**2013-2015 Business Plan**

# Aging and Disability Services Administration

Jane Beyer, Interim Assistant Secretary

September 2012

Washington State
Department of Social
& Health Services

## Vision

Safe, healthy individuals, families, and communities

## Mission

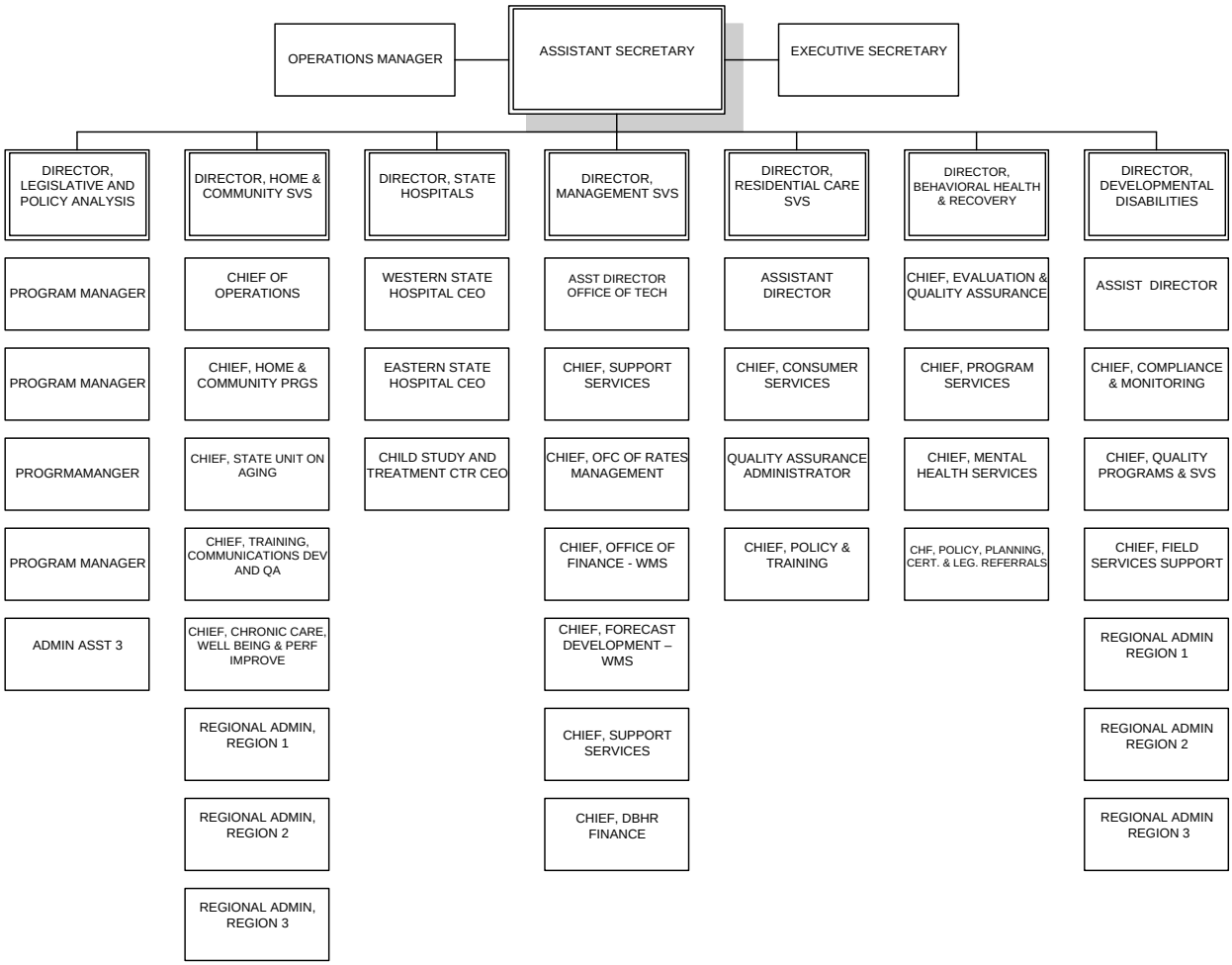
The Department of Social & Health Services will improve the safety and health of individuals, families, and communities by providing leadership and establishing and participating in partnerships.

## Values

Excellence in Service
Respect
Collaboration and Partnership
Diversity
Accountability

# Organizational Chart

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
SEPTEMBER 2012



## Introduction

As part of the Department of Social and Health Services (DSHS), Aging and Disability Services Administration (ADSA) provides support for older people, people with physical and developmental disabilities, and people who face challenges related to chemical dependency or mental illness. As importantly, ADSA supports families and communities who support those same people. ADSA's Business Plan outlines the steps we will take to bring the DSHS 2013-2015 Strategic Plan to life.

ADSA's Business Plan for 2013 to 2015 explicitly focuses on the first three of the five goals in the DSHS Strategic Plan. In each section you will find our vision, values, and the specific steps we plan to take to achieve that vision:

- **Goal 1 – Improve the health status of vulnerable populations,** covers key developmental steps for the systems of support for people with physical or developmental disabilities, and for those with behavioral health challenges. It includes the actions we will take to improve community-based options, to develop health homes for people with chronic conditions, and to capitalize on the opportunities from federal healthcare reform.
- **Goal 2 – Improve economic stability, employment and self-sufficiency,** covers key steps toward better public access to information about available options, support for families, and employment.
- **Goal 3 – Improve individual and public safety**, covers key steps related to facility regulation and complaint investigation.

ADSA's steps toward **Goal 4, Improve individuals' readiness and ability to succeed in school** are integrated in the sections on behavioral health, and on employment of people with developmental disabilities. The strong management practices that respond to **Goal 5, Increase public trust through strong management practices that ensure quality** are embedded in every part of ADSA.

**DSHS Goal 1**
Improve the health status of vulnerable populations.

**DSHS Goal 2**
Improve economic stability, employment and self-sufficiency.

**DSHS Goal 3**
Improve individual and public safety.

**DSHS Goal 4**
Improve individuals' readiness and ability to succeed in school.

**DSHS Goal 5**
Increase public trust through strong management practices that ensure quality and leverage all resources.

## DSHS Goal 1: Improve the health status of vulnerable populations.

**ADSA Strategic Objective 1.1:** Increase the quality and quantity of long-term services and supports for people with physical, cognitive, or developmental disabilities to address the continuing, unprecedented, demographically-driven increasing level of need.

**Why?** So that individuals who are unable to accomplish essential daily living tasks due to disability will have access to a sufficient level of support to maintain health and well-being.

**Strategy 1.1.1: Building the Power of PERSON, the FAMILY and the COMMUNITY to support people with disabilities.**

We believe the system of supports for people with developmental and physical disabilities needs to meet more of the significant and growing unmet need.

We will respond to the shift in consumer preferences toward community integration and self-direction.

We will support individuals to live in, contribute to, and participate in their communities as much as possible.

We will rely on and support shared responsibility with individuals and families to help people with disabilities remain in their home communities. Not only is that the direction preferred by most families and consumers, but it makes the most efficient use of resources.

We will encourage and participate in coordination of supports for people serviced through multiple agencies and administrations.

**We envision:**

- Steady investment in locally available options that help people live, work, and thrive.
- Improved supports for families of both children and adults.
- Individualized supports directed by consumers that allow them to make choices and realize their greatest potential.
- Service plans based on needs and the strengths of the individual and family.
- Addressing the needs of people with disabilities and their families as their situations change -- recognizing that most families continue to provide supports to their family member with disabilities throughout their lives.

**We are successful if people with disabilities:**

- Are healthy and safe,
- Have choices in their lives and services,
- Experience respect, every day relationships, competence, and

- Are involved in their communities.

**In partnership, we <u>will:</u>**

- Listen to individuals with disabilities and families who will tell us what elements need to be enhanced in the system of supports meet their needs.
- Engage individuals, families, communities, local service providers, partners, and other stakeholders in making decisions about services and supports.
- Continue to build a system of supports, based on our commitment, with the resources available.

**For July 1, 2013 to June 30, 2015:**

A. **In support of people with developmental disabilities, we will**:
   1. Develop a strategy for continued investment in the Basic Plus Waiver to prevent crises and increase community capacity, maintaining people with developmental disabilities in their family homes whenever possible.
   2. Develop resources for improved implementation of Therapeutic Options in Residential Habilitation Centers.
   3. Develop community based crisis intervention response teams with support from available Residential Habilitation Center personnel.
   4. Increase access to affordable, accessible housing for people with disabilities.
   5. Increase investment in supports for families as primary caregivers.

**B. In support of people with physical and cognitive disabilities, we will:**
   1. Develop an investment strategy for programs that promote community integration and interdependence.
   2. Expand use of site-based services (such as cluster care).
   3. Provide assistance in obtaining gainful employment.
   4. Develop resources to support nursing home diversion and relocation.
   5. Build additional provider capacity to serve higher acuity clients.
   6. Develop resources for individuals who solely need adaptive equipment.
   7. Improve capacity to support individuals with dementia in all community based settings.
   8. Develop resources to help people with disabilities remain engaged in their communities.
   9. Increase housing resources.

**C. To improve the ability of people with disabilities to direct the supports and the resources spent in their names, we will:**
   1. Develop a framework for stronger participant direction in ADSA programs, including:
      a) Participants engaged in program design, implementation and evaluation.

   b) Increased knowledge of the value of participant directed service delivery options among staff and providers.
   c) Improved staff skill in person-centered planning and self-management models.
2. Evaluate options that increase opportunities for consumer directed supports, ensure people have maximum opportunity options to make individual decisions about how resources are spent, and expand budget-based participant direction.
3. Evaluate the effectiveness of supporting self-sufficiency and independence on health and other outcomes.

**Key Performance Indicators**

1. Percent of long-term care clients served in home and community settings.
2. Percent of clients with developmental disabilities served in home and community settings.
3. Number of people with developmental disabilities DD clients receiving skill training to help them live more independently.

## DSHS Goal 1: Improve the health status of vulnerable populations.

**ADSA Strategic Objective 1.2:** Increase access to behavioral health supports integrated into a person-centered health home.

**Why?** So that individuals who are chemically dependent or who have mental illness are supported in recovery and in building resilience in partnership with clinicians.

**Strategy 1.2.1: Building on the power of PERSON, their FAMILY, and the COMMUNITY to support people who are chemically dependent or who have mental illness.**

We believe people who are chemically dependent or have mental illness can recover.

We will respond to opportunities that build systems of support for individuals as the leaders of their recovery, in partnership with clinicians.

We will support individual resilience, even as circumstances and symptoms change.

We will rely on and support shared responsibility of individuals, families, the medical care system and behavioral health provider networks to help people who are chemically dependent or who have mental illness remain in their home communities.

**We envision:**

- Steady investment in a coordinated system of supports that prevents behavioral health challenges from becoming a barrier to success.
- Treatments, based on the best evidence, provided on an equal footing and fully integrated with other medical and health care.
- Support for the whole person, including their physical, social, employment, and housing support needs.
- Individualized supports directed by consumers that allow them to make choices and realize their greatest potential.
- Crisis and intensive treatment services that support individual and public safety.

**We are successful if people with behavioral health challenges:**

- Are healthy and safe,
- Have choices in their lives and services,
- Can live, work, and learn, free from discrimination, and
- Are involved in their communities.

**In partnership, we will:**

- Engage communities, local service providers, partners, and other stakeholders.
- Listen to individuals with behavioral health needs who will tell us what elements need to be enhanced in the system of supports.
- Continue to build a system of supports, based on our commitment, with the resources available.

**For July 1, 2013 to June 30, 2015:**

A. **To increase access and develop better integration, we will:**
   1. Implement statewide integrated dual disorder treatment for persons with co-occurring mental health and substance use disorders.
   2. Implement collaborative care models to integrate medical and mental health treatment for people most effectively served by mental health clinicians in primary care settings.
   3. Implement strategies to reducing the overuse of polypharmacy and off-label prescriptions in prescribing practices of physicians.
   4. Work with counties, tribes, and community-based providers to ensure availability of high quality substance abuse and mental health-related services across the Prevention/Intervention/Treatment/Aftercare-Support Services (PITA) continuum.
   5. Develop a system of care to address the multiple, complex needs of patients, particularly those who have chronic medical conditions, who suffer from co-occurring mental health and chemical dependency problems, and those who have long-term care needs or needs related to developmental disabilities that may result in placement instability.

B. **To improve economic stability and self-sufficiency, we will:**
   1. Secure funding for rental subsidies, landlord incentives, and ensure necessary services are in place to support development of permanent supportive housing units.
   2. Provide technical assistance to RSNs and mental health providers to develop permanent supportive housing.
   3. Amend the Medicaid waiver and state Medicaid plan for statewide expansion of peer support services provided directly by consumer and family run organizations.
   4. Provide substance abuse treatment and support to National Guard personnel and underserved veterans through the federally funded Access to Recovery (ATR) grant and other avenues.
   5. Provide clinically and culturally competent treatment in a timely manner to problem gamblers and their family members.

6. Expand evidence-based programs for youth-in-transition and other programs and services that support life-skill development and independent living.
7. Improve employment opportunities for individuals with behavioral health challenges.

C. **To Improve the safety and permanency for individuals who are at-risk or who are in state care, treatment, or out-of home placement and to increase public safety, we will:**
1. Integrate alcohol and drug treatment services into drugs courts and other judicially supervised models.
2. Establish a statewide standardized utilization management protocol for both acute and extended inpatient admissions and continuing stays of people with behavioral health needs.
3. Enhance community safety through the timely completion of mental health background checks for concealed pistol permits and gun transfers.
4. Implement 2010 legislative changes in ITA and sentencing laws and statutes for effective ways to treat and detain individuals whose history provides likely predictability for crime or high risk of violence – House Bills 2422*, 2533, 2717 and 3076 and Senate Bill 6610 – (*Governor signed as of 03/18/10).
5. Support enhanced services facilities to provide community-based long-term services and supports for people who are without a community-based option.

**D. In support of people with forensic and civil commitment involvement, we will:**
1. Work toward shifting the locus of care from institutional settings to home and community based settings when appropriate and in the best interest of the individual.
2. Organize and focus institutional resources on short term interventions and stabilization of people with high acuity treatment needs in order to avoid long-term hospitalization.
3. Develop a strategy for the State Hospitals to become fully integrated with existing community-based service delivery systems.
4. Develop and increase available community supports and resources for people upon discharge from a State Hospital.
5. Increase community capacity for forensic competency evaluation and restoration services.

**E. To improve individuals' readiness and ability to succeed in school, we will:**
1. Promote and support the expansion of children's evidence based practices including Wraparound, Multi-Systemic Treatment, Multidimensional Treatment Foster Care, and Trauma-Focused and Cognitive Behavioral Therapies.
2. Support the development of cross-DSHS child/youth financing models for high-risk kids.

3. Support expansion of “Partnerships for Success “model of community development of evidence-based practices to enhance ownership and sustainability of pilots and other implementations.
4. Develop a plan for a new behavioral health service delivery system for children and young adults under age twenty-one that expands access to intensive community-based services (specifics awaiting Legislative and Governor’s action).
5. Support school-based universal, selective, and indicated substance abuse prevention efforts.
6. Maintain an array of intervention, treatment, and aftercare/support services for youth.

**Key Performance Indicators**

1. Percent of mental health consumers receiving an intake service within 14 days of the service request
2. Percent of mental health consumers receiving a service within 7 days after discharge from inpatient setting.
3. Number of adults waiting in jail more than 7 days for inpatient competency evaluations at state hospitals
4. Percent of participants in DBHR-funded recurring prevention programs that are evidence-based.
5. Percent of DSHS clients with indicated behavioral health needs who receive treatment services.
6. Number of children waiting more than 30 days for a Children’s Long-term Inpatient (CLIP) bed
7. Rates of employment and earnings for those receiving Division of Behavioral Health and Recovery chemical dependency treatment

## DSHS Goal 1: Improve the health status of vulnerable populations.

**ADSA Strategic Objective 1.3:** Increase use and coordination of person-centered, chronic care management services.

**Why?** So that individuals with multiple chronic conditions are supported in managing their health conditions and the effect those conditions have on their daily lives. So that individuals and families receive integrated health services, achieve the best possible health and people with disabilities have access to integrated health services appropriate to their needs.

**Strategy 1.3.1: Empowering individuals to manage their health care and mobilizing community resources to meet their needs.**

We believe that individuals have the central role in managing their health and health care.

We will respond to opportunities to build effective, efficient systems of care and self-management support.

We will support individuals to set goals for their health, identify barriers and challenges, and monitor their own conditions.

We will rely on and support shared responsibility of individuals, families, the medical care system, and the provider networks for behavioral health, developmental disabilities and long-term care.

**We envision:**

- Steady investment in proven programs that provide basic information, support and strategies for living with chronic conditions.
- Individuals and a coordinated system of support working together to identify each individual's health challenges, establish goals, and solve problems.
- Service planning that addresses the whole person, including needs related to acute and primary health care, mental health, substance abuse, and short or long-term disabilities.

**We are successful if individuals:**

- Have the confidence and knowledge to take action to maintain or improve their health,
- Are able to stay on course, even under stress,
- Health outcomes improve, and
- Providers throughout the system recognize that the individual is the most important manager of their own health.

**In partnership, we will:**

- Build awareness of the importance of and skill in supporting individual health goals throughout ADSA's systems of support.
- Organize the systems of support and establish linkages with the primary care system to allow a comprehensive focus on the consumer's goals.
- Reduce unnecessary use of health resources.
- Take maximum advantage of the opportunities available under the Affordable Care Act.

**For July 1, 2013 to June 30, 2015:**

**A. For better management of chronic conditions, we will:**

1. Increase community awareness of evidence-based health promotion and injury prevention programs such as for falls and medication management.
2. Increase availability of established evidence-based prevention, wellness, and disease management activities in all long-term care settings.
3. Maintain current chronic disease self-management models for individuals to achieve their identified health goals.
4. Improve integration of chronic care management principles (activation, participant direction, goal setting, motivational interviewing, etc.) into work at all levels of service delivery.
5. Develop and implement community-based health homes to supports community-based clients at risk to incur the highest medical costs, both to Medicaid and to Medicare. Including development of a health home state Medicaid Plan amendment under Section 2703 of the Affordable Care Act.
6. Explore performance-based incentives for improving health outcomes.

**B. To maximize the opportunities under the Affordable Care Act, we will:**

1. Join with the Health Care Authority to operationalize the vision of integrated service purchasing outlined in the preliminary and implementation reports required by HB1738.
2. Coordinate with the Health Care Authority in implementation of the *HealthPath Washington* plan for improved services for people dually eligible for Medicare and Medicaid.
3. Plan and implement steps necessary for smooth implementation for expanded Medicaid coverage in 2014.

**Key Performance Indicators**

1. Number of people with high medical cost or high medical risk receiving chronic care management services or health home supports.

## DSHS Goal 2: Improve economic stability, employment and self-sufficiency.

**ADSA Strategic Objective 2.1:** Connect people to benefits and services that reduce poverty and help them become self-sufficient. Improve individual and family skills, knowledge, opportunities, and their capacity to increase self-sufficiency through person-centered, strengths-based services.

**Why?** So that individuals and families have increased access to meet their basic needs and build self-sufficiency. So that low-income individuals have the knowledge, skills, and capacity to improve self-sufficiency and have typical roles and responsibilities in their communities, particularly during life transitions.

**Strategy 2.1.1: Building a strong system of supports for people with disabilities and family caregivers.**

We believe family caregivers are the main reason people with disabilities and senior citizens can live in their homes among family and friends.

We believe thousands of people would be eligible for and require costly government support if their family member or friend gave up caring for their loved one.

We know all it takes is a small investment to make a positive difference for the caregiver and a person receiving care.

We will rely on and support shared responsibility with individuals, families and communities to sustain the work of family caregivers.

**We envision:**

- Expanded Aging and Disability Resource Centers where individuals and family caregivers can access the appropriate help to fit their situation whether they are in crisis or they are making plans for their future.
- High-demand supports and services are available and respond to the caregiver's needs to prevent them from giving up and placing their loved one out-of-the-home.
- A system of supports and access to health and wellness programs that help the family caregiver remain emotionally and physically healthy.
- Employers, businesses, and community organizations supporting family caregivers and recognizing the important role the caregiver plays in society.

**We are successful if family caregivers:**

- Are healthy and experience financial stability,
- Receive adequate and satisfactory supports and services, and
- Maintain connections and participate in everyday community activities.

**In partnership, we will:**

- Engage a wide variety of people, including unpaid caregivers, kinship caregivers, Area Agencies on Aging, employers and others.
- Advocate for and work to connect family caregivers to accessible and understandable information to help them participate in planning and advocating for their family member.
- Continue to be one of the nation's leaders in building a quality system of supports for seniors and people with disabilities.

**For July 1, 2013 to June 30, 2015:**

**A. To provide better information about options for people with disabilities, we will:**

1. Continue to expand the number of Aging & Disability Resource Centers (ADRCs) in Washington to reach the goal of statewide coverage by a system that is representative of all populations. Modify our five year plan for sustainability of Aging and Disability Resource Centers to:
   a) Expand to additional sites throughout the state.
   b) Implement software that can be used by citizens to get information about available services.
   c) Implement a statewide ADRC quality assurance and improvement process.
   d) Establish a cohort of trained and nationally certified ADRC options counselors.
   e) Deploy the statewide ADRC team of trained, evidence-based care transition coaches to serve people not currently covered by other state paid programs.
   f) Develop a statewide ADRC financial sustainability plan.
   g) Provide outreach to people who need skill in navigating the public and privately paid long term service and support system.
   h) Develop coordinated referral systems that help a broad cross-section of populations gain access to a full range of service and support options.
   i) Integrate navigator services for kinship caregivers.
   j) Deploy nursing facility diversion strategies statewide based on learning from the 2008-11 nursing home diversion grant.
   k) Seek federal funding to develop and implement a nursing facility care transition services for people not yet eligible for Medicaid who seek to return to, or re-establish, living in a home or community setting.
   l) Expand the Veterans Home Care Services (VHCS) program in collaboration with the Veterans Health Administration and local Veterans Administration Medical Centers.
2. Continue to develop specialized information, supports and support groups for people with traumatic brain injury.
3. Disseminate information about memory loss and Alzheimer's disease, the importance of early diagnosis, dementia specialty organizations, increase awareness of dementia capable supports and service options.

4. Enhance information provided to the public regarding legal and financial planning for long-term services and support need (similar to the "Own Your Own Future" federal campaign).
5. Increase public awareness and use of non-Medicaid supports for long-term service and support needs, including:
   a) Other resources to meet their needs.
   b) Long-term care insurance.
   c) Training on LTC insurance for consumers, agents and agency staff.
   d) Incentives to motivate use of approved plans.
   e) Identification of savings to Medicaid.
   f) Increased knowledge of field staff on the needs and resources available to unpaid family and kinship caregivers.

**B. In support of family caregivers of people with long-term care needs, we will:**

1. Explore Medicaid funding to increase family caregiver support.
2. Explore use of caregiver assessment tools for home and community-based and veteran's support services.
3. Increase ability of Family Caregivers Support Program staff and providers to address complex caregiver needs, including those with TBI and dementia.
4. Disseminate dementia specific information and promote evidence based supports, resources and services for caregivers of persons with Alzheimer's and related dementias.
5. Increase lifespan respite information and options available to caregivers through the development of statewide Lifespan Respite website and specific training of staff within Aging and Disability Resource Centers (ADRC), FCSP and other Ii&R phone lines.

**C. In support of kinship caregivers of vulnerable children, we will:**

1. Expand and replicate public-private kinship care health related partnerships.
2. Educate kinship caregivers about health promotion interventions (e.g. Chronic Disease Self- Management Classes, Child Profile materials) based on WA State kinship health data.
3. Increase kinship caregivers' access to resources and services through statewide coverage of the Kinship Navigator Program and its linkages to local Community Service Offices and Child and Family Service Offices and updates to DSHS Kinship website.

**D. In support of people with developmental disabilities and their families, we will:**

1. Develop options for reliable growth in the Individual and Family Services Program.
2. Develop rules to implement respite services in adult Supported Living.
3. Increase the supply of behavioral specialists and/or technicians.
4. Increase the number of individually contracted behavioral specialists.

5. Increase understanding of positive behavior supports in all settings.
6. Build professional collaboration across behavioral health resources including school districts, marriage and family counseling entities and deaf/hard of hearing/multi-sensory agencies.
7. Collaborate with the Department of Early Learning, Department of Health, Medicaid Services, and Office of the Superintendent of Public Instruction to identify a cost model for child development services so every county developmental disabilities program can participate as a partner in early learning by delivering child development services to children from birth through age two.
8. Form strong partnerships with schools, Educational School Districts and other local partners to support the educational needs of children with developmental disabilities, especially targeted to students at behavioral risk.

**Key Performance Indicators**

1. Number of unpaid family caregivers receiving services in the Family Caregiver Support program (FCSP).
2. Number of families in the Developmental Disabilities Individual and Family Support program.

## DSHS Goal 2: Improve economic stability, employment and self-sufficiency.

**ADSA Strategic Objective 2.2**: Decrease barriers to employment of people with disabilities.

**Why?** So that clients have increased access to job readiness, job search and employment programs and barriers to employment for people with disabilities are eliminated, and people with disabilities acquire appropriate and timely job skills and connect with employers and others who foster employment success.

**Strategy 2.2.2: Improve employment of people with disabilities.**

We believe people with disabilities should have an opportunity for gainful employment.

We believe employment brings choice, financial stability, integration into the community, and sustainable relationships for people with disabilities.

We believe employer's bottom-line and workforce diversity increases when people with disabilities are included.

We will rely on and support shared responsibility of individuals, their families, local employment agencies, and employers to increase employment of people with disabilities.

**We envision:**

- The pursuit of gainful employment with public and private entities that increase employment of people with disabilities over time.
- Employment that reflects achievement and makes progress toward a living wage.
- Robust school-based partnerships and businesses to help students leaving high school obtain a job.
- A system of supports to help people maintain employment and increase earned income.

**We are successful if people with disabilities:**

- Are connected to employers that are inclusive and welcoming,
- Can access employment assistance, coaching and training,
- Find employment that is meaningful and provides a living wage, and
- Experience independence, dignity, and every day relationships.

**In partnership, we will:**

- Engage a wide variety of people, including clients, providers, employment agencies, businesses and educators to build an employment infrastructure in communities.

- Be intentional and lead efforts to achieve employment numbers for people with developmental disabilities that are similar to the workforce without disabilities.
- Create awareness that people with disabilities are productive workers and can contribute to an employer's goals and bottom line.

**For July 1, 2013 to June 30, 2015, we will:**

1. Increase access to supports for job development, job search and employment, for people with developmental disabilities, including:
   a) Increase the number of transition students leaving school with a job or robust portfolio of job experience.
   b) Increase access to technical assistance and training for providers, including employment specialists and other employment agency staff.
2. Decrease barriers to employment for people with developmental disabilities, including:
   a) Develop data on employment locations, earnings, and employer perspective on achievement of business goals.
   b) Developing outcome-based county employment services contracts with rates based on client acuity.
   c) Partnership with the Washington State Initiative for Supported Employment (WiSe).
3. Partner with Division of Vocational Rehabilitation and Community Based Benefit planners to improve access to Ticket to Work incentives and work employment strategies.
4. Develop and implement a comprehensive approach to improve employment outcomes among consumers with behavioral health challenges that includes a joint funding model for supported employment in state agencies, improved benefit planning assistance and consultation, provision of technical assistance and improvements to peer counseling training.
5. Continue progress toward a Recovery-Oriented Systems of Care (ROSC), including job readiness skills and employment retention.
6. Provide chemical dependency treatment to clients enrolled in Temporary Assistance for Needy Families (TANF).
7. Participate in the State's Supported Employment initiative.
8. Develop and implement pilot employment program for individuals with physical disabilities through with Money Follows the Person funding to expand access and capacity to support employment of people with physical disabilities.

**Key Performance Indicators**

1. Percent of working age adults with developmental disabilities in DD employment and day programs who are employed.

## DSHS Goal 3: Improve individual and public safety.

**ADSA Strategic Objective 3.1**: Improve safety through effective regulation and monitoring of providers, investigation of and response to abuse, and support for legal actions that protect the public.

**Why?** So service settings for children and adults are robustly regulated and monitored and abuse allegations are quickly investigated and receive timely response.

**Strategy 3.1.1: Building consumer safety and quality care.**

We believe that supports for people with disabilities in the private sector or publicly funded settings should be free from abuse and neglect.

We will support individuals and families in choosing safe and capable providers of care.

We will rely on and support shared responsibility with individuals, families, and communities to identify or respond to abuse and abusers.

We believe that individuals deserve support that meets their needs and meets quality standards.

**We envision:**

- A system of consumer protection that responds to the shift in consumer preferences toward home and community-based settings and self-direction.
- High levels of community awareness that can help prevent or respond to abuse, neglect, or financial exploitation of vulnerable adults.
- Accessible and easy-to-understand information that will help consumers choose quality supports and services that fit their individual needs and help them identify quality and safe services.
- Strong regulatory standards, enforcement authority, and monitoring.
- Well-trained providers and staff that can deliver quality care and address the diversity of consumers, including those who speak limited English.

**We are successful if seniors and people with disabilities:**

- Are healthy and safe,
- Can access the information needed to make decisions about quality service,
- Have choices in their lives and services, and
- Experience independence, dignity, and every day relationships.

**In partnership, we will:**

- Engage a wide variety of people, including private pay consumers, clients, providers, law enforcement and others.
- Lead advocacy efforts to promote prevention of abuse or exploitation of vulnerable adults.
- Continue to be one of the nation's leaders in building a quality system of supports for seniors and adults with disabilities.

**For July 1, 2013 to June 30, 2015:**

**A. To support individuals and families in making good decisions about where to get care, we will:**

1. Create a consumer oriented website.

B. **To improve our ability to monitor quality and promote protection of vulnerable adults, we will:**

1. Seek resources for better oversight and complaint investigation, including:
   a) An increased number of complaint investigators.
   b) Development of an internal quality review and accountability program.

2. Implement priority recommendations based on from the report of the Adult Family Home Quality Panel, as required by HB1277.

**Key Performance Indicators**

1. Percent of timely licensing re-inspections of adult family homes, boarding homes and nursing homes,