



Annual Report on Activities SFY 2021

Office of Developmental Disabilities Ombuds

Informing the Washington State Legislature's work to ensure safe, quality developmental disabilities services.

"The Legislature finds and declares that the prevalence of the abuse and neglect of individuals with developmental disabilities has become an issue that negatively affects the health and well-being of such individuals." SB 6564 (2016)





Members of the Legislature
Governor Jay Inslee
Don Clintsman, Department of Social and Health Services
Debbie Roberts, Developmental Disabilities Administration

October 30, 2021

We are here to assist people with developmental disabilities, no matter where in Washington State they live, to resolve their complaints and address abuse and neglect.

The legislature created the DD Ombuds program in response to abusive and neglectful conditions for people with developmental disabilities. The Office of Developmental Disabilities Ombuds closed out another year of complaint resolution, monitoring, outreach and training, and systemic policy work.

With 5.5 full time staff, located in three offices around the state, the DD Ombuds conducted 124 new individual complaint investigations. We conducted 137 monitoring visits across the state to review facilities, residences, and programs where people with developmental disabilities receive services. We were not able to hold in-person events because of the pandemic but were able to reach more than 400 people across the state to talk about our services, show our videos about the DD Ombuds and self-advocacy, give presentations about rights and responsibilities. We produced and gave out written materials, made observations, and listened.

We published a report last year, ["Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care"](#) with recommendations for improved systems. This report led to some changes in the foster care system. This past fiscal year we published a report on the Community Protection Program, ["No Way Out – An Introduction to the Community Protection Program."](#) We have received an overwhelming response to this report with a call for reform of the program.

Client rights are now in statute! We worked collaboratively with self-advocates to create videos in multiple languages to explain these rights. We brought systemic issues to the attention of the state and positive changes were made in the lives of people with developmental disabilities.

We continue to find new ways to do our work during the pandemic. We look to the future to find new ways to connect with individuals who have concerns about, or experience abuse and neglect. We see opportunities to engage in systemic policy work to address the prevention of, and response to, abuse and neglect of people with developmental disabilities.

Thank you for this opportunity to serve and empower people with developmental disabilities.

A handwritten signature in black ink that reads "Betty Schwieterman". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Betty Schwieterman, State Developmental Disabilities Ombuds
Office of Developmental Disabilities Ombuds

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Summary Policy Recommendations to the Legislature and Governor

The Legislature created an independent Office of Developmental Disabilities Ombuds (DD Ombuds) to monitor and report on services to persons with developmental disabilities. The DD Ombuds has the authority to investigate complaints, monitor services, and report on State services utilized by children and adults with developmental disabilities. The DD Ombuds also has the duty to make recommendations for service improvement to State agencies, the Governor and the Legislature. A summary of the DD Ombuds recommendations to the Governor and Legislature is below, followed by summary of the work of the DD Ombuds for the state fiscal year (SFY 2021).

Recommendation 1. - Invest in quality community supports and services for children and adults with developmental disabilities to reduce use of crisis services.

Problem: The long-term care system in Washington State is ranked as one of the best in the country. Not so for individuals with developmental disabilities: Washington State ranks 37th in the country for fiscal effort for services for individuals with developmental disabilities according to the 2017 State of the State Report. Staff turnover is close to 50% in residential supported living services, and likely higher since the pandemic. The DD Ombuds sees a pattern of both children and adults with behavioral supports needs who are unable to access needed services to stay in their own home or at home with a parent.

Proposals:

- a. Mandate caseload forecasting for DDA community supports and services.
- b. Increase direct service workers wages in supported living to reduce turnover and increase retention of well-trained staff.
- c. Address the needs of the 15,000+ clients DDA has identified who asked for services but are waiting (no paid services caseload) by increasing availability of waiver services. Identify children and youth on the no paid services caseload, under the age of 21 and on Medicaid and determine if there are unmet needs and whether those can be met under the state Medicaid plan through EPSDT.

Recommendation 2. - Prevent inappropriate hospitalization of children and adults with developmental disabilities.

Problem: Hospitals are being used as crisis placements for children and adults with developmental disabilities across the state. Since July 2018, the DD Ombuds has worked with over 100 children and adults with developmental disabilities who were or are stuck waiting in a hospital without any medical need because Developmental Disabilities Administration (DDA) cannot provide them with an appropriate residential placement in the community.

Proposals:

- a. Require DDA to expand the data collected to include all people with developmental disabilities who are taken to the hospital to find out why people are stuck there. This includes people coming out of residential service settings and private homes.

- b. Expand the number and types of specialized providers. DDA should analyze the number and type of specialized providers needed to meet the current demands for service in each Region. Using this data, DDA employ or contract directly with specialists who can provide the following services throughout the state: Psychological assessments; Consultation on behavior supports for family caregivers, staff, and medical providers; Behavior supports for people with developmental disabilities living in hospitals; Specialized habilitation services.
- c. Direct DDA to identify and remove barriers to utilization of behavioral support, such as in-home consultation, for children and adults who reside with parents.
- d. Fund increased diversion bed, emergency respite or other bed capacity so individuals with developmental disabilities have an appropriate placement available if they experience a crisis and need residential services.
- e. Fund complex transition coordination teams, mobile diversion rapid response, provider development, smaller caseloads, and enhanced support to providers to prevent unnecessary hospitalizations.

Recommendation 3. - Improve services for youth with intellectual/developmental disabilities in foster care

Problem: There are children and youth with developmental disabilities in the Title IV-E foster care system who could be better served. There are concerns about how the lack of DDA-paid services might disadvantage youth with developmental disabilities while they are in Title IV-E foster care placements and while they are transitioning from a foster care setting to an adult residential setting. The DD Ombuds gathered information about how other states serve children with developmental disabilities in foster care in its report [“Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care.”](#)

Proposal:

- a. Direct the DDA and DCYF to utilize information reported in the required November 2021 report to identify gaps in services for these children and report back to the legislature with a plan to improve services for children and youth with developmental disabilities.
- b. Require caseload forecasting for youth with intellectual/developmental disabilities existing foster care.

Recommendation 4 - Identify and close gaps in mental health/behavioral health services for people with developmental disabilities

Problem: The integration of Medicaid health care and behavioral health care has created gaps in mental health services for individuals with developmental disabilities. This major overhaul of the health care system did not adequately prepare to address the multifaceted needs of people with developmental disabilities.

Proposal: Create a mental health service system inclusive of people with developmental disabilities. Support HB 1394 Sec. 10 workgroup generated recommendations regarding proposals to identify and examine current gaps in mental health services for children and adults with developmental disabilities. Ensure recommendations from the Children & Youth Behavioral Health Work Group for improvements to services focus on services for individuals with developmental disabilities.

Recommendation 5 – “Nothing About Us Without Us”

Problem: People with developmental disabilities, their services and daily life are affected by decisions that are made by the legislature and workgroups that are created to address disability inequality in our state. In recent years there have been workgroups created that have not included self-advocates and people with lived experience to provide input and feedback.

Proposal: The Nothing About Us Without Us Act (HB1566) would ensure that people with disabilities are included in any group established by the legislature whose activities are related to people with disabilities. It will have state agencies review and give recommendations on barriers to participation for people with disabilities, and ensure that relevant training or guidance is available for legislators.

Recommendation 6 – Reform the Community Protection Program (CPP)

Problem: CPP the most restrictive community program administered by DDA. The DD Ombuds wrote a report focused on five areas of concern with CPP: People are referred to the program at a young age before they have access to other supports and services. Individuals must comply with DDA’s CPP recommendations or risk losing access to other services. The program has a low graduation rate. DDA responded slowly to DD Ombuds’ request for the information needed to produce this report. The documents produced at DD Ombuds’ request showed lax adherence to policies that protect the rights of people with disabilities.

Proposal: DDA establish a workgroup to reform the Community protection program. The workgroup must look at issues identified in the DD Ombuds report “[No Way Out – An Introduction to the Community Protection Program.](#)” The workgroup creates policy recommendations for the 2023 legislative session.

- a. DDA provide resources to meet the needs of young people with developmental disabilities who are identified as having possible “community protection issues,” diverting them from the restrictive CPP.
- b. Individuals should not be restricted from other DDA services or hours if they choose not to be in CPP.
- c. Create a clear path to graduation from CPP using a person-centered planning process.
- d. Improve DDA response time to DD Ombuds’ requests for documents within a set time frame, and DD Ombuds should have the ability to directly obtain information through electronic access.
- e. Improve DDA’s CPP documentation and assure that requirements are met and rights are protected.

Office of Developmental Disabilities Ombuds Annual Report SFY 2021

Introduction

In 2016, the Washington State Legislature declared, “The prevalence of the abuse and neglect of individuals with developmental disabilities has become an issue that negatively affects the health and well-being of such individuals.” The Legislature created an independent Office of Developmental Disabilities Ombuds (DD Ombuds) to monitor and report on services to persons with developmental disabilities.

Background

The Washington State Department of Commerce awarded the non-profit, Disability Rights Washington, through competitive bid, the contract to administer the DD Ombuds program. Disability Rights Washington created a separate program to fulfill the contract. The DD Ombuds contract began on May 25, 2017. Since then, the Office of the Developmental Disabilities Ombuds has delivered DD Ombuds services in the state of Washington.

Services for people with developmental disabilities in Washington State

Developmental Disabilities Administration (DDA) is part of Washington State’s Department of Social and Health Services (DSHS). DDA administers programs for children and adults with developmental disabilities and their families to obtain services and supports based on individual assessments, needs, and preferences. According to DDA data, there were 56,072 enrolled clients as of June 2021. Of the enrolled clients, 28,915 were receiving paid services. DSHS and other state agencies also administer services to children and adults with developmental disabilities. The DD Ombuds has the duty and authority to investigate complaints, monitor, and report on these services and make recommendations to State agencies, the Governor and the Legislature.

Powers and duties of the DD Ombuds

The Office of the Developmental Disabilities Ombuds has the duty to protect the interests of people with developmental disabilities. The DD Ombuds has the authority and duty to carry out the following:

- Provide information on the rights and responsibilities of people receiving developmental disabilities administration services or other state services and on the procedures for providing these services;
- Investigate, upon its own initiative or upon receipt of a complaint, an issue related to a person with developmental disabilities. However, the DD Ombuds may decline to investigate any complaint;
- Monitor procedures as established, implemented, and practiced by the department to carry out its responsibilities in the delivery of services to people with developmental disabilities;
- Review the facilities and procedures of state institutions, state-licensed facilities, and residences which serve persons with developmental disabilities;

- Recommend changes, at least annually, to procedures for addressing the needs of people with developmental disabilities to service providers, the department, and legislators;
- Establish procedures to preserve the confidentiality of records and sensitive information to ensure the identity of any complainant or person with developmental disabilities is protected;
- Maintain independence and authority within the bounds of DD Ombuds duties; and
- Carry out such other activities as determined by contract.

Budget and Staffing SFY 2021

State appropriation \$643,000

Commerce administrative costs \$32,150 minus \$5,000 - \$27,150

DD Ombuds contract budget is \$610,850 plus \$5000 contract amendment – \$615,850

Staffing - The Office of DD Ombuds operates with 5.5 full-time equivalent staff in Olympia, Seattle and Spokane offices.

State DD Ombuds - Betty Schwieterman - 1 FTE (Seattle)

Region 1 DD Ombuds and Legal Counsel - Lisa Robbe - 1 FTE (Spokane)

Region 2 DD Ombuds - Kathleen Chavey-Reynaud - 1 FTE (Seattle)

Region 3 DD Ombuds - Noah Seidel - 1 FTE (Olympia)

Self-Advocacy Educator - Tim McCue - 1 FTE (Olympia)

Office Assistant - Beth Beeman, then Teal Christensen - .5 FTE (Seattle)

DD Ombuds Program Approach

The Legislature considered a proactive approach to DD Ombuds services. They recognized some people with developmental disabilities are isolated and do not have the resources to reach out for assistance. Therefore, the DD Ombuds' approach is to provide services and take complaints in person as much as possible. This had to change in February 2020 with the onset of the COVID 19 pandemic.

Pre-pandemic, the DD Ombuds visited people where they live or where they receive their services to provide information, listen to their concerns, and help resolve complaints. The DD Ombuds created protocol and began monitoring visits by phone in late spring of 2020. However, many people with developmental disabilities do not use the phone or internet and the DD Ombuds continued to search for new ways to connect. The DD Ombuds resumed limited in-person monitoring in late spring 2021. The DD Ombuds continues to take complaints by phone and through a website complaint form.

The DD Ombuds resolves complaints at the lowest possible level. The DD Ombuds protects choice, autonomy, and ensures people with developmental disabilities have access to advocacy. The DD Ombuds promotes the well-being of people with developmental disabilities who receive state services. All DD Ombuds services are resident-directed and person-centered. The DD Ombuds operates within strict confidentiality protocols.

The DD Ombuds provides information on rights and responsibilities through presentations, trainings, community events, videos, social media and the DD Ombuds website,

(www@ddombuds.org.) In the winter of 2020 the DD Ombuds moved trainings and events to virtual platforms. The DD Ombuds and people with developmental disabilities create the publications, videos, and website content.

The DD Ombuds collects information from diverse stakeholders such as self-advocacy groups, parent groups, provider organizations, and others to guide its work.

The DD Ombuds convenes quarterly an advisory committee, whose membership is comprised in majority of people with developmental disabilities. The committee meets virtually to review stakeholder input and advise the DD Ombuds on priority setting, topics for systemic issue reports, organizational structure to ensure a person centered, resident directed program, and program expansion based on the Long-Term Care Ombuds model.

The DD Ombuds participates in state-led workgroups and regularly meets with state agencies to exchange information and recommend policy and practice change to improve services for people with developmental disabilities.

The DD Ombuds publishes an annual report on the work of the DD Ombuds including the types of complaints received and resolved, facilities and residences visited, systemic issues addressed, recommendations formulated and achieved, and outreach and trainings presented.

Priorities

The Washington State Legislature created the DD Ombuds because there are still high rates of abuse and neglect against people with developmental disabilities. All people have the right to be free from abuse and neglect. The DD Ombuds program is a way to have eyes and ears on the ground to collect complaints, as well as find and fight abuse against people with developmental disabilities.

The DD Ombuds prioritizes issues related to abuse and neglect of individuals with developmental disabilities, including physical and sexual abuse, personal and financial exploitation, physical, mechanical, and chemical restraint, verbal abuse, neglect, and self-neglect. Other issues are addressed as resources are available.

Objectives

The DD Ombuds delivers person-centered, complaint-based services. The DD Ombuds helps people understand their rights and responsibilities and helps people solve their complaints about their services. The DD Ombuds monitors services and reports concerns to the state and the Legislature. The DD Ombuds has the following objectives:

- Provide information on rights and responsibilities;
- Investigate complaints;
- Resolve issues at the lowest level possible through individual complaint resolution;
- Monitor service delivery and review state institutions, state-licensed facilities, and residences;
- Report annually on DD Ombuds services to people with developmental disabilities to stakeholders, the department, the Governor, and the Legislature;

- Publish reports on systemic issues to the Legislature;
- Affect positive change in services for people with developmental disabilities through recommendations for changes in policy and procedures;
- Develop and recommend a plan for growth to expand the DD Ombuds program based on Long-term Care Ombuds model to include regional Ombuds, paid staff, and a significant volunteer force.

The Work of the DD Ombuds

Information on Rights and Responsibilities

The DD Ombuds has the duty to provide information on the rights and responsibilities of individuals with developmental disabilities, including the right to access Developmental Disabilities Ombuds services. Information is provided in a variety of formats and locations across the state.

- 1. Training, Education and Outreach** - The DD Ombuds reached 483 people with information about the DD Ombuds services, trainings on topics such as how to navigate the service systems, self-advocacy and problem solving, and responding to abuse, neglect, and sexual assault through presentations and outreach at 20 events. Fewer events were held because of the pandemic.
- 2. Information and Referral** - The DD Ombuds provides detailed I&R services to people to assist them in resolving their issue. Examples of this type of I&R include providing explanations about and referrals to services, processes for applying for or requesting services including types of DDA services, the DDA eligibility process, the types of DDA service plans, the process for applying for civil legal aid services, and explanation and referral to the complaint resolution unit for abuse and neglect.
- 3. Resource Development** - The DD Ombuds developed resources to inform people with developmental disabilities, their families, service providers, and the community about the DD Ombuds and rights and responsibilities. A tri-fold brochure about DD Ombuds and two DD Ombuds videos are used in presentations and outreach. One video explains the services of the DD Ombuds, and the other covers the importance of self-advocacy. The videos are available on the DD Ombuds website in ASL, and with subtitles available in English and other languages: Chinese (Simplified and Traditional), Korean, Somali, Spanish and Vietnamese. The tri-fold brochure is now available in 8 languages and Braille. The DD Ombuds partnered with People First of Washington to translate and caption 5 videos on client right in five languages.
- 4. Website and Social Media** - DD Ombuds website (www.ddombuds.org) posted 58 posts from around the state. The DD Ombuds brochure has been added digitally to the website in 8 languages, and the DDA Client Rights videos were added to the website in five languages. There is now a fully narrated version of the newest systemic report on the Community Protection Program. DD Ombuds social media has 2,239 followers and 2,200 likes. For the period of July 1st 2020 to June 30th 2021 the website has had 7,503 unique visitors. Those users engaged in a total of 14,399 individual sessions, or

individual times they went to the website, with a continued average of 2 page views per session. This culminates in a total of 18,431 total page views.

Complaints

People with developmental disabilities and who receive services from the state are eligible for services from the DD Ombuds. Individuals with developmental disabilities, staff or providers, family members, guardians, or other interested individuals may make a complaint. The DD Ombuds keeps the identity of those who make a complaint confidential.

Complaints are generated during monitoring visits (in-person and phone) to places where people with developmental disabilities receive services, and from individuals with developmental disabilities, parents or other family members, community members, or service providers. The DD Ombuds receives complaints in-person, by phone calls or through the DD Ombuds on-line complaint form. The DD Ombuds was not able to make as many in-person visits because of the COVID-19 pandemic.

The DD Ombuds reviews, and may investigate, complaints on behalf of people with developmental disabilities who receive state services. Complaints may relate to abuse, neglect, exploitation, the quality of services, or access to services. Complaints regarding abuse or neglect are prioritized for services.

In response to a complaint, the DD Ombuds may take steps to resolve the issue by talking with others involved, monitoring a facility or residence, researching DDA policies or practices, reviewing records, and interviewing witnesses or advocating on behalf of an individual or group to resolve a complaint. Only issues where the DD Ombuds took action are listed below. The DD Ombuds addresses other issues by providing information or referral services.

Complaints worked on in SFY 2021

SFY 2020 complaints carried over to SFY 2021

Number of complaints pending - 27

New July 1, 2020 through June 30, 2021

Number of complaints opened - 124

Closed July 1, 2020 through June 30, 2021

Number of complaints closed - 110

Pending as of July 1, 2021

Number of complaints pending - 41

This fiscal year the DD Ombuds carried over 27 complaints from SFY 2020, responded to 124 new complaints, resolved/closed 110 complaints and had 41 pending as of July 1, 2021.

The majority of complaints concerned individual care issues (includes access to DDA services and care plan individualized assessments); administration issues (includes discharge/transfer from hospitals and from DSHS funded residential programs); autonomy and exercise of rights (includes dignity/respect, preference, choice and rights, privacy); followed by abuse, neglect and exploitation.

New Complaints (124) in SFY 2021 concerned people with the following issues

Note the number of complaints in each issue category does not necessarily correlate to the seriousness of the issue system-wide. For example, the staff shortage complaint number is low, however staff shortage and staff turnover is well-documented as a problem in residential services. DD Ombuds may not see or hear about staff shortages or high turnover on the particular time/date of their monitoring or phone visits. Another example is abuse and neglect which research shows high rates for people with developmental disabilities and is underreported. The majority of new complaints concerned Discharge/Transfer planning; Access to DDA service; Dignity and Respect.

Abuse, Neglect, Exploitation - 10 complaints concerning: Physical abuse (2), Verbal/psychological abuse (3), Financial Exploitation (2), Neglect (2), and Personal safety planning (1).

Autonomy and Exercise of Rights – 22 complaints concerning: Dignity/Respect (6); Preference, Choice and Rights (3); Guardianship (2); Privacy (4); Response to Complaints (2); Representative Payee (2); and Other autonomy and exercise of rights (3).

Individual Care - 40 complaints concerning: Care plan individualized assessment (1), Medications (3), Personal hygiene (2), Dental services (1), Assistive devices or equipment (3), Therapies (1) Access to DDA Services (18); Access to other state services (7), Healthcare (2) and Individual care (2).

Restraints and seclusion - 1 complaint concerning: Other restraints, seclusion or confinement (1).

Quality of Life – 1 complaint concerning: Meaningful day (1).

Environment - 3 complaints concerning: Physical accessibility (1), Cleanliness/housekeeping (1), and Infections control (1).

Administration – 37 complaints concerning: Abuse investigation/Reporting (1), Administrator unresponsive (1), Discharge/transfer planning (33) and Healthcare administration (2).

Staffing - 1 complaints concerning: Shortage of staff (1).

Housing - 4 complaints concerning: Accommodations/modifications (1) and Landlord/tenant (3).

Civil/Legal - 2 complaints concerning: Benefits (1) and DDA eligibility (1).

Complaint Resolution - Examples of assistance provided by DD Ombuds.

- 1. Summary of Complaint** - The DD Ombuds received a complaint about a woman whose primary care provider was her father who passed away. She lived with her father her whole life and they primarily spoke another language in the home. Her and her family were told that a residential placement would be found when the father could no longer provide care for her. The DD Ombuds received the complete after months of her staying with her brother. The woman wanted to move to an Adult Family Home with residents that are similar in age and interest, and to stay near her family and cultural community.

Outcome - The DD Ombuds met with the woman and her family to explain DDA services and learn what she wanted in a new home. We worked together to update her referral packet, help ask for interpreters at meetings, and debriefed after they visited Adult Family Homes. The DD Ombuds attended planning meetings with the family and DDA and stayed persistent about her not moving far away from family and community. After four months of DD Ombuds involvement an Adult Family home she liked was found! The family sent a video of celebrating moving into her new room.
- 2. Summary of complaint** - The DD Ombuds received a complaint about a person ready to discharge from the hospital but needed to go to a place for rehabilitation because they were not ready to go home. Their partner also has a disability and needed support to find resources about where she could go for rehabilitation. The hospital was not receiving feedback from DDA about discharge locations.

Outcome- Referral packets were sent out to Adult Family Homes with the thought that the person will go to a home and stay until they are comfortable moving back home, but might stay there for an extended period of time. The DD Ombuds coordinated calls with DDA, The person, and the hospital to discuss discharge locations and what services would be needed. She was enrolled in the Roads to Community Living Program, and Meaningful Day, and she qualified for the Transition Incentive of \$3000 to Adult Family Homes to move people out of the hospitals. She is currently living in the Adult Family Home and is able to see her partner.
- 3. Summary of complaint** - The DD Ombuds received a complaint from a person in the Community Protection Program. They have been in the program for many years. They complain they are not allowed to have privacy to make phone calls or have relationships without scrutiny and authorization. They want out of the program, but do not see a clear way out. They complain that their service provider doesn't trust them even though they have always complied with program restrictions. They complain that the behavior that landed them in the program when they were a teenager has never happened again, but they are treated as if the behavior is ongoing. They complain they have to speak of the behavior that took place years ago every week with their therapist and then that information is shared with everyone in a large meeting. They are ready to move on.

Outcome - The DD Ombuds provided self-advocacy assistance and information on Community Protection Program policies. DD Ombuds attended treatment team meetings with the individual, advocated in meetings for state employees and service providers to listen to the individual, and advocated with the individual at the regional and headquarters level for the Developmental Disabilities Administration to follow existing regulations, and to ensure rights are protected and services are provided in the least restrictive manner. The

individual's treatment team recommended restrictions on privacy lifted and recommended the person graduate from the program.

4. **Summary of complaint** - The DD Ombuds received a complaint from a guardian who said the residential service provider intends to terminate residential services because they disagree with the decisions of the guardian. The DD Ombuds meets with the individual separately from the guardian and learned that they like their roommates and they like the services from the provider. The individual wants the provider to respect their guardian and work out their differences.

Outcome - The DD Ombuds asks for a Critical Case Conference which should allow for person-centered planning to take place to resolve any issues and help preserve services and placement. Instead, DDA allowed the residential provider to suspend services telling the individual they were not allowed to return to their home. The DD Ombuds, the individual, and their guardian advocated for DDA to ensure contracted service providers are protecting DDA client rights and not preventing the individual from going back to their home. The DD Ombuds advocated with the individual and the guardian for person-centered planning and decision making at the regional and DDA Headquarters level to ensure that provider rights are not conflated with the individual's property rights. The DD Ombuds provided self-advocacy assistance so the individual could take the lead choosing another residential provider. The individual and their guardian found another service provider. The individual is sad to have lost their other home, service provider and roommates, but happy with their new choice of providers and hopeful for the future.

Summary of Complaint Data - Analysis and Identification of Systemic Issues

The DD Ombuds resolves individual complaints and looks for patterns that may indicate a systemic issue. Categories with the highest number of complaints include:

- Individual care issues which include access to DDA services. The majority of the Individual Care complaints were about access to DDA services. The DD Ombuds worked at the regional level of DDA to address case manager services. The DD Ombuds has identified access to behavioral supports, access to mental health care, need for increased waiver funding for 15,000 clients waiting for service, and the simplification of the eligibility process as systemic issues to be addressed.
- Administration issues, primarily discharge/transfer. The DD Ombuds continues to assist people who were in a hospital and unable to discharge into community services this fiscal year. The DD Ombuds identified this as a significant systemic issue in 2019, published a report and made specific recommendations to address this issue. DDA began to collect some limited data about people who went to the hospital from supported living services and were then unable to go back home with those services. As a result of the pandemic DDA opened a cottage on the grounds of Rainier to transfer clients who were in hospitals, unable to discharge. Toward the end of the fiscal year the DD Ombuds received an increase in the number of referrals of both children and adults stuck in the hospital.

- Autonomy and exercise of rights which include Dignity and Respect. DD Ombuds helped individuals and their families to problem solve with their service providers and their case managers to address these issues. The DD Ombuds identified Preference, Rights, Choice as issues to address systemically.

Monitoring

The DD Ombuds made 137 monitoring visits, both in-person and by phone, across the state this past fiscal year to talk with individuals with developmental disabilities and review facilities, residences, and programs. Once the pandemic hit the DD Ombuds stopped in-person visits and developed and tested a telephone visit protocol and began phone visits. Phone visits have been successful with people who typically use the phone. Monitoring visits accomplished several purposes. People who receive services, their families, their staff, and the provider administration receive information about the DD Ombuds. The DD Ombuds gives out materials that are easy to keep such as refrigerator magnets, door hangers and coasters that have information about the DD Ombuds and client rights. The DD Ombuds observe living conditions, and staff interactions and responsiveness to the residents they support. The DD Ombuds also received complaints, initiated complaints and identified locations for follow up monitoring. Phone monitoring visits serve similar purposes although are limited in that the DD Ombuds cannot observe facility or home conditions.

The DD Ombuds made 137 visits (in person or by phone) to the following types of facilities, residences and programs:

Certified Residential Services Settings - total visits –119

Supported Living - 100

State Supported Living - State Operated Living Alternatives (SOLA) - 19

Licensed Residential Settings - total visits - 1

Adult Family Homes - 1

State Residential Habilitation Centers - total visits to cottages or programs - 15

Fircrest Intermediate Care Facility (ICF) - 0

Fircrest Nursing Facility (NF) - 5

Lakeland ICF - 3

Lakeland NF - 1

Rainier - 6

Yakima NF - 0

Hospitals - total visits - 2

Eastern State Psychiatric Hospital - 1

Western State Psychiatric Hospital - 1

Total monitoring visits – 137

Systemic Change Outcomes

The DD Ombuds identified several systemic issues through monitoring visits and complaints, and recommended system improvements. As a result the following policy or procedures were changed.

1. Residential Services Training Curriculum

Problem: The 40-Core Curriculum that Direct Support Professionals for residential service providers receive is the introduction residential service providers get on how to support and interact with people with developmental disabilities. The DD Ombuds saw instances where workers were not properly trained in dignity and respect, person centered thinking, and rights of people with developmental disabilities. The DD Ombuds raised concerns to DDA and in 2018 helped make small changes to the curriculum with the understanding that a full review will happen in the future.

Outcome: In 2021 DDA convened a group of stakeholders to review the full Residential Services Curriculum Training. The DD Ombuds is currently working with self-advocates, service providers, and trainers to update the curriculum.

2. Remote legislative testimony inaccessibility

Problem: During the 2020 legislative session Washington state hearings moved to a virtual format because of the Covid-19 pandemic. This shift made it difficult for people with developmental disabilities to testify because they did not have access or know how to use the technology to testify.

Outcome: The DD Ombuds worked with other advocates to hold trainings and create materials on how to testify using the remote method. The DD Ombuds gave information to the legislature on how to make it easier for people with developmental disabilities to use remote testimony. The DD Ombuds helped connect people to resources to get equipment needed to testify. Now there are people with developmental disabilities who prefer remote testimony and the DD Ombuds is working with other advocates to support the continuation of remote testimonies.

3. Critical Case Protocol implementation

Problem: DDA clients were having their residential services terminated and being taken to general hospitals or other less supportive environments while new placements were sought. DDA created a new policy, the Critical Case Protocol, as a way to prevent hospitalizations and have people stay with their current provider.

Outcome: The DD Ombuds provided recommendations on how to create person centered meetings for people with developmental disabilities to give input on their services, what would help them be successful, and how they can best be served. The DD Ombuds will continue to monitor how this process is working.

4. DDA Client rights education

Problem: HB 1651 passed the legislature in the 2020 session. The bill gathered rights which were scattered throughout the Revised Code of Washington (RCW) and Washington Administrative Code (WAC) into one place in the RCWs. It established certain rights for

clients of the Department of Social and Health Services Developmental Disability Administration. Information about the new law was not being shared widely in Washington, and people's rights were still being violated.

Outcome: DD Ombuds worked with People First of Washington to create six videos with subtitles in the five most common languages in Washington to educate self-advocates and others about their rights. The videos are now used in multiple trainings to educate people about their rights and how to report if their rights are being violated.

5. Washington Safe Start Opening plan

Problem: During the Covid-19 Pandemic people with developmental disabilities living in residential settings were affected by the Governor's proclamation to stay home and provider implementation of Covid-19 rules and recommendations. While this was done because of safety concerns it caused people to feel isolated and disconnected from the daily life they were accustomed to and restricted their access to work and community activities.

Outcome: The DD Ombuds participated in Washington safe start meetings and met with the Health Care Authority to give recommendations on how to balance public safety and people's rights. The DD Ombuds shared experiences from community members to help shape the safe start guidelines. The DD Ombuds have been educating people about the different opening phases and what community activities they can participate in.

6. Connecting DCYF and DDA services

Problem: Staff from The Washington Department of Children, Youth, and Families (DCYF) had questions and concerns about how to best support clients who they believe qualified for DDA services.

Outcome: The DD Ombuds had ongoing meetings with DCYF to answer questions about DDA services and how to best advocate for their clients who they believe should receive DDA services. DCYF employees expressed appreciation in the support to better assist their clients.

7. Legislative recommendations and outcomes

SB 5268 -Transforming services for individuals with intellectual and developmental disabilities by increasing the capabilities of community residential settings and redesigning the long-term nature of intermediate care facilities. The DD Ombuds testified in support of more funding for services in the community. The DD Ombuds testified "other" on the bill, which did not pass, highlighting that it had positive community services, but was still lacking services that would be helpful to move people out of restrictive environments like hospitals.

HB 1061 - Concerning youth eligible for developmental disability services who are expected to exit the child welfare system. The DD Ombuds testified in support of HB 1061, which passed, for youth with DD transition out of foster care to DDA services. The DD Ombuds shared information from the DD Ombuds foster care report, [Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care](#).

HB 1320 - Modernizing, harmonizing, and improving the efficacy and accessibility of laws concerning civil protection orders. The DD Ombuds supported HB 1320, which passed, to improve the laws concerning protection orders.

HB 1411- Expanding health care workforce eligibility. The DD Ombuds testified other on HB 1411, which passed, expressing support for expanding the health care workforce while sharing concerns we heard from community members.

HB 1086 - Creating the state office of behavioral health consumer advocacy. The DD Ombuds testified in support of HB 1086, which passed, creating a state office of behavioral health consumer advocacy. This gives people more access to advocates.

HB 1218 - Improving health, safety, and quality of life for residents in long-term care facilities. The DD Ombuds testified in support of HB 1218, which passed, creating new emergency preparedness requirements in long term care facilities.

HB 1323 - Concerning the long-term services and supports trust program. The DD Ombuds signed in in support to HB 1323, which passed. The bill creates a long-term care benefit and a trust program. Persons who were disabled before the age of 18 may qualify as an "eligible beneficiary" under the Trust Program. Initially this group had been excluded from the program until advocates raised concerns.

HB 1213- Expanding accessible, affordable child care and early childhood development programs. The DD Ombuds signed in in support of HB 1213, that didn't pass, which is known as the fair start for kids act. It would provide more access for children with DD to get appropriate childcare.

Budget - The DD Ombuds testified on the state budget advocating for more funding for DD services in the community.

- 8. DD Ombuds comments on Washington Administrative Code (WACs) and Waiver Amendments** - The DD Ombuds provided comments on WACs related to DDA services.
 - a. **Phased Long-Term Care Facility Reopening Recommendations and Requirements** - DD Ombuds commented that these recommendations must be person-centered instead of provider-centered. For example, that providers must be required to involve their clients in the creation of COVID protocols that will be followed within the client's own home.
 - b. **WAC 365-18 Grievance procedures for Long-Term Care Ombudsman Program** - DD Ombuds submitted public comments online. DD Ombuds supported this update to the grievance policy to align with federal regulations. The ability to maintain independence from the pressure of host agencies or providers is a critical component of the role of an Ombuds and provides necessary assurance to those who are considering filing a complaint.
 - c. **WAC 388-829Z-005 Establishing Rules for the Emergency Transitional Respite Program** - DD Ombuds provided comments during the external review of the draft rules. DD Ombuds commented that this chapter does not define "emergency" in a person-centered way. The comments also highlighted that the rules didn't include clear time limits or directions for transitioning out of respite care into a stable placement based on the client's direction.

- d. **WAC 388-826 Out-of-Home Services** - DD Ombuds met with the Children’s Residential and Crisis Services Unit during the early review phase of this rulemaking. DD Ombuds commented that the rule needed to include a “Shared Engagement Plan” that outlines the respective responsibilities for DDA (including Case Resource Manager), MCO, HCA, and DCYF and how they will coordinate resources to serve clients in this program. DD Ombuds also commented that the definition section need to be expanded to include plain language explanations for jargon and links to related rules, and that there needs to be guidelines for a transition plan to other placements or adult services. DDA responded by adding links to relevant rules and adding language about creating a transition plan.
- e. **WAC 388-823-1095 DDA Client Rights** - DD Ombuds continued its advocacy on client rights by submitting comments on the draft and proposed rules about the need for plain language. DD Ombuds requested that DDA form a plain language stakeholder workgroup to address these concerns. DD Ombuds also presented these comments in a letter signed by six other advocacy organizations during the public hearing on the proposed rule. DDA did not follow DD Ombuds’ recommendations and stated that the language of the WAC must match the language in statute (HB 1651) and not be revised for plain language.
- f. **WACs 388-823-0500 – 0510 – 07020 Autism as an Eligible Condition** - DD Ombuds commented during the external review of the draft rules. DD Ombuds asked about what updates have been made to the rules to make them person-centered. Additionally, DD Ombuds provided information about the history of requiring IQ tests and its roots in eugenics. DD Ombuds recommended that IQ tests not be used to determine substantial limitation.
- g. **WAC 388-101D-0500 Community Protection Program Client Home Location** - DD Ombuds commented on the proposed rule formally and at the public hearing. DD Ombuds asked about the background of this rule change and whether any clients were consulted. DD Ombuds also asked questions about the coercion inherent in the Community Protection Program and how DDA is working to make the program more person-centered. DDA provided a Concise Explanatory Statement in response to DD Ombuds’ comments stating that no changes would be made to the content of the proposed rule because the purpose was to “allow the provider administrator to ensure the home is a safe option for the client...and streamline the approval process to support clients to take advantage of leasing opportunities and ensure that the agency continues to monitor for appropriate housing options.” DDA did not provide information on whether they consulted with DDA clients during the amendment process.

Reports on Systemic Issues

Stuck in the Hospital - The DD Ombuds published the [“Stuck in the Hospital”](#) report in December 2018. The report responded to the high volume of complaints the DD Ombuds received about adults with developmental disabilities stuck in a hospital without any medical need. Most of these individuals were Developmental Disabilities Administration (DDA) clients who had been receiving residential services prior to hospitalization. Some individuals went to the hospital for a medical condition, but when they were ready for discharge, they had no place to go because their residential services provider had terminated their services. Other

individuals were dropped off at the hospital by a provider who could no longer manage their care. These individuals with developmental disabilities spent weeks or months in a hospital because DDA could not locate available residential placement with staff to provide care. As a result, these individuals had to live in hospitals while waiting for residential placement. The report makes recommendations to the State and the Legislature to address this tragic issue. DDA has taken some steps to address this issue and the DD Ombuds received fewer complaints from people stuck in the hospital in SFY2020 and saw an increase in SFY2021. The issue of children and adults with developmental disabilities stuck in hospitals and unable to discharge is still prevalent.

Children and Youth with Developmental Disabilities in Foster Care – The DD Ombuds published [“Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care”](#) in September 2019. During the 2019 legislative session, the Washington State House of Representatives’ Human Services and Early Learning Committee held a work session on youth with developmental disabilities served by the child welfare system. During this work session, a group of advocates articulated serious concerns about how youth with developmental disabilities are being served by the Title IV-E foster care system. The advocates brought concerns about how the lack of DDA-paid services might disadvantage youth with developmental disabilities while they are in Title IV-E foster care placements and while they are transitioning from a foster care setting to an adult residential setting. The advocates brought these concerns to the State Legislature and the public to raise awareness and to ask for a legislative response. The action by the advocacy community prompted the DD Ombuds to look more closely at how children and youth with developmental disabilities are served in the Title IV-E foster care system. The report makes recommendations for the Developmental Disabilities Administration and the Department of Children, Youth and Families to work together to improve services for children and youth with developmental disabilities in foster care. Advocates continue to work on this very important issue. The legislature in 2021 introduced HB 1061 - Concerning youth eligible for developmental disability services who are expected to exit the child welfare system. The DD Ombuds testified in support of HB 1061, which passed, for youth with DD transition out of foster care to DDA services. This bill incorporated some recommendations made by the DD Ombuds and there is more work to be done to better serve these children and youth.

Community Protection Program - - DD Ombuds focused this report, [“No Way Out - An Introduction to the Community Protection Program”](#), on the Developmental Disabilities Administration’s (DDA) Community Protection Program (CPP). DD Ombuds hears many complaints regarding CPP. This report provides background on CPP and identifies concerns resulting from monitoring and complaint investigation. In the course of developing this report, DD Ombuds identified additional concerns to investigate further and report on in the future.

CPP is far and away the most restrictive community program administered by DDA. DD Ombuds focused on five areas of concern with CPP:

1. People are referred to the program at a young age before they have access to other supports and services.

2. Individuals must comply with DDA's CPP recommendations or risk losing access to other services.
3. The program has a low graduation rate.
4. DDA responded slowly to DD Ombuds' request for the information needed to produce this report.
5. The documents produced at DD Ombuds' request showed lax adherence to policies that protect the rights of people with disabilities.

To address these concerns, DDA must ensure that person-centered, less restrictive supported living alternatives are offered instead of a referral to CPP. DDA must also ensure that entry into the program is truly voluntary and that other DDA services are not restricted if an individual declines CPP, and each participant must know and understand their path to graduation from the restrictions of their rights. Finally, DDA must be required to respond DD Ombuds' request for information within a set time frame, and their leadership must ensure the procedures that protect the rights of people with disabilities are followed.

Office of Developmental Disabilities Expansion Plan

The DD Ombuds proposed in November 2019, an expansion plan based on the DD Ombuds experience providing services for the past two and a half years, analysis of the LTC Ombudsman Program model and stakeholder input.

Expansion of the DD Ombuds services focus on the key tasks:

- Provide information on the rights and responsibilities of people receiving developmental disabilities administration services or other state services;
- Investigate, upon its own initiative or upon receipt of a complaint, issues related to a person with developmental disabilities;
- Monitor procedures of the department to carry out its responsibilities in the delivery of services to people with developmental disabilities;
- Review the facilities and procedures of state institutions state-licensed facilities and residences which serve persons with developmental disabilities;
- Recommend changes, at least annually, to procedures for addressing the needs of people with developmental disabilities to service providers, the department and legislators.

Key areas of focus for expansion

- Reach people with developmental disabilities in rural areas and isolated settings.
- Reach people with developmental disabilities from diverse communities.
- Increase visits to people with developmental disabilities living in certified and licensed residences.
- Increase number of complaints resolved/closed from people living in the community.
- Increase capacity to respond to incidents which affect groups of people with developmental disabilities, such as a facility closure or provider decertification.
- Increase capacity to provide self-advocacy trainings and support.
- Increase capacity to work with policy makers on improvements to the service system.

The DD Ombuds modeled its program after the LTC Ombudsman Program with a State Ombuds and Regional offices but does not yet have the resources to implement a volunteer program. The DD Ombuds Program also has a self-advocacy educator to inform people with developmental disabilities about their rights and how to address their concerns about their services. The expansion plan details the model of regional offices, paid DD Ombuds and well-trained DD Ombuds volunteers, an additional self-advocacy educator and a volunteer coordinator.

The plan proposes a graduated increase in paid staff and use of volunteers over three biennium. Phase one would be to stabilize the certainty of the funding for the program by moving the DD Ombuds budget into the maintenance budget. Then Phase 2 a volunteer coordinator, self-advocacy educator and three DD Ombuds are added. Then staffing is increased by 3 DD Ombuds and an Office Assistant.

Detailed Recommendations to the Legislature

Recommendations to the Legislature are based on analysis of complaints, monitoring, Developmental Disabilities Ombuds (DD Ombuds) systemic issue identification and reports.

Recommendation 1. - Invest in quality community supports and services for children and adults with developmental disabilities to reduce use of crisis services.

Problem: The long-term care system in Washington State is ranked as one of the best in the country. Not so for individuals with developmental disabilities: Washington State ranks 37th in the country for fiscal effort for services for individuals with developmental disabilities according to the 2017 State of the State Report. Staff turnover is close to 50% in residential supported living services, and likely higher since the pandemic. The DD Ombuds sees a pattern of both children and adults with behavioral supports needs who are unable to access needed services to stay in their own home or at home with a parent.

Proposals:

- a. Mandate caseload forecasting for DDA community supports and services.
- b. Increase direct service workers wages in supported living to reduce turnover and increase retention of well-trained staff.
- c. Address the needs of the 15,000+ clients DDA has identified who asked for services but are waiting (no paid services caseload) by increasing availability of waiver services. Identify children and youth on the no paid services caseload, under the age of 21 and on Medicaid and determine if there are unmet needs and whether those can be met under the state Medicaid plan through EPSDT.

Recommendation 2. - Prevent inappropriate hospitalization of children and adults with developmental disabilities.

Problem: Hospitals are being used as crisis placements for children and adults with developmental disabilities across the state. Since July 2018, the DD Ombuds has worked with over 100 children and adults with developmental disabilities who were or are stuck waiting in a hospital without any medical need because Developmental Disabilities Administration (DDA) cannot provide them with an appropriate residential placement in the community.

Proposals:

- a. Require DDA to expand the data collected to include all people with developmental disabilities who are taken to the hospital to find out why people are stuck there. This includes people coming out of residential service settings and private homes.
- b. Expand the number and types of specialized providers. DDA should analyze the number and type of specialized providers needed to meet the current demands for service in each Region. Using this data, DDA employ or contract directly with specialists who can provide the following services throughout the state: Psychological assessments; Consultation on behavior supports for family caregivers, staff, and medical providers; Behavior supports for people with developmental disabilities living in hospitals; Specialized habilitation services.
- c. Direct DDA to identify and remove barriers to utilization of behavioral support, such as in-home consultation, for children and adults who reside with parents.
- d. Fund increased diversion bed, emergency respite or other bed capacity so individuals with developmental disabilities have an appropriate placement available if they experience a crisis and need residential services.
- e. Fund complex transition coordination teams, mobile diversion rapid response, provider development, smaller caseloads, and enhanced support to providers to prevent unnecessary hospitalizations.

Recommendation 3. - Improve services for youth with intellectual/developmental disabilities in foster care

Problem: There are children and youth with developmental disabilities in the Title IV-E foster care system who could be better served. There are concerns about how the lack of DDA-paid services might disadvantage youth with developmental disabilities while they are in Title IV-E foster care placements and while they are transitioning from a foster care setting to an adult residential setting. The DD Ombuds gathered information about how other states serve children with developmental disabilities in foster care in its report “Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care.”

Proposal: Create policy and legislative solutions to any gaps in services experienced by children with developmental disabilities served by Title IV-E foster care in Washington State.

- a. Direct the DDA and DCYF to utilize information reported in the required November 2021 report to identify gaps in services for these children and report back to the legislature with a plan to improve services for children and youth with developmental disabilities.
- b. Require caseload forecasting for youth with intellectual/developmental disabilities existing foster care.
- c. Medicaid waivers - Investigate if and how DDA waiver services may improve access to specialized services for youth with developmental disabilities in Title IV-E foster care and/or consistency of services as children and youth move between service settings.
- d. Service Coordination between State Agencies - Investigate options for better service coordination between DDA and DCYF at both the individual and systemic levels; Create opportunities for cross training between DCYF and DDA case managers.
- e. Screening and Eligibility - Research and develop protocols for automatic screening for developmental disabilities when a child or youth enters the Title IV-E foster care system; Create a system where identification of developmental disability by DCYF is referred to DDA for application and eligibility determination.
- f. Transition out of Foster Care Services -

- i. Solicit policy recommendations from the current workgroup comprised of developmental disabilities and foster care advocates looking at the issues posed by transition from foster care to adult services;
 - ii. Investigate how many months before transition the planning process needs to begin;
 - iii. Ensure all DDA eligible youth are screened for developmental disability and DDA eligibility upon entering the foster care system;
 - iv. Produce caseload forecast of the number of children and youth who will transition out of Title IV-E foster care to DDA services based on data from DDA eligibility assessments;
 - v. Investigate if and how DDA waiver services improves access to specialized services for youth with developmental disabilities in Title IV-E foster care and/or consistency of services as children and youth move between service settings.
- g. New License to Extend Age for Foster Care Homes - Research possible licensure options for continued placement of youth with developmental disabilities in foster care homes after the age of 21; Recruit and retain foster care families to provide continued services for youth with developmental disabilities past age 21.
 - h. Developmental Disability Certification for Foster Care Homes - DCYF and DDA develop foster care family training/certification for serving children and youth with developmental disabilities; DCYF recruit, train and retain foster care families to care for children and youth with developmental disabilities.

Recommendation 4 - Identify and close gaps in mental health/behavioral health services for people with developmental disabilities

Problem: The integration of Medicaid health care and behavioral health care has created gaps in mental health services for individuals with developmental disabilities. This major overhaul of the health care system did not adequately prepare to address the multifaceted needs of people with developmental disabilities.

Proposal: Create a mental health service system inclusive of people with developmental disabilities. Support HB 1394 Sec. 10 workgroup generated recommendations regarding proposals to identify and examine current gaps in mental health services for children and adults with developmental disabilities. Ensure recommendations from the Children & Youth Behavioral Health Work Group for improvements to services focus on services for individuals with developmental disabilities.

Recommendation 5 – “Nothing About Us Without Us”

Problem: People with developmental disabilities, their services and daily life are affected by decisions that are made by the legislature and workgroups that are created to address disability inequality in our state. In recent years there have been workgroups created that have not included self-advocates and people with lived experience to provide input and feedback.

Proposal: The Nothing About Us Without Us Act (HB1566) would ensure that people with disabilities are included in any group established by the legislature whose activities are related to people with disabilities. It will have state agencies review and give recommendations on barriers to participation for people with disabilities, and ensure that relevant training or guidance is available for legislators.

Recommendation 6 – Reform the Community Protection Program (CPP)

Problem: CPP the most restrictive community program administered by DDA. The DD Ombuds wrote a report focused on five areas of concern with CPP: People are referred to the program at a young age before they have access to other supports and services. Individuals must comply with DDA's CPP recommendations or risk losing access to other services. The program has a low graduation rate. DDA responded slowly to DD Ombuds' request for the information needed to produce this report. The documents produced at DD Ombuds' request showed lax adherence to policies that protect the rights of people with disabilities.

Proposal: DDA establish a workgroup to reform the Community protection program. The workgroup must look at issues identified in the DD Ombuds report "[No Way Out – An Introduction to the Community Protection Program.](#)" The workgroup creates policy recommendations for the 2023 legislative session.

- a. DDA provide resources to meet the needs of young people with developmental disabilities who are identified as having possible "community protection issues," diverting them from the restrictive CPP.
- b. Individuals should not be restricted from other DDA services or hours if they choose not to be in CPP.
- c. Create a clear path to graduation from CPP using a person-centered planning process.
- d. Improve DDA response time to DD Ombuds' requests for documents within a set time frame, and DD Ombuds should have the ability to directly obtain information through electronic access.
- e. Improve DDA's CPP documentation and assure that requirements are met and rights are protected.

Questions or comments about this report?

Contact: Betty Schwieterman, State Developmental Disabilities Ombuds
Office of Developmental Disabilities Ombuds
betty@ddombuds.org 833.727.8900 ext. 209

To learn more about the DD Ombuds visit: www.ddombuds.org