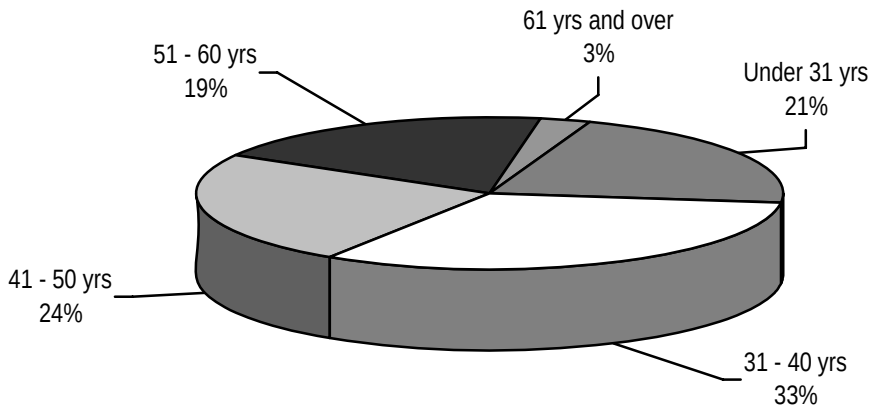
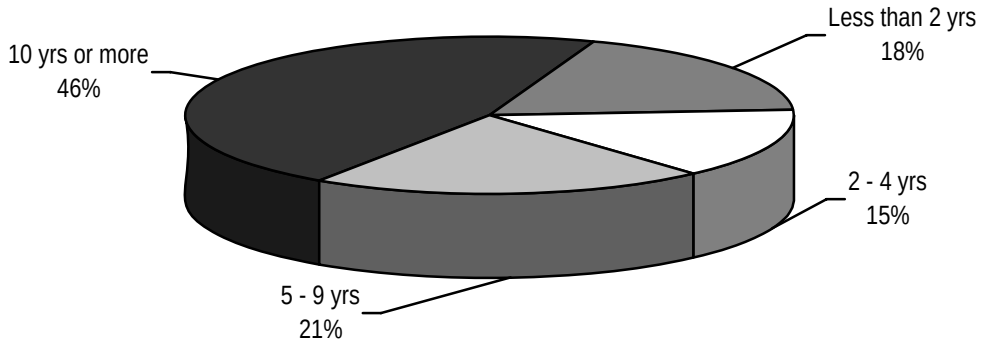


Figure 36: CCL Workers -- Length of State Service



Adult Protective Services (APS) Workers

There are around 650 APS Workers with DFPS. The typical APS worker is 41 years of age and has an average of 7.2 years of state service. Over a third of the group has less than two years of state service.[109] [110]

Figure 37: APS Workers at DFPS – Distribution of Age

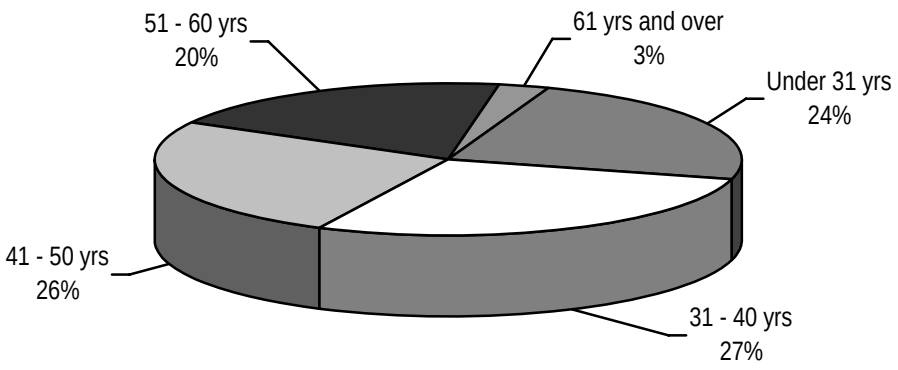
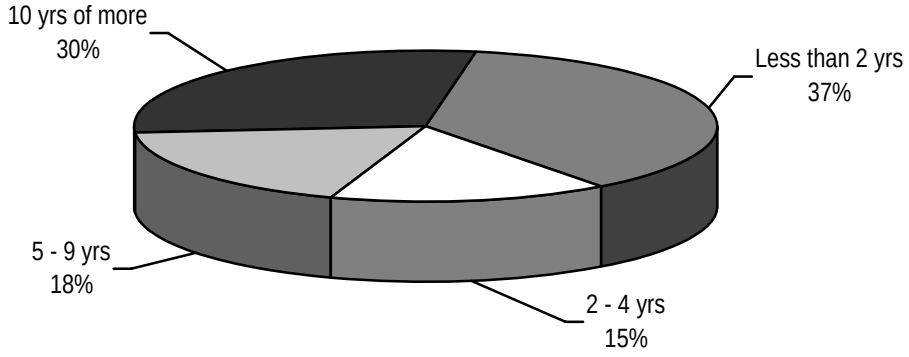


Figure 38: APS Workers at DFPS -- Length of State Service



During fiscal year 2007, APS Worker turnover reached 17.8 percent, slightly above the state average of 17.4 percent. [111] [112]

[109] HHSAS Database, as of 8/31/07.
[110] Ibid.
[111] Ibid.
[112] State Auditor's Office (SAO) FY 2007 Turnover Statistics.

With the aging of the Texas population, the agency anticipates an increasing demand for Adult Protective Services.

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

Recruitment Strategies[113]

- Continue monitoring caseworker positions that are not filled in a timely manner and work with program management and hiring staff to address any barriers to efficient hiring.

- Continue to hire persons with law enforcement experience as senior CPS investigators to improve investigations and to train other caseworkers on forensic techniques. These investigators will support investigation caseworkers in interviewing victims and suspected perpetrators, evidence gathering and coordination of criminal and civil case actions. This will help reduce investigation time needed to complete an investigation.

- Continue to recruit and hire new employees who have the necessary qualifications and skills to be successful.

- Target recruitment efforts to individuals who hold a bachelor's degree or advanced degree in at least one of the following academic areas:
  - Social work
  - Counseling
  - Early childhood education
  - Psychology
  - Criminal Justice
  - Elementary or Secondary Education
  - Sociology
  - Human Services

- Continue to implement and evaluate improvements to the DFPS hiring process of direct delivery caseworkers recommended by the Improve Hiring workgroup, as outlined in the Workforce Stabilization and Retention Initiative.

- Continue to work with the Texas Higher Education Coordinating Board to develop strategies to enhance the curriculum in institutions of higher education related to APS functions.

[113] Some of the strategies are contingent on funding approval.

- Continue to attend job fairs, use local and national recruiting websites, use perpetual postings and provide interested applicants with a realistic job preview of what it takes to be a successful CPS caseworker.

- Continue to use the following targeted employment selection devices:
  - A pre-screening test for job applicants to assess skills and performance capabilities.
  - A behavioral description interview guide, geared at assessing how each candidate would respond to real life work situations.

- Continue to monitor and evaluate the recent expansion of pre-employment testing (PET) to the Child Care Licensing (Daycare and Residential) and Statewide Intake programs.

- Continue efforts to recruit bilingual workers.

- Provide recruitment tools that depict a realistic, yet compelling, view of front-line protective services work.

- Continue to provide a $5,000 annual stipend to investigation caseworkers and supervisors.

- Offer recruitment bonuses for CPS, APS and CCL positions.

Retention Strategies[114]

- Complete the development and deployment of a new CPS Basic Skills Development (BSD) training course for new caseworkers based on an updated job and task analysis. The revised training will give graduates the requisites skills, knowledge and abilities to do their jobs.

- Continue to reduce CPS and APS caseloads for individual caseworkers.

- Continue to increase CPS Caseworker and supervisor salaries and pursue appropriate job classifications and pay structure.

- Expand structures proven to help address staff burnout and stress.

- Expand supervisory development, training and support to increase the focus on human resource management.

[114] Some of the strategies are contingent on funding approval.

- Expand the mission of the DFPS Tomorrow program to include preparation for supervision roles.

- Provide tools for supervisors to recognize and reward their staff. Continue the development of appropriate performance expectations for all positions, describing what “good” performance entails and recognizing good performance.

- Continue to provide merit salary increases to recognize employees for jobs well done in supporting the delivery of services to consumers.

- Evaluate the addition of a pay differential to staff at the Statewide Intake hotline who work the hard-to-fill overnight and weekend shifts.

- Explore a tiered approach to compensation for newly hired staff, as well as continuing stipends to encourage APS caseworkers to attain a higher level of education in APS-related fields.

- Continue to support an organizational culture where good performance by employees is recognized and the opinions of dedicated employees are appreciated.

- Provide technology to assist in documentation and improve overall caseworker efficiency.

- Continue using regional, statewide and agency level Program Improvement Committees (PICs) and agency-wide escalation processes to ensure that each employee can continue to have an avenue to articulate their concerns and suggestions, have their issues escalated to the appropriate resolution level in the agency and have a method of tracking his or her issue until a conclusion is reached.

- Continue to recognize outstanding caseworkers and seek statewide suggestions for content in DFPS Delivers, the agency’s bi-weekly, online Intranet newsletter.

- Expand the agency-specific questions on the Survey of Organizational Excellence to include questions on employee retention and post the analysis of the survey results on the agencies Intranet.

- Continue the practice of the agency’s Commissioner and members of the executive team, traveling to regional offices, visiting with leadership and frontline staff and answering questions on a face-to-face basis.

- Implement the STARS (Supporting, Training and Retaining Staff) program for all supervisors and caseworkers. This program provides many opportunities for feedback and communication between new workers and supervisors.

- Provide a continuum of leadership training that begins at the worker level and extends to the executive tiers.

- Continue the agency's partnership with the University of Texas Protective Services Training Institute (PSTI), which provides ongoing continuing education and certification of workers and supervisors and develop new training that will address issues that impact retention and turnover.

- Continue training agency supervisors/managers/leaders to perform their job duties and support their staff by strengthening their understanding of leadership and retention.

- Add "peer trainer" positions.

- Continue to enhance the work environment for staff by:
  - replacing outdated computer equipment;
  - providing tablet PCs to facilitate timely and accurate data entry and improve the quality of assessments and decision making;
  - expanding office space; and
  - developing an internal formalized process for requesting flex schedules, compressed workweeks and part-time and job-sharing opportunities.

- Award retention bonuses to APS, CCI, CPS, SWI and CCL caseworker staff.

- Discontinue use of the Protective Services Specialist I (B5) series in APS and SWI hires. The new entry level would be the Protective Services Specialist II (B6) level.

To meet the workforce demands over the next several years, DFPS will need to focus on aggressive recruitment and retention strategies.

DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES

MISSION

The mission of the Department of Assistive and Rehabilitative Services (DARS) is to work in partnership with Texans with disabilities and families with children who have developmental delays to improve the quality of their lives and to enable their full participation in society.

SCOPE

DARS administers programs that ensure Texas is a state where people with disabilities and children with developmental delays enjoy the same opportunities as other Texans to live independent and productive lives. The Department has four program areas: Rehabilitation Services, Blind Services, Early Childhood Intervention Services and Disability Determination Services. Through these program areas, DARS provides services that help Texans with disabilities find jobs through vocational rehabilitation, ensures that Texans with disabilities live independently in their communities and helps children with disabilities and developmental delays reach their full potential.

Approximately 3,000 DARS employees, in offices throughout the state, work to improve the quality of the lives of Texans with disabilities.[115]

CORE BUSINESS FUNCTIONS

DARS provides services to consumers through the following program areas:

- Rehabilitation Services (DRS) provides services in the following program areas:
  - Vocational Rehabilitation. Program staff assist Texans with disabilities prepare for, find and maintain suitable employment.
  - Office for Deaf and Hard of Hearing Services. Program staff work in partnership with people who are deaf or hard of hearing to eliminate barriers and improve equal access for people who are deaf or hard of hearing.

[115] HHSAS Database, as of 8/31/07.

- Independent Living Services and Independent Living Centers. Program staff promote self-sufficiency despite significant disability by providing people with improved mobility, communication, personal adjustment and self-direction.
- Comprehensive Rehabilitation Services. Program staff assist persons with spinal cord and brain injuries by sponsoring intensive therapies to increase independence.

♦ Disability Determination Services (DDS) employees make disability determinations for Texans with severe disabilities who apply for Social Security Disability Insurance and/or Supplemental Security Income. Staff examine and review medical evidence provided by claimants or their medical providers and make the determination on whether or not a claimant is disabled under the law.

♦ Blind Services (DBS) provides services through the following programs:
- Vocational Rehabilitation. Program staff assist adult consumers whose visual disabilities (visual impairments or total blindness) may limit their ability to work in their current jobs or secure new jobs.
- Business Enterprises of Texas. Program staff manage the program developed under federal law to provide food management opportunities for Texans who are blind or visually impaired.
- Independent Living. Program staff assist adult consumers who are blind or visually impaired to learn adaptive skills to enable them to continue to live independently and confidently with vision loss.
- Criss Cole Rehabilitation Center. Program staff provide a residential based intensive training in basic blindness skills to adult Texans who are blind or visually impaired due to a medical condition or accident which may progress to total blindness.
- Blind Children's Vocational Discovery and Development. Program staff assist children who are blind or visually impaired develop their individual potential.
- Blindness Education, Screening and Treatment. Program staff assist in the prevention of blindness through education, screening and treatment.

♦ Early Childhood Intervention (ECI) Services employees coordinate a statewide system of early childhood intervention services for families of infants and toddlers, birth to age three, with disabilities or developmental delays. Services are provided through mental health/mental retardation community centers, school districts, education service centers and private non-profit organizations.

WORKFORCE DEMOGRAPHICS

DARS is the smallest agency in the HHS System. DARS currently employs approximately 3,000 full and part-time employees, with the majority of DARS employees (2,577 employees or 82 percent) assigned to offices throughout Texas.[116] The remaining 554 employees, or 18 percent, are assigned to Central Office in Austin.[117] To better understand the agency's unique workforce, the following demographic categories are examined:

Job Families

About 89 percent of DARS employees (2,734 employees) work in 10 job families, with the largest number of employees in Vocational Rehabilitation Counselor positions (649 employees or 21 percent).[118]

Table 20: Largest Program Job Classes and Average Salaries

Job Title	Number of Employees	Average Salary
Vocational Counselors	649	$43,720
Clerical Workers	548	$33,850
Claims Examiners	498	$44,939
Rehabilitation Svcs Technicians	358	$32,905
Program Specialists	286	$57,888
Managers	148	$68,833
System Analysts	68	$59,237
Staff Services Officers	63	$44,848
Rehabilitation Teachers	62	$34,446
Human Services Specialists	54	$37,862

Salary

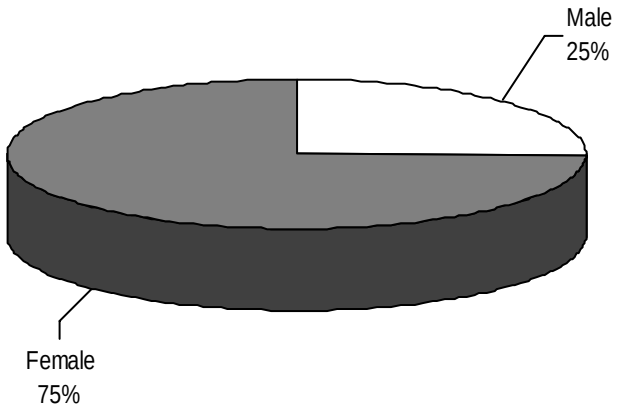
DARS employees earn an average annual salary of $44,498.[119]

[116] HHSAS Database, as of 8/31/07.
[117] Ibid.
[118] Ibid.
[119] Ibid.

Gender

DARS employees are primarily female, representing approximately 75 percent of the agency workforce (2,300 employees).[120]

Figure 39: DARS Workforce by Gender

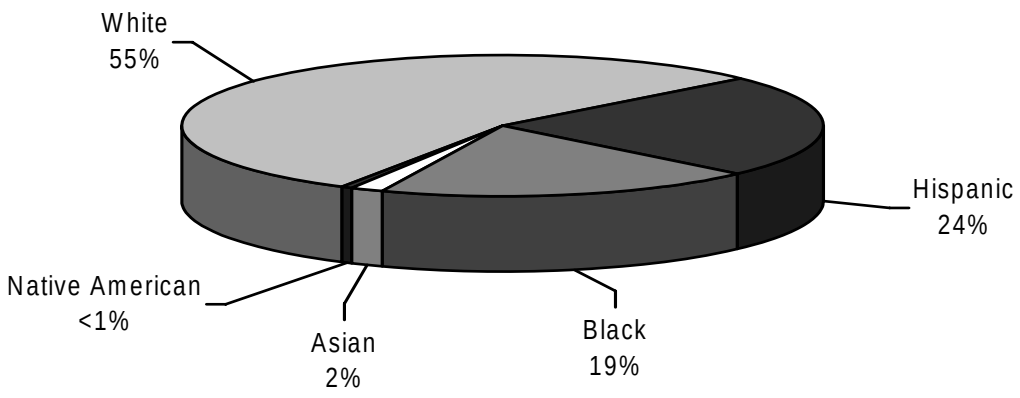


[120] HHSAS Database, as of 8/31/07.

Race

Approximately 1,694 or 55 percent of DARS employees are White, followed by Hispanic employees at 24 percent or 729 employees and Black employees at 19 percent or 592 employees.[121]

Figure 40: DARS Workforce by Race

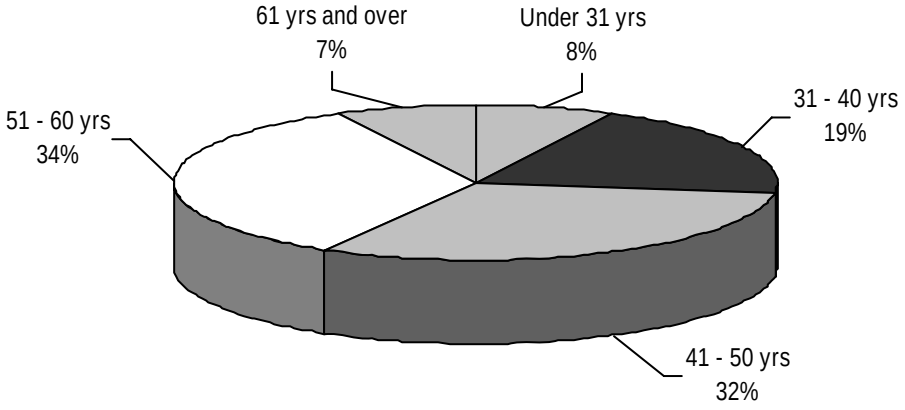


[121] HHSAS Database, as of 8/13/07.

Age

Over 70 percent of DARS employees are age 41 or older, with the average age being 48 years.[122]

Figure 41: DARS Workforce by Age



Average age: 48 yrs

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and Females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

The utilization analysis of the DARS workforce does not reflect underutilization.[123] [124]

[122] HHSAS Database, as of 8/13/07.
[123] DARS workforce data –report prepared from HHSAS Database, as of 8/13/07.
[124] CLF data – EEOC publications, "Job Patterns for Minorities and Women in State and Local Government, 2003" for Texas and "Job Patterns for Minorities and Women in Private Industry, 2003" for Texas. Modified 06/08/2005.

Table 21: DARS Utilization Analysis Results

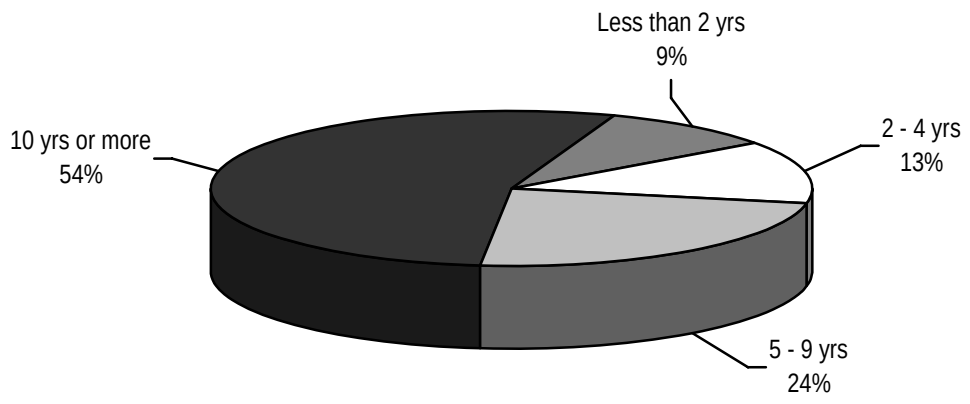
Job Category	Black			Hispanic			Female		
	DARS %	CLF %	Underutilization (If Yes, # needed)	DARS %	CLF %	Underutilization (If Yes, # Needed)	DARS %	CLF %	Underutilization (If Yes, # Needed)
Officials/ Administrators	11.9%	7.2%	No	12.4%	12.3%	No	45.1%	32.6%	No
Professionals	19.2%	9.4%	No	21.0%	11.6%	No	72.2%	49.0%	No
Technicians	5.6%	13.9%	N/A	33.3%	19.7%	N/A	55.6%	42.1%	No
Protective Service	0.0%	18.0%	N/A	0.0%	23.1%	N/A	0.0%	21.6%	No
Para-Professionals	18.6%	14.3%	No	27.8%	25.7%	No	87.6%	56.3%	No
Administrative Support	21.3%	19.4%	No	37.0%	26.8%	No	92.9%	78.8%	No
Skilled Craft	0.0%	14.7%	N/A	66.7%	35.2%	N/A	33.3%	16.5%	No
Service Maintenance	66.7%	20.4%	N/A	0.0%	43.7%	N/A	50.0%	44.4%	No

Note: "N/A" indicates that the number of employees in this category is too small (less than thirty) to test any differences for statistical significance.

State Service

DARS has a stable, long tenured workforce, with over half having at least 10 years of state service. Only nine percent of the workforce has less than two years of state service.[125]

Figure 42: DARS Workforce by Length of State Service

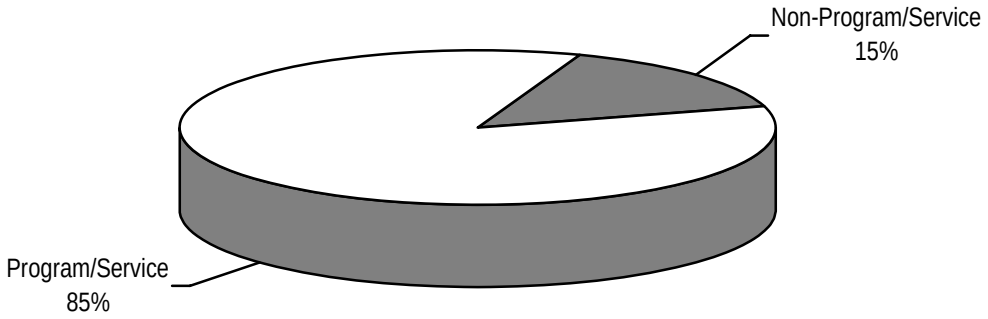


[125] HHSAS Database, as of 8/31/07.

Return-to-Work Retirees

DARS employs approximately 158 return-to-work retirees, representing about five percent of its total workforce. The majority of these retirees (85 percent) work in program/service related areas.[126]

Figure 43: DARS Return-to-Work Retirees



[126] HHSAS Database, as of 8/31/07.

TURNOVER

The DARS turnover rate during fiscal year 2007 was 10.7 percent, the lowest of all HHS agencies. This rate is significantly lower than the statewide turnover rate of 17.4 percent.[127] The majority of these separations (approximately 87 percent) were voluntary separations from state employment. This low turnover rate contributes to having a highly tenured, well trained workforce.[128]

Table 22: Reason for Separation

Reason	Percentage[129]
Voluntary Separations	
Personal reasons	53.4%
Transfer to another agency	15.7%
Retirement	18.1%
Involuntary Separations	
Termination at Will	0.3%
Resignation in Lieu	2.0%
Dismissal for Cause	6.7%
Reduction in Force	0.9%

System Support Specialist positions had the highest turnover rate during fiscal year 2007 (with three losses or a 20.7 percent turnover rate), followed by Rehabilitation Teachers (with 14 losses or an 18.8 percent turnover rate), Network Specialists (with two losses or a 17.4 percent turnover rate) and Vocational Rehabilitation Counselors (92 losses or a 13.7 turnover rate).[130]

[127] State Auditor's Office (SAO) FY2007 Turnover Statistics.
[128] HHSAS Database, FY 2007 data.
[129] Death accounted for 2.9% of separations.
[130] HHSAS Database, FY 2007 data.

Table 23: FY 07 Turnover for Significant Job Classes		
Job Title	Average Annual Headcount	Turnover Rate
System Support Specialists	14.5	20.7%
Rehabilitation Teachers	74.5	18.8%
Network Specialists	11.5	17.4%
Vocational Rehab Counselors	670.5	13.7%
Training Specialists	23.0	13.0%
Human Services Specialists	447.0	13.0%
Claims Examiners	504.8	9.5%
Case Managers	34.3	2.9%

RETIREMENT PROJECTIONS

Currently, over 15 percent of the DARS workforce is eligible to retire from state employment. Over the next five years, approximately one third of the DARS workforce will reach retirement eligibility.[131] These eligibility levels are the highest of all HHS agencies.

Table 24: DARS Projected Retirement Eligibility through Rule of 80 (FY 07 – FY 12)		
Fiscal Year	Cumulative Number of Eligible Employees	Percent of Workforce
2007	472	15.3%
2008	573	18.6%
2009	691	22.4%
2010	812	26.3%
2011	927	30.1%
2012	1051	34.1%

EXPECTED WORKFORCE CHALLENGES

Texas is one of the fastest growing states in the nation. Between July 1, 2006 and July 1, 2007, Texas gained more people than any other state, increasing the Texas population by 500,000.[132] Between 2004 and 2010, the state's population

[131] HHSAS Database, as of 8/31/07.
[132] US Census Bureau, December 22, 2006, on the Internet at http://www.census.gov/Press-Release/www/releases/archives/population/011109.html (visited March 10, 2008).

is expected to increase by 2.5 million, or eleven percent. Robust growth is also expected over the long-term. Between 2000 and 2010, total population growth could reach 16 percent and the growth rate could exceed 100 percent between 2000 and 2040, with the population doubling in size.[133]

This population growth is expected to directly increase the number of consumers receiving DARS services. Projected trends that support this increase include the following:

- The number of children born with severe visual impairments and blindness is growing.[134] With advances in modern technology, medicine and science, more children with multiple disabilities are surviving. These children have complex physical, mental health, mobility and societal needs and require a variety of service delivery options.

- The number of blind and visually impaired children who receive special education services is increasing. Blind and visually impaired students increased by 580 from school year 2003 to 2004.[135]

- By 2011, the number of Texans potentially eligible for agency services is estimated to increase by more than 50,000 persons. The largest increase is expected in the Vocational Rehabilitation (VR) program population, followed by the age 65 and over group served through the Independent Living (IL) program.

To meet the needs of this expanding population of consumers and to compensate for the potential loss of nearly a third of the agency's highly skilled and tenured workforce, the agency will need to aggressively recruit and retain its highly skilled direct-delivery Vocational Rehabilitation Counselors, Claims Examiners, Independent Living Workers and Orientation and Mobility Specialists.

Vocational Rehabilitation Counselors

As of November 2006, there were 141,000 rehabilitation counselors in the US. By 2016, this workforce group is expected to increase by 23 percent.[136] Within DARS, 649 Vocational Rehabilitation Counselors are employed in the Division for

[133] Office of the State Demographer, Texas State Data Center.
[134] Brigitte Volmer, et al., "Predictors of Long-term Outcome in Very Preterm Infants: Gestational Age Versus Neonatal Cranium Ultrasound," Pediatrics, November 2003.
[135] Texas Education Agency, Registration Report.
[136] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).

Rehabilitative Services (DRS) and the Division for Blind Services (DBS).[137] These counselors have an average of 10 years state employment and an average age of approximately 46 years.[138]

Figure 44: Vocational Rehabilitation Counselors at DARS – Length and State Service

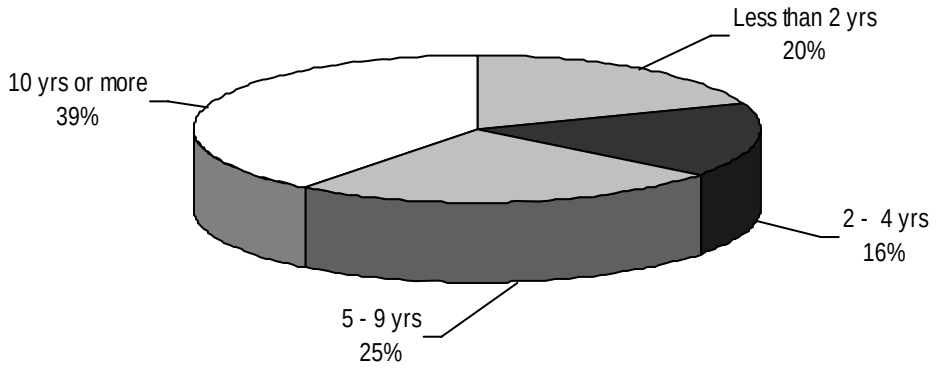
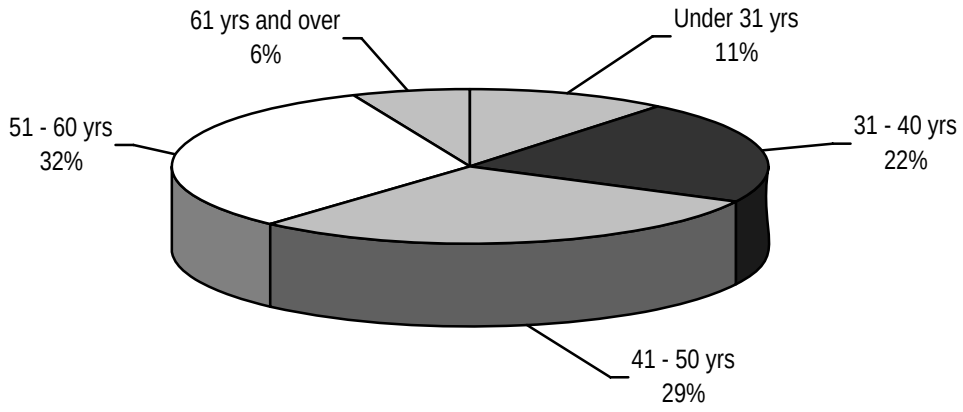


Figure 45: Vocational Rehabilitation Counselors at DARS – Distribution by Age



This highly skilled and tenured group of employees is also nearing retirement age, with 31 percent of current counselors eligible to retire by the year 2013.[139] To maintain current service levels to the expanding population of consumers, DARS must provide incentives to retain current counselors, provide succession

[137] HHSAS Database, as of 8/31/07.
[138] Ibid.
[139] Ibid.

planning opportunities to develop existing staff and aggressively recruit new counselors.

Nationally, there is a shortage of qualified vocational rehabilitation counselors. In addition, graduate programs are at reported capacity, further reducing the potential applicant pool.

The educational and certification requirements for the Vocational Rehabilitation Counselor positions (a federally mandated Comprehensive System of Personnel Development [CSPD] program) have made recruitment difficult and challenging. Entry-level counselors must have a college degree and meet eligibility requirements for Certified Rehabilitation Counselors (CRC) within seven years and nine months of hire. Counselors must also satisfy extensive training requirements after their hire, making the retention of these highly skilled employees both critical and costly to the agency.

Due to the comprehensive and specialized training program, as well as the ongoing training that newly hired counselors must take, retention of these employees is crucial. Currently, agency counselors are separating from employment at an annual rate of 13.7 percent. Though low, this loss rate should be closely monitored to identify any trends that may develop.

Claims Examiners

Within DARS, approximately 498 Claims Examiners are employed in the Division for Disability Determination Services (DDS).[140] DARS Claims Examiners have, on average, about nine years of state service, with an average age of about 43 years.[141] However, only about 19 percent of current examiners will be eligible to retire by the year 2013.

As a group, Claims Examiners are both younger and have less state service than Vocational Rehabilitation Counselors.

[140] HHSAS Database, as of 8/31/07.
[141] Ibid.

Figure 46: Claims Examiners at DARS – Length and State Service

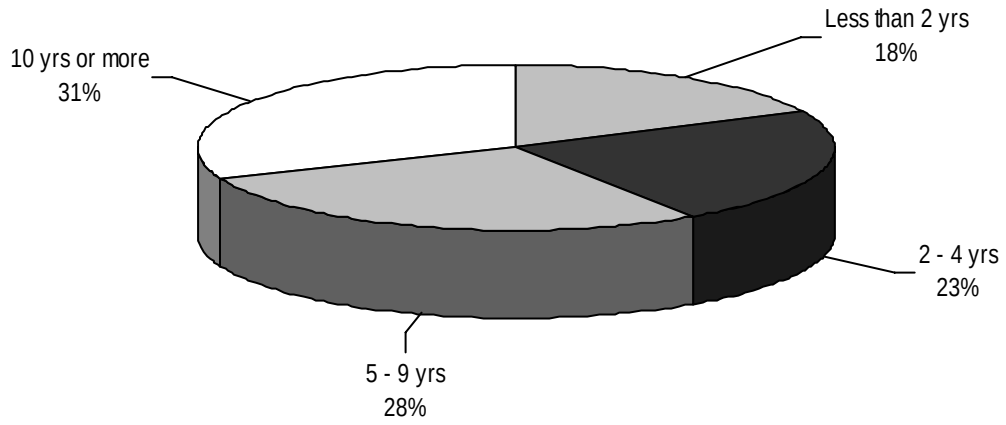
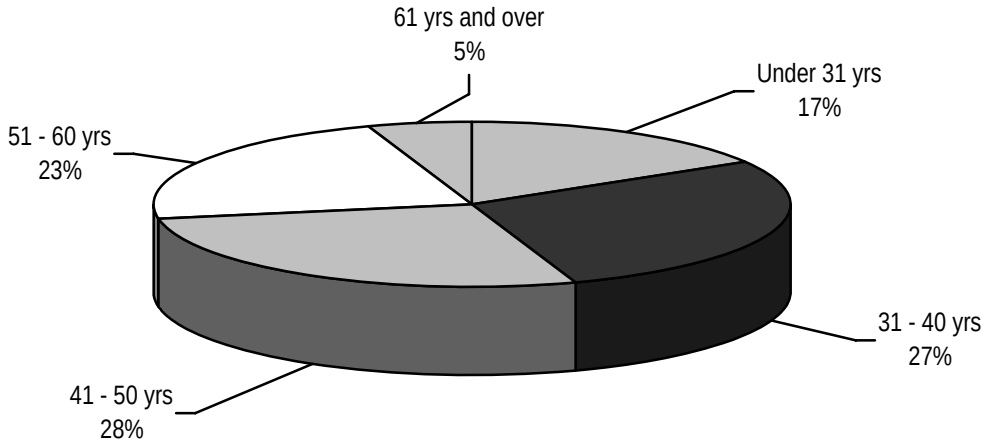


Figure 47: Claims Examiners at DARS – Distribution by Age



Entry-level Claims Examiners must have a Bachelors degree and complete a year of training before they can begin to perform their job duties. It typically takes a minimum of two years for DARS examiners to be fully competent in their work. Though Claims Examiners are separating from employment at an annual rate of only 9.5 percent, the vacancies that have occurred tend to remain open for, on average, over two months (74 days).[142]

[142] HHSAS Database, FY 2007 data.

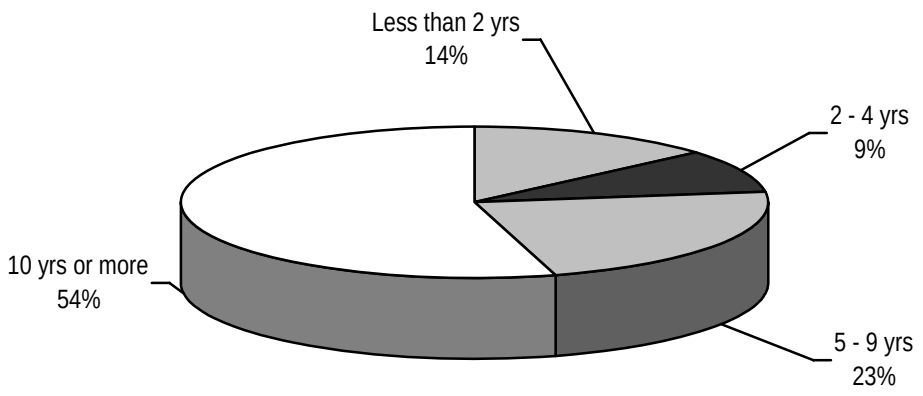
Due to the cost of this extensive training that newly hired examiners must take to become fully competent in their job, continuous monitoring of retention of these employees will remain a priority for agency management.

Independent Living Workers

Within DARS, approximately 22 Case Managers, HHS Program Coordinators, Program Specialists and Rehabilitation Teachers are employed as Independent Living Workers by DARS. These workers assist individuals who are blind or visually impaired to live as independently as possible within their community by adjusting to blindness through the development of travel skills, skills of daily living, communication skills, support systems and quality of living.

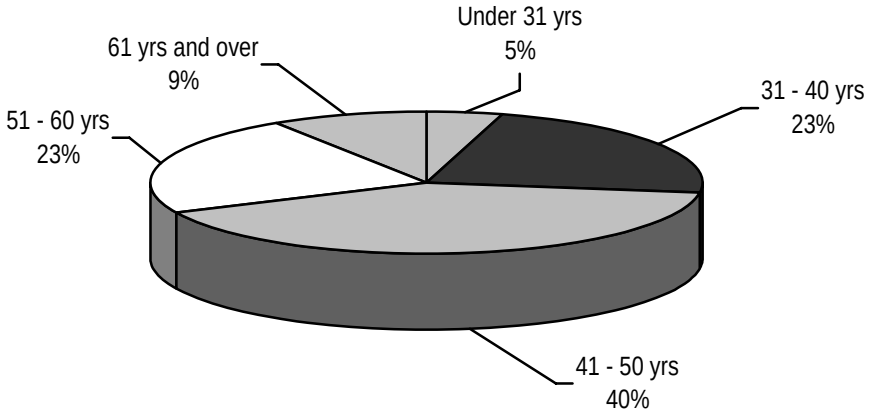
DARS Independent Living Workers have, on average, over 10 years of state service, with an average age of 47.2 years.[143]

Figure 48: Independent Living Workers at DARS – Length of State Service



[143] HHSAS Database, as of 8/31/07.

Figure 49: Independent Living Workers at DARS – Distribution by Age



Though the turnover rate for Independent Living Workers is low at 8.7 percent, the agency has historically had difficulty recruiting qualified applicants, especially in remote geographic locations, such as Odessa and Wichita Falls.

There are currently no college programs for this occupation and few individuals in the labor market possessing the knowledge and experience in working with individuals who are blind. To partially offset these limitations, new employees are required to complete an extensive two year training program to become competent in their job.

While only six Independent Living Workers (or 27 percent) will be eligible to retire in the next five years, the agency will need to develop creative recruitment strategies to replace these highly skilled and tenured employees.

Orientation and Mobility Specialists

Within DARS, approximately 14 Case Managers, HHS Program Coordinators, Human Services Specialists and Rehabilitation Teachers are employed as Orientation and Mobility Specialists by DARS. These highly skilled Specialists teach individuals who are blind or visually impaired to travel safely and independently in a familiar or unfamiliar environment.

DARS Orientation and Mobility Specialists have, on average, 7.8 years of state service, with an average age of 43.6 years.[144]

[144] HHSAS Database, as of 8/31/07.

Figure 50: Orientation and Mobility Specialists at DARS Length and State Service

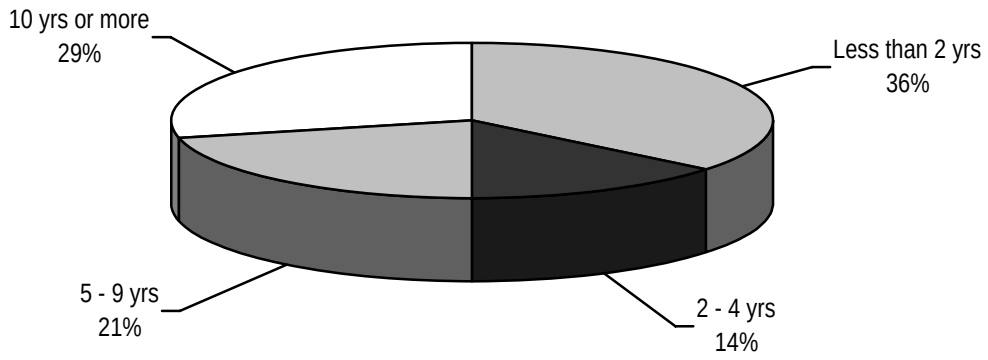
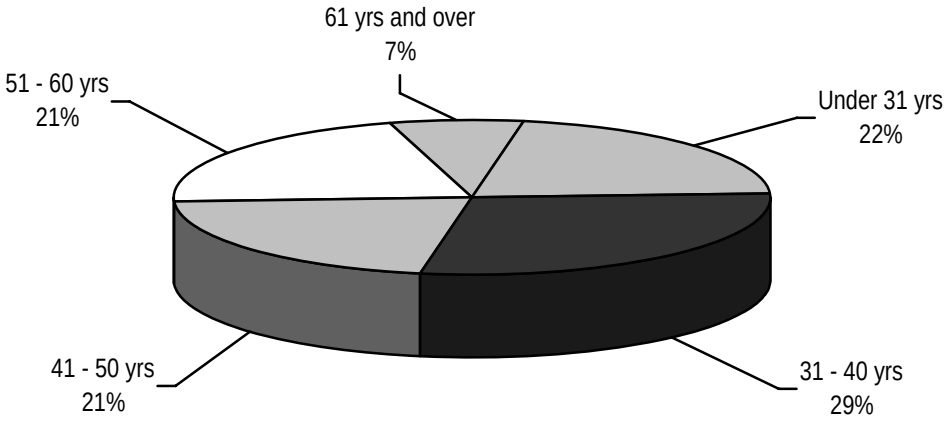


Figure 51: Orientation and Mobility Specialists at DARS Distribution by Age



While the turnover rate Orientation and Mobility Specialists is low at 7.5 percent, filling these positions has posed a significant challenge for the agency.

In the past year in Austin, the Criss Cole Rehabilitation Center (CCRC) within the Division for Blind Services posted three Orientation and Mobility positions. These positions remained vacant for an average of five months, with the three individuals hired being the only qualified applicants who applied. The shortage of qualified applicants for these positions can be explained by the highly specialized training and professional certification required for this profession, as well as the limited number of university training programs available across the country.

Adding to the shortage of qualified applicants is the intense competition from school districts that provide more flexible hours (189 day schedule versus the agency's 244 plus day schedule; and 7:30 to 3 or 3:30 versus 8-5) and higher entry level pay.

Recruitment of these highly skilled applicants will continue to be a challenge for DARS.

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

Recruitment Strategies

- Continue to allow supervisors to use the full salary range when posting vacant positions, allowing supervisors the flexibility to set the starting salary based on an applicant's education level, certification and related work experience.

- Continue to work closely with colleges and universities and establish intern programs and training placement positions for Vocational Rehabilitation Counselors.

- Contact universities offering accredited programs in areas of need and make site visits and classroom presentations to familiarize prospective graduates of career opportunities.

- Increase the number of electronic job vacancy notices sent to universities.

- Continue to use internet job posting/recruitment websites, professional publications, newspapers and trade associations to announce job vacancies.

- Work with the Social Security Administration on a national recruitment and retention strategy for Disability Determination Services (DDS) nation-wide implementation.

- Request additional Vocational Rehabilitation Counselor FTEs to meet increased program needs through the legislative appropriations request process.

- Use a comprehensive recruitment plan that includes:
  - appointing a recruitment coordinator;
  - participating in university advisory committees;

- o developing a recruitment and retention tool kit to be used by area managers as a hiring strategy for finding and keeping Vocational Rehabilitation Counselors; and
- o reviewing the 2008 Institute on Rehabilitation Issues (IRI) on recruitment and retention of Vocational Rehabilitation Counselors[145] and presenting findings to management.

- ♦ Continue to review current job descriptions to ensure the essential job functions are in alignment with division/programmatic needs and an ever changing environment.

- ♦ Review current entry level job classifications to determine if reclassifications are needed.

Retention Strategies

- ♦ Continue to allow staff to request transfers to other "like positions" within their region and around the state (when in the best interest of the employee and the agency).

- ♦ Consider higher salary reclassification of the following positions: Independent Living Worker, Vocational Rehabilitation Teacher and Blind Children's Specialist.

- ♦ Continue to promote the use of internal postings within DARS and encourage managers to promote from the internal applicant pool when filling vacant positions.

- ♦ Continue providing career ladder promotions.

- ♦ Continue to encourage Vocational Rehabilitation Counselors to obtain their Masters degree through financial incentives. When a counselor receives a Master's degree in Rehabilitation Counseling or a closely related Master's degree meeting CSPD standards, the counselor is eligible for a one-time merit of up to $1,500.

[145] Dew, D. W., Alan, G.M., & Tomlinson, P. (Eds.). (IRI 2008). Recruitment and retention of vocational rehabilitation counselors (Institute on Rehabilitation Issues Monograph No. 33). Washington, DC: The George Washington University, Center for Rehabilitation Counseling Research and Education. Web page http://library.ncrtm.org/pdf/751.004.pdf, last accessed on 5/19/08).

- Continue to encourage professional development through CRC Certification by providing a financial incentive. When a counselor is eligible to take the CRC exam, the agency pays the examination fee and travel expenses to take the exam.

- Develop, implement and make training available to Claims Examiners that focuses on the keys skills of assessing symptoms, credibility of medical information, weighing medical options and analyzing a person's ability to function.

- Develop, implement and make training available to Vocational Rehabilitation staff, to include:
  - providing updated counselor training based on revised Rehabilitation Services Administration policies; and
  - delivering training to counselors that focuses primarily on better upfront planning in the vocational rehabilitation process (specifically, intake, diagnostic interviews and the gathering of necessary documentation – skills needed to make accurate eligibility determinations and comprehensive assessments with the consumer and the planning vocational goals and services).

- Increase Professional Skill Enhancement Training.

- Evaluate the potential of including Claims Examiners in Social Security Administration succession planning/career development training opportunities.

- Fully use available recognition programs and benefits to identify and reward top performers.

Aggressive and creative recruitment and retention strategies will be necessary to ensure the agency maintains a fully employed, qualified workforce.

DEPARTMENT OF AGING AND DISABILITY SERVICES

MISSION

The Department of Aging and Disability Services (DADS) mission is to provide a comprehensive array of aging and disability services, supports and opportunities that are easily accessed in local communities.

SCOPE

The agency provides a continuum of long-term services and supports which are available to eligible older Texans, individuals with physical disabilities and individuals with intellectual or developmental disabilities. In addition, the regulatory component of DADS licenses and/or certifies providers of these services and monitors compliance with regulatory requirements.

CORE BUSINESS FUNCTIONS

DADS provides long-term services, supports, regulation, certification and outreach services. Functions listed below are provided either by DADS; Mental Retardation Authorities; Area Agencies on Aging; or other contracted providers.

- **Intake, Access and Eligibility.** Promotes eligibility determination and access to appropriate services and supports and the monitoring of those services and supports.
  - Intake, Access and Eligibility to Services and Supports
  - Guardianship

- **Community Services and Supports – Entitlement.** Provides Medicaid covered supports and services in homes and community settings which will enable elderly persons, persons with disabilities and others who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization.
  - Primary Home Care
  - Community Attendant Services
  - Day Activity & Health Services

- **Community Services and Supports – Waiver Programs.** Provides supports and services through Medicaid waivers in homes and community settings which will enable elderly persons, persons with disabilities and others who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization.
  - Community Based Alternatives (CBA)
  - Home and Community-based Services (HCS)
  - Community Living Assistance & Support Services (CLASS)
  - Deaf-Blind Multiple Disabilities (DBMD)
  - Medically Dependent Children Program (MDCP)
  - Consolidated Waiver Program (CWP)
  - Texas Home Living Waiver (TxHmL)

- **Community Services and Supports - Non-Medicaid.** Provides non-Medicaid services and supports in homes and community settings which will enable elderly persons, persons with disabilities and others who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization.
  - Non-Medicaid Services
  - Mental Retardation Community Services
  - Promoting Independence Plan
  - In-Home and Family Support
  - Mental Retardation In-Home Services

- **Program of All-inclusive Care for the Elderly (PACE).** Promotes the development of integrated managed care systems for aged and disabled individuals.

- **Nursing Facility and Hospice Payments.** Provides payments which will promote quality of care for individuals with medical problems that require nursing facility or hospice care.
  - Nursing Facility Payments
  - Medicare Skilled Nursing Facility
  - Hospice
  - Promoting Independence By Providing Community-based Individual Services

- **Intermediate Care Facilities - Mental Retardation.** Provides residential services and supports for persons with mental retardation living in intermediate care facilities (ICFs/MR).

- **Mental Retardation State Schools Services.** Provides specialized assessment, treatment, support and medical services in state school and state center programs for persons with mental retardation.

- **Capital Repairs and Renovations.** Efficiently manages and improves the assets and infrastructure of state facilities.

- **Regulation, Certification and Outreach.** Provides licensing, certification and contract enrollment services, as well as financial monitoring and complaint investigation, to ensure that residential facilities, home and community support services agencies and persons providing services in facilities or home settings comply with state and federal standards and that individuals receive high-quality services and are protected from abuse, neglect and exploitation.
  - Facility and Community-Based Regulation
  - Credentialing/Certification
  - Long-term Care Services and Supports Quality Outreach

- **Indirect Administration.** Assures efficient, quality and effective administration of services provided to elderly persons and persons with disabilities.
  - Central Administration
  - Information Technology Program Support
  - Regional Administration

WORKFORCE DEMOGRAPHICS

DADS is the largest of the five HHS agencies, employing over 14,100 employees and representing about 30 percent of the HHS workforce.[146] The majority of DADS employees (10,933 employees or 78 percent) are assigned to 11 state schools and one state center, which are 24-hour residential facilities, caring for people with mental retardation and physical disabilities.[147] The remaining 22 percent of DADS employees work in a regional or state office.

To better understand the agency's workforce, the following demographic categories are examined:

[146] HHSAS Database, as of 8/31/07.
[147] Ibid.

Job Families

About 84 percent of DADS employees (11,807 employees) work in 10 job families.

Table 25: Largest Program Job Classes and Average Salaries

Job Title	Number of Employees	Average Salary
Mental Retardation Assistants	5,980	$20,547
Clerical Workers	1,202	$25,763
Human Services Specialists	887	$32,607
Food Service Workers	656	$18,989
Rehab Therapy Technicians	621	$21,444
Nurses	609	$47,017
Program Specialists	621	$46,378
LVNs	572	$30,275
Custodians	364	$18,402
Maintenance Technicians	295	$25,580

Salary

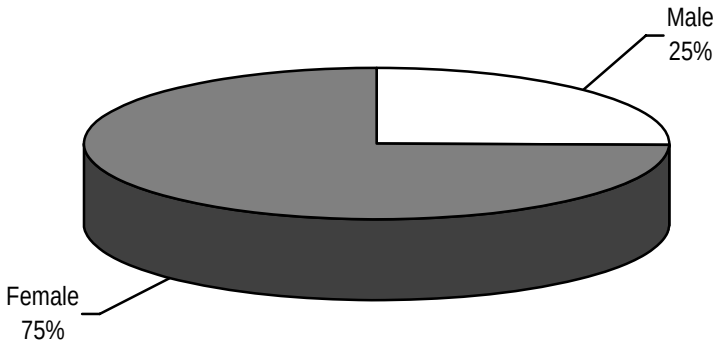
DADS employees, on average, are the lowest paid employees in the HHS System, earning an average annual salary of $27,919.[148]

[148] HHSAS Database, as of 8/31/07.

Gender

The majority of DADS employees are Female, comprising approximately 75 percent of the workforce (10,555 employees).[149]

Figure 52: DADS Workforce by Gender

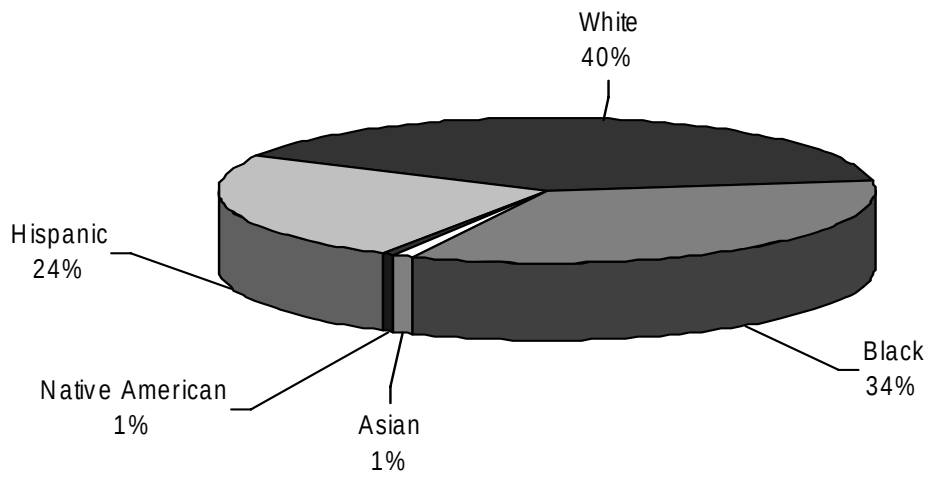


[149] HHSAS Database, as of 8/31/07.

Race

White employees represent the largest racial group at 40 percent, followed by Black employees at 34 percent and Hispanic employees at 24 percent. [150]

Figure 53: DADS Workforce by Race

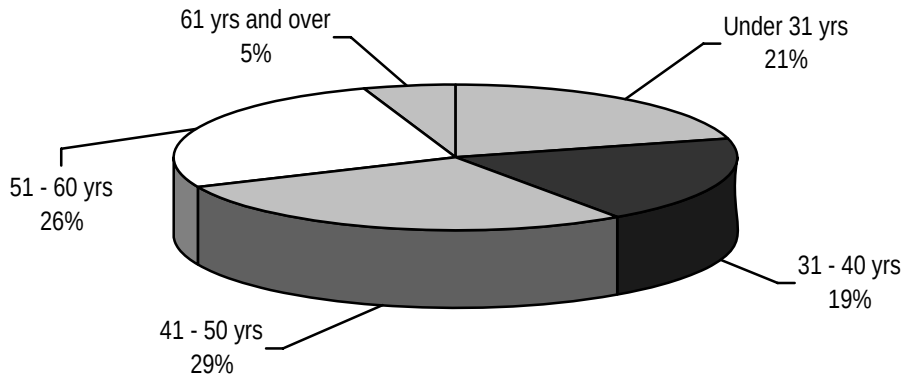


[150] HHSAS Database, as of 8/31/07.

Age

The average age of a DADS employee is 43 years. Sixty percent (60%) of the DADS workforce are 41 years or older.[151]

Figure 54: DADS Workforce by Age



Average age: 43 yrs

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and Females employed by the agency to the available statewide Civilian Labor Force (CLF) for each job category.

The utilization analysis of the DADS workforce, as indicated in Table 26, reflects underutilization in the following areas:

- Black, Hispanic and Female employees in the Skilled Craft job category; and
- Hispanic employees in the Service Maintenance job category.[152] [153]

[151] HHSAS Database, as of 8/31/07.
[152] DADS workforce data – report prepared from HHSAS Database, 08/31/2007.
[153] CLF data – EEOC publications, "Job Patterns for Minorities and Women in State and Local Government, 2003" for Texas and "Job Patterns for Minorities and Women in Private Industry, 2003" for Texas. Modified 06/08/2005.

Table 26: DADS Utilization Analysis Results

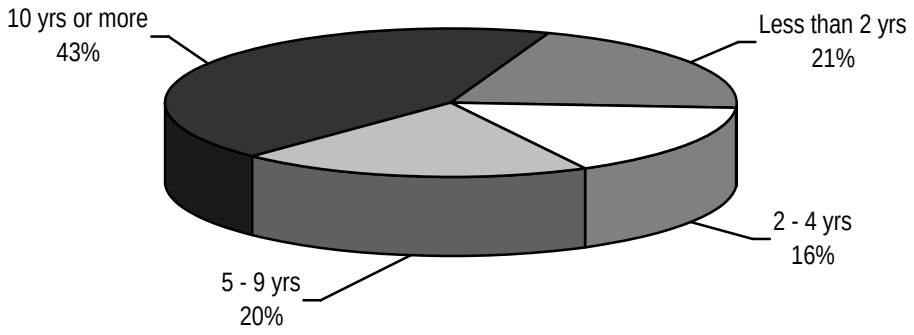
Job Category	Black			Hispanic			Female		
	DADS %	CLF %	Underutilization (If Yes, # needed)	DADS %	CLF %	Underutilization (If Yes, # Needed)	DADS %	CLF %	Underutilization (If Yes, # Needed)
Officials/ Administrators	12.5%	7.2%	No	10.2%	12.3%	No	62.5%	32.6%	No
Professionals	17.1%	9.4%	No	23.8%	11.6%	No	75.1%	49.0%	No
Technicians	24.5%	13.9%	No	20.3%	19.7%	No	88.4%	42.1%	No
Protective Service	12.7%	18.0%	No	23.9%	23.1%	No	57.7%	21.6%	No
Para-Professionals	28.5%	14.3%	No	25.3%	25.7%	No	81.5%	56.3%	No
Administrative Support	19.6%	19.4%	No	26.1%	26.8%	No	89.3%	78.8%	No
Skilled Craft	7.1%	14.7%	12	22.8%	35.2%	23	5.2%	16.5%	23
Service Maintenance	47.3%	20.4%	No	24.9%	43.7%	1,304	74.3%	44.4%	No

Specific recommendations concerning identified areas of underutilization and analysis are included in the HHS System Affirmative Action and Recruitment Plan.

State Service

DADS has a fairly tenured workforce with regard to state service, with 43 percent of the workforce having 10 or more years of state service and 57 percent having less than 10 years.[154]

Figure 55: DADS Workforce by Length of State Service

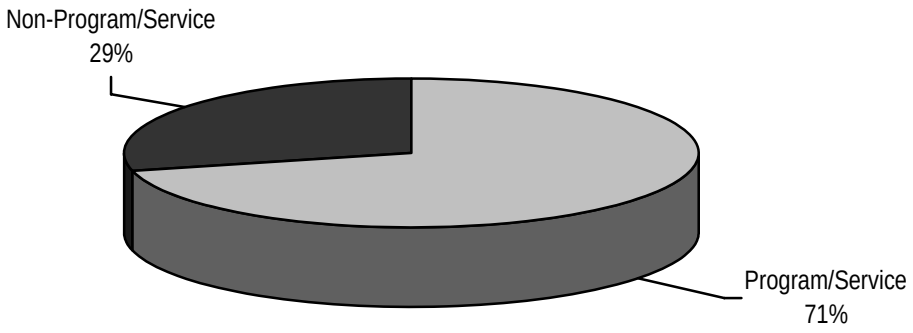


[154] HHSAS Database, as of 8/31/07.

Return-to-Work Retirees

DADS employs over 580 return-to-work retirees, representing about four percent of its total workforce. The majority of these retirees (71 percent) work in program/service related areas.[155]

Figure 56: DADS Return-to-Work Retirees



[155] HHSAS Database, as of 8/31/07

TURNOVER

The DADS turnover rate during fiscal year 2007 was over 30 percent (a workforce loss of some 4,581 employees), the highest of all HHS agencies. This rate is almost double the statewide turnover rate of 17.4 percent for all agencies.[156] While the majority of those leaving the agency left for voluntary reasons (66 percent), a significant number were dismissed for cause (about 33 percent).[157]

Table 27: Reason for Separation

Reason	Percentage[158]
Voluntary Separations	
Personal reasons	51.1%
Transfer to another agency	7.8%
Retirement	6.8%
Involuntary Separations	
Termination at Will	0.2%
Resignation in Lieu	1.2%
Dismissal for Cause	32.5%
Reduction in Force	0.0%

Psychiatrists positions had the highest turnover rate during fiscal year 2007 (three losses or a 52.2 percent turnover rate), followed by Mental Retardation Assistants (with 2,979 losses or a 44.2 percent turnover rate), Budget Analysts (five losses or 41.7 percent) and Food Service Workers (249 losses or a 34.4 percent turnover rate).[159]

[156] State Auditor's Office (SAO) FY2007 Turnover Statistics.
[157] HHSAS Database, FY 2007 data.
[158] Death accounted for .4% of separations.
[159] HHSAS Database, FY 2007 data.

Table 28: FY 07 Turnover for Significant Job Classes		
Job Title	Average Annual Headcount	Turnover Rate
Psychiatrists	5.8	52.2%
Mental Retardation Assistants	6,733.8	44.2%
Budget Analysts	12.0	41.7%
Food Service Workers	724.0	34.4%
LVNs	638.8	28.5%
Security Officers	28.3	24.8%
Pharmacists	37.0	24.3%
RNs	648.8	24.2%
Investigators	17.0	23.5%
Information Specialists	13.0	23.1%
Training Specialists	65.8	22.8%
Accountants	83.5	21.6%
Groundskeepers	37.3	21.5%
Custodians	382.5	20.4%
Guardianship Specialists	46.8	19.3%
Pharmacy Technicians	31.5	19.0%
QMRPs	206.8	18.9%

RETIREMENT PROJECTIONS

About 10 percent of the agency's workforce is currently eligible to retire from state employment. Almost a quarter of DADS workforce will reach retirement eligibility by the year 2012.[160]

Table 29: DADS Projected Retirement Eligibility through Rule of 80 (FY 07 – FY 12)		
Fiscal Year	Cumulative Number of Eligible Employees	Percent of Workforce
2007	1,349	9.6%
2008	1,715	12.2%
2009	2,121	15.0%
2010	2,534	18.0%
2011	3,002	21.3%
2012	3,454	24.5%

[160] HHSAS Database, as of 8/31/07.

EXPECTED WORKFORCE CHALLENGES

The Legislature appropriated approximately $11.6 billion to DADS for the fiscal year 2008-09 biennium, a 12.1 percent increase over appropriated funds for the previous biennium. The 80th Legislature (Regular Session, 2007) also appropriated $42.9 million in general revenue to allow DADS to hire 1,690 employees to improve staff-to-resident ratios at state mental retardation facilities.

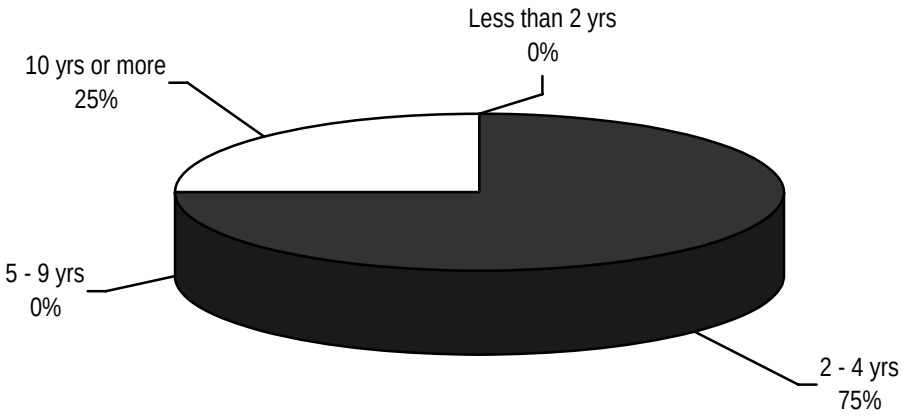
The agency continues to experience the effects of shortages in qualified medical personnel and staff that work with consumers at state mental retardation facilities. Jobs that will require the most attention are Psychiatrists, Mental Retardation Assistants, Food Service Workers, Nurses (Registered Nurses and Licensed Vocational Nurses), Pharmacists and Physicians.

Psychiatrists

Psychiatrist positions are assigned to state mental retardation facilities. Full staffing of these positions is critical to providing psychiatric services needed by residents.

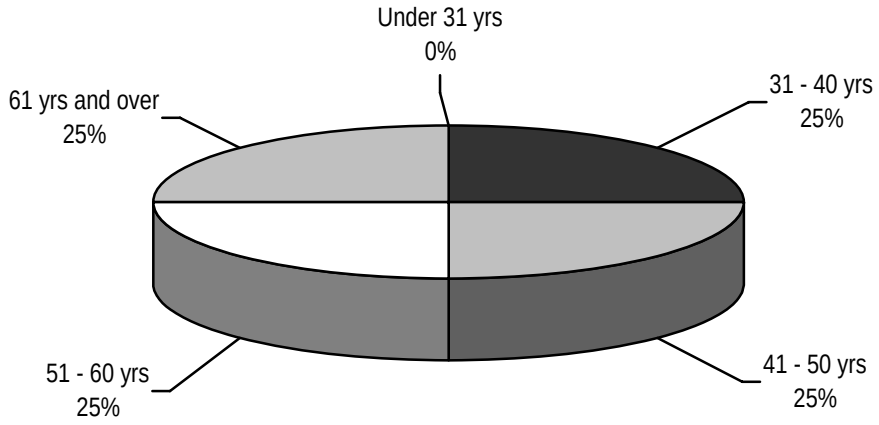
DADS Psychiatrists have, on average, about 11 years of state service, with an average age of 52.2.[161]

Figure 57: Psychiatrists at DADS – Length of State Service



[161] HHSAS Database, as of 8/31/07.

Figure 58: Psychiatrists at DADS – Distribution by Age



Turnover for Psychiatrists is the highest in the agency, at about 52 percent.[162]

DADS Psychiatrists earn an average annual salary of about $140,849.[163] Market surveys indicate that this salary is below the entry level salary for the private sector in Texas.

This discrepancy in salary levels has created difficulties in attracting qualified applicants. Currently, three Psychiatrist positions are vacant and most of these vacant positions go unfilled for months.[164] In fact, many agency postings and advertisements for these positions result in no responses from qualified applicants.

To deal with these recruitment and retention difficulties, the agency has often used contract Psychiatrists to provide required coverage. These contracted Psychiatrists are paid at rates that are well above the amount it would cost to hire Psychiatrists at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about $69[165] paid to agency Psychiatrists). Aside from being more costly, the agency has experienced other problems with contracted Psychiatrists, including a lengthy learning curve, difficulty in obtaining long-term commitments, excessive staff time spent procuring their services, difficulty in obtaining coverage, dependability and inconsistency of services due to their short-term commitment.

To address these difficulties, DADS has plans to increase entry level salaries for new Psychiatrists and for currently employed Psychiatrists during fiscal year

[162] HHSAS Database, FY 2007 data.
[163] HHSAS Database, as of 8/31/07.
[164] HHSAS Database, FY 2007 data.
[165] HHSAS Database, as of 8/31/07.

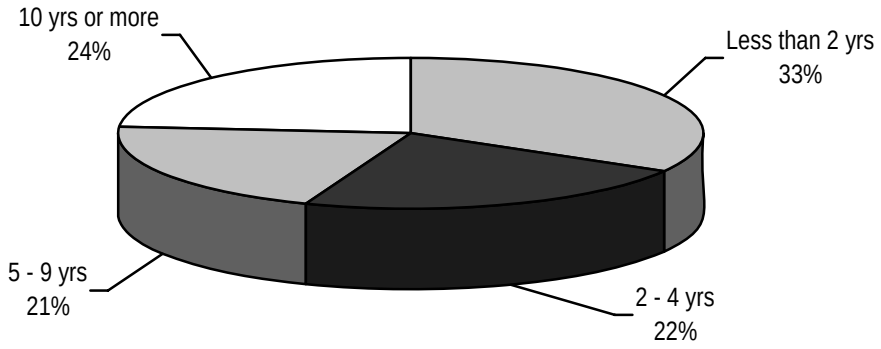
2008. Due to the complex medical and mental challenges that individuals residing in state schools exhibit, it is critical that the agency fill all budgeted Psychiatrist positions and is able to effectively recruit and retain qualified Psychiatrists.

Mental Retardation Assistants

There are nearly 6,000 Mental Retardation Assistants[166] in DADS state mental retardation facilities across Texas, representing approximately 42 percent of the agency's total workforce.[167] There are no formal education requirements to apply for a job in this series; however, extensive on-the-job training is required. Employees who perform this work must interact with consumers on a daily basis. The work is performed in shifts throughout the day and night. The pay is low and the work is difficult and physically demanding.

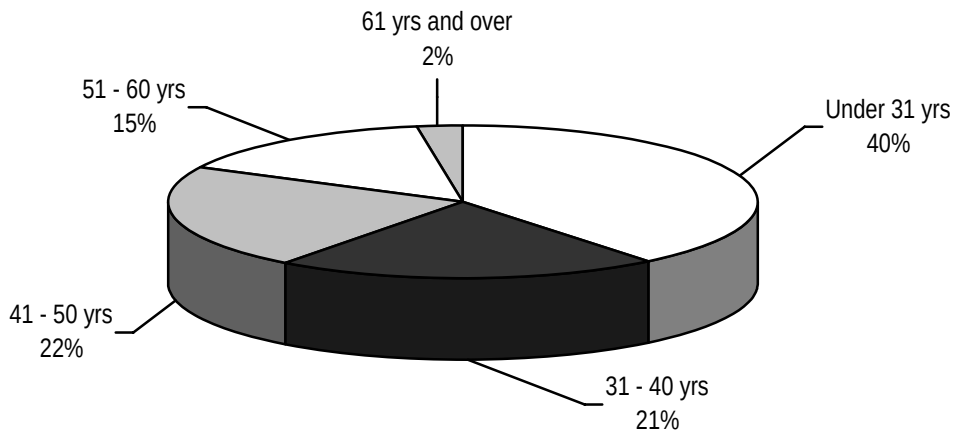
A typical Mental Retardation Assistant in the agency is 37 years old and has about seven years of state service.[168]

Figure 59: Mental Retardation Assistants – Length of State Service



[166] "Mental Retardation Assistants" are MHMR Services Aids, Assistants and Supervisors.
[167] HHSAS Database, as of 8/31/07.
[168] Ibid.

Figure 60: Mental Retardation Assistants – Distribution by Age



Turnover for Mental Retardation Assistants is high, at about 44 percent.[169] This is the second highest turnover rate of any job category in DADS. The average hourly salary rate is $9.88 per hour.[170] Retention and recruitment of these workers remains a major challenge for DADS. Maintaining required staffing levels of Mental Retardation Assistants in MR facilities is critical in meeting Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) certification requirements.

Food Service Workers

There are approximately 650 Food Service Workers[171] employed in DADS state mental retardation facilities throughout Texas.[172] The physical requirements are very demanding and there are no formal education requirements for the jobs. Food preparation is performed multiple times each day of the week, requiring a large staff at each location, using a combination of full-time and part-time employees.

The typical Food Service Worker is about 45 years of age and has an average of approximately 10 years of state service.[173]

Figure 61: Food Service Workers at DADS – Length of State Service

[169] HHSAS Database, FY 2007 data.
[170] HHSAS Database, as of 8/31/07.
[171] "Food Services Workers" are Food Services Workers, Managers and Cooks.
[172] HHSAS Database, as of 8/31/07.
[173] Ibid.

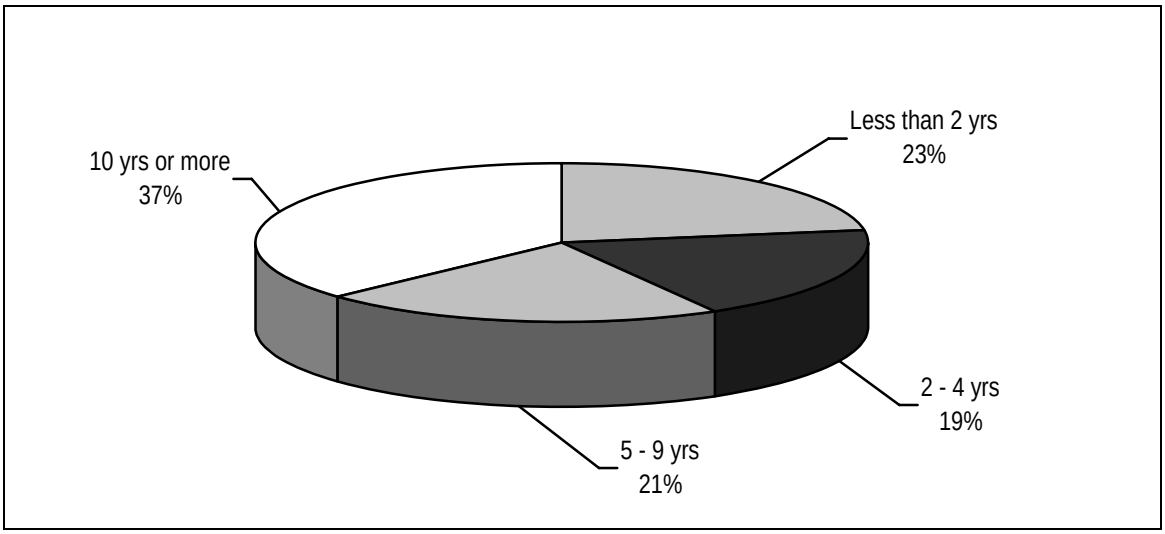
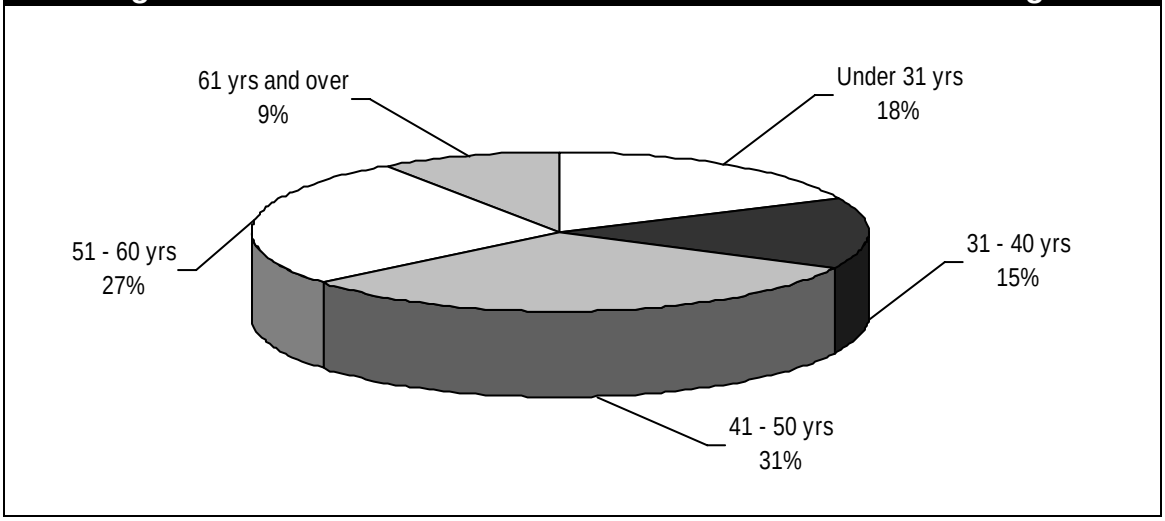


Figure 62: Food Service Workers at DADS – Distribution of Age



Turnover in Food Service Worker positions is high, at 34.4 percent. Pay is low, with an average wage of $9.13 per hour.[174] [175]

Retention and recruitment of these workers remains a major challenge for DADS.

Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs)

Nationwide, the nursing shortage is reaching crisis proportions. It is projected that there will be a need for 587,000 new RN jobs by the year 2016.[176] Job

[174] HHSAS Database, FY 2007 data.
[175] HHSAS Database, as of 8/31/07.

opportunities for RNs are expected to grow faster than the average for all occupations.[177] With this level of job growth, it is projected that there will not be enough qualified applicants to meet the increased demand.

The nursing shortage is the most significant healthcare workforce staffing concern facing both the nation and Texas.[178] The Texas nurse-to-population ratio is far below the national average of 782 Nurses per 100,000 people, with the state ratio being only 609 Nurses per 100,000 people. By some estimates, Texas will need 138,000 additional Nurses in the next 10 years to satisfy staffing demands.[179]

Nurses are generally required to work shifts. The work is difficult, requires special skills and staff often work long hours because of staffing storages. All of these job factors contribute to higher than average turnover rates.

Although there are 88 nursing school programs across the state, most of them have more applicants than room for new students and only about two-thirds of enrolled students actually graduate.[180] The shortage of trained instructors limits both the number of accepted students and the number of available classes offered.

[176] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[177] US Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *2008-09 Edition*, web page http://www.bls.gov/oco/ocos083.htm, last accessed on 3/10/08.
[178] State of Nursing Workforce in Texas – Statewide Health Workforce Symposium Policy Brief, March 2005.
[179] MedicineWorld.org, 'Lack of Resources, Not Lack of Students, Cause Nurse Shortage," web page http://medicineworld.org/cancer/lead/12-2005/lack-of-resources-not-lack-of-students-cause-nurse-shortage.html, last accessed on 1/17/06.
[180] "Professional Nursing Education in Texas: Demographics & Trends: 2006."

Registered Nurses (RNs)

There are over 600 RNs employed by DADS.[181] The typical RN at the agency is about 52 years old and has an average of approximately 10 years of state service.

Figure 63: Registered Nurses at DADS – Length of State Service

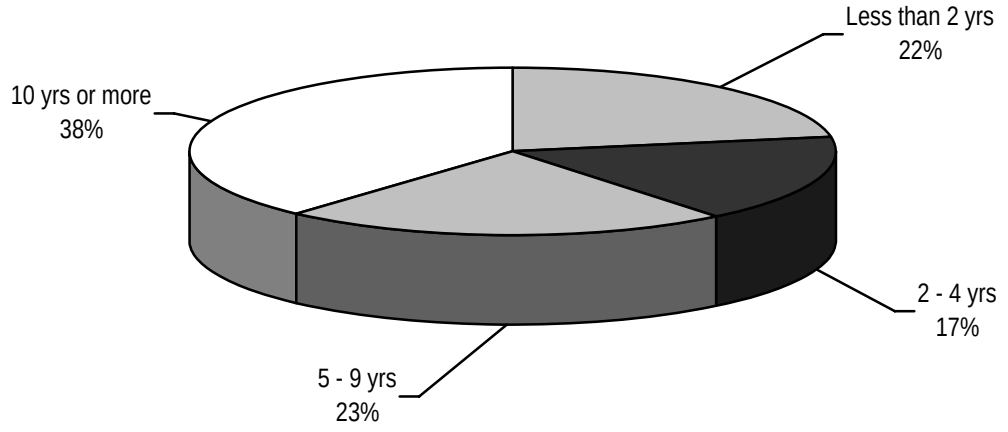
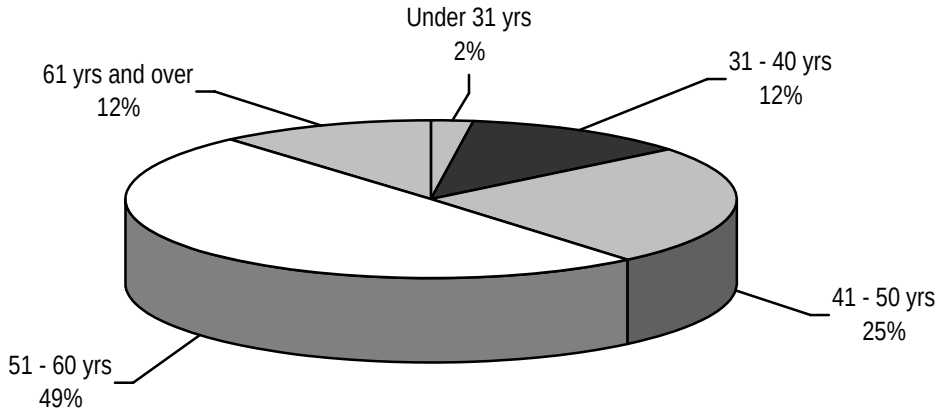


Figure 64: Registered Nurses at DADS – Distribution of Age



The turnover rate for RNs is considered high at about 24 percent. [182]

The agency finds it difficult to fill vacant nurse positions. The Texas Hospital Association reported that vacancy rates for RNs in Texas ranged from 14.6

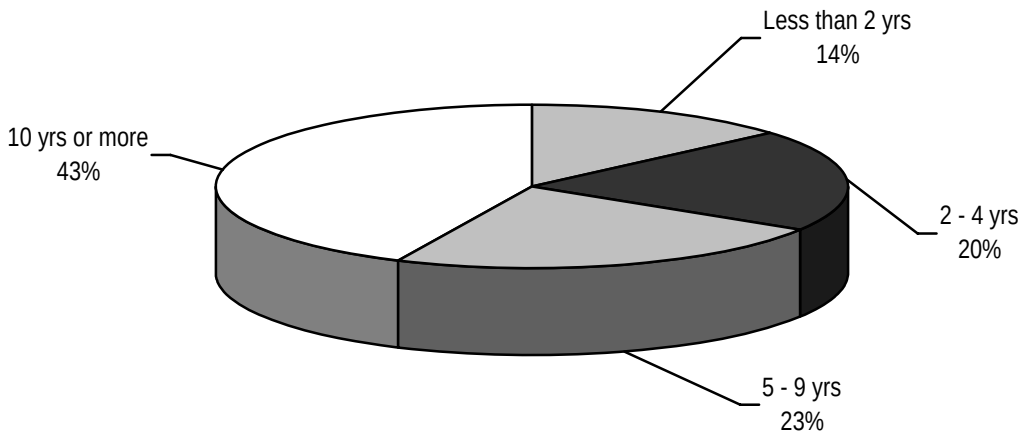
[181] HHSAS Database, as of 8/31/07.
[182] HHSAS Database, FY 2007 data.

percent in critical care occupations to about 10 percent in emergency rooms.[183] At DADS, there are always vacant nursing positions that need to be filled. With a high vacancy rate for these positions (at approximately 17 percent), RN positions often remain open for months before being filled.[184]

Licensed Vocational Nurses (LVNs)

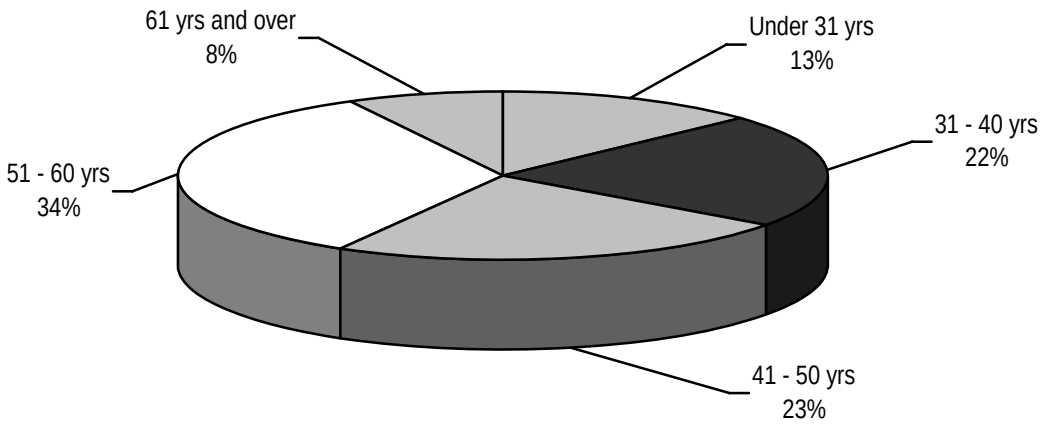
There are over 570 Licensed Vocational Nurses (LVNs) employed by DADS.[185] The typical DADS LVN is about 42 years old and has an average of approximately 11 years of state service.[186]

Figure 65: Licensed Vocational Nurses at DADS – Length of State Service



[183] Texas Hospital Association. "Hospital Workforce Study." Austin, Texas. 2004, as cited in "The state of the Nursing Workforce in Texas, "Statewide Health Workforce Symposium Policy Brief, March 4, 2004.
[184] HHSAS Database, FY 2007 data.
[185] HHSAS Database, as of 8/31/07.
[186] Ibid.

Figure 66: Licensed Vocational Nurses at DADS – Distribution by Age



As with RNs, the nursing shortage is also impacting the agency's ability to hire and retain LVNs. Turnover for LVNs is significant at 28.5 percent. DADS experienced over 175 LVN separations last fiscal year. With a vacancy rate exceeding 14 percent, vacant positions often go unfilled for several months.[187]

Targeted efforts in recruiting and retaining RNs and LVNs are required.

Physicians

There are about 40 Physicians at DADS, who primarily work at state mental retardation facilities across Texas.[188] Full staffing of these positions is critical to direct-care services.

DADS Physicians have, on average, about 12 years of state service, with an average age of 60. Local Physicians who have established long term private practices often apply as a staff Physician at state mental retardation facilities late in their working career to secure retirement and insurance benefits, thus explaining the reason for the high average age. Only two full-time Physicians are under 41 years of age.[189]

[187] HHSAS Database, FY 2007 data.
[188] HHSAS Database, as of 8/31/07.
[189] Ibid.

Figure 67: Physicians at DADS – Length of State Service

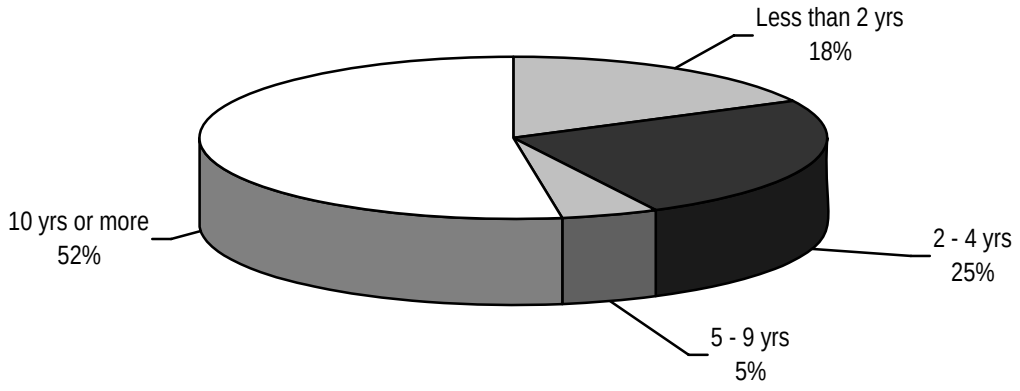
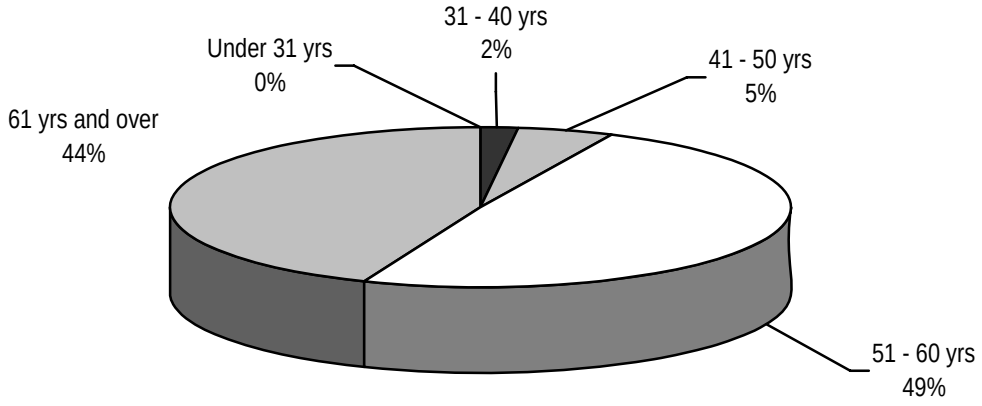


Figure 68: Physicians at DADS – Distribution of Age



Though turnover for Physicians is slightly under the state average at 17 percent, 65 percent of these highly skilled and tenured employees will be eligible to retire by 2012.

Agency Physicians earn an average annual salary of $127,807. Market surveys indicate that this salary is far below the entry level salary for private sector Physician jobs in Texas.

To deal with these recruitment and retention difficulties, the agency has often used contract Physicians to provide required coverage. These contracted Physicians are paid at rates that are well above the amount it would cost to hire

Physicians at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about $61[190] paid to agency Physicians). Aside from being more costly, the agency has experienced other problems with contracted Physicians, including a lengthy learning curve, difficulty in obtaining long-term commitments, excessive staff time spent procuring their services, difficulty in obtaining coverage, dependability and inconsistency of services due to their short-term commitment.

To address these difficulties, the agency will implement a compensation adjustment plan in 2008 to bring both starting salaries and current physician employee salaries more in line with market rates offered by other healthcare organizations.

Due to the complex medical and mental health challenges that individuals residing in state mental retardation facilities exhibit, it is critical that the agency recruit and retain qualified Physicians.

Pharmacists

Pharmacists represent the third largest health professional group in the US, with approximately 243,000 active Pharmacists as of November 2006.[191] While the overall supply of Pharmacists has increased in the past decade, there has been an unprecedented demand for Pharmacists and for pharmaceutical care services. This need is expected to grow faster than the average for all occupations due to the increased pharmaceutical needs of a growing elderly population and increased use of medications. It is projected that there will be a demand for 53,000 new Pharmacists by 2016, or a 22 percent increase in the number of total jobs.[192] However, the number of available Pharmacists is expected to grow only modestly.

There are 31 Pharmacists working at DADS. The typical Pharmacist is about 53 years old and has an average of 12 years of state service.[193]

[190] HHSAS Database, as of 8/31/07.
[191] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[192] Ibid.
[193] HHSAS Database, as of 8/31/07.

Figure 69: Pharmacists at DADS – Length of State Service

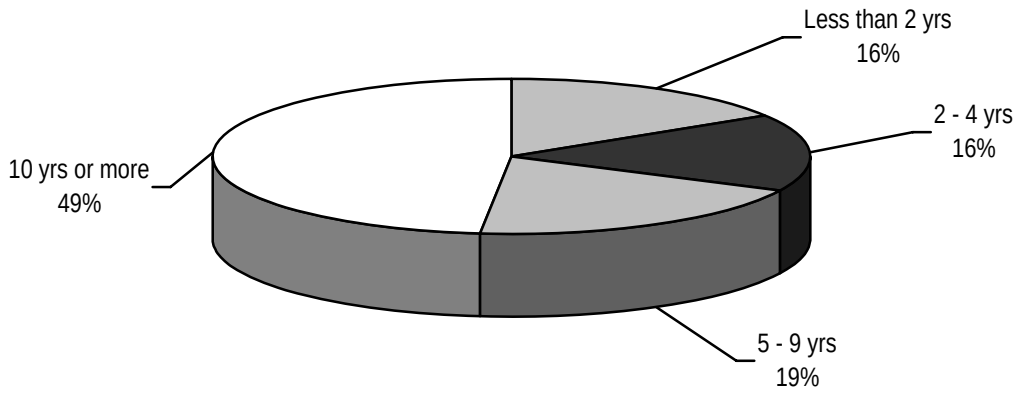
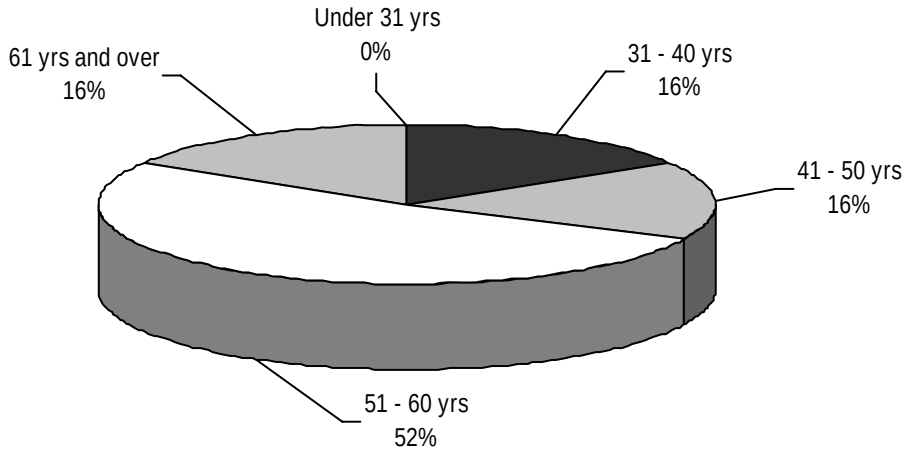


Figure 70: Pharmacists at DADS – Distribution of Age



Pharmacists at DADS earn, on average, an annual salary of $71,973. This salary falls significantly below the state market rate. The average annual salary for Pharmacists nationally is $93,500 and $96,290 in Texas.[194] This disparity is affecting the agency's ability to recruit qualified applicants for vacant positions. Pharmacist positions often remain unfilled for several months before filled.[195]

[194] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[195] HHSAS Database, as of 8/31/07.

With Pharmacist turnover high at 24 percent,[196] DADS has often used contract Pharmacists to meet program needs. These contracted Pharmacists are paid at rates that are typically above the amount it would cost to hire Pharmacists at state salaries. With a significant number of Pharmacists nearing retirement age (or have already retired and returned to work), this practice is expected to continue.

Recruitment and retention for these jobs are ongoing challenges.

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

Recruitment Strategies

Since hiring a recruiter, DADS has incorporated a variety of recruitment strategies designed to increase awareness of job opportunities within the agency. DADS has partnered with various colleges, universities, professional associations and organizations; developed a recruitment brochure; and established a new website (careersatdads.com) that is easy to remember and links to accessHR (online human resources web portal). The agency continues to place ads in newspapers, trade journals and professional magazines and has increased usage of the internet by posting hard-to-fill positions on Texas Health Match, 3rNet, Web MD and numerous other internet sites. Most recently, DADS initiated a “Tell a Friend” campaign designed to spread the word about job opportunities at the agency. Using mailing lists, DADS launched a direct mail campaign to increase awareness of job opportunities. Other strategies include:

- Increasing presence at college/university and professional career fairs.
- Posting “Hiring Banners” in front of state mental retardation facilities.
- Hosting on-site job fairs.
- Sending direct mail to schools of psychology, occupational and physical therapy and workforce centers across the state of Texas.
- Promoting DADS as eligible to participate in the Physician Education Loan Repayment Program (PELRP).
- Advertising at movie theaters.

[196] HHSAS Database, FY 2007 data.

Additional strategies under consideration include:

- Develop an agency-wide "registered nurse in training" program to include agreements with schools of nursing so that there is a constant flow of nurse trainees, both RN and LVN, in each of the DADS facilities. This training would provide a source of skilled/trained staff to assist in each of the facilities and also provide the agency with a known quantity of potential candidates when filling future job openings.

- Encourage LVNs to become RNs. Partner with nursing schools to teach classes on DADS campuses and allow current employees already in the health care field to attend classes during work-hours, to train and prepare for a career in nursing.

- Encourage direct-care staff to pursue other health care professions, such RNs or Registered Therapists.

- Encourage student internships at all state mental retardation facilities, specifically in the fields of nursing and registered therapy.

- Have professional staff present state mental retardation facility operation at schools of nursing, psychology and physical/occupational therapy.

- Have employees from critical shortage occupations attend job fairs and other hiring events so they can explain the challenges of the job, as well as the personal rewards associated with the work.

Retention Strategies

DADS is implementing several retention strategies that include:

- Raising starting salaries to assist in recruiting for:
  - Mental Retardation Assistants;
  - RNs/LVNs;
  - Pharmacists;
  - Physicians;
  - Psychiatrists; and
  - Registered Therapists.

- Using equity adjustments for several critical classifications, specifically nurses and registered therapists.

- Using the full salary range for posting hard-to-fill positions.

- Promoting from within the agency when qualified applicants were available.
- Using educational assistance programs to promote employee development and in many cases to “grow our own.”
- Promoting succession planning/career development through the agency’s “Building the Bench” program.

Additional strategies under consideration:

- Provide retention bonuses to employees in high turnover positions.
- Provide skill building training to improve employee competencies and better qualify them for advancement opportunities.
- Fully use available recognition programs and benefits to identify and reward top performers.
- Set up a professional certification program for direct care staff through local community colleges.

DEPARTMENT OF STATE HEALTH SERVICES

MISSION

The mission of the Department of State Health Services (DSHS) is to improve health and well-being in Texas.

SCOPE

DSHS administers and regulates public health and behavioral health programs.

CORE BUSINESS FUNCTIONS

DSHS is a multifaceted agency responsible for oversight and implementation of public health and behavioral health services in Texas. With an annual budget of $2.7 billion and a workforce of nearly 12,000, DSHS is the fourth largest of Texas' 178 state agencies. The DSHS mission is accomplished through the procurement or provision of services and supports that have a direct impact on the citizens of Texas. DSHS administrative and service areas include:

- **Chief Operations Officer**
  - Operations Management
  - Executive/Operations Support
  - Information Technology
  - Vital Statistics
  - Center for Health Statistics
  - Legal Services
  - Contract Oversight and Support

- **Chief Financial Officer**
  - Accounting
  - Budget
  - Client Services Contracting

- **Family and Community Health**
  - Community Health Services
  - Specialized Health Services
  - Nutrition Services

- Title V and Family Health Office

- **Mental Health and Substance Abuse**
  - Program Services
  - Hospital Services
  - Contractor Services

- **Regional and Local Health**
  - Health Service Regions
  - Capitol Health Services Clinic
  - Regional and Local Program Support
  - Local Health Authority for Cities/Counties without a Local Health Department

- **Prevention and Preparedness**
  - Public Health Information Network
  - Community Preparedness
  - Disease Prevention and Intervention
  - Laboratory

- **Regulatory**
  - Enforcement
  - Health Care Quality
  - Environmental and Consumer Safety

WORKFORCE DEMOGRAPHICS

DSHS is the second largest agency in the HHS System. Statewide, the agency employs approximately 12,000 full and part-time employees, representing about 25 percent of the HHS System workforce. The majority of these employees (7,748 employees or about 65 percent) work in inpatient facilities across the state.[197] To better understand the agency's unique workforce, the following demographic categories are examined:

[197] HHSAS Database, as of 8/31/07.

Job Families

About 71 percent of DSHS employees (8,425 employees) work in 10 job families.[198]

Table 30: Largest Program Job Classes and Average Salaries

Job Title	Number of Employees	Average Salary
Psychiatric Nursing Assistants	2,848	$21,079
Clerical Workers	1,517	$25,667
Program Specialists	996	$47,300
RNs	959	$49,049
LVNs	476	$30,432
Custodians	349	$19,006
Food Service Workers	341	$18,928
Rehab Therapy Technicians	336	$22,675
Public Health Technicians	324	$32,602
Maintenance Technicians	279	$23,809

Salary

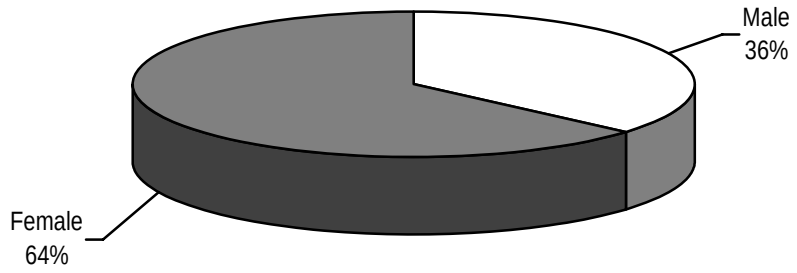
DSHS employees earn an average annual salary of $34,957, which is slightly higher than the HHS System average annual salary of $33,476.[199]

[198] HHSAS Database, as of 8/31/07.
[199] Ibid.

Gender

Females make up approximately 64 percent of the agency workforce.[200]

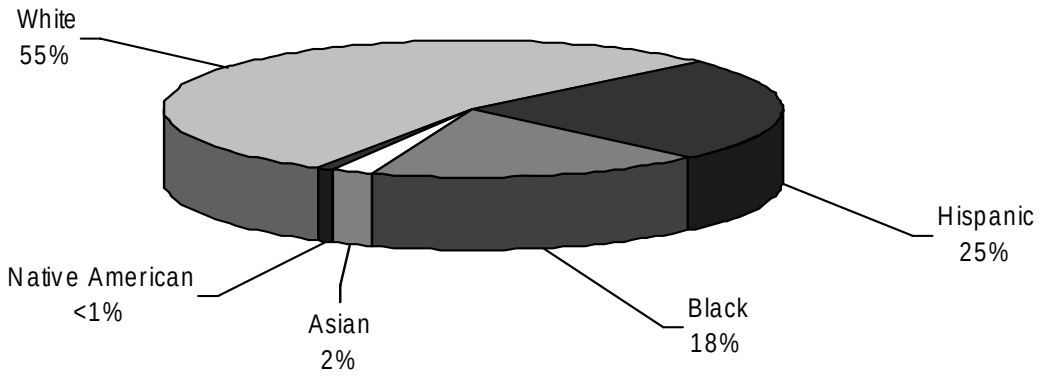
Figure 71: DSHS Workforce by Gender



Race

White employees represent the largest racial group at 55 percent, followed by Hispanic employees at 25 percent and Black employees at 18 percent.[201]

Figure 72: DSHS Workforce by Race

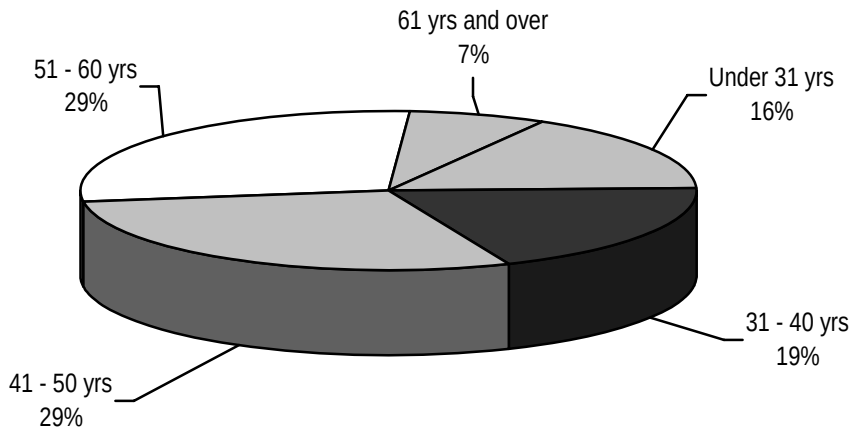


[200] HHSAS Database, as of 8/31/07.
[201] Ibid.

Age

DSHS employees have an average age of 45 years. Approximately 65 percent of the DSHS workforce is 41 years or older.[202]

Figure 73: DSHS Workforce by Age



Average age: 45 yrs

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and Females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

The utilization analysis of the DSHS workforce, as indicated in Table 31, reflects underutilization in the following areas: [203] [204]

- Hispanic employees in the Protective Service job category;
- Black employees in Para-Professional job category;
- Black employees in the Administrative Support job category;
- Black, Hispanic and Female employees in the Skilled Craft job category; and

[202] HHSAS Database, as of 8/31/07.
[203] DSHS workforce data – report prepared from the HHSAS Database, 08/31/2007.
[204] CLF data – EEOC publications, "Job Patterns for Minorities and Women in State and Local Government, 2003" for Texas and "Job Patterns for Minorities and Women in Private Industry, 2003" for Texas. Modified 06/08/2005.

- Hispanic employees in the Service Maintenance job category.

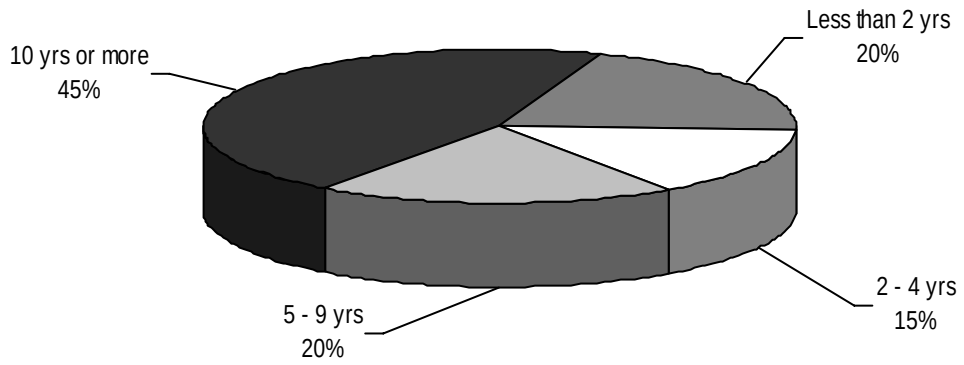
Table 31: DSHS Utilization Analysis Results

Job Category	Black			Hispanic			Female		
	DSHS %	CLF %	Underutilization (If Yes, # needed)	DSHS %	CLF %	Underutilization (If Yes, # Needed)	DSHS %	CLF %	Underutilization (If Yes, # Needed)
Officials/ Administrators	7.9%	7.2%	No	16.4%	12.3%	No	58.2%	32.6%	No
Professionals	10.2%	9.4%	No	17.8%	11.6%	No	64.3%	49.0%	No
Technicians	14.8%	13.9%	No	25.5%	19.7%	No	71.6%	42.1%	No
Protective Service	12.7%	18.0%	No	15.8%	23.1%	1	21.5%	21.6%	No
Para-Professionals	7.8%	14.3%	11	29.8%	25.7%	No	74.0%	56.3%	No
Administrative Support	14.8%	19.4%	42	31.9%	26.8%	No	88.3%	78.8%	No
Skilled Craft	4.7%	14.7%	19	26.8%	35.2%	9	3.7%	16.5%	27
Service Maintenance	31.1%	20.4%	No	29.9%	43.7%	457	56.6%	44.4%	No

State Service

Approximately 45 percent of the DSHS workforce has 10 or more years of state service. About 20 percent of the DSHS employees have less than two years of state service.[205]

Figure 74: DSHS Workforce by Length of State Service

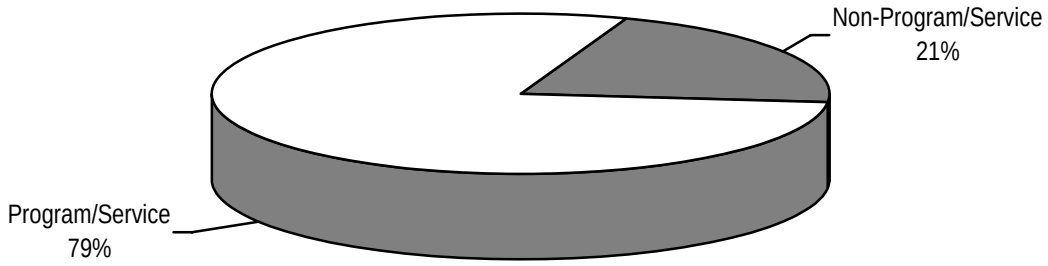


[205] HHSAS Database, as of 8/31/07.

Return-to-Work Retirees

DSHS employs 503 return-to-work retirees. The majority of these retirees (79 percent) work in program/service related areas.[206]

Figure 75: DSHS Return-to-Work Retirees



[206] HHSAS Database, as of 8/31/07.

TURNOVER

The DSHS turnover rate during fiscal year 2007 was approximately 21 percent, higher than the statewide turnover rate of 17.4 percent.[207] The majority of these employee separations (approximately 76 percent) were voluntary.[208]

Table 32: Reason for Separation

Reason	Percentage[209]
Voluntary Separations	
Personal reasons	53.9%
Transfer to another agency	11.7%
Retirement	10.2%
Involuntary Separations	
Termination at Will	0.2%
Resignation in Lieu	1.1%
Dismissal for Cause	22.1%
Reduction in Force	0.0%

Architects had the highest turnover rate during fiscal year 2007 (with two losses or a 53.3 percent turnover rate). Psychiatric Nursing Assistant positions had the largest number of losses (with 1,074 losses or a 34.9 percent turnover rate). [210]

[207] State Auditor's Office (SAO) FY2007 Turnover Statistics.
[208] HHSAS Database, FY 2007 data.
[209] Death accounted for .8% of separations.
[210] HHSAS Database, FY 2007 data.

Table 33: FY 07 Turnover for Significant Job Classes		
Job Title	Average Annual Headcount	Turnover Rate
Architects	3.8	53.3%
Laundry Workers	47.3	40.2%
Engineers	8.3	36.4%
Network Analysts	80.5	36.0%
Psychiatric Nursing Assistants	3,076.5	34.9%
Auditors	12.8	31.4%
Data Base Administrators	20.5	29.3%
Food Workers	363.3	27.8%
LVNs	509.3	27.1%
Lab Technicians	53.0	24.5%
Custodians	368.0	22.8%
Drivers	49.0	22.4%
RNs	994.5	21.7%
Budget Analysts	51.3	21.5%
Security Workers	170.5	20.5%
Clerical Workers	1,597.0	17.8%

RETIREMENT PROJECTIONS

Currently, approximately 10 percent of the DSHS workforce is eligible to retire from state employment. Over the next five years, over one-fourth of the agency workforce will reach retirement eligibility.[211]

Table 34: DSHS Projected Retirement Eligibility through Rule of 80 (FY 07 – FY 12)		
Fiscal Year	Cumulative Number of Eligible Employees	Percent of Workforce
2007	1,174	9.9%
2008	1,536	12.9%
2009	1,905	16.0%
2010	2,284	19.2%
2011	2,716	22.9%
2012	3,159	26.6%

[211] HHSAS Database, as of 8/31/07.

EXPECTED WORKFORCE CHALLENGES

DSHS anticipates that as the population of the State increases, there will be a need for additional health related services. Projected job growth, along with the gradual increase in the percentage of employees eligible for retirement, will heighten competition for qualified applicants from other health service sectors, including the federal government and the private sector.

It is anticipated there will be an increased need for employees who are:

- skilled in the applicability and use of current and emerging technological advances;
- trained in the use of evidence-based and new service delivery approaches;
- trained in contract management and monitoring; and
- knowledgeable in the areas of systems thinking, capacity building, results-based accountability and leading change.

Shortage occupation jobs that will require targeted recruitment attention are Architects, Engineers, Psychiatric Nursing Assistants, Nurses (RNs and LVNs), Rehabilitation Therapy Technicians, Clinical Social Workers, Epidemiologists, Sanitarians, Dentists, Laboratory Staff, Vital Statistics Staff, Human Services Specialists, Physicians, Psychiatrists, Pharmacists and Medical Technologists.

Architects

Architects work in the Regulatory Licensing Unit, Architectural Review Group (ARG). They interact with professionals that construct, design and build healthcare facilities, making decisions that affect patient/consumer health and safety. DSHS Architects must have a professional degree from an accredited college or university in the field of architecture and be licensed by the State of Texas.

On average, DSHS architects are 62 years old and have 17 years of state service. All of these employees are age 51 or older, with at least 10 or more years of state service.[212]

[212] HHSAS Database, as of 8/31/07.

Figure 76: Architects at DSHS – Distribution by Age

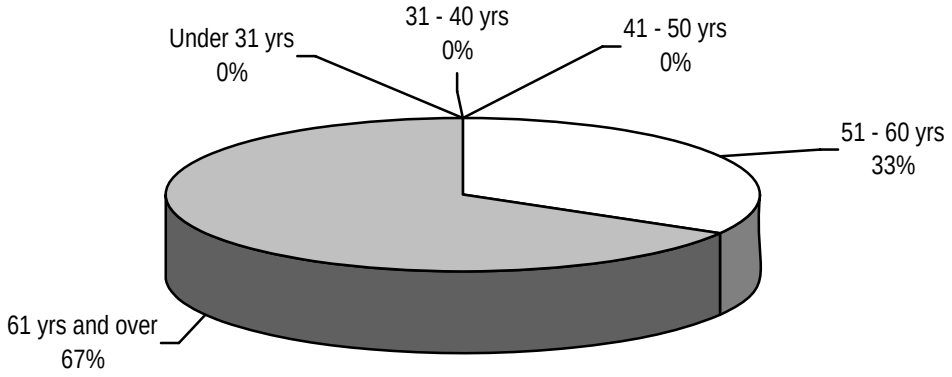
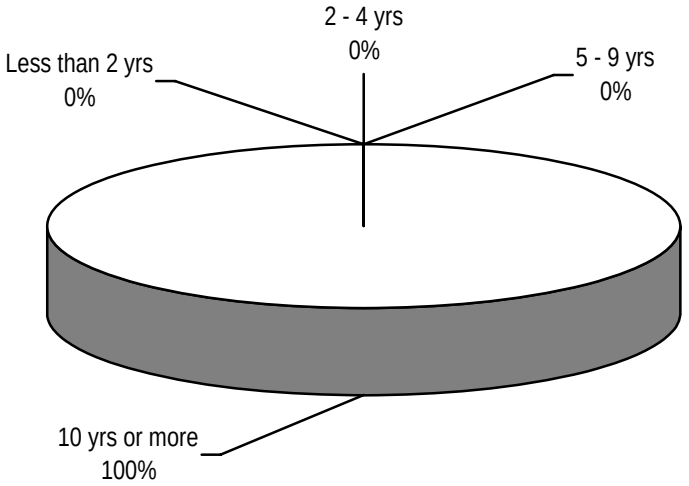


Figure 77: Architects at DSHS – Length of State Service



The agency has been unable to post vacant positions at the full salary range or to offer merit raises to current staff. In addition, the average agency salary for these positions is below that offered by other governmental/state agencies ($50,000 as compared to $69,000 and higher in other governmental/state agencies).

The annual turnover rate for Architects is high at 53 percent. The agency has experienced difficulty in attracting qualified applicants due to starting salary levels. It is not unusual for vacant positions to go unfilled for several months before a qualified applicant is found.[213]

[213] HHSAS Database, FY 2007 data.

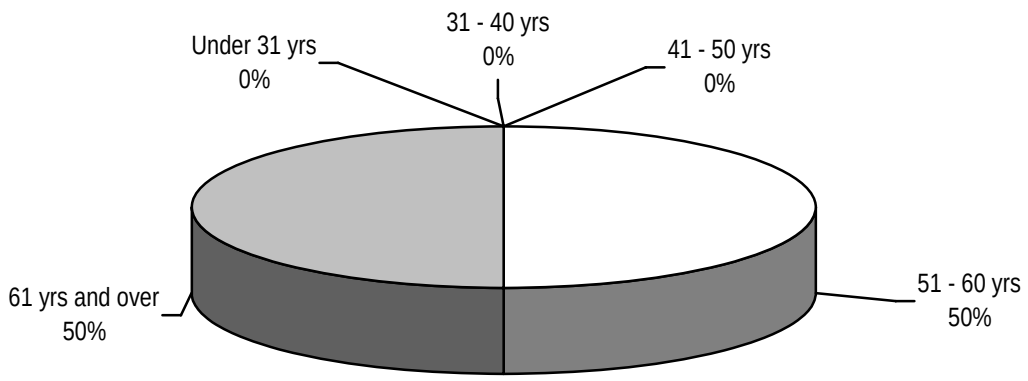
Targeted recruitment efforts will be implemented to assist in filling vacant positions.

Engineers

DSHS employs Engineers that work in the Regulatory Licensing Unit, Architectural Review Group (ARG). They interact with professionals that construct, design and build healthcare facilities, making decisions that affect patient/consumer health and safety. DSHS Engineers must have a degree from an accredited college or university in the field of engineering and be licensed by the State of Texas.

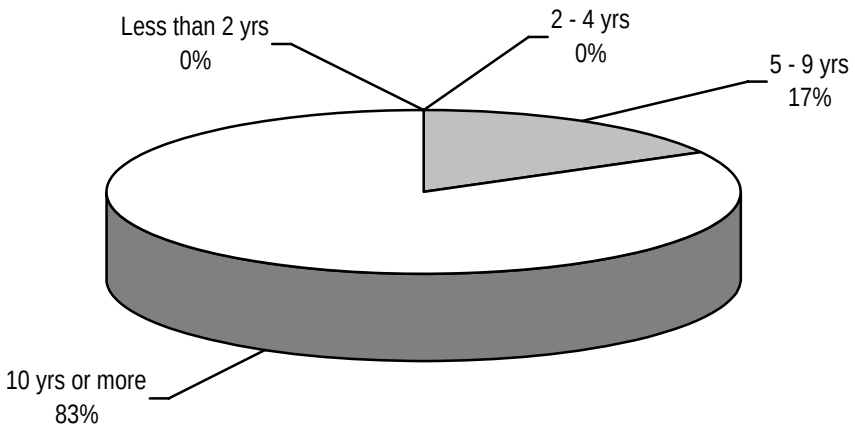
The typical Engineer is about 60 years old and has an average of 20 years of state service. [214]

Figure 78: Engineers at DSHS – Distribution by Age



[214] HHSAS Database, as of 8/31/07.

Figure 79: Engineers at DSHS – Length of State Service



Similar to DSHS Architects, the agency has been unable to post vacant positions at the full salary range or to offer merit raises to current staff. As a consequence, the turnover rate for Engineers is high at 36 percent. The agency is also having great difficulty attracting qualified applicants. Vacancies often go unfilled for months.[215]

Recruitment of qualified candidates, as well as retention of these highly skilled and knowledgeable employees continues to be problematic.

Psychiatric Nursing Assistants

There are approximately 2,850 Psychiatric Nursing Assistants employed in DSHS state mental health hospitals.[216] These positions require high school education or equivalency to perform the work; however, there is extensive on-the-job training. Workers are assigned many routine basic care tasks in the state hospitals that do not require a license to perform, such as taking vital signs, assisting with bathing and hygiene and transportation. Employees are required to interact with consumers on a daily basis. The work is performed in shifts throughout the day and night. The pay is low and the work is difficult.

The average Psychiatric Nursing Assistant is about 39 years old and has an average of seven years of state service.[217]

[215] HHSAS Database, FY 2007 data.
[216] HHSAS Database, as of 8/31/07.
[217] HHSAS Database, as of 8/31/07.

Figure 80: Psychiatric Nursing Assistants – Distribution by Age

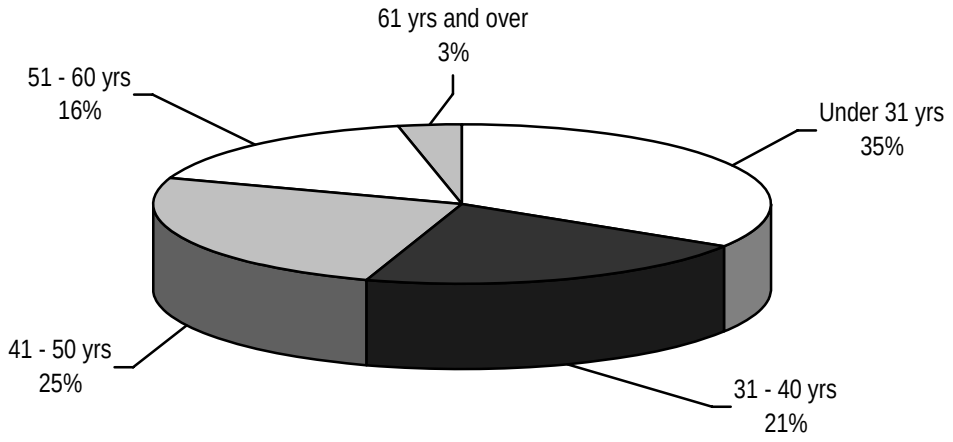
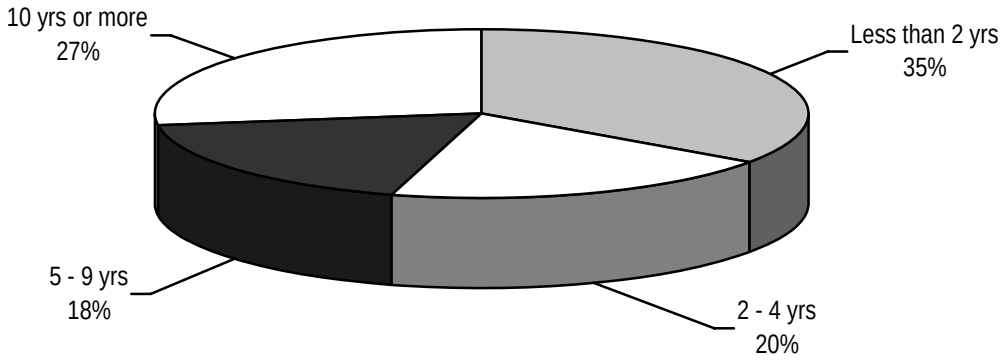


Figure 81: Psychiatric Nursing Assistants – Length of State Service



Turnover for Psychiatric Nursing Assistants is high at about 35 percent. [218] Pay is low, with an average hourly wage of $10.14 per hour. [219]

Registered Nurses and Licensed Vocational Nurses

Nationwide, the nursing shortage is reaching crisis proportions. It is projected that there will be a need for 587,000 new RN jobs by the year 2016.[220] Job

[218] HHSAS Database, FY 2007 data.
[219] HHSAS Database, as of 8/31/07.
[220] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).

opportunities for RNs are expected to grow faster than the average for all occupations.[221] With this level of job growth, it is projected that there will not be enough qualified applicants to meet the increased demand.

The nursing shortage is the most significant healthcare workforce staffing concern facing both the nation and Texas.[222] The Texas nurse-to-population ratio is far below the national average of 782 Nurses per 100,000 people, with the state ratio being only 609 Nurses per 100,000 people. By some estimates, Texas will need 138,000 additional Nurses in the next 10 years to satisfy staffing demands.[223]

DSHS nurses are generally required to work shifts. The work is demanding, requires special skills and staff often work long hours with minimal staffing. All of these job factors contribute to higher than average turnover rates.

Although there are 88 nursing programs across the state, most of them have more applicants than enrollment space for new students. As well, only about two-thirds of enrolled students actually graduate.[224] Also contributing to the low number of graduating nurses is a shortage of qualified instructors. The shortage of trained instructors limits both the number of accepted students and the number of available classes offered.

[221] US Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *2008-09 Edition*, web page http://www.bls.gov/oco/ocos083.htm, last accessed on 3/10/08.
[222] State of Nursing Workforce in Texas – Statewide Health Workforce Symposium Policy Brief, March 2005.
[223] MedicineWorld.org, 'Lack of Resources, Not Lack of Students, Cause Nurse Shortage," web page http://medicineworld.org/cancer/lead/12-2005/lack-of-resources-not-lack-of-students-cause-nurse-shortage.html, last accessed on 1/17/06.
[224] "Professional Nursing Education in Texas: Demographics & Trends: 2006."

Registered Nurses (RNs)

There are 959 RNs employed by DSHS. The typical RN at the agency is about 50 years old and has an average of approximately 10 years of state service.[225]

Figure 82: Registered Nurses at DSHS – Distribution by Age

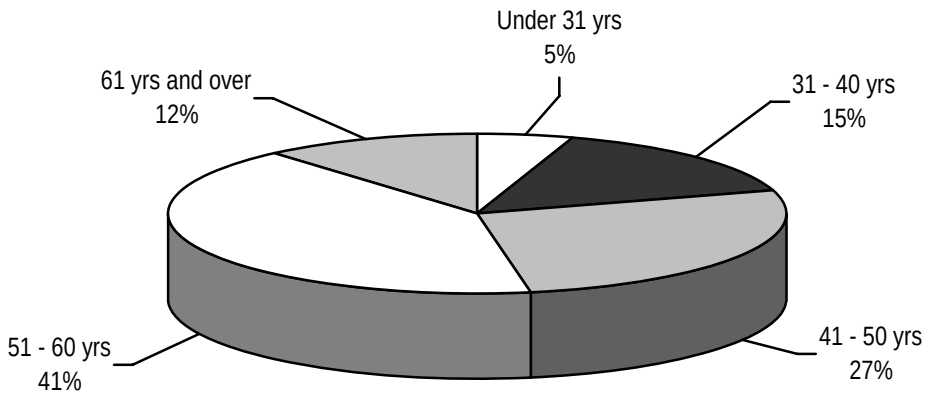
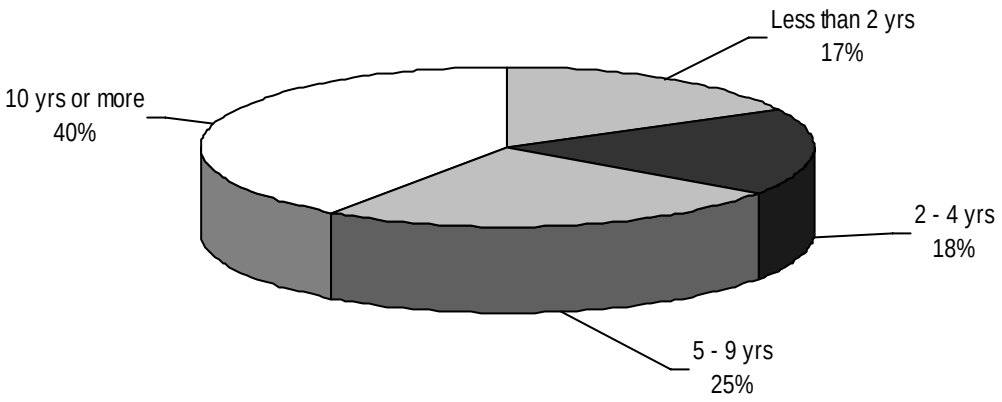


Figure 83: Registered Nurses at DSHS – Length of State Service



The turnover rate for RNs is considered high at about 22 percent.[226]
The agency is also experiencing difficulty filling vacant positions. The Texas Hospital Association confirmed that vacancy rates for RNs in Texas ranged from 14.6 percent in critical care occupations to about 10 percent in emergency rooms.[227] With a high vacancy rate for these positions at DSHS (at

[225] HHSAS Database, as of 8/31/07.
[226] HHSAS Database, FY 2007 data.
[227] Texas Hospital Association. "Hospital Workforce Study." Austin, Texas. 2004, as cited in "The state of the Nursing Workforce in Texas, "Statewide Health Workforce Symposium Policy Brief, March 4, 2004.

approximately 17 percent), RN positions are remaining open, on average, for almost 10 months before being filled.[228] In order to provide quality nursing care for consumers it is essential that the agency maintain the lowest vacancy rate possible throughout the year. The agency is striving to maintain vacancy rates for nursing positions at a level below 10 percent at any given time.

Licensed Vocational Nurses (LVNs)

There are 476 Licensed Vocational Nurses (LVNs) employed by DSHS. On average, a DSHS LVN is about 45 years old and has 10 years of state service.[229]

Figure 84: Licensed Vocational Nurses at DSHS – Distribution by Age

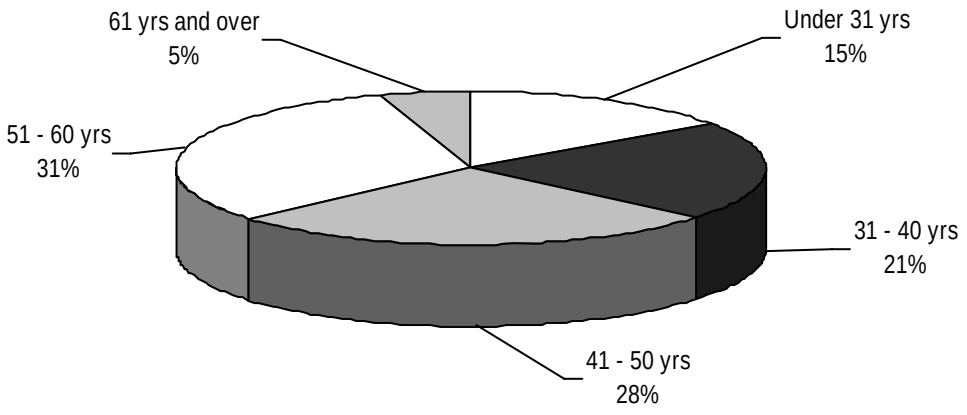
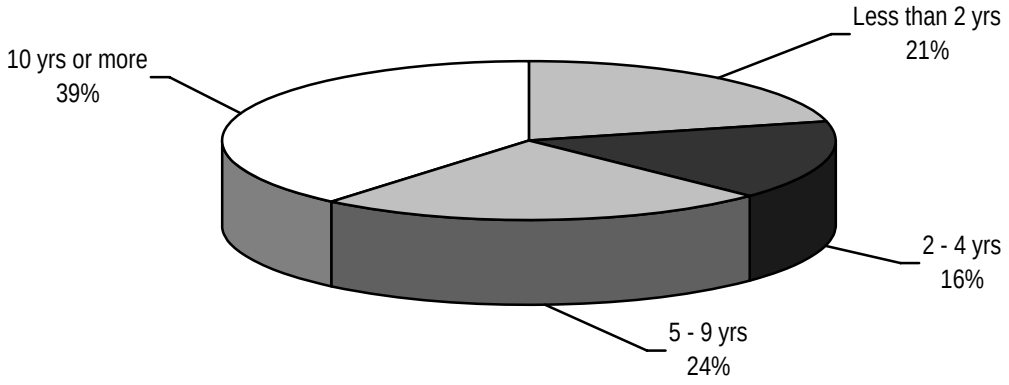


Figure 85: Licensed Vocational Nurses at DSHS – Length of State Service



[228] HHSAS Database, FY 2007 data.
[229] HHSAS Database, as of 8/31/07.

As with RNs, the nursing shortage is also impacting the agency's ability to retain and attract LVNs. Turnover for LVNs is currently high at about 27 percent. With a vacancy rate of over 10 percent, vacant positions go unfilled for months.[230]

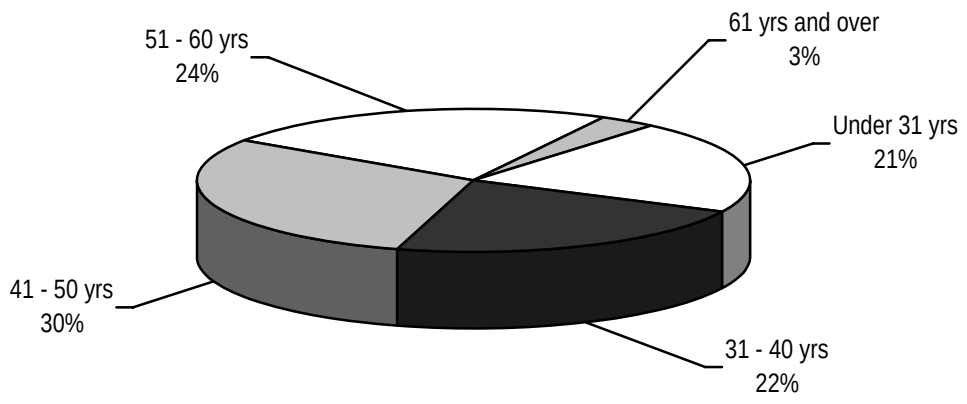
Many LVNs come into the mental health hospital system with limited training in caring for psychiatric patients. DSHS State Hospitals invest in employee training to ensure the highest quality of nursing care. The high turnover for LVN positions has a direct impact on the training resources dedicated to this occupational group. Decreasing turnover levels will significantly reduce the amount of time spent on employee training.

Rehabilitation Therapy Technicians

There are over 325 Rehabilitation Therapy Technicians at DSHS.[231]

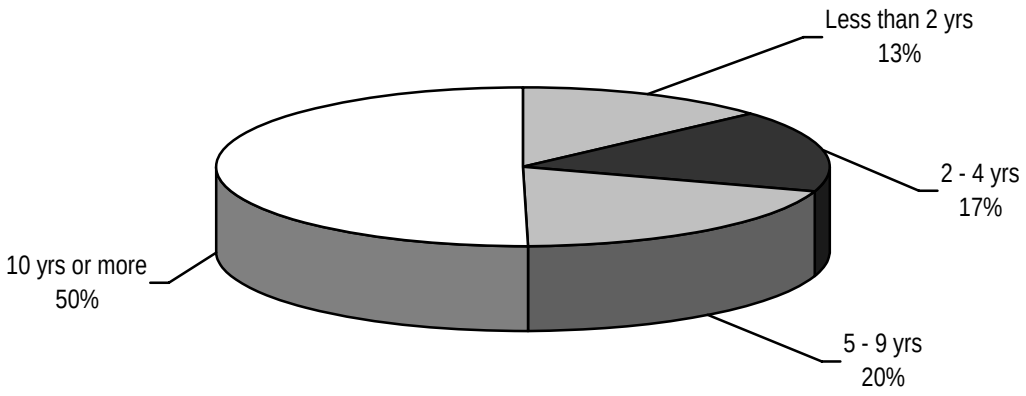
On average, DSHS Rehabilitation Therapy Technicians have about 11 years of state service, with an average age of approximately 42. Almost 50 percent of these employees have 10 or more years of service.[232]

Figure 86: Rehabilitation Therapy Technicians at DSHS Distribution by Age



[230] HHSAS Database, FY 2007 data.
[231] HHSAS Database, as of 8/31/07.
[232] Ibid.

Figure 87: Rehabilitation Therapy Technicians at DSHS Length of State Service



The turnover rate for Rehabilitation Therapy Technicians is approximately 16 percent, similar to the statewide average for all job classifications.[233]

Recruitment of qualified applicants for these jobs is an ongoing challenge.

Clinical Social Workers

There are 166 Clinical Social Workers at DSHS.[234] These employees are critical to managing patient flow in state hospitals. They take the lead role in communicating with patient families and community resources. Clinical Social Workers provide essential functions within the agency that include:

- providing comprehensive public health case management services to children, birth to 20 years of age, who have or are at risk for a health condition; and high-risk pregnant women;
- conducting psychosocial assessments, therapeutic treatment and case coordination for individuals receiving services from DSHS in-patient psychiatric hospitals and the Waco Center for Youth; and
- developing, administering and implementing a range of public health and behavioral health programs throughout the DSHS service delivery system.

[233] HHSAS Database, FY 2007 data.
[234] HHSAS Database, as of 8/31/07.

DSHS Clinical Social Workers are about 45 years old and have an average of 11 years of state service.[235]

Figure 88: Clinical Social Workers at DSHS – Distribution by Age

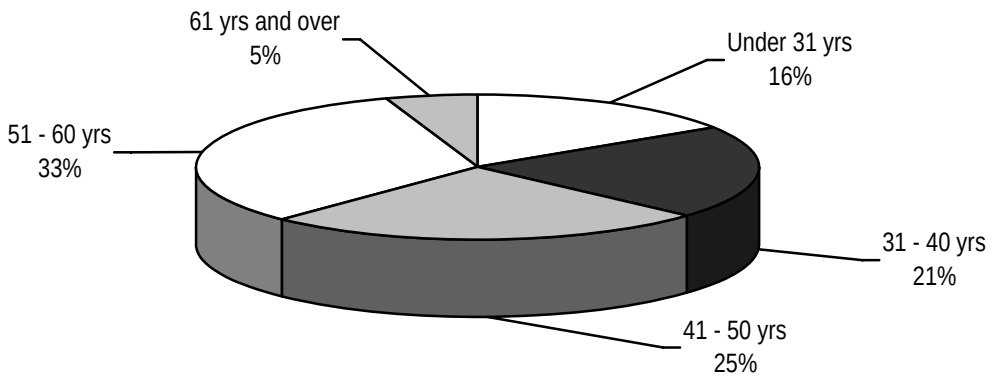
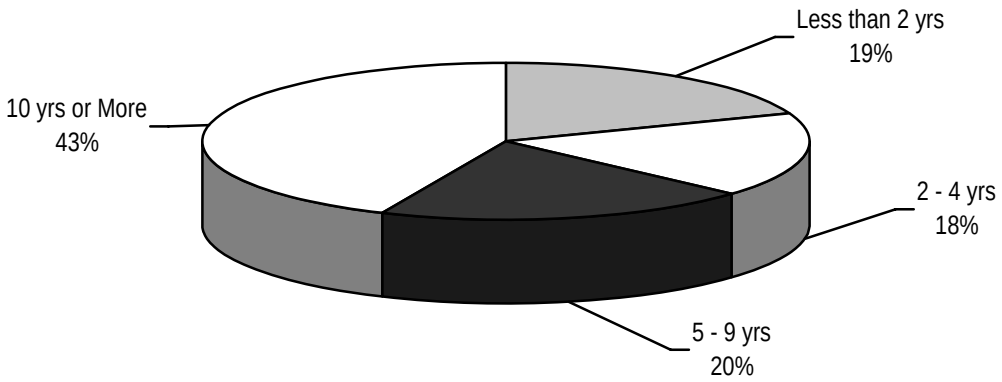


Figure 89: Clinical Social Workers at DSHS – Length of State Service



Though the overall turnover rate for Clinical Social Workers is well managed at around 14 percent, almost 33 percent of current Clinical Social Workers will be eligible to retire by the year 2012. In addition, vacant positions often go unfilled for several months until a qualified applicant is available.[236]

Factors impacting recruitment include non-competitive salaries, credentialing requirements and increased need for individuals with Spanish-English bilingual skills.

[235] HHSAS Database, as of 8/31/07.
[236] HHSAS Database, FY 2007 data.

DSHS competes with both the federal and local governments, the military and the private sector employers for Clinical Social Worker applicants. Many times the competitors are able to offer a higher starting salary.

Considering these factors, DSHS may face significant recruitment challenges in the next few years to replace those who are eligible for retirement.

Epidemiologists

One of the public health professions currently experiencing shortages is Epidemiology.[237]

DSHS employs 82 Epidemiologists who provide services in the areas of infectious disease and injury control, chronic disease control, emergency and disaster preparedness, disease surveillance and other public health areas.[238] They provide critical functions during disasters and pandemics and other preparedness and response planning.

On average it takes a year for a new Epidemiologist to learn his or her job within the agency. It may take several years to develop the specialized expertise required of senior Epidemiologists to support the state and protect public health.

DSHS Epidemiologists have, on average, about 10 years of state service, with an average age of approximately 43.[239]

[237] "2007 State Public Health Workforce Survey Results," The Association of State and Territorial Health Officials, web page http://www.astho.org/pubs/WorkforceReport.pdf, last accessed on 4/29/08.
[238] HHSAS Database, as of 8/31/07.
[239] Ibid.

Figure 90: Epidemiologists at DSHS – Distribution by Age

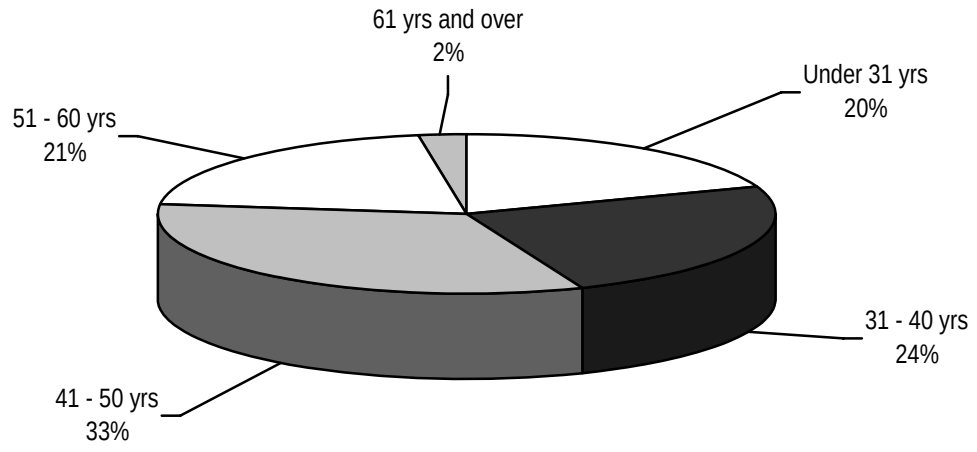
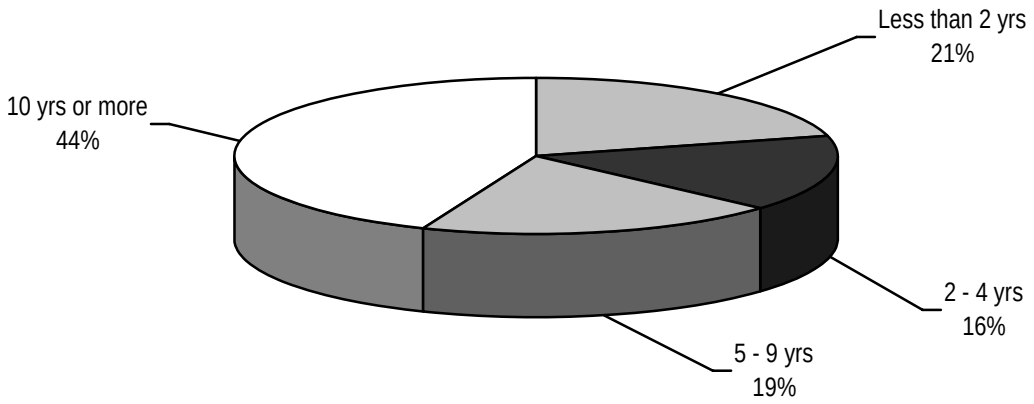


Figure 91: Epidemiologists at DSHS – Length of State Service



While the overall turnover rate for Epidemiologists at DSHS is low, at about 12 percent, the vacancy rate for these positions is high, at almost 16 percent. Vacant positions often go unfilled for months.[240]

Low pay is a factor in attracting qualified Epidemiologist applicants. DSHS Epidemiologists earn an average annual salary of $49,675. The average annual salary for Epidemiologists nationally is $60,290 and $44,250 in Texas.[241]

[240] HHSAS Database, FY 2007 data.
[241] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.

The agency will need to closely monitor this occupation due to the nationally noncompetitive salaries and a general shortage of professionals performing this work.

Sanitarians

Another public health profession currently experiencing shortages is environmental health workers (i.e., Sanitarians).[242]

There are over 100 Sanitarians employed with DSHS.[243] Registered Sanitarians at DSHS inspect all food manufacturers, wholesale food distributors, food salvagers in Texas, as well as all retail establishments in the 188 counties not covered by local health jurisdictions and conduct a multitude of environmental inspections such as children's camps, asbestos abatement, hazardous chemicals/products and many others. Sanitarians are instrumental in protecting the citizens of Texas from food-borne illness and many dangerous environmental situations and consumer products, including imported foods, drugs and consumer products. The U.S. Food and Drug Administration (FDA) and the Consumer Products Safety Commission (CPSC) have little manpower and therefore depend on the state programs to protect citizens. DSHS Sanitarians also respond to a variety of emergencies, including truck wrecks, fires, tornados, floods and hurricanes. They are the first line of defense against a bioterrorist attack on the food supply.

On average, Sanitarians employed with the agency are 49 years old and have about 13 years of state service. [244]

[242] "2007 State Public Health Workforce Survey Results," The Association of State and Territorial Health Officials, web page http://www.astho.org/pubs/WorkforceReport.pdf, last accessed on 4/29/08.
[243] HHSAS Database, as of 8/31/07.
[244] Ibid.

Figure 92: Sanitarians at DSHS – Distribution by Age

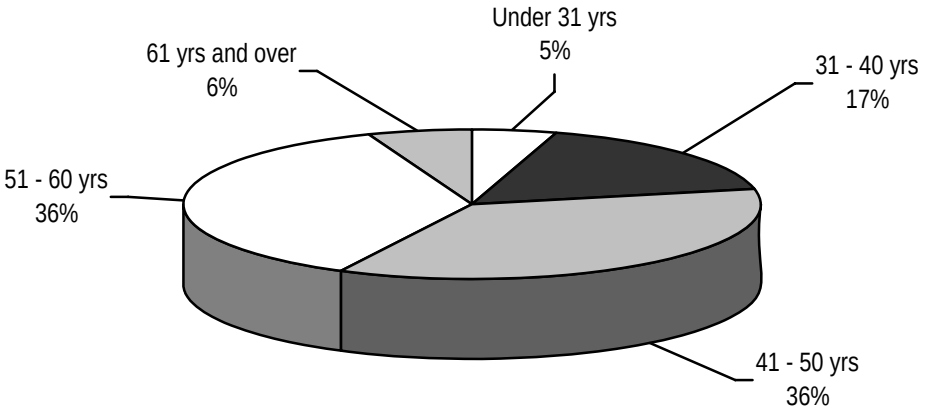
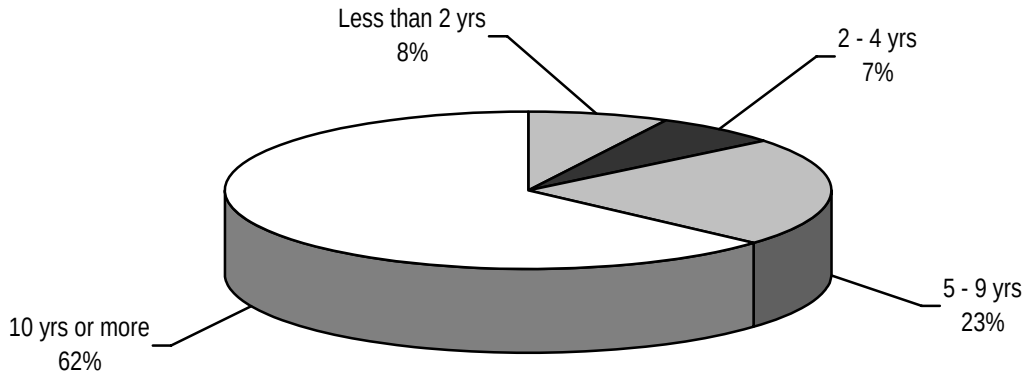


Figure 93: Sanitarians at DSHS – Length of State Service



Turnover for Sanitarians is low at only eight percent. However, vacant positions often go unfilled for many months due to a shortage of qualified applicants available for work. Historically, the agency has faced special challenges filling vacancies in both rural and urban areas of the state. In addition, the state requirement for Sanitarians to be registered and have at least 30 semester hours of science has made it increasingly difficult to find qualified individuals. The agency actually has some vacancies that have been posted for over two years and remain unfilled.[245]

[245] HHSAS Database, FY 2007 data.

These vacancy problems are expected to worsen as employees approach retirement. About a quarter of current sanitarian staff will be eligible to retire by 2012.[246]

DSHS Sanitarians earn an average annual salary of $40,145, significantly lower than the starting salaries offered by local health jurisdictions, federal counterparts (U.S. Food and Drug Administration, USDA and the Consumer Product Safety Commission) and private industry. [247]

Over the past four years, DSHS has lost a total of 28 full time sanitarian staff. Examples of the impact salary disparity with competitors is having include:

- one employee recently hired by the FDA, who more than doubled his salary to an average of nearly $80,000;
- employees hired by industry, who increased their average annual salaries by an average of 50 percent ($60,000);
- DSHS sanitarians hired by local health jurisdictions, who increased their salaries by about 24 percent; and
- one employee hired by the Texas Commission for Environmental Quality, who received a 26 percent salary increase.

DSHS has already implemented a number of steps to retain Sanitarians, including:

- paying for license renewals;
- providing classes that enable Sanitarians to maintain continuing education hours required for license renewal; and
- finding ways to offer training classes in subjects that are relevant to their work.

Dentists

The demand for dentists nationwide is expected to increase as the overall population grows. [248]

[246] HHSAS Database, as of 8/31/07.
[247] Ibid.
[248] US Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *2008-09 Edition*, web page http://www.bls.gov/oco/ocos072.htm, last accessed on 3/10/08.

There are 12 Dentists employed by DSHS.[249] Central Office staff and five regional dental teams conduct dental surveillance, data collection and reporting and provide preventive oral health services. Services are provided primarily to low-income, pre-school and school-age children in rural areas with limited or no access to these services. State hospital Dentists provide preventive care and treatment services to patients.

The typical agency Dentist is about 51 years old, with an average of 13 years of state service.[250]

Figure 94: Dentists at DSHS – Distribution by Age

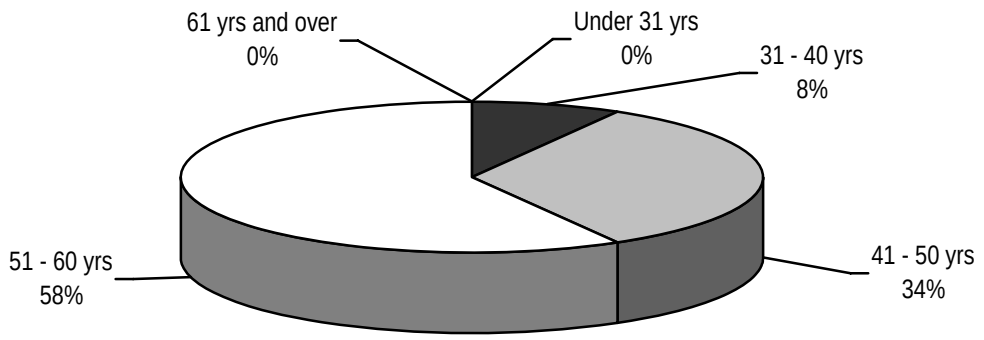
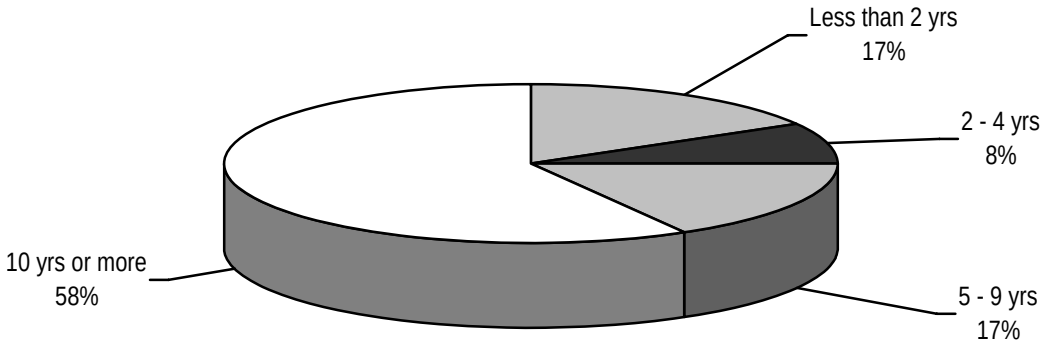


Figure 95: Dentists at DSHS – Length of State Service



[249] HHSAS Database, as of 8/31/07.
[250] Ibid.

Though Dentist positions are currently experiencing little turnover, vacant positions are going unfilled for many months.[251]

It has become extremely difficult to recruit and attract qualified dentist applicants at the starting salary levels offered by the agency.

There is a large disparity between private sector and agency starting salaries. Dentists at DSHS earn, on average, an annual salary of $87,060.[252] This salary falls significantly below the market rate. The average annual salary for Dentists nationally is $140,950 and $149,630 in Texas.[253] This disparity is affecting the agency's ability to recruit qualified applicants for open positions.

In addition, DSHS may face significant recruitment challenges in the next few years to replace those who are eligible for retirement. Nearly half of these employees (47 percent) will be eligible to retire by 2012.[254]

Laboratory Staff

DSHS operates a state-of-the-art state laboratory in Austin. The agency also operates two regional laboratories, one in San Antonio and the other in Harlingen. While laboratory staff is made up of a number of highly skilled employees, there are three job groups that are essential to laboratory operations: Chemists, Microbiologists and Laboratory Technicians.

Chemists

There are 58 Chemists employed at DSHS, all located in Austin.[255]

The typical agency Chemist is about 48 years old and has an average of 12 years of state service. More than half of the employees have 10 years or more of state service.[256]

[251] HHSAS Database, FY 2007 data.
[252] HHSAS Database, as of 8/31/07.
[253] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[254] Ibid.
[255] HHSAS Database, as of 8/31/07.
[256] Ibid.

Figure 96: Chemists at DSHS – Distribution of Age

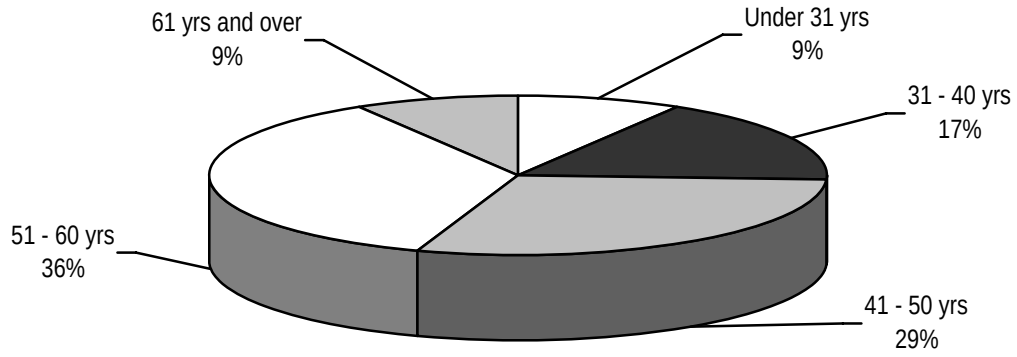
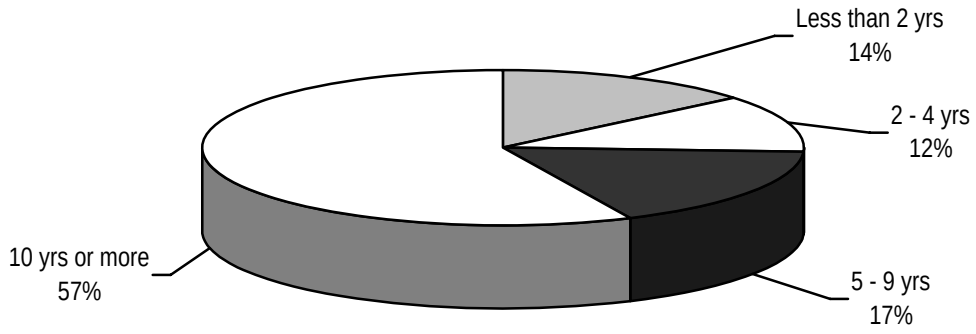


Figure 97: Chemists at DSHS – Length of State Service



The turnover rate for DSHS Chemists is about 11 percent annually. While this rate is considered low, about 31 percent of current Chemists will be eligible to retire by the year 2012.[257]

Chemists at DSHS earn an average annual salary of about $42,246.[258] This salary falls below the market rate. The average annual salary for Chemists nationally is $66,040 and $57,940 in Texas.[259]

[257] HHSAS Database, FY 2007 data.
[258] HHSAS Database, as of 8/31/07.
[259] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.

Microbiologists

There are 124 Microbiologists at DSHS, with the majority working at the Austin laboratory.[260]

DSHS Microbiologists have, on average, about nine years of state service, with an average age of about 39 years.[261]

Figure 98: Microbiologists at DSHS – Distribution of Age

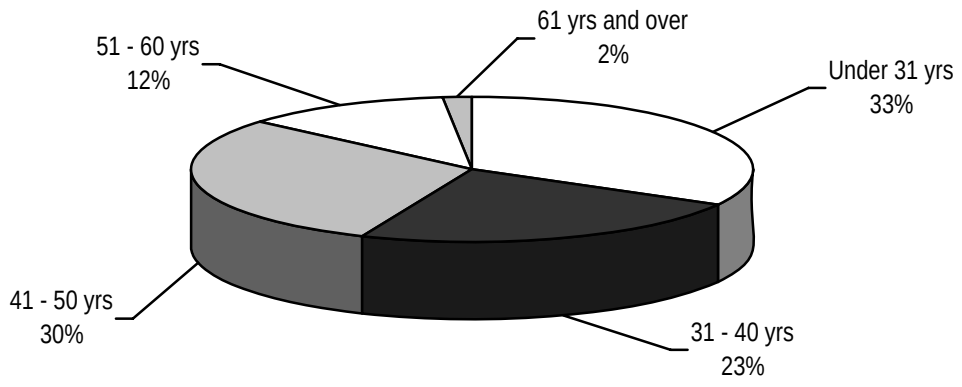
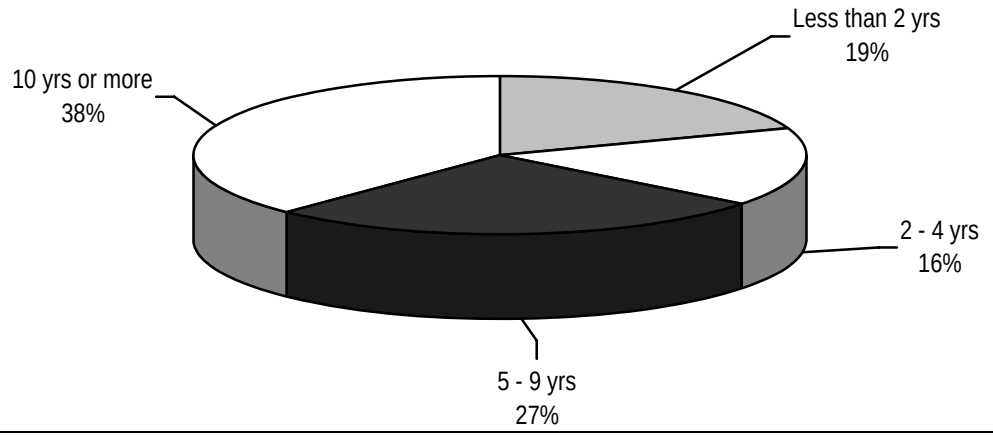


Figure 99: Microbiologists at DSHS – Length of State Service



The turnover rate for DSHS Microbiologists is about 16 percent.[262] This rate is slightly lower than the statewide turnover rate of 17.4 percent.[263]

[260] HHSAS Database, as of 8/31/07.
[261] Ibid.
[262] HHSAS Database, FY 2007 data.
[263] State Auditor's Office (SAO) FY 2007 Turnover Statistics.

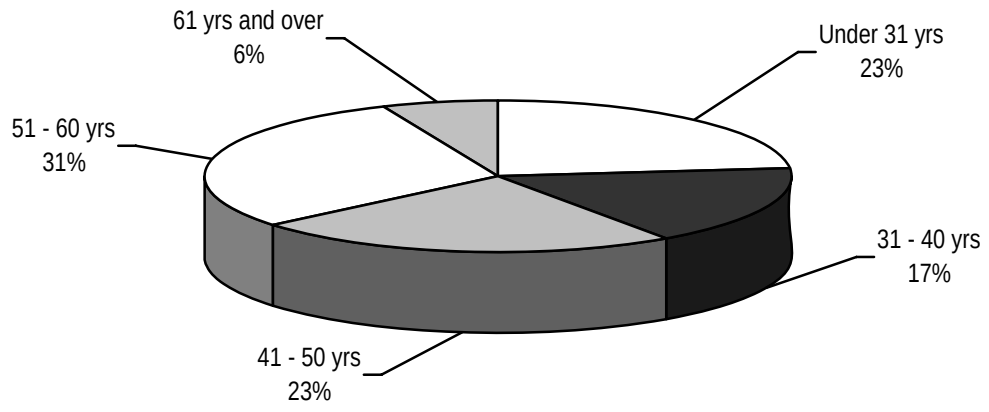
Agency Microbiologists earn an average annual salary of about $39,563. This salary falls below the national and statewide market rates for this occupation. The average annual salary for Microbiologists nationally is $65,200 and $47,280 in Texas.[264] [265] This disparity in earnings is affecting the agency's ability to recruit qualified applicants for open positions. Microbiologist positions often remain unfilled for several months.[266]

Laboratory Technicians

There are 47 Laboratory Technicians employed at DSHS.[267]

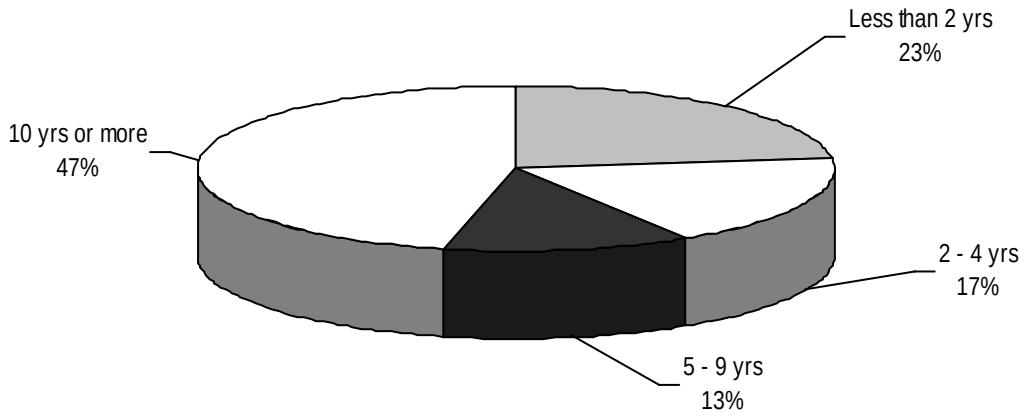
The typical Laboratory Technician is about 44 years old and has an average of 11 years of state service.[268]

Figure 100: Laboratory Technicians at DSHS – Distribution of Age



[264] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[265] HHSAS Database, as of 8/31/07.
[266] Ibid.
[267] Ibid.
[268] Ibid.

Figure 101: Laboratory Technicians at DSHS – Length of State Service



Annual turnover for DSHS Laboratory Technicians is considered high at approximately 25 percent.[269]

Targeted recruitment and retention strategies are used to ensure that agency laboratories have enough staff to meet agency goals.

One strategy has been to contract with private laboratories. This has not been a particularly desirable alternative to hiring laboratory staff. Barriers to using contracts with private labs include securing a cost effective contract arrangement and the difficulty in obtaining a long term commitment. In most cases, contracting with private lab services is more costly than hiring staff to perform these services.

Vital Statistics Staff

There are 154 employees in the Vital Statistics Bureau (VSB) in Austin.[270] Staff includes Managers and Directors, Program Specialists, Research and Statistical Technicians, Data Entry and Systems Supports staff and Administrative Assistants and Staff Services Officers.[271]

New federal legislation has increased the demand for services by about 50 percent over previous levels in the last two years due in part to the Western

[269] HHSAS Database, FY 2007 data.
[270] HHSAS Database, as of 8/31/07.
[271] Ibid.

Hemisphere Travel Initiative of the United States Department of State, Passport Services Office.

The agency anticipates new business demands will be placed on VSB employees due to the acceptance of faxed credit card requests, by advertising at hospitals where babies are born and from accepting third party requests from private organizations.

The average Vital Statistics staff member is approximately 43 years of age, with about 11 year of state service.[272]

Figure 102: Vital Statistics Staff at DSHS – Distribution of Age

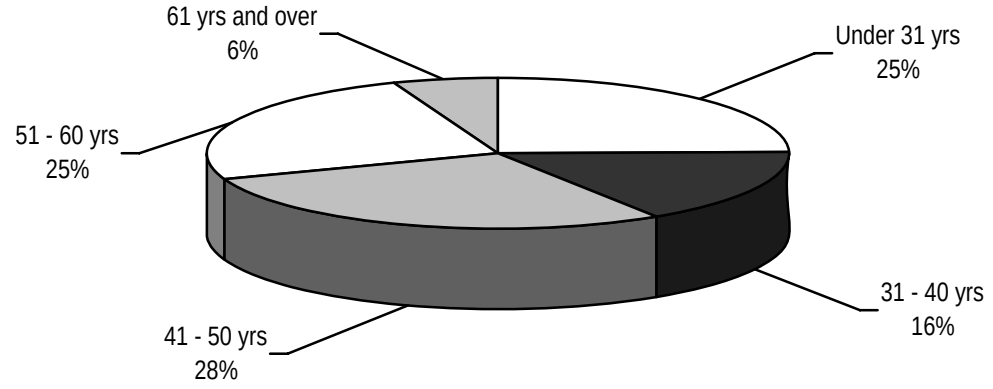
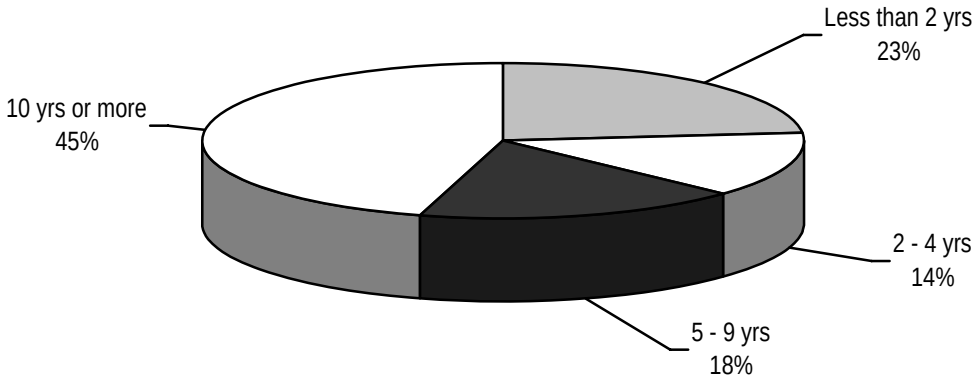


Figure 103: Vital Statistics Staff at DSHS – Length of State Service



[272] HHSAS Database, as of 8/31/07.

Turnover of Vital Statistics employees is high at about 19 percent, with Administrative Assistants and Staff Services Officers having the highest turnover at about 21 percent.[273]

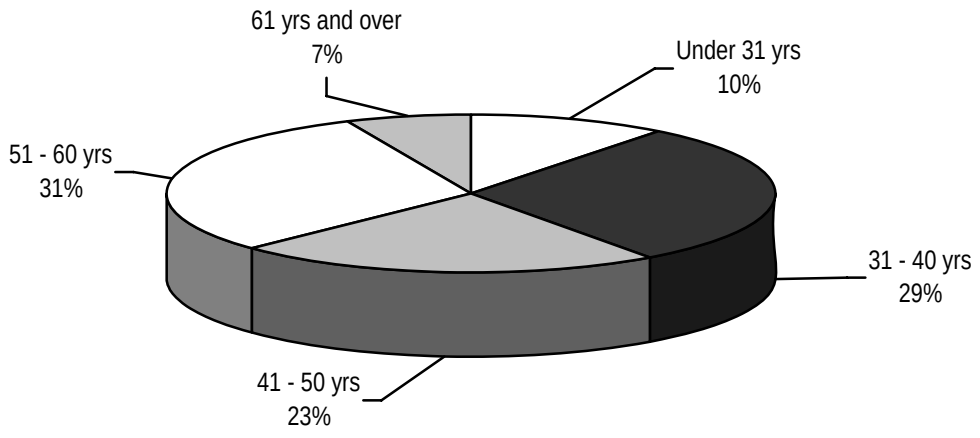
Recruitment and retention for these jobs is an ongoing challenge.

Human Services Specialists

Over 100 Human Services Specialists are employed at DSHS.[274] These employees provide comprehensive case management to children with health conditions/health risks and to high-risk pregnant women of all ages. Together, the case manager and family assess the medical, social, educational and other medically necessary service needs of the consumer. Employees must have a high level of flexibility, since employees in these positions work with a variety of consumers who vary in age, socioeconomic status, ethnicity, disability and service need. Human Services Specialists are either licensed social workers or registered nurses.

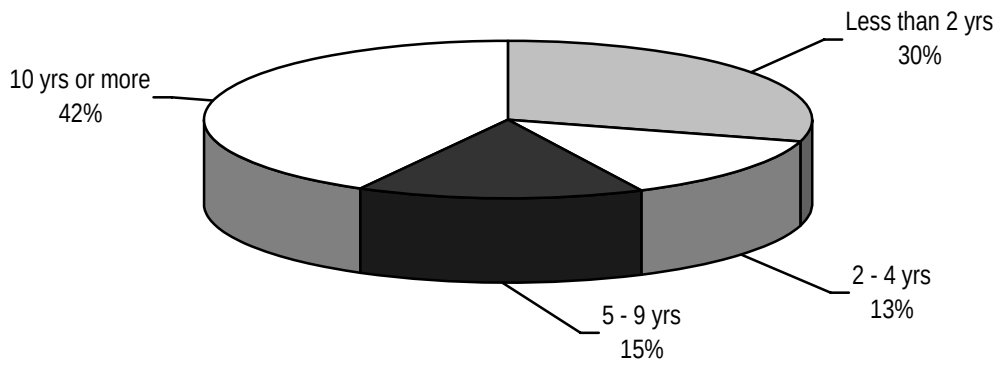
The typical Human Services Specialist is about 45 years old and has an average of nine years of state service.[275]

Figure 104: Human Services Specialist VIIs at DSHS – Distribution by Age



[273] HHSAS Database, FY 2007 data.
[274] HHSAS Database, as of 8/31/07.
[275] Ibid.

Figure 105: Human Services Specialist VIIs at DSHS Length of State Service



Turnover for Human Services Specialists during fiscal year 2007 was 16.5 percent, slightly under the state average of 17.4 percent.[276] [277]

The workload of public health case managers is expected to increase as the public becomes more aware of available services. Demand for new services and increases in pre-existing duties indicate a strong potential need for additional staff in the future. This increase will further compound current difficulties in recruiting and retaining case managers due primarily to below market pay, requirements for licensure and the need for oral and written bilingual skills.

Low starting salaries contribute to the difficulty in attracting qualified Human Services Specialist applicants. Human Services Specialists at DSHS earn, on average, an annual salary of $37,298.[278] This salary is not competitive with the private sector and does not compensate for the need to be available 24/7 or work extended hours to meet the needs of consumers. Occupations with a comparable skills set include Registered Nurses and Licensed Social Workers. Licensed Social Workers earn an average annual salary nationally of $44,950 and $38,270 in Texas; while comparable Registered Nurses earn an average annual salary nationally of $59,730 and $57,180 in Texas.[279]

[276] State Auditor's Office (SAO) FY 2007 Turnover Statistics.
[277] HHSAS Database, FY 2007 data.
[278] HHSAS Database, as of 8/31/07.
[279] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.

This disparity in earnings is affecting the agency's ability to recruit qualified applicants for open positions. These positions often remain unfilled for several months before filled. [280]

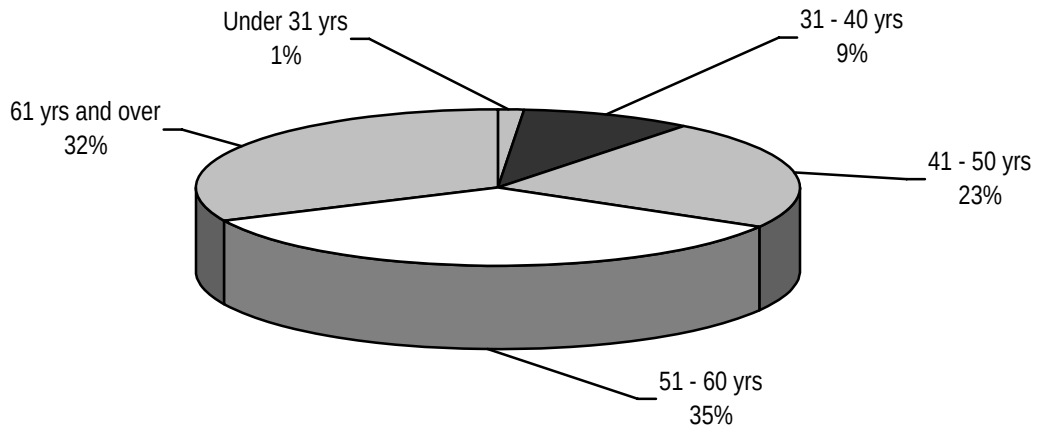
Recruitment and retention for these jobs is an ongoing challenge.

Physicians

There are about 75 Medical Doctors at DSHS.[281] These Physicians are essential to providing medical care in state hospitals. They take the lead role in diagnosing, determining a course of treatment, making referrals to outside medical hospitals, prescribing medications and monitoring the patients' progress toward discharge. They are critical to the agency's preparedness and response to medical services provided by the state and to major public health initiatives, such as obesity prevention, diabetes, disease outbreak control and others.

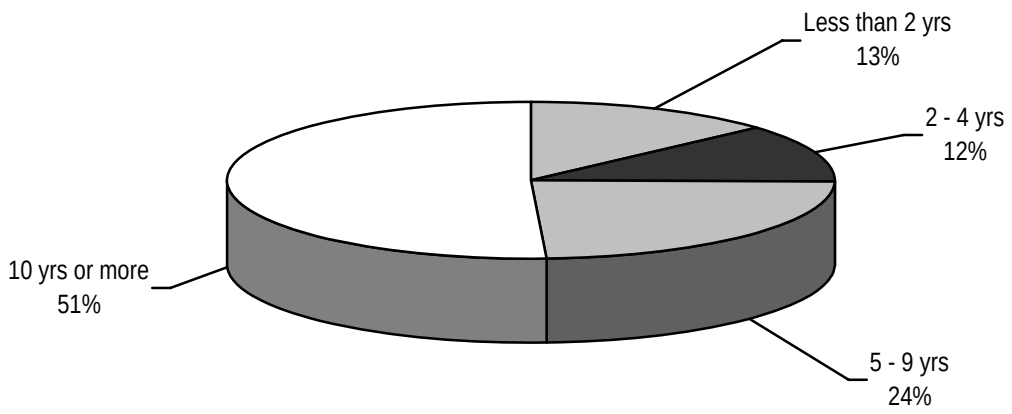
DSHS Physicians have, on average, about 12 years of state service, with an average age of 57. Local Physicians who have established long term private practices often apply as Physicians at DSHS hospitals late in their working career to secure retirement and insurance benefits, thus explaining the high overall age. Only eight full-time Physicians are under 41 years of age.[282]

Figure 106: Physicians at DSHS – Distribution of Age



[280] HHSAS Database, FY 2007 data.
[281] HHSAS Database, as of 8/31/07.
[282] Ibid.

Figure 107: Physicians at DSHS – Length of State Service



Though turnover for Physicians is low at only about 11 percent, 33 of these highly skilled and tenured employees (45 percent) will be eligible to retire by 2012. [283] [284] As retirement opportunities near, the agency will lose some of the most experienced medical personnel – those with institutional knowledge and skills that will be difficult to replace, with expertise that will be difficult to match and even harder to recruit. Three senior public health Physicians have left DSHS in the last six months (one to state retirement and private medical consulting and two to local health departments). Another, less senior Physician, is leaving for a higher paying position in the private health policy and research sector. Non-competitive salaries are having a significant effect on retaining qualified physicians with the agency. It can take over a year to fill a physician position with someone who has appropriate skills and expertise.

Agency Physicians earn an average annual salary of $138,185. This salary falls below the market rate. The average annual salary for Physicians nationally is $142,220 and $158,060 in Texas. [285] [286]

The state hospital system faces increasing difficulty in recruiting and retaining qualified Physicians. This has resulted in excessively high work loads for the Physicians on staff and often increases the patient-to-doctor ratio. The hospitals are seeing more and more medically acute patients in the state hospital system, requiring close medical monitoring of their conditions. It can also place Joint Commission accreditation and Medicare certification at risk.

[283] HHSAS Database, FY 2007 data.
[284] HHSAS Database, as of 8/31/07.
[285] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[286] HHSAS Database, as of 8/31/07.

To deal with these recruitment and retention difficulties, the agency has often used contract Physicians to provide required coverage. These contracted Physicians are paid at rates that are well above the amount it would cost to hire Physicians at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about $66[287] paid to agency Physicians). These contracted Physicians may not be immediately available in an emergency (increasing the risk to patients) and are unable to provide the individualized treatment that arises from daily contact with staff and patients. Consequently, the patient's length of stay increases and annual number of patients served decreases.

Recruitment of qualified candidates, as well as retention of these highly skilled and knowledgeable employees, continues to be a challenge for the agency. Compensation levels need to be increased to effectively compete in a market where qualified applicants are in short supply and healthcare competitors offer a higher starting salary. The cost of obtaining clinical staff through a placement service or contract far exceeds the cost of hiring and retaining an agency physician. Attracting and keeping clinical staff that are trained in the use of DSHS electronic equipment and clinical practices, as well as familiarity with the consumer population, is more productive and cost effective.

Psychiatrists

There are currently 123 Psychiatrists at DSHS.[288] These highly skilled employees provide essential medical and psychiatric care in state hospitals. They take the lead role in diagnosing, determining a course of treatment, prescribing medications and monitoring the patients' progress.

DSHS Psychiatrists have, on average, about 11 years of state service, with an average age of 54. Over half of these employees have 10 or more years of service.[289]

[287] HHSAS Database, as of 8/31/07.
[288] Ibid.
[289] Ibid.

Figure 108: Psychiatrists at DSHS – Distribution by Age

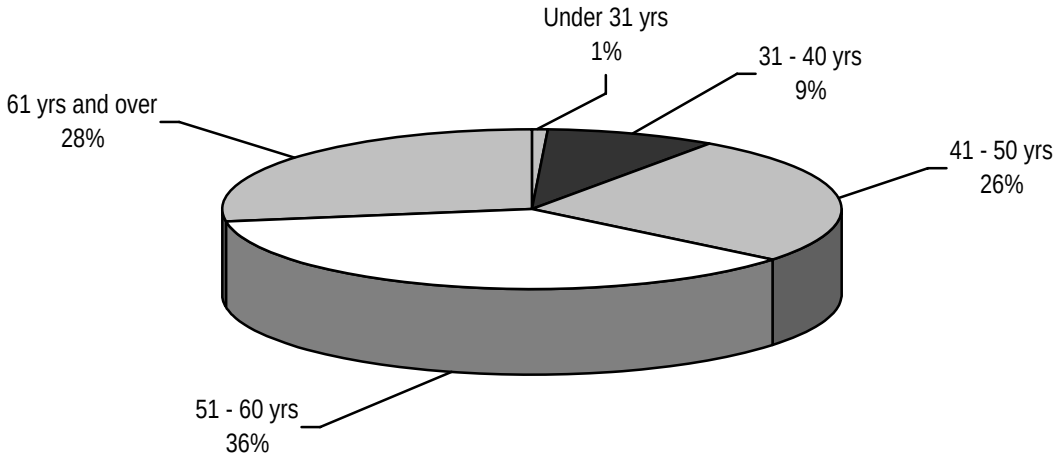
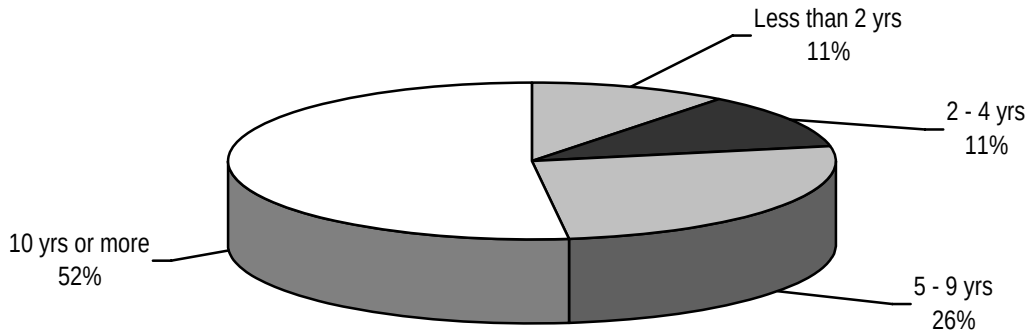


Figure 109: Psychiatrists at DSHS – Length of State Service



Annual turnover for Psychiatrists is low at only 9.5 percent. Approximately 38 percent of these highly skilled and tenured employees will be eligible to retire by 2012.[290]

Texas has a severe shortage of Psychiatrists. It has been reported the supply ratio for Psychiatrists in the state of Texas has decreased from 6.2 per 100,000 adults in 1985 to 5.6 in 2005. In general, the supply of Psychiatrists is lower in

[290] HHSAS Database, FY 2007 data.

rural and border counties. The need to recruit and retain professionals is crucial to the mental health care of residents in these underserved areas.[291]

DSHS Psychiatrists earn an average annual salary of about $157,536.[292] Nationally, Psychiatrists are being offered an average annual salary of $186,000 (with the low at $160,000 and high at $230,000).[293] This discrepancy in earnings has created difficulties in attracting qualified applicants. Most vacant Psychiatrist positions go unfilled for months.[294]

The state hospital system faces increasing difficulty in recruiting qualified Psychiatrists. This has resulted in excessively high work loads for the Psychiatrists on staff, reducing the ability of hospitals to function at full capacity and increasing the average length of stay. It has also placed Joint Commission accreditation and Medicare certification at risk.

To deal with these recruitment difficulties, the agency has often used contract Psychiatrists to provide required coverage. These contracted Psychiatrists are paid at rates that are well above the amount it would cost to hire Psychiatrists at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about $76[295] paid to agency Psychiatrists). These contracted Psychiatrists may not be immediately available in an emergency (increasing the risk to patients) and are unable to provide the individualized treatment that arises from daily contact with staff and patients. Consequently, the patient's length of stay increases and annual number of patients served decreases. Since medical records of patients are almost completely electronic, Psychiatrists are required to be proficient at computer entry and documentation. It often takes many weeks to train a contract Psychiatrist on the nuances of the electronic medical record.

Due to the complex medical and mental challenges that individuals residing in state hospitals exhibit, it is critical that the agency is able to effectively recruit and retain qualified Psychiatrists. Continued targeted recruitment strategies and retention initiatives for these highly skilled professionals must be ongoing.

[291] "Highlights: The Supply of Mental Health Professionals in Texas – 2005,"DSHS Center for Health Statistics, Publication 25-12347, 2006, webpage http://www.dshs.state.tx.us/chs/hprc/MHhigh05.pdf, last accessed on 4/29/08.
[292] HHSAS Database, as of 8/31/07.
[293] "2007 Review of Physician and CRNA Recruiting Incentives," MHA Merritt Hawkins & Associates, webpage http://www.merritthawkins.com/pdf/2007_Review_of_Physician_and_CRNA_Recruiting_Incentives.pdf, last accessed on 4/29/08.
[294] HHSAS Database, FY 2007 data.
[295] HHSAS Database, as of 8/31/07.

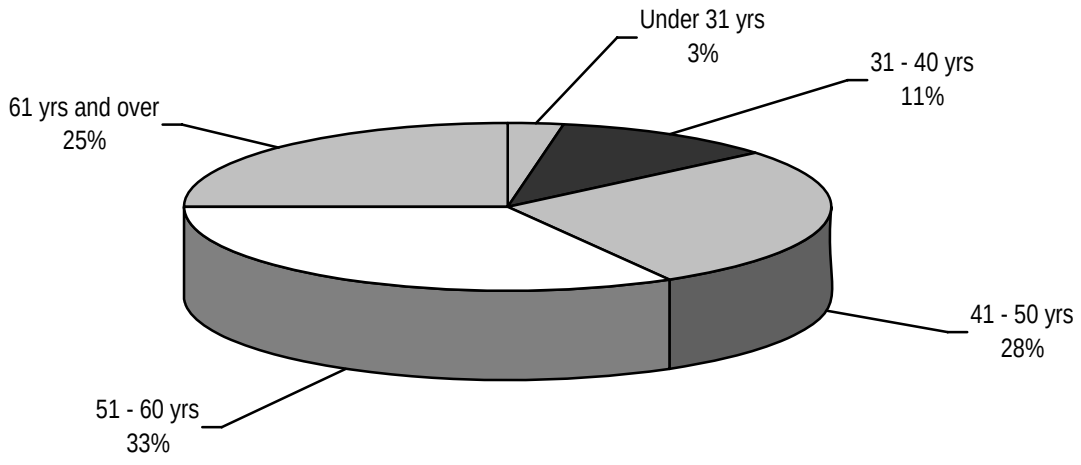
Pharmacists

Pharmacists represent the third largest health professional group in the US, with approximately 243,000 active Pharmacists as of November 2006.[296] While the overall supply of Pharmacists has increased in the past decade, there has been an unprecedented demand for Pharmacists and for pharmaceutical care services. This need is expected to grow faster than the average for all occupations due to the increased pharmaceutical needs of a growing elderly population and increased use of medications. It is projected that there will be a demand for 53,000 new Pharmacists by 2016, or a 22 percent increase in the number of total jobs.[297] However, the number of available Pharmacists is expected to grow only modestly.

There are 36 Pharmacists working in various capacities at DSHS.[298] For example, Pharmacists are essential to the timely filling of prescribed medications for patients in state hospitals and work within other areas of DSHS, such as the Drugs and Medical Devices program, the Kidney Health Program and the agency's Pharmacy Branch.

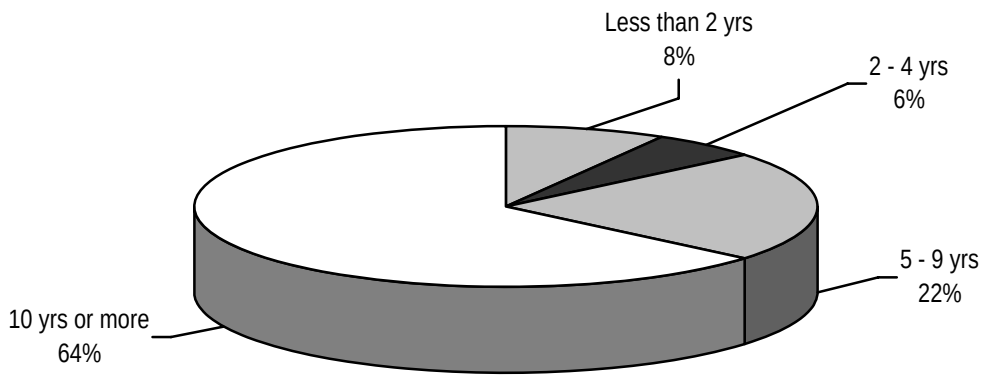
The typical Pharmacist is about 53 years old and has an average of 15 years of state service. Sixty-four percent (64%) of these employees have 10 or more years of service.[299]

Figure 110: Pharmacist IIs at DSHS – Distribution of Age



[296] Arlene Dohm and Lynn Shniper, "Occupational employment projections to 2016" Monthly Labor Review, November 2007, web page http://www.bls.gov/opub/mlr/2007/11/art5full.pdf, last accessed on 3/9/08).
[297] Ibid.
[298] HHSAS Database, as of 8/31/07.
[299] Ibid.

Figure 111: Pharmacist IIs at DSHS – Length of State Service



Pharmacists at DSHS earn, on average, an annual salary of $88,388.[300] This salary falls significantly below the market rate. The average annual salary for Pharmacists nationally is $93,500 and $96,290 in Texas.[301]

Though the annual turnover rate for Pharmacists is low at about 14 percent, approximately 44 percent of these highly skilled and tenured employees will be eligible to retire by 2012.[302]

Higher starting salaries and increasing the salary levels for current pharmacists will assist with recruitment and retention efforts of this occupational group.

Medical Technologists

There are about 20 Medical Technologists at DSHS.[303] These laboratory employees are critical to providing efficient and quality healthcare.

DSHS Medical Technologists have, on average, about six years of state service, with an average age of approximately 39 years.[304]

[300] HHSAS Database, as of 8/31/07.
[301] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.
[302] HHSAS Database, FY 2007 data.
[303] HHSAS Database, as of 8/31/07.
[304] Ibid.

Figure 112: Medical Technologist Is and IIs at DSHS – Distribution of Age

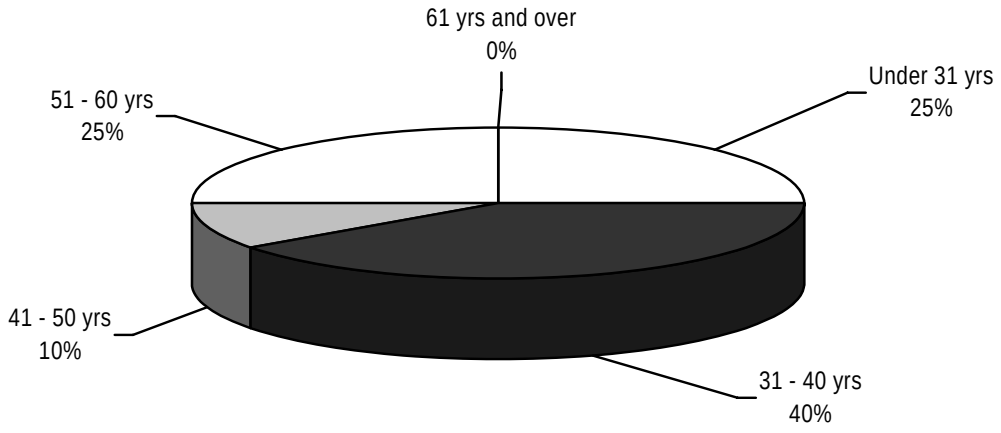
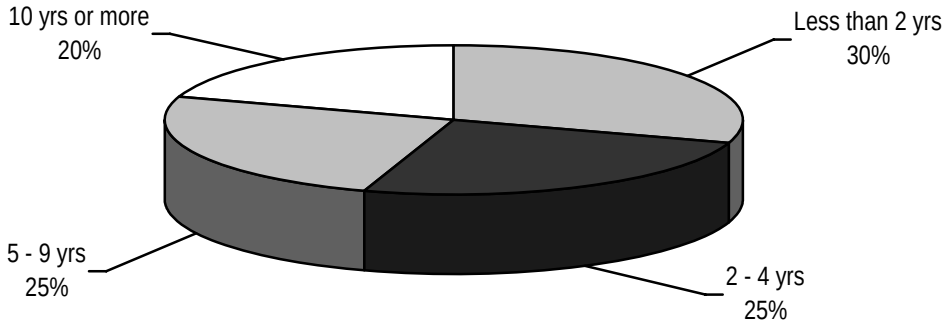


Figure 113: Medical Technologist Is and IIs at DSHS Length of State Service



Turnover for Medical Technologists is considered high at approximately 25 percent. When a vacancy in one of the positions occurs, it is not unusual for the position to go unfilled for several months before a qualified applicant is found. [305]

DSHS Medical Technologists earn, on average, an annual salary of $31,669.[306] This salary falls significantly below the market rate. The average annual salary for Medical and Clinical Laboratory Technologists is $50,550 and $46,730 in

[305] HHSAS Database, FY 2007 data.
[306] HHSAS Database, as of 8/31/07.

Texas. This disparity is affecting the agency's ability to recruit qualified applicants for open positions.[307]

Another factor that contributes to the high turnover rate is the fact that most Medical Technologists are hired at the minimum salary for the position and remain at the low end of the salary scale. Thus, newly hired and inexperienced Medical Technologists receive a salary similar to that of experienced employees in the same position.

Another factor that explains the high turnover rate is the lack of a career ladder. Consequently, there are fewer opportunities for employees to apply for Medical Technologist positions with a higher base salary. Due to the fewer number of higher level positions, less experienced Medical Technologists are leaving the laboratory for job advancement. They are either accepting positions in the private sector with higher pay or with other state agencies that have career ladders/advancement opportunities.

This high turnover affects current staff that are required to devote more time to training new employees and assessing their competency, resulting in a decrease of productivity. In addition, excess strain and fatigue occur for staff that are required to cover duties of vacant positions.

The high turnover and long delays in filling laboratory positions with qualified individuals represent a loss of institutional knowledge that could impact laboratory results that are critical to patient follow up and diagnosis.

Targeted recruitment efforts will continue to ensure a qualified applicant pool is available to select from as vacancies occur.

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

Recruitment Strategies

- Solidify a "pipeline" from academia to DSHS for students to learn about the work of the agency and gain experience, skills and qualifications through internships.

- Continued use of internet-based job postings, billboards, job fairs, professional newsletters, list serves and recruitment firms.

[307] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2006; last accessed on 3/10/08.

- Offer incentives and educational leave to encourage DSHS non-licensed staff in hospitals to train to become RNs or other critical shortage staff.
- Involvement in HHSC System-wide efforts to address health and human services workforce issues, including recruitment of staff to fill essential positions.
- Continued posting of difficult-to-recruit positions in professional publications.
- Recruit individuals from diverse academic institutions.
- Review current Sanitarian salaries from local health departments, industry and the federal government and make necessary salary adjustments.
- Request the creation of a trainee classification for individuals to gain the necessary experience to become a Sanitarian.
- Evaluate options for paying for continuing education programs.
- Enhance capacity to recruit bilingual Human Services Specialist case managers by providing a salary incentive.
- Consider the use of recruitment bonuses and moving allowances for highly competitive job categories such as Physicians, Psychiatrists and Pharmacists.

Retention Strategies

- Systematic process for audit of job positions to ensure consistency across the agency.
- Involvement in HHSC System-wide efforts to address health and human services workforce issues, including retention of staff filling essential positions.
- The development of a methodology for performance-based merits.
- Use of the DSHS Employee Advisory Committee to identify strategies for retaining staff.
- Explore opportunities for flexible work schedules.

- Continue to provide adequate training to assist employees in preparedness of their jobs and expand opportunities for cross-training.
- Improve supervisory skills to improve the work environment.
- Improve the work environment through provision of adequate technological tools and streamlined business processes.
- Improve employee communications.
- Evaluate the use of career ladders for a limited number of technical classifications and the expansion of the nurse career ladder to address public health nurses.
- Reimburse Architects and Engineers for their license renewal and for the cost of required continuing education.
- Consider opportunities to provide formally approved continuing education for various licensed healthcare professionals that meet requirements for credentialing.

Appendix G

Survey of Organizational Excellence

Introduction

The Survey of Organizational Excellence (SOE) designed by and conducted under contract by the University of Texas School of Social Work, offers participating agencies the opportunity to observe agency employees' perceptions and opinions of their employment experience. Understanding how employees perceive various aspects of the workplace is critical to identifying and successfully implementing needed organizational changes. Data gathered over time provides additional insight into trends in employee perceptions.

In 2008, as in 2006, the five agencies in the Health and Human Services (HHS) System were among the Texas state agencies administering the survey. The administration of the survey in February and March 2008 was primarily handled online, with the notable exception of using of paper surveys for many of the employees of the state mental health and mental retardation facilities who lack ready access to workplace computers. This summary highlights survey results for the HHS Enterprise as a whole. Each agency in the Enterprise has also prepared a summary of its own results and is responsible for communicating results to its employees and determining appropriate follow up actions.

Response Rate

The University of Texas School of Social Work views the percentage of agency employees participating in the SOE as an indicator of organizational health, with higher response rates being an indicator of healthy investment by employees in an organization. Response rates greater than 50 percent, and response rates that are rising over time, are viewed as positive, while response rates lower than 30 percent may indicate a strong basis for concern. In 2008, 48,923 surveys were distributed to HHS System employees, with 23,060 employees providing responses. The response rate of 47percent was a modest decrease from the 2006 response rate. This is viewed as an

average response rate. The response rates listed below for each agency in the HHS System show that DARS again had an exemplary response rate, with DFPS also registering a high response rate again.

Table G.1
2008 SOE Response Rates for Agencies in the HHS System

	2006	208
HHSC	53%	45%
DADS	41%	32%
DARS	82%	82%
DFPS	66%	67%
DSHS	46%	41%

Table G.1: Health and Human Services, 2008.

Structure of the SOE

The SOE addresses five workplace dimensions: work group, physical work setting/accommodations, organizational features, communication patterns, and personal demands. Together these dimensions reflect aspects of the total work environment.

Twenty survey constructs support the five workplace dimensions. The constructs are designed to profile organizational strengths and weaknesses so that interventions can be targeted appropriately. These constructs, which are sets of related questions, offer data about how employees view the organization. They provide management with information about what actions might strengthen the organization. In addition to the dimensions and constructs, which are based on 76 questions used statewide in the administration of the SOE, the HHS Enterprise agencies also included in the survey 12 questions designed by each agency for its own use and 7 questions used at all Enterprise agencies.

Scores for the constructs range from a low of 100 to a high of 500, with 300 as the neutral point on the scoring continuum. Scores greater than 300

suggest that employees perceive a construct more positively than negatively, and scores of 400 or greater indicate areas of substantial strength. Conversely, scores below 300 indicate employee perceptions leaning to the negative, and scores below 200 should be viewed as a source of significant concern and receive immediate attention.

Highlights of HHS Enterprise Results

This section addresses highlights of the survey results for the HHS Enterprise at the construct level. As indicated in Figure G.1, with one exception the construct scores for the HHS Enterprise were clustered in a modestly to moderately positive range of between 312 and 363. Perhaps the most noteworthy and encouraging result for HHS Enterprise agencies in the 2008 results is that the scores increased for all constructs, an indication of broadly improving employee perceptions just a few years after undergoing agency restructuring and as other fundamental changes continue.

HHS employees gave their highest score to the Strategic construct. This indicates a strong degree of confidence in the ability of the HHS System agencies to respond to external factors that play a role in defining the organizations' missions, visions, and services. Implied in this construct is the ability to understand the environment and to seek out and work with relevant external stakeholders.

Closely related to the Strategic construct is the Quality construct, which received the second highest score. This construct focuses on the extent to which quality principles such as customer service and continuous improvement are part of the organizational culture. This construct also addresses the degree to which employees feel they have the resources to deliver quality services. Implied in this construct is a good understanding of the needs of customers, consumers, or clients, and a zealous drive to meet those needs.

Most noteworthy in terms of a result on the negative side are employee perceptions reflected in the Fair Pay construct. As in 2006, this was by far the lowest-scoring construct for HHS System employees. This construct consists of questions relating to whether salaries keep up with inflation, whether salaries are competitive with similar jobs in an employee's community, and whether people are paid fairly for their work. A score of 202 on the question of whether pay keeps up with rising living costs pulled down the score for this construct to the 224 shown for this construct in Figure G.1, on page G-5.

The scores on the HHS Enterprise level for the seven questions included specifically for use by the HHS agencies are another very positive outcome of the SOE in 2008. One positive aspect of these results was that, with the exception of one neutral score, these scores were all in a mild to moderately positive range of 3.13 to 3.25. In 2006, only one of these seven questions yielded a score of 3.0 or above across the HHS Enterprise. Those questions all addressed perceptions of employees relating to the more integrated HHS Enterprise created pursuant to House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003. The marked improvement on these questions indicates employee perceptions are positive and improving on items such as the level of coordination among HHS System agencies, whether client services are improving, employees' feeling a part of and understanding the broader HHS Enterprise, and the support employees receive from other HHS agencies. Improvement was also registered on whether employees felt recent changes were enabling them to be more efficient or effective in their work, a question on which the overall result was neutral.

Figure G.1.
FY 2008 SOE Survey Constructs for HHS Enterprise

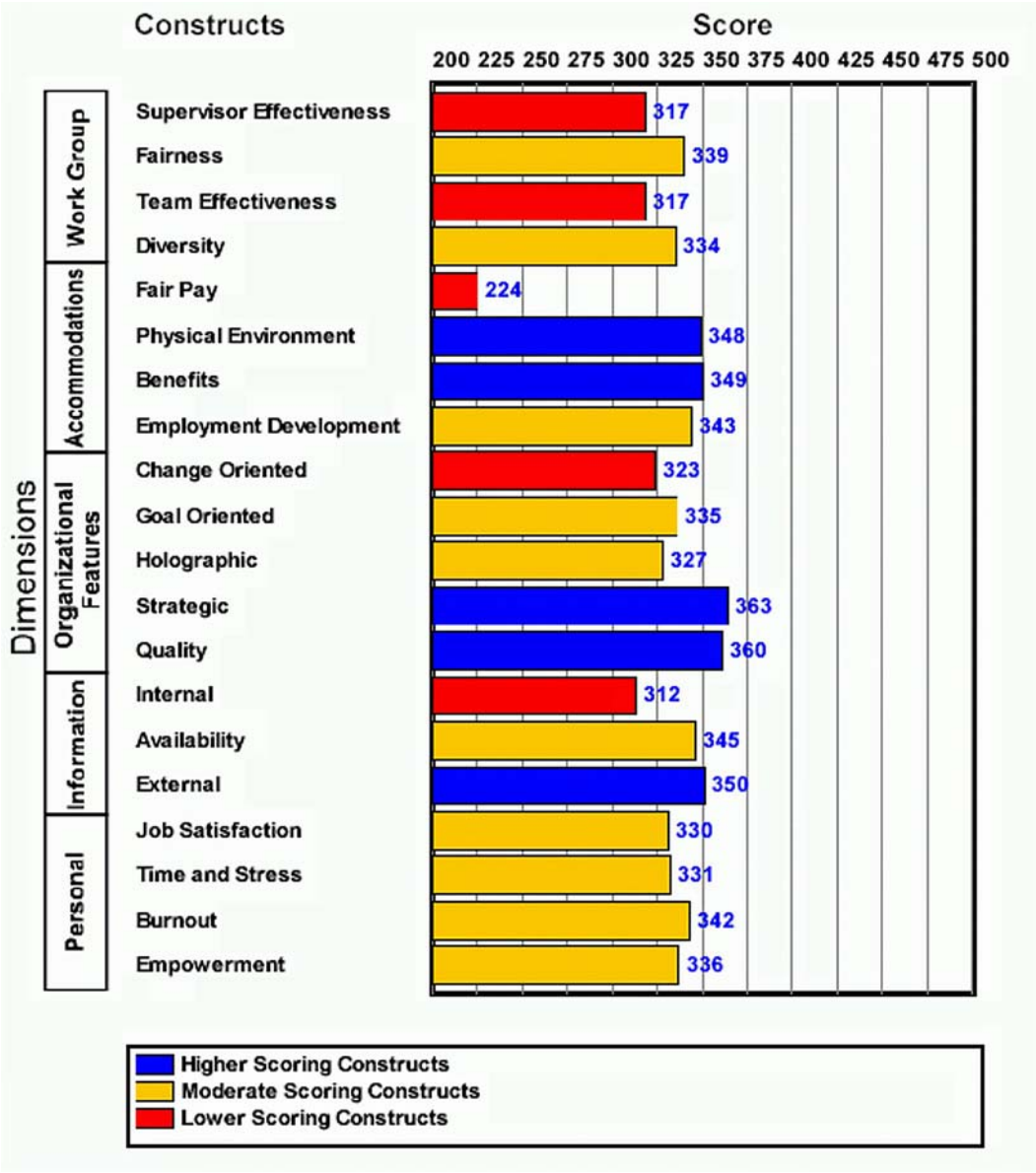


Figure G.1: University of Texas School of Social Work, HHS System Survey of Organizational Excellence, 2008, and HHSC Planning and Project Management.

Appendix H

Workforce Development System Strategic Planning

Introductory Note

This Appendix is submitted in accordance with Texas Government Code, §§2308.1015 and 2308.104. This statutory mandate requires the Texas Workforce Investment Council (TWIC or the Council) to facilitate the seamless delivery of integrated workforce services to the state. The Council is required to develop a strategic plan that establishes the framework for budgeting and operating a workforce development system (including school-to-careers and welfare-to-work components) administered by agencies represented on the Council. This plan must include two types of performance measures, including formal measures identifying outcomes that are essentially consistent across all workforce programs, and less formal measures to provide information determined by the Council to be essential in developing the strategic plan.

The Council is required to evaluate the agencies' workforce programs to identify duplication, gaps, or problems that adversely affect the seamless delivery of services. The Council develops and implements long-range strategies to address the identified problems, identifies the agencies responsible for these strategies, and establishes a timeline for implementation.

Appendix G was developed with guidance from the LBB instructions and guidance and a template from TWIC. Through this planning activity, the Health and Human Service Commission (HHSC) and the Department of Assistive and Rehabilitative Services (DARS) work together with TWIC to improve workforce development services.

TWIC Instructions on Programmatic Measures

Part 1a. Indicate each programmatic Long Term Objective that applies to your agency and its workforce programs. Provide specific page numbers where applicable references may be found within the agency strategic plan.

✓	Page Number	Destination 2010: FY2004-FY2009 Strategic Plan for the Texas Workforce Development System Long Term Objectives	LTO ID#
		Programmatic Long Term Objectives	
		Increase the percentage of adult education students completing the level enrolled from 64 percent to 70 percent by Q4/2007.	CU3.0
		Increase the percentage of adult education students receiving a high school diploma or GED from 6.7 percent to 10 percent by Q4/2007.	CU3.1
		Increase job placements as a result of SEP mature worker programs and services from 17percent to 25 percent by Q4/2005	CU3.2
		Increase academic and future workplace success of youth by increasing the HS graduation and/or certification (GED) rates from 92.5 percent to 95 percent by Q4/2007.	CU3.3
		Reduce the percentage of student dropouts from public schools between grades 7 and 12 from 8.6 percent to 6.6 percent by Q4/2007.	CU3.4
		Increase the percentage of exiting secondary students pursuing academic and/or workforce education from 75.3 percent to 76 percent by Q4/2007.	CU3.5
		Increase TX higher education participation rate from 5 percent to 5.2 percent (150,000 additional students) by Q4/2005.	CU3.6
		Increase the number of certificates, associates and bachelors degrees awarded annually by 50 percent to 134,000 by 2005.	CU3.7
		Sustain job placements for students exiting post secondary programs at a total annual rate of 80 percent or greater.	CU3.8
✓	78-79	Decrease number of TANF recipients cycling on and off TANF.	CU3.9

		Establish a standard for job placement for adult and youthful offenders prior to release by Q4/2004. Increase the percentage of adult offenders placed in jobs prior to release by 5 percent per year to Q4/2009. Increase constructive activity rate for youthful offenders by 5 percent per year to Q4/2009.	CU4.0
✓	132-137	Increase the percentage of persons receiving vocational rehabilitation services from the Department of Assistive and Rehabilitative Services (DARS) who remain employed after exiting the program.	CU5.0

HHS System Response to Programmatic Measures

Please see page numbers referenced in the table.

TWIC Instructions on System Measures

Part 1b. Indicate each system Long Term Objective, as applicable, in which your agency is a participant. If applicable, provide specific page number references where discussion of these Long Term Objectives may be found within the agency strategic plan.

☑	Page Number	Destination 2010: FY2004-FY2009 Strategic Plan for the Texas Workforce Development System Long Term Objectives	LTO ID#
		System Long Term Objectives	
✓	(Please see note below.)*	All system partners and associated workforce service providers will participate in the scope and development of a system-wide universal information gateway designed to provide a	SI2.0

* The Division for Rehabilitation Services and the Division for Blind Services of DARS fulfill their responsibilities for long-term objectives SI2.0, CU1.0, and CU2.0 by their involvement in the System Integration Technical Advisory Committee.

		consistent and universal framework for all system customers and provider information on system projects, services and solutions. System providers will achieve uniform utilization by Q4/2005 and uniform utilization by TWDS customers by Q2/2006.	
✓	(Please see note below.)*	Increase system-wide, the number of employers using TWDS products and services by a percentage growth rate to be determined by Q4/2009.	CU1.0
✓	(Please see note below.)*	Employer Customer Satisfaction levels in system programs and services will increase as determined by the combined satisfactory and above satisfactory categories in the Council's System Employer Survey.	CU2.0
		Achieve job growth increases of 18 percent from 2000 to 2010.	SC1.0
		Develop, approve, fund and implement a strategic alliance business model that targets a minimum of three strategic industry clusters by Q1/2006. These alliances are targeted to industries that hold long-term strategic relevance to the State.	SC2.0
		Expand existing program or create a new program that enables employers to directly, readily and accountably access funds for new hire or incumbent worker training by Q2/2005.	SC3.0
		Design and implement a methodology and system for identifying and assessing employer needs with the first complete assessment and recommendations delivered by Q1/2005.	SC4.0
		Develop system to review workforce education programs and make recommendations to revise or retire them as appropriate to the current and future workforce needs identified in coordination with employers.	SC5.0
		Increase the awareness, access rates, participation, and relevance of services to small and mid-size businesses throughout the State. The results of these efforts will achieve an increase in usage (to be determined) of TWDS products, services, and solutions.	SC6.0

* The Division for Rehabilitation Services and the Division for Blind Services of DARS fulfill their responsibilities for long-term objectives SI2.0, CU1.0, and CU2.0 by their involvement in the System Integration Technical Advisory Committee.

TWIC Narrative Instructions

Part 2. Provide a brief narrative description of the activities and programs your agency is implementing or plans to implement within the context of agency's workforce Strategy Statement included in Destination 2010: Fiscal Years 2005-2009 Strategic Plan for the Texas Workforce Development System.

Within this narrative please provide specific information regarding your agency's efforts in the following issue areas:

1. **Systems/method to ensure accountability to customers (employers and participants), i.e. customer satisfaction surveys, etc.**

2. **How do you secure and support retention of customer (participant) employment opportunities?**

3. **Capacity for coordination and sharing of information, data, and analyses with other system partners as it relates to workforce programs, services, and initiatives. For example, this may include planning and implementation of joint data projects, Memorandums of Understanding (MOU), etc.**

HHS System Narrative Response

With the structural changes of H.B. 2292, the old Strategy Statements referenced in the instructions no longer apply. Instead of aligning comments with the legacy DHS Strategy Statement, HHSC has provided comments on its vision and activities. Instead of addressing the separate legacy Strategy Statements of TCB and TRC, DARS has provided comments on its vision and activities.

Issue Area 1: Ensuring Accountability to Consumers

Health and Human Services Commission

The Health and Human Services Commission conducts surveys of its consumers on a regular basis. In response to stakeholder input, HHSC strives to improve the delivery of customer service by reviewing and streamlining business and policy development processes. HHSC continues

to explore formal methodologies to obtain consumer input about Medicaid, CHIP, and other agency programs. In addition to these formal evaluation efforts, HHSC utilizes a variety of less formal methods to solicit customer input, such as public forums, focus groups, advisory groups, public hearings, and web-based sites that receive and respond to issues and legislative inquiries.

The HHSC Medicaid/CHIP division provides health care to eligible adults and children. Customer satisfaction evaluations are an ongoing activity in the Texas Medicaid/CHIP program. For example, the Institute for child Health Policy, HHSC's contracted External Quality Review Organization, annually conducts a formal Consumer Assessment of Health Plans for clients in Medicaid Managed Care and CHIP health plans. The HHSC Ombudsman office receives consumer issues and complaints and coordinates across the HHS Enterprise to achieve resolution.

Department of Assistive and Rehabilitative Services

The Division for Blind Services (DBS) and the Division for Rehabilitation Services (DRS) conduct surveys of consumers exiting the program to determine the level of satisfaction with the services provided. This survey includes consumers who exit as successful (with an employment outcome), as well as those who exit as unsuccessful with a plan. An independent contractor conducts these surveys to ensure the results are an objective measure of consumer satisfaction.

Issue Area 2: Securing and Supporting Consumer Employment Retention

Health and Human Services Commission

In the Texas Works Program, an eligibility point is to ensure that all TANF and Food Stamp consumers who are non-exempt from work requirements are referred to the Texas Workforce Commission (TWC). Texas Workforce Commission staff works with these clients to help them obtain a job or training as needed. If a consumer does not comply with work requirements, then TWC sends eligibility staff a request to sanction the consumer. Benefits are restricted until the consumer achieves compliance. The consumer is eligible to receive benefits following policy guidelines when the consumer cooperates.

Department of Assistive and Rehabilitative Services

The Division for Blind Services and the Division for Rehabilitation Services provide follow-up for a period of at least 90 days after the consumer begins working to ensure the employment is suitable for the consumer. This follow-

up period is extended when necessary (based on the individual needs of consumers). A wide range of services may be provided during this time when necessary to assist the consumer with maintaining the employment. When the consumer exits, each consumer is advised to contact the vocational rehabilitation counselor at any time in the future if it appears that additional services are needed.

Issue Area 3: Capacity for Data Coordination

Health and Human Services Commission

The Commission and TWC have a memorandum of understanding to share information as it relates to workforce programs, services, and initiatives. The eligibility system currently has automated interfaces to share information with TWC regarding consumers who are required to comply with work requirements.

Department of Assistive and Rehabilitative Services

The Division for Blind Services and the Division for Rehabilitation Services have a memorandum of understanding with the Texas Workforce Commission and other workforce partners. In addition, local memoranda of understanding exist with 27 of the 28 local workforce boards. The local memoranda of understanding address issues such as the following:

- Methods for referring consumers for services;
- Services typically provided by each of the workforce partners; and
- Technical assistance available to the local workforce boards and local workforce centers provided by DRS and DBS regarding effective service provision for persons with disabilities.

Appendix I

Glossary of Acronyms

ACRONYM	FULL NAME
AAA	Area Agency on Aging
AAS	Access and Assistance Services
ACF	Administration for Children and Families
ACS	American Community Survey
ADRC	Aging and Disability Resource Center
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
APS	Adult Protective Services
ASD	Autism Spectrum Disorders
BCVDD	Blind Children's Vocational Discovery and Development
BEST	Blindness Education, Screening, and Treatment
BET	Business Enterprises of Texas
BMI	Body-Mass Index
BPIP	Business Planning and Improvement Process
BRFSS	Behavioral Risk Factor Surveillance System
CACFP	Child and Adult Care Food Program
CAFM	Computer-Assisted Facility Management
CAPTA	Child Abuse Prevention and Treatment Act
CBA	Community Based Alternatives
CCL	Child Care Licensing
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Service
CHD	Coronary Heart Disease
CHIP	Children's Health Insurance Program
CIL	Center for Independent Living
CISM	Critical Incident Stress Management
CLASS	Community Living Assistance and Support Services
CMPAS	Consumer Managed Personal Assistance Services
CMS	Centers for Medicare and Medicaid Services

COBRA	Consolidated Budget Reconciliation Act
COG	Council of Government
COPSD	Co-Occurring Psychiatric and Substance Use Disorders
CPS	Child Protective Services
CRCG	Community Resource Coordination Group
CRO	Civil Rights Office
CRS	Comprehensive Rehabilitation Services
CSFP	Commodity Supplemental Food Program
CSHCN	Children with Special Health Care Needs
CSP	Coordinated Strategic Plan
CVD	Cardiovascular Disease
CWP	Consolidated Waiver Program
CYD	Community Youth Development
DADS	Department of Aging and Disability Services
DAHS	Day Activity and Health Services
DARS	Department of Assistive and Rehabilitative Services
DBMD	Deaf-Blind with Multiple Disabilities
DBS	Division of Blind Services
DDS	Disability Determination Services
DFPS	Department of Family and Protective Services
DHHS	Deaf and Hard of Hearing Services
DHS	Department of Human Services
DIR	Department of Information Resources
DM	Disease Management
DRA	Deficit Reduction Act
DRS	Division for Rehabilitation Services
DSH	Disproportionate Share Hospital
DSHS	Department of State Health Services
DSI	Disability Service Improvement
DTaP	Diphtheria-Tetanus-Pertussis
EBT	Electronic Benefit Transfer
ECI	Early Childhood Intervention
HER	Electronic Health Records
EMS	Emergency Medical Services
ESRD	End-Stage Renal Disease
FBSS	Family Based Safety Services
FGDM	Family Group Decision Making

FMAP	Federal Medical Assistance Percentage
FMNP	Farmer's Market Nutrition Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FVP	Family Violence Program
GAO	General Accountability Office
GOBPP	Governor's Office of Budget, Planning and Policy
HCS	Home and Community-Based Services
HCSSA	Home and Community Support Services Agencies
HERR	Health Education and Risk Reduction
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
HUB	Historically Underutilized Businesses
ICF-MR/RC	Intermediate Care Facility for Persons with Mental Retardation or Related Conditions
ICM	Integrated Care Management
IDEA	Individuals with Disabilities Education Act
IDEAS	Infectious Disease Epidemiology and Surveillance
IEE	Integrated Eligibility and Enrollment
IL	Independent Living
ILC	Independent Living Center
IMPACT	Information Management Protecting Adults and Children in Texas
IMR	Infant Mortality Rate
IRSP	Information Resources Strategic Plan
IT	Information Technology
IVR	Interactive Voice Response
JCAHO	Joint Commission on Accreditation of Health Care Organizations
KHC	Kidney Health Care
LAR	Legally-authorized Representative
LEP	Limited English Proficiency
LIMS	Laboratory Information Management Systems
LMHA	Local Mental Health Authority
LTC	Long-term Care

MDCP	Medically Dependent Children Program
MFP	Money Follows the Person
MH	Mental Health
MMR	Measles, Mumps, and Rubella
MR	Mental Retardation
MRA	Mental Retardation Authority
NATCEP	Nurse Aide Training and Competency Evaluation Programs
NFFVP	Nursing Facility Financial Viability Project
NIS	National Immunization Survey
NPAOP	Nutrition, Physical Activity and Obesity Program
NSLP	National School Lunch Program
NUPAWG	Nutrition and Physical Activity Workgroup
OAA	Older Americans Act
OBRA	Omnibus Budget Reconciliation Act of 1993
OCA	Office of Court Administration
OECC	Office of Early Childhood Coordination
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPV/IPV	Polio Vaccine
OSAR	Outreach, Screening, Assessment and Referral
OSEP	Office of Special Education Programs
PACE	Program for All-Inclusive Care of the Elderly
PASARR	Pre-Admission Screening and Annual Resident Review
PCCM	Primary Care Case Management
PCS	Purchased Client Services
PCPE	Prevention Counseling and Partner Elicitation
PEI	Prevention and Early Intervention
PHC	Primary Home Care
PIP	Program Improvement Plan
PIAC	Promoting Independence Advisory Committee
PII	Promoting Independence Initiative
PIP	Promoting Independence Plan
Q & A	Question and Answer
QA & I	Quality Assurance and Improvement
QRS	Quality Reporting System
RDM	Resiliency and Disease Management
RGSC	Rio Grande State Center

SBP	School Breakfast Program
SDC	State Data Center
SFSP	Summer Food Service Program
SHCC	Statewide Health Coordinating Council
SILC	State Independent Living Center
SMHF	State Mental Health Facility
SMHH	State Mental Health Hospital
SMP	School Milk Program
SMRF	State Mental Retardation Facilities
SNAP	Simplified Nutrition Assistance Program
SNP	Special Nutrition Program
SOC	State Operations Center
SPAN	School Physical Activity and Nutrition
SRO	Service Responsibility Option
SSA	Social Security Administration
SSAB	Social Security Advisory Board
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STAR	Services to At-Risk Youth
STAR	State of Texas Access Reform
STD	Sexually Transmitted Disease
STHCS	South Texas Health Care System
SUA	State Unit on Aging
SVP	Sexually Violent Predators
SWI	Statewide Intake
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TBI	Traumatic Brain Injury
TCADA	Texas Commission on Alcohol and Drug Abuse
TCAPDD	Texas Council on Autism and Pervasive Developmental Disabilities
TCDD	Texas Council for Developmental Disabilities
TCID	Texas Center for Infectious Disease
TCM	Targeted Case Management
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDC	Texas Diabetes Council
TDH	Texas Department of Health

TDI	Texas Department of Insurance
TKIDS	Texas Kids Information Data System
TDMHMR	Texas Department of Mental Health and Mental Retardation
TEXCAP	Texas Commodity Assistance Program
THSteps	Texas Health Steps (formerly EPSDT)
TIERS	Texas Integrated Eligibility Redesign System
TIRN	Texas Information and Referral Network
TIS	Texas Immunization Survey
TVRC	Transition Vocational Rehabilitation Counselors
TWC	Texas Workforce Commission
TWIC	Texas Workforce Investment Council
TxHmL	Texas Home Living Waiver Program
UPL	Upper Payment Limits
USDA	United States Department of Agriculture
VAWP	Violence Against Women Plan
VR	Vocational Rehabilitation
VRC	Vocational Rehabilitation Counselor
VSAT	Very Small Aperture Terminal
WHCoA	White House Conference on Aging
WHL	Women's Health Laboratory
WIA	Workforce Investment Act
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
WIN	WIC Information Network
YRBS	Youth Risk Behavior Survey

Appendix J

Statutory References by Goals

The following statutes affect agencies in the health and human services (HHS) system generally.

- 42 U.S. Code, Sections 1397-1397f. (Block Grants to States for Social Services)
- 42 U.S. Code, Chapter 126. (Equal Opportunity For Individuals With Disabilities, also known as the Americans with Disabilities Act)
- Texas Government Code, Chapter 531. (Health and Human Services Commission)
- Texas Government Code, Title 10. (General Government)
- S.B. 1, 79th Legislature, Regular Session, 2005. (2006-07 General Appropriations Act)

All the HHS agencies comply with the following federal statutes: the Civil Rights Acts, the Age Discrimination Act of 1975, the Equal Employment Opportunities Act of 1972, and the Pregnancy Discrimination Act.

Health and Human Services Commission

Goal 1: HHS Enterprise Oversight and Policy

- Texas Government Code, Chapter 531. (Health and Human Services Commission)

Goal 2: Medicaid

- 42 U.S. Code, Sections 1396-1396v. (Grants to States for Medical Assistance Programs, also known as Medicaid)
- Texas Government Code, Chapter 533. (Implementation of Medicaid Managed Care Program)

- Texas Government Code, Chapter 534. (Locally Based Medicaid and Other Related Health Care Initiatives)
- Texas Human Resources Code, Chapter 32. (Medical Assistance Program, also known as Medicaid)

Goal 3: CHIP Services

- 42 U.S. Code, Sections 1397aa-1397jj. (State Children's Health Insurance Program (CHIP))
- Texas Health & Safety Code, Chapter 62. (Child Health Plan for Certain Low-Income Children (CHIP))

Goal 4: Encourage Self Sufficiency

- 7 U.S. Code, Chapter 51. (Food Stamp Program)
- 7 U.S. Code, Chapter 102. (Emergency Food Assistance)
- 8 U.S. Code, Chapter 12. (Immigration and Nationality)
- 42 U.S. Code, Sections 601-619. (Block Grants to States for Temporary Assistance for Needy Families)
- 42 U.S. Code, Sections 651-669b. (Child Support and Establishment of Paternity)
- 42 U.S. Code, Sections 670-679b. (Federal Payments for Foster Care and Adoption Assistance)
- 42 U.S. Code, Chapter 13. (School Lunch Programs)
- 42 U.S. Code, Chapter 13A. (Child Nutrition)
- 42 U.S. Code, Chapter 67. (Child Abuse Prevention and Treatment and Adoption Reform)
- 42 U.S. Code, Chapter 110. (Family Violence Prevention and Services)
- Texas Family Code, Chapter 231. (Title IV-D Services)
- Texas Government Code, Chapter 752. (Immigration)
- Texas Health & Safety Code, Chapter 63. (Health Benefits Plan for Certain Children (for immigrant children in low-income families))
- Texas Human Resources Code, Chapter 31. (Financial Assistance and Service Programs)
- Texas Human Resources Code, Chapter 33. (Nutritional Assistance Programs)
- Texas Human Resources Code, Chapter 34. (State Temporary Assistance and Support Services Program)
- Texas Human Resources Code, Chapter 51. (Family Violence Centers)

Department of Aging and Disability Services

The following statutes affect the Department of Aging and Disability Services generally.

- 42 U.S. Code, Sections 1395-1395hhh. (Health Insurance for Aged and Disabled, also known as Medicare)
- 42 U.S. Code, Sections 1396-1396v. (Grants To States For Medical Assistance Programs, also known as Medicaid)
- 42 U.S. Code, Chapter 35. (Programs for Older Americans, also known as the Older Americans Act)
- Texas Health & Safety Code, Title 7. (Mental Health and Mental Retardation)
- Texas Human Resources Code, Chapter 22. (General Functions of Department Of Human Services)
- Texas Human Resources Code, Title 6. (Services for the Elderly, including the authorizing statute for the legacy Texas Department on Aging)
- Texas Human Resources Code, Title 11. (Aging, Community-Based, and Long-Term Care Services)
- Texas Probate Code, Chapter XIII. (Guardianship)

Goal 1: Long Term Care Services and Supports

- Texas Government Code, Section 531.043. (Long-Term Care Vision)
- Texas Government Code, Chapter 2109. (Volunteers)
- Texas Human Resources Code, Chapter 32. (Medical Assistance Program)
- Texas Human Resources Code, Chapter 35. (Support Services for Persons with Disabilities)

Goal 2: Regulation, Certification, and Outreach

- Texas Health & Safety Code, Chapter 142. (Home and Community Support Services)
- Texas Health & Safety Code, Chapter 242. (Convalescent and Nursing Homes and Related Institutions)
- Texas Health & Safety Code, Chapter 247. (Assisted Living Facilities)
- Texas Health & Safety Code, Chapter 252. (Intermediate Care Facilities for the Mentally Retarded)
- Texas Health & Safety Code, Chapter 255. (Quality Assurance Early Warning System for Long-Term Care Facilities; Rapid Response Teams)

Department of Assistive and Rehabilitative Services

The following statutes affect the Department of Assistive and Rehabilitative Services generally.

- Texas Human Resources Code, Chapter 73. (Interagency Council On Early Childhood Intervention Services)
- Texas Human Resources Code, Chapter 81. (Texas Commission for the Deaf and Hard of Hearing)
- Texas Human Resources Code, Chapter 91. (Texas Commission for the Blind)
- Texas Human Resources Code, Chapter 111. (Texas Rehabilitation Commission)
- Texas Human Resources Code, Chapter 117. (Department of Assistive and Rehabilitative Services)

Goal 1: Children with Disabilities

- 20 U.S. Code, Chapter 33. (Education of Individuals with Disabilities, also known as the Individuals with Disabilities Education Act)

Goal 2: Persons with Disabilities

- 20 U.S. Code, Chapter 6A. (Vending Facilities for Blind in Federal Buildings)
- 20 U.S. Code, Chapter 33. (Education of Individuals with Disabilities, also known as the Individuals with Disabilities Education Act)
- 29 U.S. Code, Chapter 16. (Vocational Rehabilitation and Other Rehabilitation Services)
- 29 U.S. Code, Chapter 30. (Workforce Investment Systems)
- Texas Education Code, Section 29.011. (Transition Planning)
- Texas Education Code, Section 54.205. (Blind, Deaf Students)
- Texas Human Resources Code, Chapter 82. (Confidentiality of Interpreted, Transliterated, or Relayed Conversations)
- Texas Human Resources Code, Chapter 94. (Vending Facilities Operated by Blind Persons)
- Texas Utilities Code, Section 56.151. (Specialized Telecommunications Assistance Program)

Goal 3: Disability Determination

- 42 U.S. Code, Sections 421, 423, 1382, and related sections. (Social Security Act: Federal Old-Age, Survivors, and Disability Insurance Benefits)

Department of Family and Protective Services

The following statute affects the Department of Family and Protective Services generally.

- Texas Human Resources Code, Title 2. (Department of Human Services and Department of Protective and Regulatory Services)

Goal 1: Protective Services

- 42 U.S. Code, Sections 620-629i. (Child and Family Services)
- 42 U.S. Code, Sections 670-679b. (Federal Payments for Foster Care and Adoption Assistance)
- Texas Family Code, Title 5. (The Parent-Child Relationship and the Suit Affecting the Parent-Child Relationship)
- Texas Government Code, Section 411.114. (Access to Criminal History Record Information: Department of Protective and Regulatory Services)
- Texas Government Code, Section 531.0162. (Use of Technology)
- Texas Government Code, Section 531.048. (Caseload Standards)
- Texas Government Code, Section 531.078. (Pooled Funding for Foster Care Preventive Services)

Goal 2: Indirect Administration

Goal 3: CPS Reform

- Texas Government Code, Section 2155.1442. (Foster Care Residential Contract Management)

Department of State Health Services

The following statutes affect the Department of State Health Services generally.

- Texas Health & Safety Code. (all titles)

Goal 1: Preparedness and Prevention Services

- 42 U.S. Code, Sections 300k-300n-5. (Preventive Health Measures with Respect to Breast and Cervical Cancers)
- 42 U.S. Code, Sections 300hh-300hh-13. (National Preparedness for Bioterrorism and Other Public Health Emergencies)
- 42 U.S. Code, Sections 701-710. (Maternal and Child Health Services Block Grant)
- 42 U.S. Code, Sections 1396-1396v. (Grants to States for Medical Assistance Programs, also known as Medicaid)
- Texas Code of Criminal Procedure, Chapter 63. (Missing Children and Missing Persons)
- Texas Family Code, Chapter 2. (The Marriage Relationship)
- Texas Family Code, Title 5. (The Parent-Child Relationship and the Suit Affecting the Parent-Child Relationship)
- Texas Government Code, Chapter 418. (Emergency Management)
- Texas Occupations Code, Chapter 2152. (Regulation of Circuses, Carnivals, and Zoos)

Goal 2: Community Health Services

- 42 U.S. Code, Sections 300-300a-8. (Population Research and Voluntary Family Planning Programs)
- 42 U.S. Code, Sections 300x-300x-66. (Block Grants Regarding Mental Health and Substance Abuse)
- 42 U.S. Code, Sections 701-710. (Maternal and Child Health Services Block Grant)
- Texas Code of Criminal Procedure, Articles 16.22, 17.032, and 42.12. (concerning defendants with mental illness)
- Texas Code of Criminal Procedure, Chapter 46. (Insanity As Defense)
- Texas Code of Criminal Procedure, Chapter 46b. (Incompetency to Stand Trial)

- Texas Education Code, Chapter 38. (Health and Safety)
- Texas Family Code, Chapter 55. (Proceedings Concerning Children with Mental Illness or Mental Retardation)

Goal 3: Hospital Facilities and Services

- Texas Code of Criminal Procedure, Chapter 46. (Insanity As Defense)
- Texas Code of Criminal Procedure, Chapter 46b. (Incompetency to Stand Trial)
- Texas Family Code, Chapter 55. (Proceedings Concerning Children with Mental Illness or Mental Retardation)

Goal 4: Consumer Protection Services

- Texas Alcoholic Beverage Code, Section 106.115. (Attendance at Alcohol Awareness Course; License Suspension)
- Texas Code of Criminal Procedure, Article 42.12, Section 11 (a) (15). (Basic Conditions of Community Supervision)
- Texas Insurance Code, Section 1355.058. (Assistance of the Texas Department of Mental Health and Mental Retardation)
- Texas Insurance Code, Chapter 1368. (Availability of Chemical Dependency Coverage)
- Texas Occupations Code, Chapter 104. (Healing Art Practitioners)
- Texas Occupations Code, Chapter 504. (Chemical Dependency Counselors)
- Texas Transportation Code, Sections 521.374-376. (regarding authority to certify drug offender education courses)