Annual Report on Activities SFY 2022
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)

Office of Developmental Disabilities Ombuds

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

October 31, 2022

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 Office of Developmental Disabilities Ombuds (DD Ombuds) program in response to abusive and neglectful conditions for people with developmental disabilities. DD 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, DD Ombuds opened 146 new individual complaint investigations. We conducted 124 monitoring visits across the state to review facilities, residences, and programs where people with developmental disabilities receive services. We were able to reach more than 1,261 people across the state to talk about our services, show our videos about DD Ombuds and self-advocacy, and give presentations about rights and responsibilities. We gave out materials, made observations, and listened.

In 2021 we published a report on the Community Protection Program, "No Way Out – An Introduction to the Community Protection Program." In 2022 we published a shortened version of the report and mailed it to everyone in the program. We have received an overwhelming response to this report with a call for reform of the program and for us to continue to advocate for client's rights.

In 2022, we began talking to families and youth who were stuck in the hospital or sent out of state because no services were available in Washington. We published the report, "I Want to Go Home – Reevaluating DDA' Children's Services to Prevent Hospitalization and Out of State Placement" and will continue to highlight this issue for systemic change.

As the pandemic concerns lessen, we find new ways to do our work. We look to the future to connect with individuals who have concerns about, or experiences with, 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.

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

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Policy Recommendations to the Legislature, Governor and State Agencies

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 is below, followed by a summary of the work of the DD Ombuds for the state fiscal year (SFY 2022).

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 identified behavioral supports needs who are unable to access services to stay in their own home or at home with a parent. The DD Ombuds also sees a pattern that people currently in crisis don't have service plans that meet the minimum requirements to prevent crisis.

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. Continue focus on 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.
d. Ensure that DDA and contracted support providers have more training in developing individual and person-centered service plans that meet state and federal requirements to prevent crisis.

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 135 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. To prevent further or extended hospitalization, ensure that people currently waiting for placement have assessments and person-centered service plans meet all state and federal requirements to meet their medical and behavioral support needs.

c. 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.

d. 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.

e. Fund increased diversion beds, emergency respite or other bed capacity so individuals with developmental disabilities have an appropriate placement available if they experience a crisis and need immediate residential services.

f. Fund complex transition care coordinators or teams, mobile diversion rapid response, Intensive Habilitation Services, youth peer mentors, provider development, 24 hour personal care and state operated personal care, smaller caseloads, and enhanced support to providers to prevent unnecessary hospitalization and out of state placement.

g. Ensure services such as WiSE are trained and equipped to serve youth with developmental disabilities.

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 funding for recommendations from the Children & Youth Behavioral Health Work Group for improvements to community based 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 is 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: Direct DDA to implement reforms to the Community Protection Program. The reforms must address the issues identified in the DD Ombuds report "No Way Out – An Introduction to the Community Protection Program" and ensure that services do not isolate people further from the community.

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. DDA should propose agency sponsored legislation so individuals are not restricted from other DDA services or hours if they choose not to be in CPP.
c. DDA should ensure each person has a clear path to graduation from CPP using a person-centered planning process.
d. Ensure DDA and their contracted providers meet all federal, state and policy requirements to guarantee that people are not subjected to unwarranted restrictions of their civil and human rights.

Office of Developmental Disabilities Ombuds Annual Report SFY 2022

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 nonprofit Disability Rights Washington, through competitive bid, the contract to administer DD Ombuds program. Disability Rights Washington created a separate program to fulfill the contract. DD Ombuds contract began on May 25, 2017. Since then, DD Ombuds has delivered its services across 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 57,095 enrolled clients as of June 2022. Of the enrolled clients, 28,674 were receiving paid services. DSHS and other state agencies also administer services to children and adults with developmental disabilities. DD Ombuds has the duty and authority to investigate complaints and monitor and report on these services in order to make recommendations to state agencies, the Governor, and the legislature.

Powers and Duties of DD Ombuds

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

- Provide information on the rights and responsibilities of people receiving DDA 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, 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 2022

State appropriation $643,000
Commerce administrative costs $32,150
DD Ombuds contract budget is $610,850

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 - Leigh Walters - 1 FTE (Seattle)
Region 3 DD Ombuds - Noah Seidel - 1 FTE (Olympia)
Self-Advocacy Educator - Tim McCue - 1 FTE (Olympia)
Office Assistant - 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, 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, DD Ombuds visited people where they live or where they receive their services to provide information, listen to their concerns, and help resolve complaints. DD Ombuds created protocol and began conducting monitoring visits by phone in late spring of 2020. However, many people with developmental disabilities do not use the phone or internet, and DD Ombuds continued to search for new ways to connect. DD Ombuds resumed limited in-person monitoring in late spring 2021. During the spring of 2022, DD Ombuds increased visits to people’s homes. DD Ombuds continues to take complaints by phone and through a website complaint form.

DD Ombuds resolves complaints at the lowest possible level. DD Ombuds protects choice, autonomy, and ensures people with developmental disabilities have access to advocacy. 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. DD Ombuds operates within strict confidentiality protocols.

DD Ombuds provides information on rights and responsibilities through presentations, trainings, community events, videos, social media, and DD Ombuds website, (ddombuds.org.) DD Ombuds and people with developmental disabilities create these publications, videos, and website content.

DD Ombuds collects information from diverse stakeholders such as self-advocacy groups, parent groups, provider organizations, and others to guide its work. DD Ombuds convenes an advisory committee every quarter, with a membership comprised in majority of people with developmental disabilities. The committee meets virtually to review stakeholder input and advise 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.

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.

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

Disability Justice Principles

DD Ombuds examines our work with disability justice principles in mind. People can experience oppression as a direct result of the DDA service system. DD Ombuds brings issues to DDA that highlight that oppression and also amplifies a narrative where people with developmental disabilities are free from abuse and neglect and able to live the life of their choosing. When creating work plans and whenever we attend meetings with DDA, disability justice principles inform and guide our work. Here are some examples of those principles:

Intersectionality - DD Ombuds is mindful of intersectionality framework as we do our work, create our agenda and as discussion occurs in meetings. DD Ombuds recognizes that people have multiple identities that make them whole and cannot be separated from the person.

Intentional Language - DDO uses intentional language centering individuals with disabilities as the ones who know best. There often is coded language used in oppressive systems and DD Ombuds questions this language used by people working in the service system to bring them back to person-centered practices and the principle of “nothing about us without us.”

Priorities

The Washington State Legislature created 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. 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.

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; and verbal abuse, neglect, and self-neglect. Other issues are addressed as resources are available.

Objectives

DD Ombuds delivers person-centered, complaint-based services. DD Ombuds helps people understand their rights and responsibilities and helps people solve their complaints about their services. DD Ombuds monitors services and reports concerns to the state and the legislature. 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 DD Ombuds program based on Long-term Care Ombuds model to include regional Ombuds, paid staff, and a significant volunteer force.

The Work of DD Ombuds

Information on Rights and Responsibilities

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

1. **Training, Education and Outreach** - DD Ombuds reached 1,261 people with information about 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 63 events. Fewer events were held because of the pandemic. DD Ombuds was able to attend, present a workshop on self-advocacy, and engage with over 150 people at the People First Convention in Spokane. People received products with DD Ombuds contact information. Products included tote bags, water bottles, pens, and magnets. Twenty people picked up paper copies of the Community Protection Program Report.

2. **Information and Referral** - DD Ombuds provided 68 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, referrals for education advocacy, and explanation and referral to the complaint resolution unit for abuse and neglect.

3. **Resource Development** - DD Ombuds developed resources to inform people with developmental disabilities, their families, service providers, and the community about 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 DD Ombuds, and the other covers the importance of self-advocacy. The videos are available on 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. DD Ombuds partnered with People First of Washington to translate and caption 5 videos on client rights in five different languages.

4. **Website and Social Media** – DD Ombuds website (ddombuds.org) posted 38 posts to the blog from around the state. A short, plain language version of the report about the DDA Community Protection Program report "No Way Out" has been added to the website. The online complaint form has also been updated to be easier to use. DD Ombuds social media has 2,239 followers and 2,200 likes. For the period of July 1, 2021 to June 30, 2022 the website has had 7,007 unique visitors. Those users engaged in a total of 8,628 individual sessions, or individual times they went to the website, with a continued average of 1.6 page views per session. This culminates in a total of 13,875 total page views. The majority of visitors to the website over that period were new to the website, which means they had never visited before, so a lot of new people are learning about DD Ombuds office.

Complaints

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

Complaints are generated during in-person monitoring visits 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. DD Ombuds receives complaints in person, by phone calls, or through DD Ombuds online complaint form. DD Ombuds was not able to make as many in-person visits in SFY 2022 because of the COVID-19 pandemic.

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, 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 DD Ombuds took action are listed below. DD Ombuds addresses other issues by providing information or referral services.

Complaints worked on in SFY 2022

SFY 2021 complaints carried over to SYF 2022
Number of complaints pending – 41

New July 1, 2021 through June 30, 2022
Number of complaints opened – 146

Closed July 1, 2021 through June 30, 2022
Number of complaints closed – 128

Pending as of July 1, 2022
Number of complaints pending – 59

This fiscal year DD Ombuds carried over 41 complaints from SFY 2021, responded to 146 new complaints, resolved/closed 128 complaints, and had 59 pending as of July 1, 2022.

The majority of complaints concerned administration issues (includes discharge/transfer from hospitals and from DSHS-funded residential programs); individual care issues (includes access to DDA services); autonomy and exercise of rights (includes dignity/respect, guardianship, personal funds); followed by abuse, neglect, and exploitation.

New Complaints (146) in SFY 2022 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 housing complaints are low, however access to accessible and affordable housing is well-documented as a problem in residential services. Another example is abuse and neglect, which research shows as occurring at a high rate for people with developmental disabilities and is underreported. The majority of new complaints opened in SFY 2022 concerned discharge/transfer planning; access to DDA services; and autonomy and exercise of rights.

Abuse, Neglect, Exploitation - 9 complaints concerning: Physical abuse (2), Financial Exploitation (2), Neglect (2), Individual-to-individual physical abuse (1), Lack of response by authorities (1), and Other abuse/neglect issue (1).

Access to Information - 2 complaints concerning: Access to own records (2).

Autonomy and Exercise of Rights - 21 complaints concerning: Dignity/Respect (3); Care Planning (3); Guardianship (4); Personal Funds (4); and Other autonomy/exercise of rights (7).

Individual Care - 37 complaints concerning: Injuries (1); Request for assistance (1); Care plan individual assessment (3); Personal hygiene (1); Access to communication (1); Therapies (1) Access to DDA Services (25); Access to other state services (2), and Healthcare (2).

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

Quality of Life - 6 complaints concerning: Activities (1); Active integration into the community (1); Transportation (1); Safety and security (2); Other quality of life (1).

Environment - 4 complaints concerning: Physical accessibility (2), Air/environment (2).

Administration - 57 complaints concerning: Administrator unresponsive (4), Inappropriate or illegal administration (2); Discharge/transfer planning (49) and Healthcare administration (2).

Staffing - 3 complaints concerning: Shortage of staff (2) and Other staffing (1).

Employment - 1 complaint concerning: Divisions of Vocational Rehabilitation

Housing - 5 complaints concerning: Access/lack of housing (1); Accommodations/modifications (3) and Other housing (1).

Complaint Resolution - Examples of assistance provided by DD Ombuds:

1. **Summary of complaint** - DD Ombuds received a complaint about a women 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. DD Ombuds received the complaint 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 - DD Ombuds met with the women 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. 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 to the DD Ombuds of the celebration when she moved into her new room at the Adult Family Home. .

2. **Summary of complaint -** DD Ombuds received a complaint about a person who received a termination of services from their supported living provider. The supported living provider was terminating services due to lack of staffing and health and safety concerns in the person's home. In the past this person received assistance from DD Ombuds when a different provider terminated services, and they had to spend time stuck in a hospital until a new provider was found. They had fears that they would again be stuck in a hospital for months.

Outcome - DD Ombuds participated in Client Critical Case Protocol (CCCP) meetings which should allow for person-centered planning to take place to resolve any issues and help preserve services and placement. The person wanted to remain in their current residence so they could be close to other providers, activities they liked, and their family. The supported living provider did not allow the person to stay with them as a client, but did extend services while a new provider was being searched for to avoid hospitalization. DD Ombuds helped reframe meetings to focus on what the person wanted and supported the person to attend meetings to express their wants. The person was able to find a new residential service provider that serves people in a similar geographical location. Unfortunately, the person did need to move to a new home, but it is nearby to where they were living. DD Ombuds participated in transition planning and attended staffing meetings while the person settled into their new residence and new provider.

3. **Summary of complaint -** DD Ombuds continues to receive complaints from people in the Community Protection Program (CPP) who have had their rights taken away without required protections from harm in place. They complain of isolation, stigma, and plans not in compliance with Home and Community Based Services (HCBS) regulations. For example, a person in CPP complained that DDA won't allow them to have a cell phone to communicate privately with friends and family even though they are eligible for a free government-issued cell phone.

   Outcome - DD Ombuds first provided self-advocacy assistance and information on Community Protection Program policies, DDA Client Rights, and HCBS federal regulations to inform the person of their rights to communicate privately with people of their choosing. Over the next 3 months, DD Ombuds attended numerous meetings with DDA CPP staff and DDA Head Quarters personnel to persistently advocate for the person's right to have a cell phone. Finally, DDA agreed to assist the person to apply for a government-issued phone. The application was submitted. The person now has a cell phone with limited minutes available each month to make phone calls to their friends and family.

4. **Summary of complaint** – A person who receives supported living services left a message on DD Ombuds complaint line with concerns about their treatment in residential services. DD Ombuds returned their call. The residential service provider staff answered the phone and said that the person is not allowed to have a private phone call with DD Ombuds (a guaranteed minimum right according to DDA client rights). The provider said that all phone calls must be on speaker. The provider handed the phone to the person. The person said "yes, that is right, I have to have all my phone calls on speaker so staff can hear." The person said they have never been allowed to make private phone calls. DD Ombuds explained to the person that they have the right to speak privately with DD Ombuds and asked whether they wanted privacy to address their concern. They said they did.

   Outcome – DD Ombuds asked the person's onsite residential "house manager" to call their supervisor to clarify the person's right to private phone calls. The house manager called the

residential supervisor who also said that privacy was not allowed and all calls must be on speaker. DD Ombuds asked the person if they were ok with conferencing DDA in on the call and asking DDA to explain the rights to privacy to the residential provider. They were. While on speaker with the person and their residential provider, DD Ombuds called the DDA case manager and conferenced them in. DD Ombuds asked the DDA Case Manager to explain the right to private phone calls with the DD Ombuds to the residential provider. DDA Case Manager told the residential provider they would not be penalized for allowing the person to have privacy to speak to us. The person was then able to take the cordless phone into their bedroom and shut the door. They could express their concern about their services safely in private. They have since been able to access DD Ombuds complaint resolution services privately. They report telling others who receive services from the same residential provider that they too have the right to make private phone calls to DD Ombuds.

Summary of Complaint Data - Analysis and Identification of Systemic Issues

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

- The number one type of complaint DD Ombuds assisted with were Administration issues, primarily discharge/transfer. DD Ombuds continues to assist people who were in a hospital and unable to discharge into community services this past fiscal year. 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 last fiscal year, DD Ombuds received an increase in the number of referrals of both children and adults stuck in the hospital. DD Ombuds researched the issues with children stuck in the hospital and began a systemic report on the issue. This continues to be a significant area of advocacy.

- Individual care issues, which include access to DDA services. The majority of the individual care complaints were about access to DDA services. DD Ombuds worked at the regional level of DDA to address case manager services. 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.

- Autonomy and exercise of rights, which includes 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. DD Ombuds identified Preference, Rights, Choice as issues to address systemically. Many of these issues happen to people in the Community Protection Program. DD Ombuds has worked with many people who are in the most restrictive program and do not know what they need to do to graduate. This continues to be a significant area of advocacy.

Monitoring

DD Ombuds made 124 in-person monitoring visits across the state this past fiscal year to talk with individuals with developmental disabilities and review facilities, residences, and programs. Monitoring visits accomplished several purposes. People who receive services, their families, their staff, and the provider administration receive information about DD Ombuds. DD Ombuds gives out materials that are easy to keep such as refrigerator magnets, door hangers, and coasters that have information about DD Ombuds and client rights. DD Ombuds observes living conditions and staff interactions and responsiveness to the residents they support. DD Ombuds also received complaints, initiated complaints, and identified locations for follow-up monitoring.

DD Ombuds made 124 visits in person to the following types of facilities, residences, and programs:

Certified Residential Services Settings - total visits - 92
Supported Living - 73
State Supported Living - State Operated Living Alternatives (SOLA) - 19

Licensed Residential Settings - total visits - 11
Adult Family Homes - 11

State Residential Habilitation Centers - total visits to cottages or programs - 15
Fircrest Intermediate Care Facility (ICF) - 2
Fircrest Nursing Facility (NF) - 0
Lakeland ICF - 1
Lakeland NF - 0
Rainier - 6
Yakima NF - 6

Hospitals - total visits - 3
Eastern State Psychiatric Hospital - 1
Western State Psychiatric Hospital - 2

Total monitoring visits – 124

Systemic Change Outcomes

DD Ombuds identified several systemic issues though 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. DD Ombuds saw instances where workers were not properly trained in dignity and respect, person-centered thinking, and the rights of people with developmental disabilities. 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. DD Ombuds continues to work with self-advocates, service providers, and trainers to update the curriculum to be more respectful and person-centered.

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 to or know how to use the technology to testify. During the 2021 and 2022, remote testimony continued.
   Outcome: DD Ombuds worked with other advocates to hold trainings and create materials on how to testify using the remote method. DD Ombuds gave information to the legislature on how to make it easier for people with developmental disabilities to use remote testimony. 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 DD Ombuds is working with other advocates to support the continuation of remote testimonies. DD Ombuds continues training people on how to utilize remote testimony options.

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. Concern that policy is implemented narrowly and is not being applied to people receiving services from SOLA.
   Outcome: 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. 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 that 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: DD Ombuds participated in Washington safe start meetings to give recommendations on how to balance public safety and people's rights. DD Ombuds shared experiences from community members to help shape the safe start guidelines. DD Ombuds educated people about the different opening phases.

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: DD Ombuds had meetings with DCYF to answer questions about DDA policies 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. **Creating Plain Language Letters with RCS and DDA**
   Problem: DDA Client Rights requires that people receive written notification when DSHS takes enforcement actions against their DDA residential provider. Notification should contain plain language rather than jargon.
   Outcome: DD Ombuds participated in a workgroup with RCS and DDA to review and edit 4 types of enforcement action letters for plain language. Anticipate DSHS to finalize letter templates in SFY2023.

8. **Home and Community Based Services (HCBS) Waiver Quality Assurance (QA) Committee**
   Problem: HCBS QA Committee can be better utilized according to QA measures reported in DDA's waiver application.
   Outcome: DD Ombuds attends these meetings regularly and is sharing information about HCBS charter and advocating for the committee to focus on QA work.

9. **DDA's HCBS Community Protection Program (CPP) Waiver Renewal.**
   Problem: People in CPP service settings complain of blanket restrictions of rights to visitors and activities. DD Ombuds does not see evidence of the required documentation and informed consent necessary before restricting rights.
   Outcome: DD Ombuds met with DDA waiver team, QA teams, DDA leadership, and CPP management to share concerns. Submitted formal comments during waiver renewal process. Asked DDA to submit all CPP settings to CMS for Heightened Scrutiny. DDA declined.

10. **HB 1411 Informed Choice Workgroup**
    Problem: People with disabilities are not able to hire trusted individuals of their choice as care providers when those individuals are not able to pass a background check.
    Outcome: DD Ombuds was named in legislation to participate in a workgroup facilitated by DSHS. The work group will identify recommendations on informed choice through a process to allow older adults and people with disabilities to hire a trusted individual with a criminal record that would otherwise disqualify the person from providing paid home care services. The recommendations on an informed choice process must include client safety, client direction, racial equity, cultural competence, economic consequences of unpaid caregiving, categories of eligible workers, any disqualifying crimes, mechanisms for consideration, and workforce development. A report will be delivered to the legislature.

11. **Community Protection Restrictions**
    Problem: Individuals in the CPP continue to complain about blanket restrictions of their rights and that they see no way out of the program.
    Outcome: DD Ombuds wrote a shortened version of CPP investigation report "No Way Out" and mailed it to all individuals in the CPP with plans to contact 15 % of people in the program early SFY 2023.

12. **Positive Behavior Support Plans (PBSP's).**
    Problem: Reviewed dozens of Functional Assessments/PBSP's from a variety of settings including RHC's, SOLA's, Supported Living, Community Protection and LSR's. Of the FA's/PBSP's reviewed, the person had disruptions in services such as: suspension/termination, requested CCCP, use of police, complaints about abuse, hospitalization, frequent IR's, etc. Some of the PBSP's were written by a DDA employee under the Roads to Community Living program. None of the FA's/PBSP's reviewed contain all the necessary components outlined in rule and policy.
    Outcome: Asked DDA to review all plans written by RCL program employee. Review completed by DDA's clinical psychologist confirmed that none of the 9 plans they reviewed met the minimum requirements. DDA's QA team is completing additional QA activities on PBSP's written by contracted providers.

13. **Adult Family Home (AFH) Liability Insurance Workgroup**
    Problem: Senate Bill 5092 requires the workgroup to consider modifications to enforcement action practices that are creating challenges for AFH providers in acquiring and maintaining coverage.

Outcome: Participated in an RCS facilitated workgroup to develop agreed upon draft WAC language.

14. Self Advocacy Committees

Problem: DDA needs more involvement from Self Advocates to shape policy and give feedback.

Outcome: DD Ombuds staff attends DDA HQ Self Advocacy and Eastern WA Self Advocacy committee meetings.

15. DD Ombuds Dear Provider Letter

Problem: DDA and some contracted providers were unwilling to provide contact information for people receiving services to DD Ombuds. This prevented DD Ombuds from reaching out to the people the legislature intends us to reach.

Outcome: Worked with DDA Liaison to update Dear Provider letter to clarify DD Ombuds access to people in DDA services.

16. Advocacy for Systemic Reform of Community Protection Program

Problem: Individuals in the CPP express concerns about blanket restrictions and no way out of the program.

Outcome: DD Ombuds invited DDA HQ and DDA regional leadership to CPP treatment team meetings. Wrote numerous emails to DDA leadership on behalf of individuals in the CPP with specific concerns. Facilitated conversations between individuals in the CPP and DDA leadership. Concerns remain largely unresolved.

17. Specialized Home "closing"

Problem: Service provider announces they are closing a house they provide services in – requiring people to move. The house is specially designed to be accessible with room for wheelchairs and medical equipment. Concern that individuals need someone from DDA to make sure their choices are heard and rights they have as tenants are protected.

Outcome: Numerous visits to home, meetings with DDA, advocating for CCCP meetings, creativity contracting DSP's and nurses, education to people on rights tenants have. All people in the home had to move elsewhere.

18. Remote Supports Advocacy

Problem: DDA announces availability of remote supports for people on HCBS Waivers during the pandemic but excludes people assessed at needing 24 hours per day of service.

Outcome: DD Ombuds advocates that remote supports should be an option available to all people on the HCBS waiver. DDA announced remote supports available to everyone except those in the CPP.

19. APS Stakeholder work

Problem: For several years DSHS has proposed changes to RCW 74.34, the vulnerable adult statute to include a way for some people to have their names removed from the vulnerable adult registry. And to modify RCW 74.34 to clarify definitions, give authority to APS to share information with law enforcement and some state agencies, and clarify APS authority to share information with DD Ombuds

Solution: DD Ombuds, people with disabilities and their families have worked on this issue in order to increase the pool of qualified caregivers, clarify definitions and
Give law enforcement and DD Ombuds access to APS information in order to better serve people with disabilities.

20. Children and Youth Behavioral Health Work Group

Problem: Currently there are not service for children and youth who need specialized behavioral support. Many children and youth end up stuck in the hospital or sent out of state.

Solution: DD Ombuds participates on this workgroup to advocate for community based services for children and youth.

Legislative recommendations and outcomes (SFY 2022)

HB 2083 - Addressing consent to long-term care placement and services. DD Ombuds signed in opposition of HB 2083, that didn't pass.
DD Ombuds believed the bill would take rights away from people with disabilities and set up unnecessary guardianships.

SB 5790 - Strengthening critical community support services for individuals with intellectual and developmental disabilities. DD Ombuds testified in support of SB 5790. The bill passed.
The bill states DSHS must establish a School to Work Program in all counties in the state to connect IDD students who are receiving high school transition services to supported employment services. This will help students receive employment when they leave school.

SB 5819 - Concerning the developmental disabilities administration's no-paid services caseload. DD Ombuds testified in support of SB 5819. The bill passed.
The bill states DDA must hire two permanent, full-time employees to regularly review and maintain the no-paid services caseload. This should help DDA track the no paid service caseload and help more individuals get connected to paid services

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. DD Ombuds testified other. The bill passed.
DD Ombuds was in support of more funding for services in the community. DD Ombuds testified highlighting that the bill had positive community services, but was still lacking services that would be helpful to move people out of restrictive environments like hospitals.

HB 2008 - Eliminating the use of intelligence quotient scores in determining eligibility for programs and services for individuals with developmental disabilities. DD Ombuds testified in support of HB 2008. The bill passed.
The bill states that beginning July 1, 2025, the DDA may not use IQ scores for determining an individual has a developmental disability. Individuals determined eligible for DDA services under criteria in place prior to July 1, 2025, must maintain their eligibility for services. IQ scores have been a barrier for many people to receive DDA services.

HB 1153 - Increasing language access in public schools. DD Ombuds testified in support of HB 1153. The bill passed. The bill increases language access and interpretation in schools and creates an advisory group to review policies and make recommendations moving forward. This should give more access to more individuals and families to access resources from schools' districts.

SB 5376 - Promoting awareness of the governor's office of the education ombuds. DD Ombuds testified in support of HB 1153. The bill passed.
Beginning August 1, 2023, public schools, including charter schools and state tribal compact schools, and institutional education providers must provide students and their parents or guardians with a description of the services available through the OEO and the OEO's contact information at the time of initial enrollment or admission. This should give more awareness and access to OEO.

HB 1980 - Removing the prohibition on providing employment services and community access services concurrently. DD Ombuds testified in support of HB 1980. The bill passed.
The prohibition on a DDA client participating concurrently in Employment services, also known as "Supported Employment," and "Community Access," also known as "Community Inclusion" services is removed. This allows people to receive employment and community access services at the same time. This should allow people to be more engaged in their community.

HB 1802 - Increasing access and representation in policy-making processes for individuals with disabilities. DD Ombuds testified in support of HB 1802. The bill did not pass.
Provides for certain membership requirements for any statutorily created or statutorily mandated task force, work group, advisory committee, or other entity created in or mandated by statute that is tasked with examining policies and issues directly related to people with disabilities. This would be beneficial because it will increase participation of people with disabilities in creating policies that affect their lives.

HB 1872 - Establishing the care worker center to promote caregiving professions. DD Ombuds testified in support of HB 1872. The bill did not pass.
The bill would have The Workforce Board establish the Care Worker Center as a central access point of knowledge, research, resources, and best practices for care workers, employers, career counselors, education, and training providers. This would help train more care providers.

Budget Bills - DD Ombuds testified on the state budget advocating for more funding for DD services in the community. DD Ombuds focused on Caseload forecasting, expand access to the enhanced case management program, Community Supports for Children -Families caring for children, DDC to partner with racially diverse communities to build capacity of a coalition of IDD self-advocates and advocates, and youth with significant behavioral challenges, and Residential Crisis Stabilization Programs.

DD Ombuds comments on Washington Administrative Code (WACs) and Waiver Amendments
DD Ombuds provided comments during SFY 2022 on WACs related to DDA services.

WAC 388-101D-0500 Community Protection – Client home location

Comments submitted on the proposed rule in July 2021—DD Ombuds commented that the proposed rule continued to leave out the DDA client in the critical decision-making process of finding a place to live. DD Ombuds also pointed out that DDA did not provide answers to questions about where the changes came from or whether people in the Community Protection Program were consulted.

WAC 388-101D-0200 - 201 Terminating and Suspending Services

Comments submitted during the external review in September 2021—DD Ombuds commented that suspension and termination processes need to explicitly protect DDA clients' rights to their home under landlord tenant law and that providers can't be positioned as a go-between. DD Ombuds recommended that DDA delay issuing a proposed rule until they can solicit specific feedback from people who receive supported living services, pointing out that the state rulemaking process can be very inaccessible.

WAC 388-829C-131 - 135 Companion Home Daily Rate and Behavior Support Plan

Comments submitted during external review in September 2021—DD Ombuds commented that the draft rules did not include the requirement that the client direct the process of developing their positive behavior support plan or even that they approve it. DD Ombuds recommended DDA solicit feedback from people who companion home services before proposing changes to the rule.

WAC 388-847 SAIF Program

Comments submitted comments during external review and on proposed rule during public hearing in December 2021 through March 2022—DD Ombuds commented that this new WAC chapter does not outline differing approaches, additional staff qualifications, behavioral supports, or person-centered planning tools to support someone who is experiencing crisis. Further, since this program is not regulated by Residential Care Services, DD Ombuds shared concerns about the lack of detail describing the services that people should expect to receive while at this facility and the lack of regulatory oversite.

WAC 388-823-0510 Substantial Limitation Due to Autism

Comments submitted during external review and on proposed rule during public hearing in February 2022 through May 2022—DD Ombuds commented that while this amendment may result in reducing the barriers to eligibility that are currently preventing people from receiving needed services, it still legitimizes the harmful practice of FSIQ testing by requiring a "substantial limitation" in order to bypass it. DD Ombuds further recommended DDA consult with people who have lived experience as they develop alternatives to FSIQ testing.

Reports on Systemic Issues

Stuck in the Hospital **-** DD Ombuds published the "Stuck in the Hospital" report in December 2018. The report responded to the high volume of complaints 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 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. In 2022 continued to see an increase of people stuck in the hospital. DD Ombuds began a report about youth with developmental disabilities stuck in the hospital or sent out of state for placement. We published the report, "I Want to Go Home – Reevaluating DDA' Children's Services to Prevent Hospitalization and Out of State Placement" and will continue to highlight this issue for systemic change.

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. Each participant must know and understand their path to graduation. Participants must be informed of their rights and the process that must be followed before any restriction of rights is planned. Finally, DDA must be required to respond DD Ombuds' request for information within a set time frame. DDA leadership must ensure DDA staff and DDA contracted providers meet federal, state and policy requirements that protect the rights of people with disabilities.

Office of Developmental Disabilities Expansion Plan

DD Ombuds proposed in November 2019, an expansion plan based on 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 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.

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. 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 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. The DD Ombuds continues to look for opportunities to expand services to people with developmental disabilities.

Questions or comments about this report?

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