

**Developmental
Disabilities
Administration**

Evelyn Perez, Assistant Secretary

2013-2015

Strategic Plan

June 2014



VISION

We envision:

Supporting individuals to live in, contribute to, and participate in their communities;

Continually improving supports to families of both children and adults;

Individualizing supports that will empower individuals with developmental disabilities to realize their greatest potential;

Building support plans based on the needs and the strengths of the individual and the family;

Engaging individuals, families, local service providers, communities, governmental partners and other stakeholders to continually improve our system of supports.

MISSION

To transform lives by providing support and fostering partnerships that empower people to live the lives they want.

VALUES

Respect gained through positive recognition of the importance of all individuals;

Person-Centered Planning to support each person to reach his or her full potential;

Partnerships between DDA and clients, families and providers in order to develop, and sustain supports and services that are needed and desired;

Community Participation by empowering individuals with developmental disabilities to be part of the workforce contributing members of society; and

Innovation to create services and supports that meet the needs of those individuals DDA serves.

Introduction

People with developmental disabilities and their families are valued citizens. Programs administered by the Developmental Disabilities Administration (DDA) are designed to assist individuals with developmental disabilities and their families to obtain services and supports based on individual preferences, capabilities, and needs.

DDA strives to develop and implement public policies that promote:

- Individual worth, self-respect, dignity; and power and choice;
- Healthy, safe and fulfilling lives; and
- Supports that meet the individual’s needs during the person’s life span.

In order to meet the needs of individuals and families, DDA offers the following supports and services:

- **Case Management for everyone receiving services.**
Over 25,000 individuals receive services from the DDA annually. Case management is a service that promotes collaboration for assessments, service determination and individual support planning. Case Resource Managers also coordinate, authorize, monitor and evaluate the effectiveness of services available to address an individual’s identified health and welfare needs.
- **Individual and Family Supports that are offered in the family home to meet respite and other critical needs such as therapies, minor home modifications, etc.**
The Individual and Family Services (IFS) Program is a state-only funded program of DDA that provides over 1,800 individuals and their families with a variety of services to help support the DDA eligible family member to be able to remain living in the family home.
- **Employment and Community Access services to increase the independence, self-respect and dignity of individuals with developmental disabilities.**
Employment and Community Access services offer all persons with intellectual and developmental disabilities the ability to fully participate in society. They provide access to employment and other community activities, a path out of poverty and increased independence from social service systems. DDA currently provides employment and day supports to over 7,000 individuals.

DSHS Goals

Goal 1

HEALTH – Each individual and each community will be healthy.

Goal 2

SAFETY – Each individual and each community will be safe.

Goal 3

PROTECTION – Each individual who is vulnerable will be protected.

Goal 4

QUALITY OF LIFE – Each individual in need will be supported to attain the highest possible quality of life.

Goal 5

PUBLIC TRUST – Strong management practices will ensure quality and efficiency.



- **Residential Services that include community homes for children and adults as well as residential habilitation centers.**

Community residential services provide housing and support services to individuals with intellectual and developmental disabilities who need support services to be able to live in and fully participate in the community. Supports range from a few hours a week to 24 hours a day. DDA currently provides residential supports to almost 6,000 individuals who live in their own homes, Adult Family Homes (AFH) or State Operated Living Alternatives (SOLAs).

- **Medicaid/Waiver Personal Care Services provide in-home assistance with activities of daily living.**

Personal Care services are Medicaid covered services that provide in-home supports for physical and verbal assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) to over 12,500 individuals. ADL tasks include supports for bathing, bed mobility, body or foot care, dressing, eating, locomotion in room, locomotion outside of room, medication management, personal hygiene, transfers, toileting and walking in room. ADL tasks include supports for meal preparation, transportation to medical appointments, essential shopping, wood supply, and housework.

Goals

Governor Jay Inslee’s Results Washington Goals

DDA is a partner in Governor Jay Inslee’s **Results Washington**, a focused effort to create effective, efficient, and accountable government.

Results Washington Goal Area number 4 is Healthy and Safe Communities. Under this goal area, DDA has lead responsibility for two success metrics under the **Supported People: Stability and Self Sufficiency** success indicator. DDA’s two **Results Washington** success metrics are.

- Increase the percentage of clients with developmental disabilities served in home and community-based settings from 96.2 percent to 96.7 percent by June 30, 2015.
- Increase the percentage of working age adults with developmental disabilities in DD employment and day programs who are employed from 64 percent to 66 percent by June 30, 2015.

Department of Social and Health Services (DSHS) Goals

As a member of the DSHS team, DDA also has lead responsibility for performance metrics that fit within DSHS’ departmental goals. DSHS has the following five broad goals:

- **Health** – Each individual and each community will be healthy.
- **Safety** – Each individual and each community will be safe.
- **Protection** – Each individual who is vulnerable will be protected.
- **Quality of Life** – Each individual in need will be supported to obtain the highest possible quality of life.
- **Public Trust** – Strong management practices will be used to ensure quality and efficiency.



DDA has the following success metrics in support of the DSHS Goals listed below:

Health:

- Improve health and daily living support for individuals.

Safety:

- Improve safety and permanency of individuals who are at risk of institutionalization.
- Ensure that individuals enrolled in the Community Protection Program are supported to achieve their required treatment goals.

Protection:

- Transparency in providing services and supports.
- Equip clients, families, and providers with information to support health and safety of individuals.

Quality of Life:

- Increase the effectiveness of community residential programs to support individuals to have quality lives.
- Increase opportunities for individuals who are institutionalized to have the option to move to the community and be supported as needed.
- Establish a Community of Practice to look at the needs of families and individuals through their lifespan and begin efforts to move the system towards proactively meeting needs.
- Increase the number of clients employed.
- Provide individuals with in-home supports to enable them to remain in their communities.

Public Trust:

- Transparency in providing services and supports.
- Fiscal stewardship of programs and activities.
- Effective communication with stakeholders.

Strategic Plan

Below are the details of our Strategic Plan to meet our Strategic Objectives. Each Strategic Objective is discussed under its larger DSHS goal area. Each Strategic Objective includes a statement of its importance, quantified success measures, a timeline and, most importantly, an Action Plan. DDA Strategic Objectives are monitored and reported quarterly at <http://www.dshs.wa.gov/ppa/strategic.shtml>. Each DDA Action Plan is also updated quarterly.

Strategic Objectives, Importance, Success Measures and Action Plans

DSHS Goal 1: Health - Each individual and each community will be healthy.

Strategic Objective 1.1: Identify individual health and welfare needs in a timely manner in order to support individuals to have healthy and active lives.

Importance: Identify individual health and welfare needs in a timely manner.

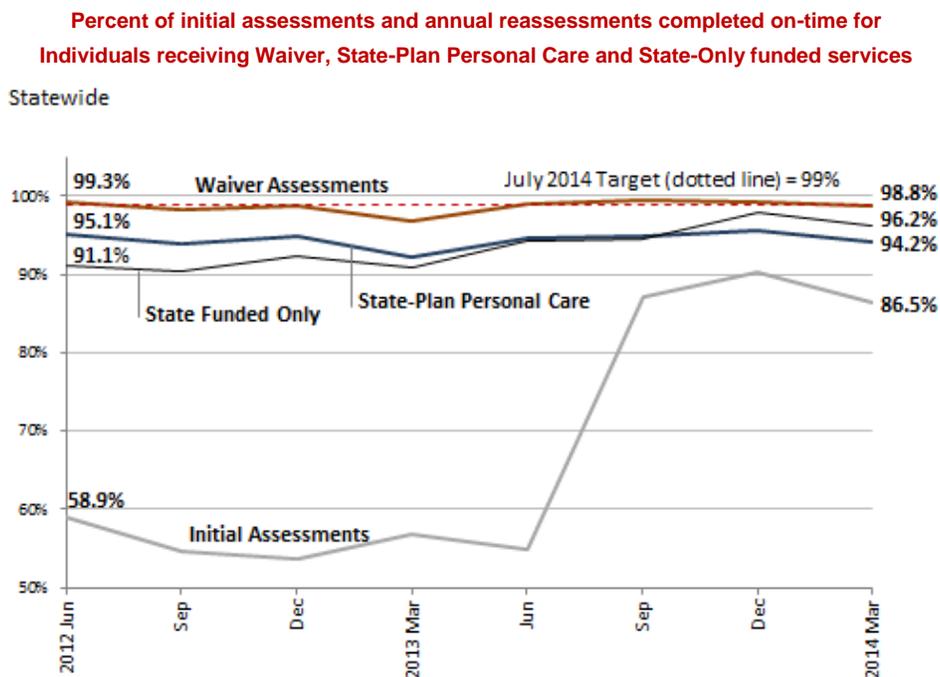


Success Measure: On-time completion of initial assessments and annual reassessments will increase from an average 85.7 percent in June 2013 to 99 percent by July 2014.

Action Plan:

- Case Resource Managers will complete initial assessments within 30 days and annual reassessments for Waiver, State-Plan Personal Care and State-Only Funded Services before the client’s Individual Support Plan (ISP) ends.
- DDA Field Services Administrators will monitor assessment timeliness of case resource managers on a monthly basis and work with regional supervisors to resolve issues and prioritize workload assignments.
- DDA management team will track assessment timeliness on quarterly basis to ensure compliance with policy expectations governing completion of assessments.
- Regional Administrators will continue recruitment efforts to fill case management vacancies when they occur.

See analysis and plan at: [DDA Action Plan 1.1 – Identify individual health and welfare needs](#)



Analysis / Status:

- DDA central office has established data collection methods and has provided regional management team with data reports to identify overdue assessments and reassessments.
- DDA hired 14 Case Resource Managers to fill vacant positions during the third quarter of 2013.
- DDA hired 16 Case Resource Managers to support expansion of Individual and Family Services and Basic Plus waiver programs during the fourth quarter of 2013.
- Recruitment efforts will continue to fill vacancies as they occur.



Strategic Objective 1.2: Identify individual health and welfare needs of children in a timely manner in order to support children to have healthy and active lives.

Importance: Identify children’s health and welfare needs in a timely manner.

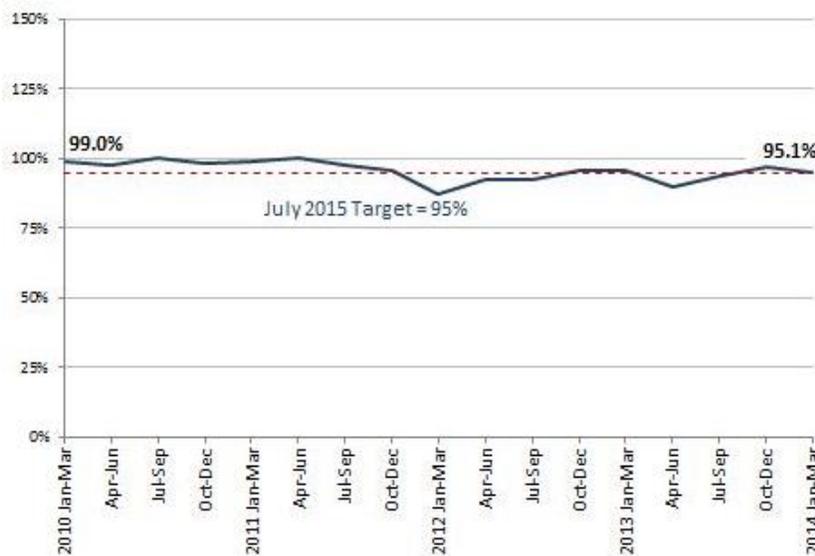
Success Measure: Timeliness of required planning and monitoring for children receiving Voluntary Placement Services and Children’s Intensive Behavior Support will increase from 94.6 percent to 95 percent by July 2015.

Action Plan:

- Case Resource Managers will complete required quarterly planning and monitoring meetings to review and evaluate the effectiveness of services and supports.
- Case Resource Managers will review and update CARE systems and support plans to address identified support needs.
- Voluntary Placement and Children’s Intensive Behavior Support Program Managers will conduct monthly monitoring to track progress of meeting required planning and monitoring requirements.
- DDA management team will track timeliness on quarterly basis to ensure compliance with policy expectations governing required planning and monitoring.
- Regional Administrators will continue recruitment efforts to fill case management vacancies when they occur.

See analysis and plan at: [DDA Action Plan 1.2 – Identify individual health and welfare needs \(children\)](#)

Percent of required quarterly monitoring and planning completed for clients receiving Voluntary Placement or Children’s Intensive In-home Behavior Support Services



Analysis / Status:

- DDA developed a new report to provide managers and supervisors with additional detail for monitoring timeliness of visits for Voluntary Placement and Children's Intensive In-home Behavior Support Services. Regional staff have received training on how to use the report to track their work.
 - Goal target of required monitoring achieved during the fourth quarter of 2013. DDA will continue to track and assist supervisors in monitoring activity of case resource managers in meeting this goal standard.
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DSHS Goal 2: Safety - Each individual and community will be safe.

Strategic Objective 2.1: Improve safety and successful long-term placement of individuals who are at risk of institutionalization in state hospitals.

Importance: Individuals should be able to live safely in environments common to other citizens, with reasonable supports offered to protect their safety while promoting community inclusion.

Success Measure: Establish baseline data for admission and recidivism rates for DDA clients at state hospitals.

Action Plan:

- Analyze data collected regarding recidivism;
- Work with Research Data and Analysis team to develop Core Metric charts to track recidivism rate of DDA clients at state hospitals;
- DDA Mental Health program manager will work with mental health and state hospital team members to develop an A-3 to identify breakdown the problem, Identify root causes, develop countermeasures, targets and action plan.

Analysis / Status:

- Data has been collected regarding recidivism rates of DDA clients at state hospitals;
 - DDA Mental health program manager will work with mental health and state hospital team members to identify root causes of recidivism and possible countermeasures to reduce recidivism.
-

Strategic Objective 2.2: Ensure that individuals enrolled in the Community Protection Program are supported to achieve their required treatment goals.

Importance: Supporting an individual to achieve their identified treatment goals is critical to helping them remain in their community and decrease incidences of involvement with crisis services, i.e. law enforcement and/or psychiatric hospitalization. Proper supports afford individuals with a history of challenging behaviors opportunities to grow and develop and in turn decrease the need for crisis services.

Success Measure: Timeliness of required quarterly treatment meetings will increase from 94.6 percent in June 2013 to 96 percent by July 2015.

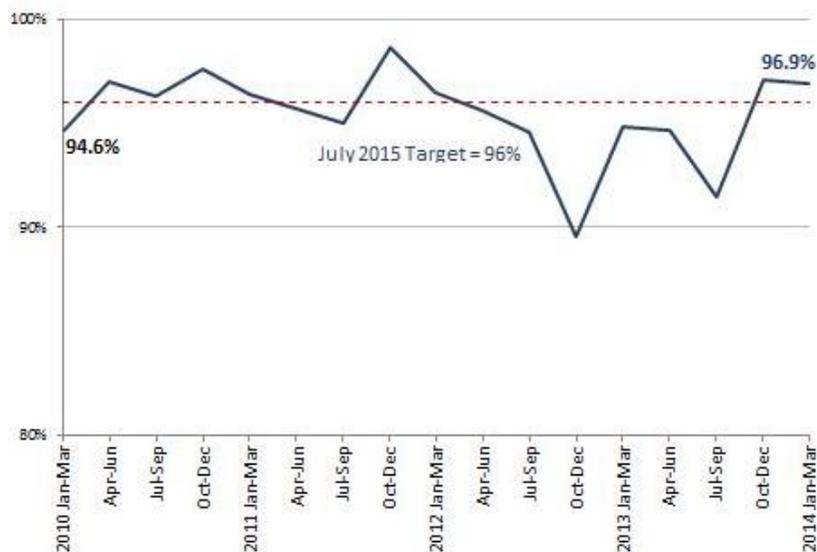


Action Plan:

- Case resource managers will complete required quarterly planning and monitoring meetings to ensure required therapies are in place to support individuals.
- Case resource managers will review and update CARE system and support plans to address identified support needs.
- The DDA Community Protection Program Manager will conduct monthly monitoring to track progress of meeting required planning and monitoring requirements.
- DDA management team will track timeliness on quarterly basis to ensure compliance with policy expectations governing required planning and monitoring.
- Regional Administrators will continue recruitment efforts to fill case management vacancies when they occur.

See analysis and plan at: [DDA Action Plan 2.2 – Ensure individuals are supported](#)

Percent of required quarterly monitoring and planning completed for clients enrolled in the Developmental Disabilities Administration's Community Protection Program



Analysis / Status:

- The upward trend in the fourth quarter of 2013 for completion of monitoring responsibilities is related to improvements documenting required visits in tracking database.
- Enhancements to provide additional detail on tracking reports to monitor timeliness of visits for individuals enrolled in the Community Protection Program completed in March 2014.
- Goal target of required monitoring was achieved during the fourth quarter of 2013. DDA will continue to track to assist supervisors in monitoring activity of case resource managers in meeting this goal standard.



DSHS Goal 3: Protection - Each individual who is vulnerable will be protected.

Strategic Objective 3.1: Develop a statewide Crisis Support system, including the supports and availability of the Residential Habilitation Centers that will provide needed interventions for individuals and families.

Importance: Provide relevant and timely support for individuals and their families in times of crisis.

Success Measure: Establish baseline data of Crisis Support system services accessed by DDA clients.

Action Plan:

- Analyze data collected regarding utilization of crisis/diversion services;
- Work with Research Data Analysis team to develop Core Metric charts to track utilization of crisis/diversion services;
- DDA Mental Health program manager will work with regional team members to develop an A-3 to: identify/breakdown the problem, identify the root causes, develop countermeasures, targets and action plan to achieve strategic objective.

Analysis / Status:

- DDA is working with Research Data Analysis team to develop Core Metric to track and monitor data regarding this strategic objective;
- DDA Mental Health Program Manager is working with regional team members to develop and complete A-3.

Strategic Objective 3.2: Equip clients, families and providers with information to support health and safety of individuals.

Importance: Provide time sensitive and critical information to families in all mediums so that they have the information they need to make critical decisions.

Success Measure: 100 percent of “Alerts” or “Pod” casts are posted when an issue is identified.

Action Plan:

- The DDA Residential Provider Training Manager will provide “Alerts” through provider networks, social media and DDA internet.
- DDA will partner with the Developmental Disabilities Council and Provider Networks to distribute alerts.

Analysis/Status:

- The following “alerts” or “Pod” casts were provided in partnership with the Developmental Disabilities Council on the Informing Families Building Trust and Provider Networks.
 1. Ready...Set...Know: What to Expect and How to Respond to Changes in Medicaid (May 2012);
 2. Assistive Technology (June 2013);



3. Transition Checklist (October 2013);
 4. Transition Planning 101 (October 2013)
- DDA will continue to provide alerts and pod cast but will be eliminating this as a success measure in future versions of DDA's strategic plan since alerts and pod casts are periodic in response to issues that arise.
 - DDA is working on developing a new strategic objective and success measure to track DDA's progress in following up on allegations of abuse and neglect.

DSHS Goal 4: Quality of Life - Those in need will be supported to attain the highest possible quality of life.

Strategic Objective 4.1: Increase access to home and community-based services.

Importance: The federal government, Washington State government, individuals with disabilities and their families and stakeholders recognize the need to offer services and resources to individuals in ways that meet needs and promote activities, routines and relationships common to most citizens. This includes being able to live in integrated settings, in their own communities rather than in institutions.

Success Measure: Increase the percentage of clients with developmental disabilities served in home and community-based settings from 96.2 percent to 96.7 percent by June 30, 2015.

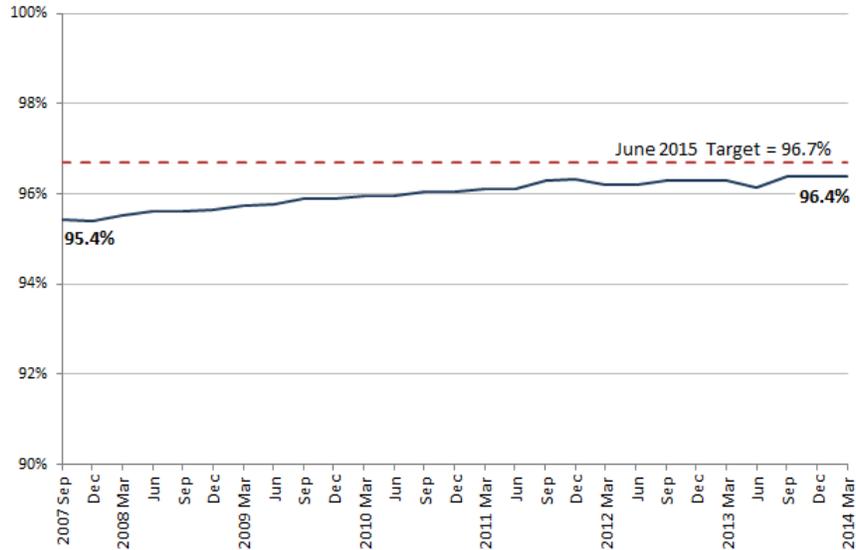
Action Plan:

- The DDA Waiver committee will review waiver enrollment requests and within available funding will prioritize approvals for individuals who need home and community based services to prevent out-of-home or institutional placement.
- The DDA Waiver committee will approve long-term funding to transition-age individuals who are currently financially and functionally eligible for personal care and want employment support.
- The Roads to Community Living (RCL) team will work with staff in the regions and at institutions to offer individuals in institutions the opportunity to receive transition supports if they are interested in moving from an institution into an integrated community residential setting.
- The DDA Individual and Family Services (IFS) program manager will work with regional DDA staff to have 2,500 individuals enrolled onto the IFS program by June 30, 2015.

DDA will conduct monthly monitoring of caseload counts for institutions and community-based settings to track progress on increasing the number of clients served in in-home and community-based settings.



See analysis and plan at: [DDA Action Plan 4.1 – Increase access to Home & Community-based services](#)



Analysis/Status: Between July 1, 2013 and March 31, 2014:

- 35 individuals have accessed RCL funding to move out of an institution to a community based setting.
- 440 individuals were enrolled onto the Basic Plus waiver.
- 646 individuals have been enrolled onto the IFS program to access family support services.

Strategic Objective 4.2: Increase the effectiveness of community residential programs to support individuals to have quality lives.

Importance: Habilitation services improve quality of life. All individuals continue to grow and develop, and those with developmental disabilities need additional supports in order to continue to make progress in their lives.

Success Measure: By July 2015, 100 percent of Individual Instruction and Support Plans for individuals receiving supported living services will show evidence of habilitation goal implementation.

Action Plan:

- DDA Quality Assurance Office Chief will hire staff to monitor quality of life issues.
- DDA Quality Assurance Office Chief, in collaboration with interested parties, will develop a monitoring tool and plan for implementation.
- DDA staff assigned to monitor supported living programs will develop a process governing corrective action plan for residential agency findings.
- The DDA residential Social and Health Program Consultant will conduct reviews of Individual Instruction and Support Plans for implementation evidence of supports for habilitation goals.



- Regional DDA residential specialists will monitor supported living agencies to verify client habilitation activities occur.

Analysis/Status:

- A Social and Health Program Consultant was hired on July 16, 2013 to monitor quality of life issues.
 - The DDA Quality Assurance Office Chief, in collaboration with Regional staff and providers, has developed a monitoring tool and plan for implementation of monitoring.
 - All three Regional Residential Specialists are hired and receiving training.
 - A pilot project has begun to test the assumptions about gathering accurate information on IISP quality.
 - The three Residential Specialists will be reporting directly to Central Office as of July 1, 2014.
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Strategic Objective 4.3: Increase opportunities for individuals who are institutionalized to have the option to move to the community and be supported as needed.

Importance: This measure reflects the response to consumer preferences for home and community-based care. It is also an indicator of efficiency, since community care is the least expensive.

Success Measure: Clients moving from Residential Habilitation Centers, state hospitals, nursing homes and Children’s Long-Term Inpatient Program placements annually will increase by 25 percent by July 2015.

Action Plan:

- The Roads to Community Living (RCL) team will work with staff in the regions and at institutions to make full use of opportunities provided by the Roads to Community Living (Money Follows the Person) federal grant.
- The RCL team will implement strategies to further educate those who have lived long-term at an RHC and encourage full exploration of community options.
- RCL team members will continue to develop and oversee projects and trainings that increase the ability of the community to provide necessary supports.

Analysis/Status:

- The RCL team continues to meet weekly with regional staff to discuss client needs and strategies for providing supports needed for individuals interested in moving to the community.
- The RCL team hosted a day-long event at two RHCs, for RHC clients, families and staff which included presentations and discussions about building on partnerships and implementing transition supports that have helped individuals move from state operated institutions to homes in the community.
- The RCL team has contracted with a “Family Mentor” to provide one-on-one consultation and supports to families considering moving their family member to the community.



Period	1/1/13 to 6/30/13	7/1/2013 to 12/31/2013	1/1/2014 to 3/31/14
Total number of active clients enrolled on RCL grant	49	68	81
Number of clients enrolled on RCL grant who moved from an Institutional setting to community based setting	6	17	18
Total number of clients receiving RCL services in the community.	35	27	41
Total Number of clients who are receiving RCL transition supports in an institution.	-	6	16

Strategic Objective 4.4: Establish a Community of Practice to look at the needs of families and individuals through their life span and begin efforts to move the system towards proactively meeting needs.

Importance: Individuals prefer home and community-based care. Participation in this grant recognizes the importance of the family’s role and support of individuals living in their home.

Success Measure: Establish a Stakeholder Committee and develop a five-year action plan by December 2014.

Action Plan:

- Under the leadership of the DDA Deputy Assistant Secretary, partner with the Developmental Disabilities Council (DDC) to develop a Community of Practice as part of a five-year national grant (five states were chosen to participate).
- The Core committee of DDA and DDC staff will establish a statewide steering committee of stakeholders.
- The Core committee will host a statewide “Kick-off” event to explore, inquire and identify purposes, goals and visions for supporting individuals and families living in the community.
- The Steering Committee, under the direction of the Core committee will develop a five-year plan of action.



Analysis/Status:

- DDA, working with the Developmental Disabilities Council successfully received a federal grant to become part of a five-year project entitled “Communities of Practice,” focused on the needs of families and their children with developmental disabilities and how to better serve them (June 2013).
 - A Core Committee was formed, with both the DDC and DDA leadership participating (July 2013).
 - A Statewide Stakeholder Committee was convened in September 2013 to plan a “Kick Off” Event in November 2014.
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Strategic Objective 4.5: Increase the number of clients employed.

Importance: Earning a wage is one of the most self-affirming and cost-beneficial achievements for a person with a developmental disability. Employment support continues to be a service emphasis and continuing the investment in increasing access to employment allows individuals to fully participate as contributing members of society.

Success Measure: Increase the percentage of working age adults with developmental disabilities in DD employment and day programs who are employed from 64 percent to 66 percent by July 2015.

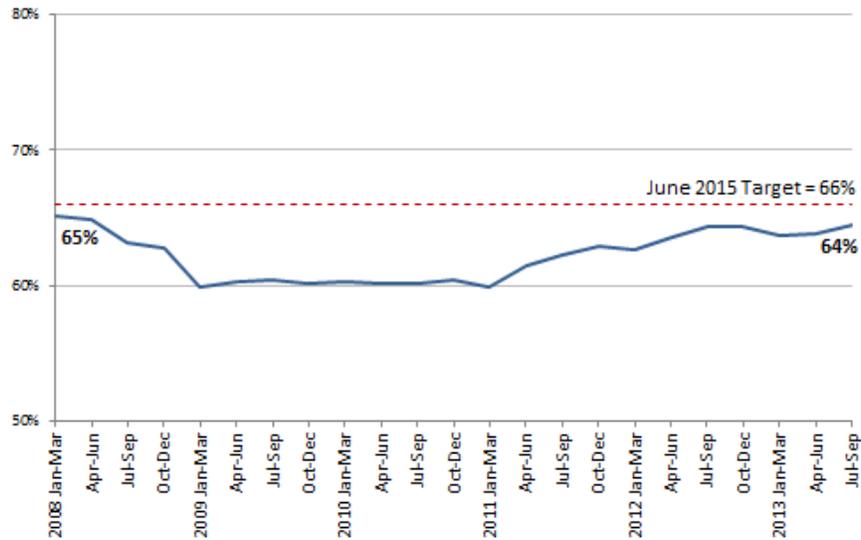
Action Plan:

- The DDA Employment Program Manager will provide each county with goal targets to increase the number of individuals who are employed and earning a wage.
- The DDA Employment Program Manager will monitor and provide reports on a monthly basis regarding employment and expenditure activity to DDA Executive Management Team and counties.
- The DDA Waiver Committee will approve long-term waiver funding to transition students who are currently financially and functionally eligible for personal care and want employment support.



See analysis and plan at: [DDA Action Plan 4.5 – Increase number of clients employed](#)

Percent of working-age adults with developmental disabilities in day programs who are employed



Analysis/Status: Between July 1, 2013 and March 31, 2014:

- 427 waiver enrollment requests were for individuals seeking long-term employment supports. Of the 427:
 - 347 individuals are transition-age;
 - 54 individuals exited Department of Vocational Rehabilitation with a job;
 - 198 individuals are receiving supported employment services;
 - 58 individuals are earning a wage; and
 - 52 individuals are earning minimum wage or better.

Strategic Objective 4.6: Provide individuals with in-home supports to enable them to remain in their communities.

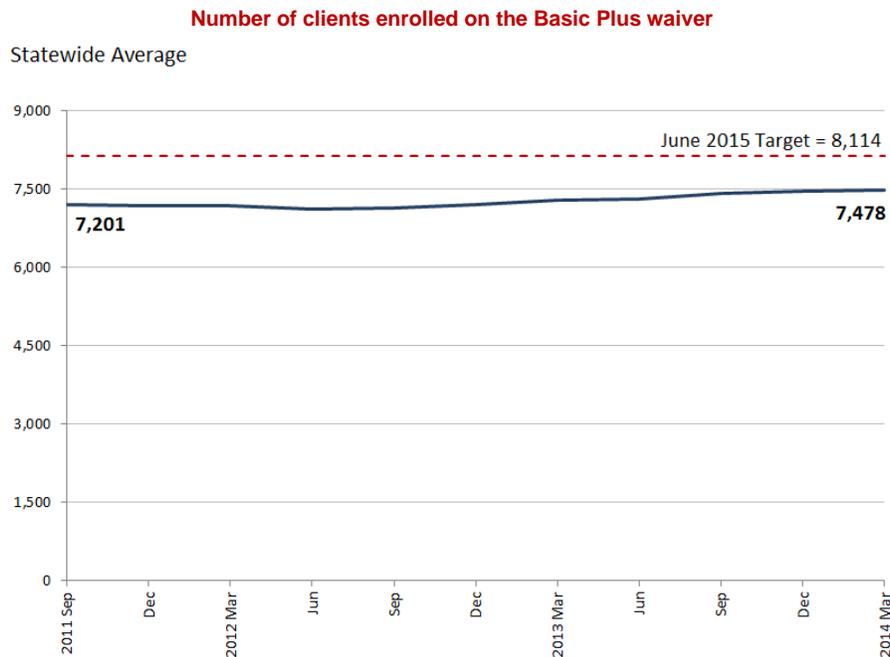
Importance: In-home services support individuals to remain safely in their own homes by providing resources to assist them in meeting their health and welfare needs.

Success Measure 1: Increase capacity of the Basic Plus waiver to support 7,380 individuals in July 2013 to 8,114 individuals by June 2015.



Action Plan:

- Case Managers will prioritize doing assessments and making waiver enrollment requests for transition-age individuals who are currently financially and functionally eligible for personal care and want employment support.
- The Employment Program Manager will work with County Coordinators to support individuals of transition age to receive long-term funding to support employment goals.
- The Waiver Program Manager will use attrition capacity to provide supports to individuals who are in crisis and at risk for out of home placement.



Analysis/Status: Between July 1, 2013 and March 31, 2014:

- 469 waiver enrollment requests were approved for individuals requesting services on the Basic Plus waiver.
 - 79 were for children under the age of 18;
 - 17 were for individuals between the ages of 18 through 20; and
 - 373 were for individuals over the age of 21.
 - 286 of the 373 waiver enrollment requests for individuals over the age of 21 were for individuals seeking long-term employment supports.

Note: After a waiver enrollment request is approved, individuals must have their financial and SSI disability eligibility determined before they can be enrolled onto the waiver.

Success Measure 2: Individuals enrolled in Individual and Family Services (IFS) program and SSP in lieu of IFS will increase from 1,150 to 3,500 by July 2015.

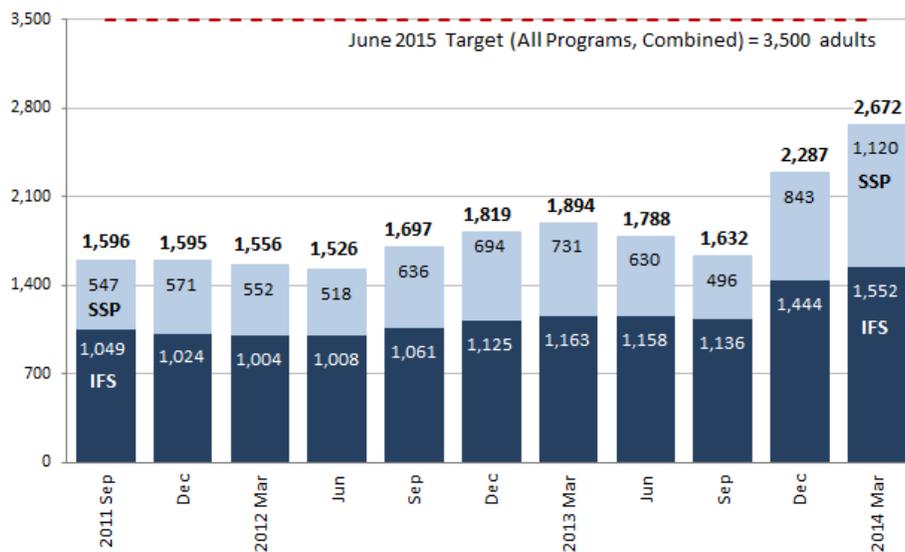
Action Plan:

- Regional Administrator will recruit case managers to support legislatively funded expansion of the IFS program.



- The Individual and Family Services (IFS) Program Manager and regional coordinators will manage the current wait list and prioritize individuals not receiving any DDA paid services for access to the IFS program.
- Regional IFS coordinators will provide case managers with the names of clients who should be contacted for an assessment.
- Case resource managers will schedule an assessment to determine client’s eligibility for the IFS program.
- Case resource managers will enroll clients into the IFS program who meet the IFS eligibility requirements.

Number of individuals enrolled on the DDA Individual and Family Services (IFS) and State Supplementary Payment (SSP) in lieu of IFS programs by Quarter



Analysis/Status: Between July 1, 2013 and March 31, 2014:

- 394 individuals have been enrolled onto the IFS program; and
- 490 individuals have chosen to receive SSP in lieu of IFS

DSHS Goal 5: Public Trust - Use of strong management practices that ensure quality and leverage all resources.

Strategic Objective 5.1: Transparency in providing services and supports in order to use data to support or change services administered by the DDA.

Importance: Not all services administered by DDA are entitlements. This limits the amount of available funding to serve individuals with developmental disabilities. Monitoring service utilization trends will assist DDA to develop models to identify and meet future service needs.

Success Measure: Complete annual DDA Caseload and Cost Data report by November 2013.

Action Plan:



- The DDA Office Chief of Policy and Program Development will utilize data systems to monitor and inform the Administration and stakeholders of the status of caseload activities and costs.
- The Office Chief of Policy and Program Development will provide the DDA Caseload and Cost Data Report to: DDA Regional Administrators, The Arc of Washington, the Developmental Disabilities Council and liaisons at the Office of Financial Management (OFM) and Washington State Legislature for use in regional legislative forums.
- The DDA Research Director will work with the Human Services Research Institute (HRSI) to analyze 10 years of historical data from the National Core Indicators (NCI) surveys and develop a report on trends and patterns.
- The DDA Executive Management Team will review information and data from the DDA Caseload and Cost Report and NCI survey reports to inform decisions about future enhancements to current service models.

Analysis/Status:

- The DDA Caseload and Cost report was completed and distributed to all parties on October 31, 2013.
- The 10-year report on historical responses to the NCI is complete. Currently working with publications to have report printed.



Strategic Objective 5.2: Fiscal stewardship of programs and activities.

Importance: Eliminate unnecessary processes and products not required by our clients; monitor service utilization trends to identify future efficiencies; and increase fiscal responsibility.

Success Measure 1: Complete one continuous improvement activity each quarter.

Action Plan:

- DDA staff will be provided training on the “Lean process” and will work on process improvement activities to eliminate unnecessary work processes and promote efficiencies.
- The Performance and Accountability program manager will implement at least one “Lean” activity per quarter.

Analysis/Status:

Continuous Improvement Activities completed:

- “Improve Planned Action Notice process and format” Lean project was completed in the third quarter of 2013.
- “Streamline enrollment and monitoring processes for Medically Intensive Children’s Program (MICP)” was completed in the third quarter of 2013.
- “Increasing Community Access” A3 completed in the fourth quarter of 2014.
- “Increasing Employment of Adults” and “Assessment Timeliness” A3s completed in the first quarter of 2014.



Success Measure 2: Expenditures reflect full utilization of budget allocation for program services.

Action Plan:

- Management Services Division will conduct a monthly fiscal review of each budget category with DDA Executive Staff and Regional Management.
- The DDA Employment Program Manager will conduct monthly monitoring of county expenditures.
- The DDA Residential Program Manager will conduct monthly monitoring of residential expenses with Regional Administrators and Resource Administrators.
- Any deviations from projected expenditures will be brought to the attention of the Deputy Assistant Secretary for action.

Analysis/Status:

- Monthly fiscal reviews were held and current expenditures are under budget.
- The Employment Program Manager monitored county expenditures each month and set up target goals for counties to achieve to ensure available funds are used to meet the needs of individuals receiving employment and day program services.
- The Residential Program Manager met monthly with regional personnel and review utilization trends and barriers to accessing services.
- The Office Chief of Policy and Program reported to the Assistant Secretary and Deputy Assistant Secretary on those areas deviating from expectations and developed strategies to promote compliance.

Success Measure 3: Ensure appropriate services are provided for every approved provider payment as required by cost report policy for supported living contractors.

Action Plan:

- The Residential Program Manager and Management Services Division will develop a more robust electronic residential cost report to ensure cost reporting policy requirements are met.
- The Office of Quality Programs and Stakeholder Involvement will establish a two-year project position to audit community residential contractors to ensure client service hours purchased are reconciled with payroll records.
- The Residential Program Manager, working with regional staff and Management Services Division, will implement an electronic rate worksheet to reduce payment errors and bring efficiencies to the program.

Analysis/Status:

- DDA made changes to Policy 6.04 to add standards for calendar year 2014 cost reporting. Additional schedules were also added to the cost report to provide additional details on payments. The revised policy went into effect on July 1, 2013.
- The electronic worksheet was developed and implemented on July 1, 2013.
- DDA hired a staff person in September 2013 to ensure supported living contractors are meeting financial reporting requirements in accordance with DDA policy.



- All DDA regions have transitioned work processes to use the new electronic worksheet for adults receiving supported living services.
 - The DDA Residential Program Manager continues to review outcomes and is making recommendation to refine the electronic rate worksheet.
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Strategic Objective 5.3: Effective communication with stakeholders.

Importance: Continue open dialog to understand and provide relevant services for individuals and families.

Success Measure 1: Increase the distribution of quarterly newsletters to clients on the “No Paid Services” caseload of DDA from two to four times a year by July 2015, through a partnership with the Developmental Disabilities Council.

Action Plan:

- The Office of Quality Programs and Stakeholder Involvement will contract with the Developmental Disabilities Council to provide four newsletters a year to individuals on the “No Paid Services” caseload about DDA services and supports as well as community resources.
- The Office Chief for Quality Programs and Stakeholder Involvement partners with the DDC to decide what topics will be in each newsletter.

Analysis/Status:

- The Stakeholder committee has identified three goals for the five-year project. Plans are being made to implement those goals;
 - A folder of resources helpful for families has been developed and is being distributed widely to families and organizations. 2,000 have already been distributed with plans for another 25,000 to be shared in progress.

Success Measure 2: 100 percent of DSHS Policy 7.01 American Indian Policy plans is completed/updated annually.

Action Plan:

- The Regional Administrators will is in process of updating annual plans in compliance with DSHS Policy 7.01 by due date.
- The Tribal Liaison for Management will participate in meetings four times a year to continue open dialog with stakeholders in order to gather feedback and suggestions.

Analysis/Status:

- Tribal Liaison Program Manager attends monthly IPAC meetings. Attended January and February 2014 meetings.
- Tribal Liaison attended a tribal meeting with HCS/AAA on September 11, 2013.
- Tribal Liaison attended a Tribal health fair on October 23, 2013.

Success Measure 3: By July 2015, 100 percent of all new Case Resource Managers will complete Tribal Cultural Relevance and Awareness Training as a part of their academy curriculum.



Action Plan:

- Tribal Liaison Program Manager is working in partnership with the Office of Indian Policy (OIP) and the Tribes to Develop Tribal Cultural Relevance and Awareness training.
- Training will be integrated into DDA Core Academy Curriculum by June 2015. In June 2014, the OIP will give the first overview of Government to Government training to new case managers.
- Loni Grenninger of OIP is presenting in April to all HQ staff an overview of the 7.01 training.
- Tribal Liaison worked with ADS IPAC subcommittee and created a DDA plan to improve the visibility of DDA services to all Tribes. DDA representative to visit Tribal lands in their respective regional area at least once annually. To commence in April 2014.

Analysis/Status:

- OIP created curriculum for the short-term and is working jointly with regional OIP staff to create a curriculum inclusive of a statewide desktop manual reflecting the history and unique culture of all recognized Tribes in Washington State.

