



Annual Report on Activities SFY 2023

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
Jilma Meneses, Department of Social and Health Services
Tonik Joseph, Developmental Disabilities Administration

October 31, 2023

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 around the state, DD Ombuds opened 114 new individual complaint investigations. We conducted 127 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 1,358 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. We analyze trends and use information gathered to bring attention to issues of concern. We bring those issues to the state agencies with recommendations for change.

This fiscal year, we published the report, [“I Want to Go Home – Reevaluating DDA’ Children’s Services to Prevent Hospitalization and Out of State Placement”](#) . This report highlights the issues regarding youth who were stuck in the hospital or sent out of state because no services were available in Washington. We will continue to focus on this issue for systemic change.

In 2021, we published a report on the Community Protection Program, [“No Way Out – An Introduction to the Community Protection Program.”](#) We continue to bring concerns about restrictions of rights and failure to comply with federal rules. We have received an overwhelming response to this report and call for elimination of the program.

We look to the future to find new ways to reach people who have concerns about, or experiences with, abuse and neglect. We will continue to engage in 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

Table of Contents

Policy Recommendations	4
DD Ombuds Annual Report SFY 2023 Introduction	8
Powers and Duties of DD Ombuds	8
Budget and Staffing SFY 2023	9
DD Ombuds Program Approach	9
Priorities	10
The Work of DD Ombuds.....	11
Information on Rights and Responsibilities.....	11
Complaints.....	12
Monitoring.....	16
Systemic Change Outcomes.....	17
DD Ombuds Reports on Systemic Issues.....	23

Policy Recommendations to the Washington State 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. Policy recommendations from the DD Ombuds are below, followed by a summary of the work of the DD Ombuds for the state fiscal year (SFY 2023).

Recommendation 1 - Prevent inappropriate hospitalization of children and adults with developmental disabilities.

Problem: Community 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 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 services in the community.

The DD Ombuds released two reports about this issue [our Youth report “I Want to Go Home”](#) in SFY 2023 and our [Adult report “Stuck in the Hospital”](#) in 2018.

Proposal:

- 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 all ages, and 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 that meet all state and federal requirements to meet their medical and behavioral support needs.
- c. Expand the number and types of specialized providers such as psychologists and behavioral support specialists. 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 should 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 additional diversion beds, emergency respite or other bed capacity to meet the current need for crisis services so individuals with developmental disabilities have an appropriate placement available.
- f. Continued increase in funding for 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 service providers, such as WiSE, are trained and equipped to serve youth with developmental disabilities.

Recommendation 2 - Eliminate the Community Protection Program (CPP).

Problem: CPP is the most restrictive community program administered by the Developmental Disabilities Administration (DDA.) The DD Ombuds wrote a report focused on areas of concerns 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. The DDA documents produced at DD Ombuds’ request showed lax adherence to policies that protect the rights of people with disabilities.

Proposal:

DDA should propose agency-request legislation to eliminate the Community Protection Program and create specialized services in the existing waivers. The changes 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 from the community.

- a. DDA should collaborate with every person in CPP to create a person-centered service plan to transition them to other waivers with specialized services.
- b. DDA should find and develop resources to meet the needs of young people with developmental disabilities who are identified as having possible “community protection issues,” and take other actions to divert them from the restrictive programs like CPP.
- c. DDA agency sponsored legislation should ensure individuals are not restricted from other DDA services or hours if they choose not to be in restrictive programs like CPP.
- d. DDA should ensure each person has a clear path to graduation from CPP or other restrictions using a person-centered planning process.
- e. DDA and their contracted providers must meet all federal, state and policy requirements to guarantee that people are not subjected to unwarranted restrictions of their civil and human rights.

Recommendation 3 - Identify and fix systemic gaps with Washington’s abuse investigations and mortality reviews.

Problem: Washington is behind on abuse and neglect investigations in residential service settings, which created a considerable backlog in complaint responses. This has led to a significant delay in completing investigations. In addition, there are gaps with how Washington conducts mortality reviews for individuals with developmental disabilities receiving residential services from Developmental Disabilities Administration (DDA).

Proposal:

- a. Create internal controls in Residential Care Services to comply with requirements to ensure timely and comprehensive investigation of complaints of provider practice and client abuse and neglect.

- b. Mandate Residential Care Services to have a specific mortality investigation protocol/review of suspicious deaths.
- c. Create a Mandatory Reporting requirement for DDA to report suspicious deaths to the medical examiner or the coroner's offices.
- d. Examine DDA mortality review process to identify gaps and assess internal controls for timely and accurate reviews.
- e. Create and fund increased quality assurance mechanisms for DDA to use with residential providers.
- f. Review how DDA enforces residential quality standards for their contracted providers.

Recommendation 4 - Enact "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 (HB 1541) 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 5 – Legislative investment 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 41st in the country for fiscal effort for services for individuals with developmental disabilities according to the 2019 State of the State Report. Staff turnover is close to 50% in residential supported living services. 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.

Proposal:

- a. Increase direct service workers wages in supported living to reduce turnover and increase retention of well-trained staff.
- b. Institute Caseload Forecasting for DDA community supports and services.
- 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 and comply with the Federal Integrated Settings Rules.

Recommendation 6 - 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. Ensure children and youth with developmental disabilities in foster care are able to access DDA waiver services as required.

Recommendation 7 - Identify and close gaps in mental health/behavioral health services for children and youth people with developmental disabilities.

Problem: The integration of Medicaid health care and behavioral health care created gaps in mental health services for children and youth 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 behavioral/mental health service system inclusive of children and youth with developmental disabilities.

- a. Support Children & Youth Behavioral Health Work Group generated recommendations regarding proposals to identify and examine current gaps in mental health services for children and adults with developmental disabilities.
- b. Ensure funding for recommendations from the Children & Youth Behavioral Health Work Group for improvements to community based services for individuals with developmental disabilities. Link for Workgroup <https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhgw>

Office of Developmental Disabilities Ombuds Annual Report SFY 2023

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 investigate complaints and monitor and report on services to persons with developmental disabilities.

Background History

The DD Ombuds began its services across the state of Washington in 2017. 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. The DD Ombuds operates under the authority of RCW 43.382.

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 59,897 enrolled clients as of June 2023. Of the enrolled clients, 29,650 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 2023

State appropriation \$643,000

DD Ombuds contract budget was \$643,000

Staffing - The Office of DD Ombuds operates with 5.5 full-time equivalent staff statewide.

State DD Ombuds - Betty Schwieterman - 1 FTE

Region 1 DD Ombuds and Legal Counsel - Lisa Robbe - 1 FTE

Region 2 DD Ombuds - Leigh Walters - 1 FTE

Region 3 DD Ombuds - Noah Seidel - 1 FTE

Self-Advocacy Educator - Tim McCue - 1 FTE

Office Assistant – Trang Le - .5 FTE

DD Ombuds Program Approach

The 2016 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. Many people with developmental disabilities do not have access to a phone or the internet.

During 2023, with the pandemic lessening, DD Ombuds increased in-person visits although at times, had to cancel because of COVID outbreaks. 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 at www.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. With the leadership changes at DDA, DD Ombuds has seen an increased responsiveness by DDA to address concerns. DD Ombuds recognizes larger culture change at DDA is necessary to prevent and remedy harm and support DDA in the effort.

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:

Intentional Language - DD Ombuds 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.”

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.

Leadership of the Most Impacted - DD Ombuds centers the leadership of people with intellectual and developmental disabilities (I/DD). In order to do our work, we seek out opinions and listen to individuals with I/DD. People who use services and supports must be involved in creating and evaluating those services.

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. This includes individuals who are stuck in the hospital, and people in the restrictive Community Protection Program.

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 1,358 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 56 events.

Some examples of presentations include:

DD Ombuds collaborated with Open Doors for Multicultural Families to deliver the Self Advocate Leadership Training (SALT) to multicultural youth with disabilities for the second year in a row. SALT youth learned about topics such as personal self-advocacy and advocating to local leaders on broader issues.

DD Ombuds gave a presentation about Supporting Self Advocacy to 40 staff members at Lakeland Village RHC, and an additional presentation to a small group of administrators at State Operated Living Alternatives (SOLA) in Spokane.

DD Ombuds delivered a three-hour presentation on several advocacy topics to the Parent Institute for Engagement program (PIE), for the third year in a row. Topics presented include the DD Ombuds office, supporting self-advocacy, legislative advocacy, and games that make learning about self-advocacy fun.

DD Ombuds collaborated with People First of Washington to present information about DD Ombuds services and resources to three transition programs and two special education classes in Spokane.

DD Ombuds continued Emerging Leaders presentations during the 2023 Legislative Session over Zoom. Emerging Leaders support self-advocates with developing plans for legislative advocacy, such as providing them with information on the current state of legislation and helping them figure out who their legislators are and how to meet them.

DD Ombuds attended, held a resource table, and presented at the first in-person Community Summit since the pandemic. New advocacy presentations for this year include Supporting Self Advocacy, Half Decade of DD Ombuds and The Vote is Right.

- 2. Information and Referral** - DD Ombuds provided 87 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 complaints.

- 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 16 posts to the blog on a variety of subjects. A new report about youth stuck in the hospital, “I Want to Go Home” was added to the website. DD Ombuds social media has 2,239 followers and 2,200 likes. For the period of July 1, 2022, to June 30, 2023, the website has had 6,765 unique visitors. Those users engaged in a total of 8,207 individual sessions, or individual times they went to the website, with a continued average of 1.21 page views per session. This culminates in 12,203 total page views. 91% of visitors to the website over that period were new to the website, which means they had never visited before, which means that many 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 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 on an individual complaint are listed below. DD Ombuds addresses other issues by providing information or

referral services. DD Ombuds uses information gained during complaint investigations to address larger systems issues and works for change to improve services and people's lives.

Complaints worked on in SFY 2023

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.

SFY 2022 complaints carried over to SFY 2023

Number of complaints carried over into SFY 2023 – 59.

New July 1, 2022 through June 30, 2023

Number of complaints opened - 114

Closed July 1, 2022 through June 30, 2023

Number of complaints closed - 133

Pending as of July 1, 2023

Number of complaints carried over into SFY 2024 - 40

This fiscal year DD Ombuds carried over 59 complaints from SFY 2022, responded to 114 new complaints, resolved/closed 133 complaints, and had 40 pending as of July 1, 2023.

New Complaints (114) in SFY 2023 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, 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 2023 concerned discharge/transfer planning; access to DDA services; autonomy and exercise of rights; and abuse/neglect.

Abuse, Neglect, Exploitation - 10 complaints concerning: Physical abuse (1), Verbal/Psychological abuse (1), Financial Exploitation (2), Neglect (4), Individual-to-individual physical abuse (1), and Personal Safety Planning (1).

Access to Information - 1 complaint concerning: Access to own records (1).

Autonomy and Exercise of Rights - 20 complaints concerning: Dignity/Respect (2); Right to Refuse Care/Treatment (6), Care Planning (7); Guardianship (1); Personal Funds (2); Personal property (1); and Other autonomy/exercise of rights (1).

Individual Care - 37 complaints concerning: Request for assistance (3); Care plan individual assessment (3); Active treatment (1); Assistive devices or equipment (1); Mental Health treatment (1); Therapies (1) Access to DDA Services (25); and Healthcare (2).

Quality of Life - 1 complaint concerning: Other quality of life (1).

Environment - 1 complaint concerning: Physical accessibility (1).

Administration - 40 complaints concerning: Inappropriate or illegal administration (4); and Discharge/transfer planning (36).

Staffing - 1 complaints concerning: Staff unresponsive (1).

Housing-2 complaints concerning: Accommodations/modifications (1) and Landlord/Tenant (1).

Complaint Resolution - Examples of assistance provided in SFY 2023 by DD Ombuds:

- 1. Summary of complaint** - While visiting people receiving residential supports, the DD Ombuds met a woman who smelled of urine, appeared to have poor dental health and mouth sores, and whose other hygiene needs appeared to be neglected. In response, the DD Ombuds filed a complaint with Residential Care Services (RCS). Later, when checking on the status of the RCS report, the DD Ombuds learned this person had passed away. To learn more about the person, the DD Ombuds requested and read their DDA records. From the person's records, the DD Ombuds learned that many of the person's care needs might not have been met, like going to the doctor for appointments and treatment, or making sure she got the right medication. The DD Ombuds also learned that the initial DDA's Mortality Review and RCS' investigation of the person's death had inaccurate information and did not have all of the information about the person not getting all of their needs met.

Outcome - The DD Ombuds advocated for DDA to reconsider the initial Mortality Review, correct inaccurate information, and add additional information that was missing from the initial review of the person's death. DDA listened to the DD Ombuds' concerns, corrected and added additional information to their Mortality Review. DDA sent their updated version of the person's Mortality Review to RCS. RCS is doing a new investigation of the person's death.
- 2. Summary of complaint** - The DD Ombuds received a complaint from a woman in supported living who wanted to have a sexual relationship with a man but had been told by her case managers she was not allowed to have sexual relationships or have private conversations with friends or family.

Outcome - The DD Ombuds reviewed her planning documents which indicated that she needed to demonstrate "readiness" before being allowed to have an intimate relationship. The DD Ombuds compared the Home and Community Based Settings rule requirements with her actual plans and found no documentation in the plan to justify such an extreme restriction of her human rights. The DD Ombuds escalated the concern to DDA HQ who assigned an investigator. A few months later, the woman in supported living reports she has a cell phone, has more privacy as well as a new boyfriend.
- 3. Summary of complaint** - The complaint came from a parent who needed more support for her 11-year-old son. He was going a long distance to school. The school said they could not provide the support he needed and needed to be picked up early. The family could not find

any care providers to serve him. The mother is a single parent household and the mother had to leave her job because the son could not be alone. Out-of-home placement including out-of-state options were being explored. Many organizations were involved in the wrap around meetings to put more support in place. The complaint was opened almost a year.

Outcome - DD Ombuds helped the mother advocate for services close to home. Residential services were found in Washington. After months of waiting for placement and then transition meetings the youth moved into his new home in a location that his mother could visit and be involved in his care.

- 4. Summary of complaint** - The DD Ombuds received a complaint about a person who had to go to the hospital because he fell. The supported living staff expected it to be a short hospital stay to just to have him get checked out. The person had a possible Urinary Tract Infection (UTI) and was viewed as non-responsive. The hospital called the person's brother who is his power of attorney. The hospital and brother decided to start end of life care - meaning no treatment for the UTI and stopping insulin.

Outcome - DD Ombuds visited with the person in the hospital and helped him express to hospital staff his desire to get treatment and go home. The DD Ombuds talked with his brother and supported living provider to plan for him to get care and go home. The person received medicine and did therapy at the hospital to get ready to go home. The provider got ready for him to come back home. The DD Ombuds checked in with him awhile after he went home and he was happy and doing well.

- 5. Summary of complaint** – The DD Ombuds received a complaint from a person in the Community Protection Program (CPP) who was told they were not allowed to drink more than one soda pop per day according to an “exception to policy” (ETP) restriction. These types of restrictions are approved or denied by DDA regional staff.

Outcome – The DD Ombuds escalated the concern to DDA's regional administrator who again authorized the restriction of soda pop even though it was not related to a medical concern or dangerous behavior. DD Ombuds advocacy and investigation continued. After reviewing records, the DD Ombuds discovered none of DDA's planning documents included safeguards to prevent harm from improper restrictions. Also, the person's reported “behaviors” were not identified as sufficient for eligibility for the restrictive Community Protection Program. The DD Ombuds asked if the “behaviors” were likely a result of being told “no” you can't have another soda pop or other restrictive procedures preventing them from watching movies or visiting their family. The DD Ombuds submitted more concerns to DDA HQ and CMS. Months later, the person has DDA services without having to be in the restrictive CPP. They now have a soda pop machine in their home, can visit their family and watch movies of their choice.

Complaint Data – Summary, 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:

- **Discharge/Transfer.** 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 2018, published a report, and made specific recommendations to address this issue. Toward the end of SFY 2022, 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 published a report [“I Want To Go Home”](#) in SFY 2023. This continues to be a significant area of advocacy.
- **Individual Care.** 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 this restrictive program and do not have a copy of their program plan or know what they need to do to graduate. This continues to be a significant area of advocacy.
- **Abuse/neglect.** DD Ombuds assisted people who had complaints about abuse, neglect or exploitation. Often people want to complain but do not know how or where to complain. Sometimes people are afraid to complain for fear of retaliation. DD Ombuds identifies gaps or problems in the abuse response system and advocates for improvements.

Monitoring

DD Ombuds made 127 in-person monitoring visits across the state in SFY 2023 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 provider administrations receive information about DD Ombuds. DD Ombuds gives out materials 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 127 visits in person to the following facilities, residences, and programs:

Certified Residential Services Settings - total visits - 87

Supported Living - 69

Supported Living Community Protection Program (CPP) - 10

State Supported Living - SOLA - 5

State Supported Living - SOLA Community Protection Program (CPP) - 3

Licensed Residential Settings - total visits - 8

Adult Family Homes - 3

Assisted Living Facilities - 5

State Residential Habilitation Centers - total visits to cottages or programs - 19

Fircrest Intermediate Care Facility ICF - 3

Fircrest Nursing Facility NF - 1

Lakeland ICF - 3

Lakeland NF - 1

Rainier - 9

Yakima NF - 0

Hospitals and Community Psychiatric Facilities - total visits - 9

Community Psychiatric- 1

Eastern State Psychiatric Hospital - 3

Western State Psychiatric Hospital - 2

General Hospital - 3

Day program – 1

Voluntary Placement Children - 3

Systemic Change Outcomes

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. Gaps in 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.”](#)

Outcome: In the 2023 legislative session a bill passed, HB 1188. The bill requires that Medicaid waiver services administered by the Developmental Disabilities Administration (waiver services) be provided to eligible individuals who have received certain specified child welfare services, and that these waiver slots are forecasted and budgeted as maintenance level costs. Additional advocacy needed to ensure these youth and children actually receive DDA services and are able to transition to DDA adult services.

2. 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 to DDA 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 continues to monitor how this process is working.

3. 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. The DD Ombuds advocated for a steering committee and for the committee to focus on QA work. The steering committee focused on transparency in the waiver amendment and renewal processes. There is also a need for people who utilize waiver services to be central in the process. Information must be plain language and accessible.

4. DDA's HCBS Community Protection Program (CPP) Waiver Renewal and Amendments

Problem: DD Ombuds made comments on the CPP waiver amendments and renewals that DDA is not in compliance with the HCBS Settings Rule. DDA continues to insist that DDA is in full compliance. This negates the experiences of people living under the restrictions in CPP.

Outcome: DD Ombuds requested DDA review specific instances where peoples' rights were restricted in DDA's services before ensuring that their Person Centered Service Plans (PCSP's) contained necessary documentation and their consent for restrictive procedures.

DDA reported finding no instances of isolation but still did not provide any PCSP's that met HCBS requirements. Ultimately, DDA developed and asked the DD Ombuds to review a new policy and training for Case Resource Managers and contracted providers. Although the DD Ombuds appreciates DDA's efforts to develop the new policy and training materials, much more work is needed to ensure that people receiving DDA services are not continuing to be isolated because of unwarranted restrictions.

DD Ombuds met with DDA waiver team, QA teams, DDA leadership, and CPP management to share continued concerns. DD Ombuds submitted formal comments during waiver renewal and amendment processes. DD Ombuds asked DDA to submit all CPP settings to Center for Medicaid and Medicare Services (CMS) for Heightened Scrutiny. DDA declined. DD Ombuds then submitted documentation to CMS. As a result CMS announced an in-person, on-sight visit.

5. Advocacy for Elimination of Community Protection Program

Problem: The CPP labels people as deviant and dangerous. People can be referred into the program without objective evidence. Although DDA insists the program is voluntary, if people refuse CPP they cannot access other DDA waiver services and the label remains, even as they attempt to access other services. People have been in the program for years without a clear path to eliminate restriction of rights and graduate from CPP. The harm experienced by people in CPP needs to be remedied.

Outcome: DD Ombuds: asked DDA HQ and DDA regional leadership to attend 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 and submitted hundreds of pages of documentation to CMS, indicating DDA's lack of response to HCBS Settings Rule concerns and harm experienced by people in the program. Concerns remain largely unresolved. Although DD Ombuds has seen instances of specific restrictions being lessened, DDA does not yet acknowledge the ongoing harm caused by the CPP. DD Ombuds continues to work for elimination of CPP.

6. Sixty (60) Voices from the Community Protection Program

Problem: People are isolated in the restrictive program with limited ways to express their concerns or advocate for their rights.

Outcome: The DD Ombuds sent a shortened version of the CPP report "No Way Out" to every person in the CPP program. Then the DD Ombuds called everyone and was able to reach and speak with 60 people in the program. As a result, CPP participants were able to express their concerns about the program. DD Ombuds gave presentations throughout SFY 2023 about what CPP participants had to say about their services. It is important for people to have their voices heard and for changes to services be directed by the people served. During the interviews people said: They do not know the path to graduation; they are not allowed to visit who they want; it is hard to participate in community activities, have to have permission for everything; they have no privacy and are under 24 hour surveillance; they are not allowed cell phones, social media, or streaming movies; they are afraid to make a mistake because they could lose more rights or have a longer wait to earn back their rights; they can't disagree with services without "blow back."; they are not getting the services they signed up for; and they people want their rights back.

7. Positive Behavior Supports Plans Systemic Advocacy

Problem: The DD Ombuds continues to highlight problems with DDA's oversight of functional behavior assessments and Positive Behavior Support Plans. Plans contain restrictive procedures and threats that violate DDA's guarantee of client rights. The training DDA developed is problematic and not adequate. For example: As part of our investigations, the DD Ombuds discovered a training video created over 5 years ago that has long been part of DDA's Functional Assessment/Positive Behavior Support Training curriculum. Instead of demonstrating Positive Behavior Support however, this video advocated for coercion and control by preventing an adult from watching a rated R movie. The DD Ombuds shared the video and our concerns at a meeting with DDA HQ personnel in January 2023, where development and use of the video was defended by some DDA leaders and denounced by others.

Outcome: By February 2023, DDA removed the video from the training curriculum, however DDA has not corrected the harm caused by training that is not person-centered or in line with existing HCBS Settings Rules. DD Ombuds continues to advocate for PBSP subject matter experts and training that reflect best practice.

8. 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 to provide information and support others to have their voices heard.

9. Children and Youth Behavioral Health Work Group

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

Outcome: DD Ombuds participates on this workgroup to advocate for community based services for children and youth. DD Ombuds continues to advocate for behavioral health services to be appropriate, accessible and effective for individuals with developmental disabilities.

DDA Complaint Process

Problem: DD Ombuds brought issues concerning the DDA complaint process to HQ staff.

Outcome: Although DDA made many changes to the complaint process, there are additional concerns with accessibility and responsiveness of DDA staff to the complaints. DD Ombuds will continue to give feedback to DDA on issues of clarity, ease of use, and accountability to the people.

Legislative recommendations and outcomes (SFY 2023)

HB1407- Maintaining eligibility for developmental disability services. The DD Ombuds testified in support of the bill. The bill passed. The bill makes it so if the child has been determined to be eligible for DDA services on or after the child's third birthday they no longer must have a redetermination for services under the age of 18.

HB 1580 - Creating a system to support children in crisis. The DD Ombuds testified in support of the bill. The bill passed. The bill requires that the Governor maintain a Children and Youth Multisystem Care Coordinator (Care Coordinator) to serve as a state lead on addressing complex cases of children in crisis, creates a Rapid Care Team for the purpose of supporting and identifying appropriate services and living arrangements for a child in crisis, and that child's family, if appropriate. The bill allows the Care Coordinator to have access to flexible funds to support the safe discharge of children in crisis from hospitals and long-term, appropriate placement for children in crisis who are dependent.

SB 5506- Establishing an enhanced behavior support homes model. The DD Ombuds testified other for this bill. The bill didn't pass. The bill would have established the Enhanced Behavior Support Homes Program. The DD Ombuds expressed support for more services for people in crises and needing more behavior supports, but expressed concerns about the facility model compliance with federal regulations, Commerce's instead of DSHS involvement, and building on existing services.

HB 1188- Concerning individuals with developmental disabilities that have also received child welfare services. The DD Ombuds testified in support of the bill. The bill passed. The bill requires that Medicaid waiver services administered by the Developmental Disabilities Administration (waiver services) be provided to eligible individuals who have received certain specified child welfare services, and that these waiver slots are forecasted and budgeted as maintenance level costs.

SB 5278 - Implementing audit recommendations to reduce barriers to home care aide certification. The DD Ombuds signed in to support the bill. The bill passed. The bill allows the Department of Health more discretion for the preparation, grading, and administration of the home care aide certification examination. Requires the Departments of Health and Social and Health Services to address delays between training and testing, the lack of test sites, and performance and contract management processes, by completing specific requirements and submitting a preliminary report to the Governor and Legislature no later than June 30, 2024.

SB 5103-Concerning payment to acute care hospitals for difficult to discharge Medicaid patients. The DD Ombuds testified in support of the bill. The bill passed. Requires hospitals to be reimbursed for medical assistance enrollees staying in a hospital when they do not meet inpatient care criteria and are not discharged from the hospital because an appropriate placement is not available.

HB 1506- Concerning leases on land managed or occupied by the department of social and health services. The DD Ombuds signed in opposition to this bill. The bill didn't pass. The opposition to this bill is because it does not require the highest and best use of the property for the benefit of the Dan Thompson Account.

HB 1541- Establishing the nothing about us without us act. The DD Ombuds testified in support of the bill. The bill didn't pass. The bill would establish certain membership requirements for task forces, work groups, and advisory committees that report to the Legislature on issues directly and tangibly affecting underrepresented populations. This would increase representation from the I/DD community.

SB 5370 - Concerning adult protective services. The DD Ombuds testified in support of the bill. The bill passed. The DD Ombuds supported the section stating- "Confidential information relating to vulnerable adults may be disclosed as authorized by the Office of Developmental Disabilities Ombuds program".

E2SHB 1694 - Addressing home care workforce shortages. The DD Ombuds signed in to support the bill. The bill passed. The bill expands timelines for long-term care workers seeking certification as a home care aide. Expands the list of family members who are exempt from having to become certified home care aides and reduces the training requirements for these caregivers. Exempts certain home care aides and nursing assistants whose licensing credentials have expired from paying late fees or renewal fees.

E2SHB 1479 - Concerning restraint or isolation of students in public schools and educational programs. The DD Ombuds testified in support of the bill. The bill didn't pass. The bill would prohibit certain isolation and restraint of students including chemical restraint and mechanical restraint. Phases out the use of isolation on students and the use of isolation rooms by January 1, 2026. Expands the procedures following the use of restraint or isolation including notifications, incident reviews, incident reports, and behavioral intervention plans. Adds training and professional development requirements. Requires multiple reports to the Legislature and directs the Office of the Superintendent of Public Instruction to provide

technical assistance, monitor and support compliance with these requirements, and publish certain data.

HB 1128 - Raising the residential personal needs allowance. The DD Ombuds testified in support of the bill. The bill passed. The bill establishes that the baseline personal needs allowance is \$100 per month effective July 1, 2023.

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, expanded access to the enhanced case management program, community supports for children, families caring for children, project for 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 2023 on WACs related to DDA services.

WAC 388-101D Termination and Suspension of Services

WAC comments on 388-101D submitted during the external review period October 2022. DD Ombuds recommended decreasing provider control over Home and Community Based services, increasing person-centeredness and requiring provider accountability to current rules regarding termination of services to specifically identify why they are not able to meet a person's needs. DD Ombuds has attended numerous Client Critical Case Protocol (CCCP) meetings. The DD Ombuds recommends that CCCP has more alignment with Home and Community Based Settings rules to ensure people receive support to direct their meetings to the greatest extent possible. Ensuring that DDA contractors are held accountable to existing rules could help prevent people from being stuck in hospitals in Washington.

WAC 388-823-1095 DDA Client Rights

WAC comments on 388-823–1095 DDA client rights submitted during the external review period May 2023.

The DD Ombuds comments continued to ask DDA to specifically reach out to people who use DDA services and use the rule making process to develop client rights WACs in plain language instead of simply cutting and pasting from statute.

WAIVER Comments

Home and Community Based Services (HCBS) Waiver Amendments and Renewals

Comments submitted by DD Ombuds to DDA on the HCBS Waiver Amendments and Renewals in September 2022 and March 2023. Wide variety of concerns submitted, most related to concerns with DDA's failure to guarantee that people do not have their rights restricted unnecessarily.

Home and Community Based Settings Rule – CMS notified

The federal Centers for Medicare and Medicaid (CMS) was notified of DD Ombuds concerns about Washington DDA in November 2022. DD Ombuds alerted CMS to restrictions without

justifications in HCBS services, particularly the Community Protection Program. In March 2023, CMS notifies DDA that they are conducting a site visit to review concerns, identify best practices and give technical assistance to DDA.

DD Ombuds Reports on Systemic Issues

Stuck in the Hospital

The issue of children and adults with developmental disabilities stuck in hospitals and unable to discharge is still prevalent. In 2022, DD Ombuds 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 continue to highlight this issue for systemic change.

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 SFY 2022, DD Ombuds 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. In SFY 2023, DD Ombuds published the report, [“I Want to Go Home – Reevaluating DDA’ Children’s Services to Prevent Hospitalization and Out of State Placement”](#).

Children and adults with developmental disabilities continue to be boarded in community hospitals without a medical need. They are not receiving the habilitative services they need, sometimes are restrained and cannot go outside for the duration of their stay. Hospital staff are not trained to work with individuals with developmental disabilities. Hospitals do not have the capacity to board individuals who have no medical need to be hospitalized.

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, analysis of the LTC Ombudsman Program model and stakeholder input. The DD Ombuds has not yet been funded to expand services. DD Ombuds continues to do this important work with the hope to serve more people across the state with additional resources.

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.

Conclusion: The DD Ombuds staff are dedicated to listening to the concerns and complaints of individuals with developmental disabilities and their families. The DD Ombuds then works with individuals to solve their complaints and when necessary takes action at the systemic level to improve systems of supports. Progress has been made in SFY 2023 and the DD Ombuds work continues.

Questions or comments about this report?

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