Perspectives on the Closure of the Frances Haddon Morgan Center

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August, 2012

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-Larry Rhodes, Ph.D., Joyce Dean M.Ed., page 9

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Abstract

The Frances Haddon Morgan Center (FHMC) was closed in December, 2011, at the direction of the Washington State Legislature and Governor. Serving 52 individuals with intellectual/ developmental disabilities at the start of the closure, FHMC was known for its expertise in supporting individuals with disabilities that are on the autism spectrum. The Department of Social and Health Services (DSHS) engaged independent contractors to obtain feedback from stakeholders involved in or affected by the institution closure in order to apply the experience to better maintain and enhance its services to individuals with developmental disabilities.

Focus groups and individual phone interviews were selected as the most cost-effective methodology to obtain feedback, allowing a guided, prescribed conversation to ensure that the topic would be covered thoroughly and that all members of the focus groups would have an opportunity for input. Researchers developed questions, with input from DSHS Division of Developmental Disabilities (DDD) staff. This paper summarizes the processes for achieving FHMC closure, the methods used to identify the focus groups and interview participants, and the perspectives of nearly 130 stakeholders representing groups that were affected by the closure of FHMC.

Stakeholders represented family members of former FHMC residents; former FHMC professional, Human Resources, Physical Plant, and support staff; staff from newly developed State Operated Living Alternatives, other Residential Habilitation Center staff; private community residential and employment providers that received FHMC residents; staff from DDD Central Office, including RCL staff; DDD Regions 2 and 3; and DSHS staff who worked with established closure work groups.

Feedback from these groups included concerns expressed about delays related to the political decision-making process, hurried timelines, human resources processes related to transitioning FHMC staff, and a myriad of communication issues. Many participants praised the professionalism and dedicated efforts of FHMC, DDD, county and community staff who were working under difficult circumstances to achieve closure timelines established by the legislature. The paper ends with conclusions and recommendations based on the analysis of input.

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Introduction

The Frances Haddon Morgan Center (FHMC) was closed at the end of 2011, at the direction of the Washington State Legislature and Governor. FHMC was known for its expertise in supporting individuals with disabilities that are on the autism spectrum, and was serving 52 individuals with intellectual/developmental disabilities at the time the closure was announced. In December 2011, the Department of Social and Health Services (DSHS) engaged independent contractors to evaluate the closure process by obtaining feedback from stakeholders involved in or affected by the institution closure. The purpose of obtaining the feedback was to document experiences and gain the perspectives of stakeholders to learn from the closure experience lessons related to maintaining and enhancing services to individuals with developmental disabilities.

Residential Habilitation Centers in Washington

Prior to its closure, the Frances Haddon Morgan Center was one of five Residential Habilitation Centers (RHCs) in the state supporting persons with developmental disabilities. As of the time of the enactment of the bill, approximately 900 individuals resided in RHCs across the state, as long-term residents, or for short-term or respite stays, including 36 individuals under age 21. DDD also provides community-based services through a number of programs to approximately 20,000 clients over age 18. These services are designed as alternatives to institutions for eligible individuals with intellectual/developmental disabilities who either reside with family members, in rented housing, or in contracted or licensed residential housing in the community. Besides the individuals who receive some services either through an RHC or in the community, an estimated 14,000 eligible clients do not receive any paid services due to lack of available funding.[1] Washington's decision to downsize RHCs, and, in particular, close FHMC, mirrors a national trend toward creating smaller community alternatives to larger and more segregated institutional settings.

[1] From: Final Bill Report 2SSB 5459

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Historical Perspective

FHMC was a Residential Habilitation Center (RHC)—commonly referred to as an institution—funded by a combination of federal Medicaid and state general fund dollars. Originally established in 1972, the FHMC began as a children's day center, supporting children with autism who were admitted as young as five years old. In the mid-1980s, the state's policy changed to allow families' sons/daughters to stay at the center as they grew older, transforming FHMC to a long-term residential care facility. In 2011, the average age in the Center was 31. [2]

Residents of FHMC faced significant challenges, as summarized in a predesign study for the future use of the facility:

> Prior to closure at the end of 2011, the residential census of Frances Haddon Morgan Center remained at about 56 clients for over 20 years. Client needs changed over this time due to residents growing older along with the varied needs and numbers of people admitted for short term care. Short term needs resulted in more emphasis on medical and behavioral interventions. All clients required 24-hour supervision, care and monitoring of a varying , individualized degree. Many residents had a diagnosis of autism; many had a co-existing mental health condition; many had social/emotional and behavioral conditions. The majority of the people supported at the RHC had significant behavior challenges such as aggression, self-injurious behavior, property destruction, and inappropriate social behavior.
>
> Services at the FHMC also included planned short-term respite care for those 18 and older, or those approved by exception to policy[3]. FHMC provided 24-hour supervision by qualified staff and residential care, recreational and community activities as was appropriate.
>
> FHMC typically did not support children under the age of 14, individuals who were not ambulatory, or individuals who required extensive medical or nursing services, or nursing home care.[4]

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[2] Washington State Department of Social & Health Services (2011, December 21). Frances Haddon Morgan Center Predesign Study for Future Use Options: ESHB 1497.

[3] Access to an RHCs for persons under 18 must be approved as an exception to policy.

[4] Ibid. p.5

At least since 1991, the Washington State Developmental Disabilities Council has recommended that the legislature fund the downsizing of RHCs in Washington. In addition, several consecutive legislative sessions identified FHMC as a possible option for closure. In January 1991, the Council stated "It is the position of the Developmental Disabilities Council that: 1) the Legislature should pursue a policy on downsizing RHCs with the goal of eventually closing institutions contingent upon development of adequate and appropriate programs and facilities; 2) that the Legislature should create appropriate state-operated and community-operated programs to support citizens with developmental disabilities; and 3) that the Legislature should pursue the appropriate federal waivers to make downsizing and subsequent community service plans financially and programmatically successful."[5]

Closure Goals

In the 2009-2010 biennium, Governor Gregoire proposed a plan for reforms in Washington's care for individuals with developmental disabilities. Through this plan the Governor set an expectation that Washington would offer a sustainable system of care to serve more people with intellectual/developmental disabilities with a wider range of options near their families and local schools – that is to say, a home and community-based system of care. The Governor's proposals were based on the belief that many persons with developmental disabilities are best served in integrated community-based settings rather than in the state's Residential Habilitation Centers. The Governor's vision called for the appropriate transition of residents at RHCs to smaller, community-based residential homes, and proposed the development of a greater capacity and new services that would address the need for crisis care and behavioral supports in the community.

Implementation of the Governor's objectives began in January 2011 with DSHS undertaking advance planning for the closure of Frances Haddon Morgan Center. Originally proposed to close in June 2011, advocacy against FHMC's closure delayed legislators' passage of the bill, affecting the final closure date. After nearly six months of deliberations, on May 25, 2011, the legislature passed the Second Substitute Senate Bill (2SSB) 5459 (Chapter 30, Laws of 2011, p.v.), which clearly stated the legislature's intent:

- Community-based residential services supporting people with developmental disabilities should be available in the most integrated setting appropriate to individual needs; and

[5] As quoted in Policy No. 103 on Residential Habilitation Centers, adopted November 15, 1991; downloaded 3/12/2012 from http://www.ddc.wa.gov/Policies/103_residential_habilitation_centers.pdf)

- An extensive transition planning and placement process should be used to ensure that people moving from a residential habilitation center to a community setting have the services and supports needed to meet their assessed health and welfare needs.

The legislature also defined several principles to guide the overall system of services for individuals with intellectual/developmental disabilities:

- A developmental disability is a natural part of human life and the presence of a developmental disability does not diminish a person's rights or the opportunity to participate in the life of the local community.
- The system of services for people with developmental disabilities should provide a balanced range of health, social, and supportive services at home or in other residential settings. The receipt of services should be coordinated so as to minimize administrative cost and service duplication, and eliminate unnecessarily complex system organization.
- The public interest would best be served by a broad array of services that would support people with developmental disabilities at home or in the community, whenever practicable, and that promote individual autonomy, dignity, and choice.
- In Washington State, people living in residential habilitation centers and their families are satisfied with the services they receive, and deserve to continue receiving services that meet their needs if they choose to receive those services in a community setting.
- The relative need for residential habilitation center beds is likely to decline as other care options for people with developmental disabilities become more available. The legislature recognizes, however, that residential habilitation centers will continue to be a critical part of the state's long term care options; and that such services should promote individual dignity, autonomy, and a home-like environment.
- In a time of fiscal restraint, the state should consider the needs of all persons with developmental disabilities and spend its limited resources in a manner that serves more people, while not compromising the care people require.

The enacted bill directed DDD to close Frances Haddon Morgan Center in Bremerton by the end of December 2011. The law also froze admissions into Yakima Valley School (YVS)[6]. The concept for FHMC closure, as presented in the RHC Consolidation bill was simple:

[6] The law also froze admissions into Yakima Valley School (YVS) with the exception of crisis stabilization and respite services which would remain at then current levels. The law assured that no permanent resident of YVS would be compelled to move, but that the long term plan for YVS was conversion into State-Operated Living Alternatives, both in the community and at two YVS cottages.

- Close the Frances Haddon Morgan Center by 12/31/11.
- Establish at least two State Operated Living Alternatives (SOLAs) on the grounds of FHMC if people desire that service and if the SOLAs meet Federal requirements for funding in this type of physical setting.
- Within available funds, establish community SOLA houses for people moving from FHMC and provide opportunities for RHC employees to work in them.

The law also addressed larger system changes:

- As of July 1, 2012, no person under the age of 16 would be able to receive services at an RHC.
- As of July 1, 2012, no person under the age of 21 could be admitted to a RHC unless there are no community options available to meet the person's needs.
- Up to eight crisis stabilization beds and up to eight respite beds would be established in the geographic areas where the greatest need exists.
- The law reiterated the Federal intent that a person moving from an RHC has the right to return to an RHC.

In order to meet the timeline required by the Legislature, the majority of the 52 individuals living at FHMC would need to be placed in new residences within a four to five-month period in order to allow time to close down the facility campus.

Supports for the Closure

The Division of Developmental Disabilities acted to inform and educate families about community options, including developing videos about SOLA community residences, and of families whose family member had completed transition from an RHC to the community; holding resource events in Port Orchard (April 5, 2011), Tacoma (May 23, 2011) and Yakima (June 4, 2011); developing and using Comprehensive Discharge Planning Documents; working with Roads to Community Living staff to develop person-centered transition plans for individuals indicating interest in living in the community; and hosting monthly meetings between families of both FHMC and YVS with the Secretary of DSHS. In addition, the legislature approved funding for The Family Mentor Project, to be operated by the Developmental Disabilities Council to offer peer support to families. However, funding for this project was not approved by the legislature until the end of the legislative session. As a result, the Family Mentor Project was not operational until late in the FHMC closure process.

Washington State also assigned individuals from outside of FHMC to support the staff during closure: the federally-funded *Roads to Community Living* (RCL, a "Money-Follows-the-Person" grant) staff were assigned to FHMC to help with the closure immediately after their hiring; a project director was brought in to manage the overall planning and implementation of the move; and central office staff from facilities and human resources assisted some of the planning teams.

RCL staff assumed responsibilities during the downsizing and closure process that were meant to enhance coordination, expertise, and oversight. Their activities included:

- Educating families impacted by the closure about the wide array of available residential support options;
- Attending transition planning meetings and assisting in developing person-centered transition plans;
- Providing consultation to community residential providers regarding positive behavior support plans;
- Staying in contact with families by personally visiting with individuals/families—both at the institution and in their new home—to answer questions, provide information and support, and to provide continuity for the individual and his/her family throughout the closure process;
- Contracting with experts to provide additional technical assistance and consultation to community residential providers for enhancing each person's transition process, including person-centered planning, environmental supports and accessibility, communication supports, swallowing precautions and meal safety, positive behavioral supports, assistive technology, and employment supports;
- Developing and implementing a Family/Guardian/Advocate telephone survey conducted between three and six months after the move to obtain their impressions of: 1) the moving process, 2) their observations of the health and welfare of their family member after the move, and 3) satisfaction with services provided at the new residential setting.

Quality Assurance During Closure

Based on a Quality Assurance Report issued February 1, 2012[7], the Division of Developmental Disabilities and a variety of other entities employed many processes to ensure the safety and

[7] The first Quality Assurance report is available at http://www.dshs.wa.gov/ddd/RHC/documents/The%20Closure%20of%20FHMC%20-%20A%20Quality%20Assurance%20Report%20.pdf. A second Quality Assurance report will be published in the fall of 2012.

well-being of persons living at FHMC as they transitioned from the facility. State, regional, and county staff as well as local private vendors of services all played important roles in ensuring that every family and resident of FHMC had information and choices about their residential options and that the transition and move to new homes went as smoothly as possible. Quality assurance surveys included baseline interviews conducted while each person was still residing at FHMC, along with follow-up interviews at predetermined time periods after each individual's move.

Tragically, one person died following placement from FHMC to a community residence. There has been extensive review of this death by state agencies. It was determined that the death was the result of staff error, specifically by the staff not following protocols that were in place for the resident.

The Post-Closure Study

In December 2011, RCL staff contacted independent researchers to design and conduct a study that would gather perspectives from the range of stakeholders that were involved in or affected by the facility's closure. The purposes of this study were to:

1) Facilitate the feedback of stakeholders involved in the institution and closure process,
2) Document stakeholder experiences, and
3) Gain the perspectives of stakeholders to learn from their closure experience in order to better maintain and enhance services to individuals with intellectual/developmental disabilities.

The remainder of this paper describes the methods used for gathering and analyzing data, results of the focus groups and interviews, and a discussion of conclusions and recommendations.

Methods

In December, 2011, the Division of Developmental Disabilities (DDD) selected two researchers, Joyce Dean, M.Ed. and Larry Rhodes, Ph.D. (see Appendix A) to lead the process of obtaining stakeholder feedback. This overall effort to gather and analyze stakeholder feedback is referred to here as "the study." Working with staff from the DSHS federal project, Roads to

Community Living, researchers determined that focus groups and individual phone interviews would be the optimum, cost-effective methodology to obtain feedback. Both methods would allow open-ended response or conversation around a topic area that could be followed by more specific probe questions. This qualitative approach allowed a guided, prescribed conversation to ensure the topic would be covered thoroughly and that all members of the focus groups would have an opportunity to give input. It must be noted that the resulting comments and feedback represent the perspectives of those participating in the focus groups. While themes drawn from this feedback are useful in evaluation and process improvement, individual comments are not generalizable; that is, it cannot be assumed that other groups or individuals would hold the same views. Indeed, in a large group comprising many stakeholders, it would be surprising if there were not many divergent points of view.

DDD staff identified several stakeholder groups that participated in or were affected by the closure of FHMC. These stakeholder groups were:

- Family members of former FHMC residents who moved to community residential providers or SOLAs
- Family members of former FHMC residents who moved to other RHCs
- Former FHMC professional staff, human resources, physical plant, and support staff members
- Former FHMC employees who had transferred to newly developed SOLAs
- Staff members from other Residential Habilitation Centers that received FHMC residents
- Private community residential providers that received former FHMC residents
- Community employment service providers who are providing services to former FHMC residents
- DDD Region 2 staff members
- DDD Region 3 staff members
- DDD Central Office staff, including RCL staff
- Other DSHS staff members who supported some of the established work groups

Over a series of conversations with DDD staff, the project consultants developed a set of questions, which were then validated through review from representatives from several of the planned stakeholder groups. Questions included pre- and post-attitudes about the closure, the planning phase, the facility transition process, availability of assistance and resources, collaboration, roles and responsibilities, the staff transition process, and the residents' transition process. Not every group was called upon to answer every question, as the questions asked were based on the role in the closure process played by that group. In addition, questions were tailored to the specific role of each stakeholder group in the closure process.

DDD staff selected the individual participants to be included in the focus groups. Selection of participants was based upon the intent to draw from the broadest possible set of stakeholder interests, and included individuals representative of each of the stakeholder groups listed above. Although several individuals were involved in the closure in more than one way, participants were generally limited to attending just one focus group. The final set of focus groups planned were:

- Human Resources Work Group
- Physical Plant Work Group
- Residential Provider Group
- FHMC Professional Group, including both administrative and professional services staff members
- RHC Receiving Staff, including staff members from both Fircrest and Rainier
- DDD Region 2 Staff
- DDD Region 3 Staff
- DDD Central Office Staff
- SOLA Staff
- Employment Providers
- Family members of former FHMC residents.

Once identified, DDD contacted potential participants by phone to ascertain their interest in participation. If they expressed interest, DDD then sent a letter of invitation from the Assistant Director of Developmental Disabilities containing information and instructions for participation. DDD staff received interest from five to 15 participants for most stakeholder focus groups. Several parents expressed interest in participating but were unable to attend a focus group due to distance and timing. Therefore, these individuals participated in individual telephone interviews with a researcher and facilitator, to ensure the project would obtain sufficient input from family members.

A protocol for starting and conducting each focus group was created for facilitators. It included introductions, the purpose of the data collection project, a brief overview of topics, confidentiality, and the next steps in how the data would be used. The facilitators invited participants to speak their minds about anything relative to the closure of FHMC regardless of the question, speak honestly but respectfully, and to speak up if they did not share a perspective offered by another group member.

Following the completion of all focus groups and interviews, researchers completed a preliminary analysis of comments and themes, and identified possible areas for

recommendations. Comments were sorted by themes, so that it was readily apparent which comments and concerns multiple stakeholder groups expressed.

The day after completing the preliminary analysis, researchers met with a final group of 16 stakeholders. This group consisted of a cross section of stakeholders who had participated in leading the closure process. Their role was to consider initial feedback and recommendations coming from the previous focus groups, adding their own feedback and reflection to the process. Some of the members of this group had participated in a previous stakeholder focus group, and others were new to the process. The advantage of employing new members was that it provided an opportunity to substantiate the work of the initial groups. The advantage of bringing back selected members was that it gave members a chance to reflect on the focus topics, thus being better prepared to formulate suggested recommendations.

During the meeting with this "reflections" group, researchers presented an overview of the evaluation process, the stakeholder groups, and preliminary results related to positive highlights, recommendations and concerns expressed by the stakeholders during interviews and the previous focus groups. Researchers asked reflection participants to work in small groups to review the analysis, determine if stakeholders or researchers missed any important areas, and identify the most significant concerns and recommendations among the data presented. Finally, participants were reassembled as a full group and were asked to reflect at a broader level on the analyses they had reviewed in small groups.

The current paper is a result of the preliminary analysis, the feedback from this reflection group, and additional data analyses completed after input from this final group process.

Results of the Study

Focus groups were held in Bremerton, Tacoma, Olympia, and Seattle on February 14-17, 2012, approximately three months following the closure of FHMC. Groups were scheduled to last one and one-half to two hours. Forty-five minutes were scheduled for each individual telephone interview. One hundred twenty-nine stakeholders involved in the closure participated in groups or personal interviews. Two facilitators—both former DDD staff members—used discussion scripts to guide the groups and interviews, while the researchers collected data on responses and discussions.

Most of the actual focus groups, while targeted to a single role or set of similar roles, included more than one type of stakeholder. Thus, one SOLA staff was included with the private providers in the residential provider group; DDD, DSHS and FHMC support staff were in the physical plant group; the human resources group included SOLA, former FHMC, DSHS Human

Resources, and a union representative; the employment providers group included county staff and schools; the FHMC professional group included Region 3 staff; the DDD Central Office group included RCL staff, as well as Fircrest and DSHS Planning, Performance, and Accountability; and the family member group included those whose son/daughter had moved to a SOLA or other community residence and those whose son/daughter had moved to another RHC. In addition to the groups, researchers also conducted individual phone interviews with four family members of former FHMC residents who had either moved to another RHC or SOLA and who could not attend the group meetings.

The general topic areas that guided the stakeholders' discussions provide much of the organizational framework for presenting the perspectives derived from the focus groups and interviews. These areas, presented below, are Attitudes about the Closure, Facility Closure Process, Transitions for Individual Residents, Community Preparation and Development, Transitions for FHMC Staff, and Results After Closure (Outcomes).

Attitudes about the Decision to Close FHMC

It came as no surprise to staff or families of residents that Frances Haddon Morgan Center was again on the legislative list for closure. A regional staff member commented that it made sense to start with FHMC because *"in this case it was the smallest facility."* Despite this, most believed that closure would probably be avoided as it had been in all previous proposals. *"The first time I heard about this proposed closure, I thought it wouldn't be any different,"* said one DDD Central Office staff, adding, *"And then, it really was different."* For many outside of the RHC staff and families of FHMC residents, the prospect of an institution closing was exciting. Said one community advocate, *"Historically, I was excited this could happen...the idea we really are putting our money where our mouth is, consolidating or closing RHCs and moving people into community."* The Division of Developmental Disabilities had expressed its preference for community over institutional services for years, *"as a values but also a fiscal decision,"* said one staff member. But the difficulty of the task was recognized: *"I thought, 'Oh my gosh, this is going to be a lot of work and heartache' – excitement, but a lot of work."*

> *"We've all worked together for years.... I worked here (at FHMC) for fifteen-plus years. We battled every year about whether we would stay open or close. When it finally hit, it literally felt like a death."*
>
> *FHMC Staff Member*

Some respondents experienced mixed or shifting feelings about the closure. One community residential provider said, *"Initially I thought it was unfortunate, before I met anyone there. Once I started visiting there, I felt different. Once I met the person who was coming into our program,*

I was sure he was going to be moving into a better situation. But I felt bad he would be leaving a place and staff he knew so well."

Participants repeatedly voiced the perception that the changes and delays in the legislative decision to close FHMC caused extra stress among the family members, the staff of FHMC, DDD Regional staff, and the staff of the RHCs, SOLAs or community programs where the individuals were moving. But it was understood by all stakeholders that closure was a political process. Over the years, coalitions of parents and RHC staff members saw a common interest in working together to avoid closure. Said one parent, *"I can't speak for anyone else, but I don't like the idea that the Morgan Center was closed. The Morgan Center was a very unique place. It seems to be the poor and the handicapped that always get hurt...It is unfortunate it is closed, as there are more and more autistic children, like an epidemic..."* FHMC staff members voiced similar sentiments: *"Closure was always on the back of our minds. After 18 years, all we heard was closure, closure, closure. But we escaped it. Every time the budget came through, the Morgan Center was out of the budget. There was a false sense of security on the staff's part, and on the union's part."*

> *"...(FHMC) was one of the institutions that had an active respite program...and looked at helping people transfer back home and to other community residential settings... It seemed a strange place to start."*
>
> *DDD Central Office Staff Member*

This false sense of security turned into anger and sorrow when it was clear that closure would happen—anger at the decision, the process of deciding, and even the way the decision was announced. *"I felt like they were doing this behind our backs for months...."* *"We were in a training meeting, and it was announced so nonchalantly that we were closing."* *"We watched (the residents) grow. To have that pulled out from under you instantly..."* Many of the FHMC staff felt they had built a strong and close team over the years, and the loss was personal.

There were those who believed the decision to close FHMC versus another institution was questionable particularly given the specialized nature of the facility in serving residents with autism. *"The only real debate was whether the only facility that focused on autism would be the one closed,"* said one DDD regional staff member. A DDD Central Office staff person agreed: *"In terms of service provision and looking at the whole system, it seemed like an odd choice."*

These perceptions of service value and scope, coupled with years of indecisiveness over closure, led some staff and families to believe that it would not happen. When the decision was

finally announced, many experienced a strong sense of betrayal and anger that carried into the closure process itself.

Facility Closure Process

The team responsible for the closure, from DDD Central Office to FHMC direct support staff, in every stakeholder group expressed the commitment and effort to do the right thing for the residents affected by the closure. *"There were certain principles that had to be followed through the process—choice, safety, honoring the mission and a vision of DD. The more I learned, I realized there probably were lots of people living there who could be successful in the community."*

Other systems issues and changes. In addition to the stress of closing FHMC, several other issues and changes were occurring that affected staff working on the closure. One, a $300,000 embezzlement, led to changes in policy and business office functions at the same time as the closure to ensure that it could not happen again. *"Business office did not function,"* said one Physical Plant group member. *"They didn't function very well. They didn't have a leader,"* agreed another.

> *"The person leading the business office, was resigning the end of June, so with the facility closing, why do anything anyway? Bills didn't' get paid. We almost had the power shut off."*
>
> *Physical Plant Group Member*

> *"It was the perfect storm. Except for a fire, I don't know what else could have happened."*
>
> *Physical Plant Group Member*

During the last few months of the closure, business operations, including facility, maintenance, and HR, were all consolidated by DSHS, delaying some important processes such as work orders. Further, the FHMC HR person was on leave for times during the closure, and every department was losing staff.

Roles in the closure process. Almost every group of stakeholders, regardless of their role, had participants that identified confusion, lack of direction, and/or lack of clarity of roles in the closure process. From a representative of the DDD Central Office: *"You work through it, and hope someone tells you if you are not doing it right. I had a two-sentence blurb telling us what to do. I had to just work through it and figure it out."* Work groups were set up to do the necessary planning and resolve closure issues but were without job

> *"There is no set of guidelines on how to do this, so a lot was just winging it...and our roles grew exponentially."*
>
> *Physical Plant Focus Group Member*

descriptions. One person commented, *"It is better to have more than just names for the work groups. What did they actually intend for these groups to do?"* Said a DDD Region 2 staff member, *"It was a little confusing at times. There were a lot of people trying to figure out their roles. It wasn't that they were not trying to collaborate."*

A project leader in the Reflections Group commented that it was unrealistic for everything to be scripted, and that it seemed some staff members responsible for the transition of individuals were waiting to be told what to do rather than working things out within the scope of their authority. Problems were anticipated, in part because there was no clear model to follow and in part because of tight timelines to complete the closure. One leader later reflected that it had been more than 20 years since the previous institution had been closed in Washington. There was simply no time to develop a model closure, so it was "learn as you go." This belief was echoed in focus group comments, such as this one from a Physical Plant group member: *"Leadership believed you could do it. If you needed help, you could ask and they would somehow work it out."*

For the FHMC staff members responsible for transitioning the residents, roles were changing, or at least growing, as residents moved and other staff departed. Said one, *"We had to absorb the roles of people who had gone, so we had to learn their jobs too. I'm surprised I'm not crazy."* And for the FHMC staff who transitioned with residents to the new SOLA residences, their jobs changed too, encompassing a level of responsibility that prior to the move had been shared with professional and facilities staff at FHMC: *"Now we had to contact dentists and doctors and vocational programs, get the guys in school, buy groceries, deal with (the house) heating and water systems, shovel snow..."*

Timelines. The confusion over roles and who was making what decisions was exacerbated by imprecise or changing timelines. *"We were so up in mid-air when decisions would happen,"* commented one DDD Central Office staff member.
A regional staff member said, *"I felt like I never quite knew what was happening. I don't know how the timelines were developed."* Said another, *"We didn't get the opportunity to learn what people would need in the community when they left, since (the closure process) went so fast."*

> *"...Changes in the closure date created chaos..."*
>
> *FHMC Professional Staff Member*

Empowering family decisions. Respondents described many events to provide family members with information that would facilitate the principle of choice, including parent conversations and family meetings. There was evidence that these activities paid off: *"The fact is we went from only fourteen considering community placement to thirty-two who actually did."* But some leaders of the closure process understood the process could have been

improved. As expressed by this DDD Central Office staff member: *"There are a lot of things I wish had gone differently. I had no idea about this when I took this position. How important it is to have a one-to-one relationship between the parent and whomever else (is involved). It is important that parents have their own decision-making processes, and are able to talk with other parents about the fears, concerns, and all the things that go with doing something new. I saw it as important, but now I think it is one of the most important things to consider."*

While focus group respondents seemed to take pride in their own professionalism around the closure, there were those that believed that not all staff acted professionally, particularly within the FHMC staff. For example, it was believed by some DDD staff that information was withheld from families, or was simply not presented clearly. Some DDD staff felt that FHMC staff, due to their limited experience with community-based services, were not prepared to talk with families about the process, or even carried an "institution bias" into their conversations with families. Several community agency staff, for their part, expressed the view that the RHC staff did not know enough about community services to reflect these services accurately to families.

The interactions between staff and parents during the closure process represent one of the areas of greatest disagreement among focus group participants, with a wide range of perspectives expressed. For example, while many members reported that FHMC administrators and others did a good job of encouraging families to come to orientation gatherings, several former direct support staff members were maintaining *"parents were coming to us for emotional support, and we were told to shut our mouths by administration--to not talk about the closure with parents."*

Thus, staff members at FHMC received mixed reviews of their support for providing information to families that would enable informed choices about living options. One DDD Central Office respondent noted that some families felt empowered to search out options on their own after meeting with other families who had previously been involved in moving from an institution to the community. Nonetheless, she said the process worked less well for some than others because of the decision support received from staff of FHMC and the RHC facilities. *"Some staff were good at (the process of polling families about their interests in community options), some were not. Some people who had been working at FHMC for a long time didn't understand the community setting very well, yet they were doing calls to families."*

Human resources and labor issues. Nearly every stakeholder group expressed concerns with human resources support. A staff member of a receiving RHC spoke for many when she said, *"You had Department of Personnel coming in to help, but our (FHMC) HR was overwhelmed."*

> *"There was no concise plan, no explanation of what would happen, so FHMC staff would just take the first job they could, then later regret it. They would say they had made a bad decision, but people felt a sense of despair."*
>
> *FHMC Professional Staff Member*

In part, the human resources issues were seen as the inevitable results of hurried timelines. For the staff of FHMC, however, the issues with the human resources process and information provided were personal. One person said that HR came in too late with options for staff, *"by two to three months."* Others lamented poor communication or information. Said one staffer, *"I would have rather heard the hard line bitter truth. It was hard to swallow not just having the information about closure given in a straightforward manner."* Another decried what was perceived as mixed messages, *"Nothing is guaranteed--you can be told one thing and the whole thing can be changed overnight."* Someone else said that FHMC staff members "*were confused, not getting straight answers on either the process or their personal options. It could have been smoother, with a better sense of 'these are your options' so people wouldn't be under such stress."* Other former FHMC staff members said that for most staff there was only a single job option. Said one, *"The options that were provided were distant."* Said another, *"People were told they were going to get a job, but they were not told it might be in Eastern Washington."* An FHMC professional staff was blunt, *"I was given only one option...I felt lied to about the possibilities..."* A member of the HR workgroup echoed this: *"If you had high seniority, we thought you would get all the options—but they only gave one."*

> *"The process for determining who was hired was horrid, with some people with good records and twenty-plus years of service not even being interviewed for available jobs."*
>
> *SOLA Focus Group Member*

For the staff members at FHMC, the most frequently voiced concern had to do with fairness in the decisions about who would lose their jobs or transfer to other opportunities at SOLA or other residences. A former FHMC employee made this comment: *"Some people were promised jobs by the administration outside of the HR process. Where is the fairness? It was a war zone."* Said another, *"It was hard to maintain support for each other when some staff were getting jobs and others were losing their own--especially when you couldn't see fairness in the decisions."*

HR personnel agreed that options were often distant, or required transportation that was not available to the FHMC staff. They also identified communication issues with staff: *"If you communicated too early or if you would speculate, it would be taken as hard fact even if it was*

brainstorming." HR staff commented that some FHMC staff "disengaged" and didn't take options that were available, *"and then had a hard time getting back into the job market."*

Even though the closure had the support of the legislature and the Governor, and the creation of the SOLA residences decreased the concerns of the union, there still were many internal HR obstacles to be overcome. *"I've been around a long time, but to have support at that level, and still have internal people throwing bats and bricks into the system to make things harder, I don't get it," said one DDD Central Office manager.*

While the transition of FHMC staff to the new SOLA homes was widely praised by staff and families alike, it created challenges for HR processes. Said one member of the HR workgroup, *"The Secretary said that those employees who are at the institution will follow (the residents of FHMC) to SOLA homes. This was an error. It caused many problems."*

An additional area of difficulty perceived by both union and managers working on closure was the rigidity of the collective bargaining agreement in a closure of this magnitude. Said one HR representative, speaking of staff seniority, *"The contract language around layoff, I think, is good if you are closing a unit. But if you are closing a whole facility, the younger ones (those with less seniority) get laid off first, while the more senior people have no place to go."*

In the minds of many, promises of help from HR never materialized. One of the FHMC professional staff commented that there was a need *for "a more organized, thoughtful, honest approach from HR,"* while many FHMC staff representatives commented that the information from HR was confusing, and contradictory. When asked to comment on what might be done differently to improve the process, one DDD Central Office staff member suggested the state examine the collective bargaining agreement to address some of the obstacles that were faced in implementing the closure: *"When they begin developing the collective bargaining agreement for the next biennium maybe they could look at the language to make it less complex for HR."*

Facilities. Physical plant personnel experienced the same issues in closing the facilities that were encountered by others responsible for resident supervision and transition: uncertainty about if and when FHMC would close, followed by urgency about closing it quickly. Despite this, participants praised the physical plant team for their role in the actual physical plant closure. *"The plans for the buildings were obviously done well--were well thought out. They deserve kudos for that."*

Upgrades on the facilities continued until the closure decision was made, including both maintenance such as exterior painting and roofing that would enable the physical asset to be sold, and renovations to make cottages safer. According to focus group participants who were responsible for the physical assets of the institution, the struggle seemed to be knowing how and if to implement maintenance and facilities' improvements given the uncertainty of closure. There also was the concern that funds already spent on facility maintenance and renovation were wasted: *"There was a waste of all we had done to make FHMC a safe, habitable place,"* said one participant." In addition, even with the facility's ultimate closure, there have been continuing physical plant decisions and work to be done. One participant explained, *"We have had to look at mothball options. We are still looking at how to secure the facilities, board up the houses, reduce energy to save on costs."*

> *"There were so many forces operating at the same time, we were not sure who was to assume the responsibility of the campus."*
>
> *Physical Plant Group Member*

Respondents raised concerns that maintenance had slipped at the facility after the closure. *"The building was always polished and clean when residents were there. Yet at a recent meeting there were so many comments about how it is looking a little bit worse, so I am wondering how it is being maintained."* With the closure, only one maintenance staff person is responsible for the facility. *"A good maintenance person just can't do it all."* The process of shifting the facilities to other, day uses continues to create challenges. New lease agreements are trying to address operational and maintenance issues, but focus group participants expressed concerns such as *"it is difficult to get buy-in"* by the various stakeholders involved in using the facilities.

Transitions for Individual Residents

Much of the rhetoric across professional and direct service staff and providers centers on the concepts of choice, "person-centered" services and actions, and individual safety. In these focus groups and interviews, respondents even within the same stakeholder group often expressed conflicting opinions. The preponderance of feedback did indicate that individual decisions frequently were driven by expediency.

Family perceptions. Many suggested that the process of transitioning the residents from FHMC went rather smoothly considering the speed with which the transitions occurred. A parent whose son moved to a community residence reported, *"it worked out well, beyond my expectations."* But the changing timelines were again a problem for families and staff. The

words of one parent whose daughter was institutionalized for twenty years gives a sense of the parent's myriad concerns that were compounded by the shifting timelines:

> *"My feeling was when they were going to close, 'oh my gosh—now a change in doctors again, and they will give her back drugs.' They had lowered her drug dosage because of swallowing problems, but I was afraid the new place would give drugs to her. That was the beginning of the year, like March, when we were told it would close. We were told not to fear, it would close in December, so I was ok as I thought I had plenty of time. Then I was told they were moving her in June. ...They wanted me to rush right away, but I said no. She will not be moved in June because she was not sleeping for two weeks in a row. ...She had pneumonia in May. I don't think it is right to move her when she just was sick. They moved her finally September 7."*

There were reports of staff creativity and focus on individual needs that went into resident transition. For example, one parent reported how his son became accustomed to his new residence, by staff taking him to the house to do landscaping work, without telling him it would be his home. He became used to it before he was made aware it would be his new residence, easing his eventual transition.

Where some families criticized the lack of communication (*"The only communication was a dinner to talk to us about moving to the community. Nobody asked us to participate in the planning for our son's move..."*), not all family members agreed. Said one, *"I don't have any problem with what happened. I mean they planned everything, and were very professional about it. My son was happy at FHMC, but I think he is happier there.*

Issues with the physical move. Common complaints among family members were that some of their son or daughter's belongings did not move with them, including clothing, bedspreads, pictures, and other items. A staff member who is responsible for personal and state property explained that they were required to create a full inventory of belongings signed by the asset manager, and signed again by the receiving manager. It was stated that *"things got lost before this process, not in the process."* Staff members from receiving residences noted that people would *"typically be missing a communication device or something personal.*

> *"We required a full inventory of belongings signed by the Assets Manager and signed again by the receiving manager (of the new residential placement). I was surprised by how out of date inventories were."*
>
> *Physical Plant Group Member*

It would usually come over a day or two later." Physical plant staff spoke of the frustration of trying to plan residence accommodations to meet the needs of some of the residents prior to their move, only to have no homes available when the person was supposed to move. *"To plan around that was a moving target. None of us had ever done that before."*

> *"We had to fight to get boxes for moving the belongings of residents."*
>
> *Physical Plant Focus Group Member*

Communication. There were many comments about communication, both positive and negative, by members of various stakeholder groups . A sampling of the positive statements included the following:

- *"Parents of the three that went through our office reported that information from FHMC direct support staff was incredibly helpful."* (DDD Regional Staff)
- *"The staff--everyone was available to you to help. Staff members were giving us cell phone numbers. They offered to come visit the house. The whole process I found invigorating."* (Residential Provider Representative)
- *"Staff were helpful. I thought they would have a chip on their shoulder, but they were pitching in. Giving cell numbers, calling, coming by. All different ways."* (Residential Provider Representative)

Most family members interviewed expressed that from the initial planning meetings through the entire closure process they received incomplete, inaccurate, or less-than-truthful information. *"I originally thought I was being bombarded by how great things were in other places. People were not telling me the truth..." "Parents didn't get the information they needed to have an informed choice in selecting a placement option,"* said one RHC professional. Many DDD regional staff members agreed. In the words of one, *"When we talked with families more, we realized they did not have the level of information they needed to make informed choices. Families were having difficulty making a decision because of uncertainty. It was easier for them to choose another institution rather than a community residence."* Despite this, the majority of families chose community placement after receiving information on placement options.

> *"We made a plan based upon what we thought they were going to do, which we thought was the 31st of December. Then they had to be out on Nov. 15th. We thought there would be visits to the houses. She had NO visits to the house before she moved, as they promised."*
>
> *Family Member of Resident Who Moved to a SOLA Home*

Other stakeholders perceived communication concerns as well:

- *"Providers would call and say they were confused because they would get contradicting information from each source they spoke with."* (DDD Region 3 staff)
- *"Information kept changing."* (FHMC Professional Staff)
- *"The answers that were being received about transition were changing almost daily."* (Community Employment Provider)
- *"Family questions were not answered, including 'What happens if we try community placement and it doesn't work?'"* (DDD Regional Staff)
- *"The collaboration previous to the decision was superior to after the decision to close was made. The emotion and anxiety of the people still working there, people were distracted by that, even though they kept doing a good job".* (DDD Regional Staff)

Person-centered transitions. According to one residential provider, *"The process was the process; it needed to be what was right for the person. It felt to me like every individual was looked at as an individual, and what was right for them and their family to be comfortable. Although time frames were looming, I never heard anyone say 'we've got to get this done' within a given timeline."* However, others felt the process could have been even more "person centered." Said one DDD Central Office staff member, *"What do the person and family want for his/her life? What is the opportunity here...sometimes it is so directed at the budget, the politics...we forget we are supposed to reinforce the life the person wants to live."* There was expression by DDD Central Office staff that FHMC staff being laid off impeded the process. *"There were some employees more concerned about their job loss than transitioning residents."* Some staff described the *"very highly emotional"* state created by long time employees losing their jobs, as adding to the *"chaos at FHMC"* that was attributed to so many residents moving in the same day or week.

Many family representatives were particularly critical of the lack of person-centered planning relative to their sons/daughters. *"The residents? There was never any plans for them other than where they were going to go,"* said one father, speaking of his adult child's move to another RHC. *"Any plan would have been fine. But the people at Fircrest (RHC) didn't know my son, didn't have basic information."* Other family members were critical of the fact that in lieu of a simple transition plan, *"boxes of decades old records"* were sent to the receiving residence—a practice that was perceived as not only useless but potentially dangerous. One father said the only planning in which the family was included had to do with transporting their son to his new residence at Fircrest: *"FHMC wanted him strapped to a gurney to transport him, and we said 'no.' We had two meetings about this. The only topic was transportation—how soon and what type."* Another parent described being left out of the most basic help in making the transition from FHMC to a SOLA home successful for her daughter: *"We thought we would be more a part of the planning and preparation. We wanted to help decorate her room, help with transition. But it was too rushed. They didn't have curtains, didn't have a clothes bar in the closet."*

Sometimes, being person-centered made the timing of the transition more difficult. So to some, time spent in giving families opportunities to explore residential options and make decisions about their choice of residence reduced the time available for the move itself. *"We gave families an extraordinary amount of latitude, and they worked right up to that deadline. But we need more time on the other side of it to actually make the transition plan and process. Some people pushed right up to mid-November almost,"* according to one DDD Regional staff member.

Human rights issues. For some people in the focus groups, the issues went beyond the process simply failing a "person-centered standard," and involved a failure of the process to respect basic human rights. The respondents were referring to what they perceived with some individuals, and not as general statements. One community employment representative suggested that in the future, a Human Rights Committee should be formed and used as a review. *"So many rights were violated—and it is wrong. You can't just take somebody from one place and drop them in another."*

Individual safety issues. Many of the safety issues identified by parents involved medications. Said one parent, *"They started to medicate him, changed his medication just prior to the move. They continued to change it despite my protests...it was my word against the doctors, but any of his records or the direct care staff would have told you the same thing (not to change the medications at that point)."*

Many FHMC professionals and members of the Physical Plant group echoed parental concerns about safety in community placement settings, ranging from the physical accommodations and safety of the new residence to supervision. *"SOLA needs guidelines for how the residences are built, whether they are strong enough to keep people safe from self-injury,"* said one member of the Physical Plant group.

Continuity of staff. Both SOLA staff members and family representatives expressed the belief that successful individual transitions were largely the result of having one or more staff with personal knowledge of and experience with a resident transitioning with him/her to the new SOLA community residence. This strategy had been presented early in the closure process, and, in some cases, worked. However, as the facility came closer to closing, and FHMC staff were leaving to accept new positions elsewhere in the state, DDD Regional staff ran into issues related to planning.

> *"I felt that the process of moving people from one position to another made it difficult for us, one day working with a staff person, then the next day they weren't there. The staff person to work with was constantly changing."*
>
> *DDD Regional Staff Group Member*

Collaboration. There were many examples of people and agencies coming together to work out problems with the closure. There were also many examples of areas where collaboration was lacking: Said a staff member from an institution receiving FHMC residents, *"There were staff at FHMC who were very, very angry, and sometimes that bled over to the transition of people to Fircrest. It made it difficult for both the Fircrest staff and the clients at the point of transition. The days right around those of the actual moves were the worst times."* Said another, the FHMC staff *"wanted to tell us everything to do, and we had our own ways. That made it difficult."* The tension that existed between these RHC groups was evident in the comments: *"With some people (among the FHMC staff) you didn't know when somebody was going to throw you under the bus. Again, it was a very small group, but it made things very difficult. With those people, you had to be very careful what you say, or it would come back as a complaint."* From the FHMC staff, there were similar criticisms directed the other way, with most staffers participating in focus groups expressing concerns about the safety and well-being of the residents who transferred to Fircrest. *"There is no consistency at Fircrest. You have to have consistency with autism."*

Issues around collaboration, in some ways, stemmed from lack of clarity in roles. *"At the beginning of the process,"* stated one DDD Regional staff person, *"it was unclear about how much I should do in each case, should more people be involved or should I just go do it?"*

Some stakeholders also described problems in collaborating with SOLAs in the establishment of the new SOLA residences. Said one facilities support person, *"The hardest thing to figure out was how to work with the SOLAs,"* going on to describe frequently changing messages about what was to be moved and where it was to be moved. *"The SOLAs didn't communicate well with administration. They would ask for things that wouldn't even work in the SOLA house,"* citing examples such as gas dryers being delivered to houses without a gas line. Others reported that maintenance/facilities personnel offered to help prep all the new SOLA residences, but were turned down.

Experience with community transitions. FHMC staff members were proud that they had helped some residents transition to a community placement well before the decision to close occurred. In some cases, they expressed that sometimes it was a family member who was the barrier. *"Her parent would say, 'I know what my kid can do' but that was from 10 years ago. We would talk about it every meeting, how to get out into the community. The beds are meant for people in crisis...and the longer people are here, the fewer people in crisis can be served."*

Community Preparation and Development

The perception of many DDD Central Office staff group members was that there was a real attempt not just to create a safe transition, but an attempt *"to create something the families wanted,"* to honor choice. Creating new SOLA residential opportunities was a big part of this attempt. In Region 3, the size of the SOLA program more than doubled. There were five new SOLA residences developed to accommodate the closure, a *"huge development in four months"* noted one participant. Community development was also affected by the shifting timelines associated with the closure decision and personnel agreements. One DDD Central Office representative stated, *"We had SOLA houses, the residents were ready, the families had agreed, but because of the collective bargaining agreement (the houses) sat empty for three months..."* For the staff members of the newly created SOLA residences, the huge growth in a short period of time was seen as problematic. Either because of the speed with which the SOLA residences were developed or for other reasons, the perspectives of many in the focus groups were that the community was inadequately prepared for the SOLA residences. *"I don't think enough research or work was done up front. They pushed us into a house that does not work for us, but they made it look good...some residents have had hip surgery, and there are steps in these homes."* Said another, *"(We) had to set these houses up. Everything---negotiate the leases, everything. And on top of it they wouldn't pay me overtime for 60 hours a week."*

Three areas stand out in the feedback that may be considered important to "community preparation": (1) presence or absence of needed community services to accommodate

transitioning residents, (2) community staff preparation and training and (3) community/neighborhood acceptance of new residential homes and residents.

Presence or absence of needed community services. A DDD Central Office group staff member made the point that there was a commitment on the part of the Governor that community capacity would be created to offset the loss of the institution. The new SOLA residences were part of this, but *"community crisis stabilization services are still missing."* A FHMC professional staff member explained this as part of the trade-offs: *"Many residents were placed in more rural areas (i.e. Kitsap County) due to lesser costs, but where there were fewer services available."* Many others, including FHMC staff and parents echoed the need for specialized services, identifying behavioral health care in the community as a continuing problem. In particular, many DDD regional and SOLA group staff members noted that providers could not be found to prescribe long-term psychotropic medicine. Said one SOLA staff member, *"...physician care and related therapy and psychiatric care were not going to be available."* According to one FHMC Professional Staff Group Member, "*We haven't addressed the problems the community already has. We have to fill that gap. There needs to be a collaborative effort. Why are we constantly reacting to things? Until the State becomes proactive, looking at the whole picture, closing an RHC may solve one problem but doesn't address the gap that exists in the community"*

> *"A lot of our residents scare the crap out of the community doctor..."*
>
> *"Nurses in the community are not used to dealing with people with autism, and don't know how to do what we were trained to do—so even a simple flu shot creates a major issue."*
>
> *SOLA Focus Group Member Comments*

For FHMC staff and residents' families, the crucial reason for opposition to closing FHMC was the loss of a secure environment where needed resources were centrally located and available. A former FHMC professional staff person said that he was not concerned about losing his job, rather about the loss of a choice for residents and their families, a choice that in his mind created a more secure environment in which people can *"walk around campus, go to a coffee shop independently"* or enjoy similar freedoms that might not be available to them in the community if their new residence were in an isolated neighborhood.

DDD Region 3 staff commented that some ancillary services were not available, and the extent of the problem may still not be known. An additional concern raised by Region 3 staff group members is that even two months after the closure of FHMC, not enough specialized resources are available to the community

> *"I doubt that we have yet discovered the resource issues around dental and emergency services."*
>
> *DDD Region 3 Group Member*

residences, with the result being that *"residents just sit at home."* Some SOLA providers echoed this concern, *"When you were in the institution, you could get a crisis team to respond immediately. That was promised us in the community, but it is still not set up."*

Preparation and training of community staff. With the exception of medical and behavioral supports in some communities, many stakeholders felt that community services could expand to absorb the former residents of FHMC, particularly in King County. However, the expansion of services caused stress on the community system in the more rural Kitsap County. For its part, DDD Central Office representatives expressed the view that some community agencies did not get as much support as needed to be prepared for the individuals being moved from FHMC, sometimes due to those agencies' assertion that they were ready. Some regional staff felt that with the passage of months and after understanding the challenges firsthand, community providers might now better recognize their need for technical assistance or training. As one regional staff member put it, *"There is stuff you know you don't know, but also there is the stuff you don't know you don't know. That is why you need people coming in to take a look, to let them know they need to look at something even though they don't realize its importance."*

Many stakeholder groups identified training needs that related to *other* stakeholders. In particular, FHMC staff viewed the community providers as needing training in autism and community providers viewed the FHMC/SOLA staff as needing training in working within a community services' structure. These comments seemed to be based on deeper "community versus institution" beliefs.

Community/neighborhood acceptance of new homes and residents. There was an apparent lack of acceptance by neighbors of the SOLA residences and some others within the community. One SOLA residence has only two immediate neighbors, *"and they both hate us"* said one SOLA staffer. One provider said, *"I was accosted by a neighbor because I parked at the SOLA home. Maybe nobody let her know what to expect...profanities were spewing."* Parents described the same interactions with neighbors, hostile confrontations in which a neighbor was demanding to know who they were, how long they would be visiting, and what was transpiring. Many of the stakeholder groups lamented the limited work with neighbors prior to the closure. *"In terms of what could be done better, what we would recommend...if there were more time, the neighborhood should be looked at carefully. There needs to be a better plan..."*

Transitions for FHMC Staff

Understandably, the staff at FHMC joined residents and parents as having an enormous stake in the closure. Permanent employees accounted for 95 people, with another 20 who were temporary employees with different status and no promise of continued employment. Staff

faced the prospect of layoff, creating anxiety over their personal futures even while addressing the challenges of a workplace in upheaval. *"Toward the end, the morale was really bad, even amongst those that were here for a long time. A lot of people were really sad...People had the attitude, 'we are closing so why should we care?'"* Ultimately, out of 95 employees, 76 staff members secured placements in other positions, 37 of which transferred to SOLAs.

Training for staff of new SOLA residences. Despite an experienced and trained staff moving from FHMC to the SOLA residences, there were training issues reported within many of the stakeholder groups. Community providers frequently voiced the concern that the staff from FHMC had "different" training than exists in the community—that both philosophy and skill sets were different. *"They do more training for behavioral restraints than using positive behavior supports,"* said one provider, adding *"They have response teams for crisis situations, but don't use a functional assessment of behavior."* Said another, *"Their (former FHMC staff) orientation is toward control, not addressing the needs that might be creating the behavior problem."*

FHMC staff transitioned to SOLA residences expressed many concerns that they were not equipped to do some of the functions of their new jobs, and that *"people might get hurt"* as a result of what they didn't know. One SOLA staff member indicated, *"It is scary to be on that learning curve when you have people depending on you. Emotional support, financial matters, medical...trying to do everything to protect (the residents) in those areas, and suddenly you find out you are not doing something, or when the medical (resource) is not in place."*

The FHMC staff members expressed confidence in their knowledge about individual residents' needs, as well as their abilities to address those needs in a highly skillful way. However, at FHMC they relied upon medical personnel, crisis teams, nutritionists, and other specialists, and found themselves uncertain as to how to operate in the community when those specialists were not immediately available.

Outcomes

At the time of the forums, the FHMC had been closed approximately two months. It was closed well before the December 31st deadline, with residents relocated either into SOLA or other homes in the community (31 residents), or to another RHC (21 residents). Nearly all families had been opposed to the closure of FHMC, and most of these opposed to *any* community placement for their family member. Despite this, 31 residents' families ultimately chose community placements as a result of the

> *"I had my doubts (about relocating son) to say the least, but it all has worked out quite well."*
>
> *Parent of FHMC Resident moving to SOLA Home*

information process (i.e., parent conversations and family meetings). This is significant since initially only 14 families had indicated a preference for community placement, according to the survey of parents conducted by FHMC staff early in the closure planning process.

Many family representatives continued to believe the closure of FHMC was a mistake, but expressed relief or happiness at how well things had turned out. One parent, whose son went to a new SOLA community residence, stated that he had been very opposed to the closure, that FHMC was a *"very unique place"* that was needed particularly for the growing number of people with autism. Still, he concluded, *"I feel my son is very fortunate and I am happy that he is where he is at."*

For the stakeholders that believed that services should not be delivered in institutions, the closure was less than successful in that many residents were transferred to Fircrest or other RHCs. Some identified the five newly opened community SOLA residences as a positive outcome of the closure.

> *"I was surprised that so many people went to Fircrest. I was disappointed that we had so many people going to a less inclusive program."*
>
> *DDD Regional Staff Group Member*

Many stakeholders identified several gaps in services as evidence that it was too soon to pronounce an end to the closure of FHMC. Parents in particular expressed concern that the unique needs of their sons/daughters may not be met in their new residences, including both institutional and community placements. From the parent of a person who moved to Fircrest: *"My son experienced a very serious decrease in the quality of his life. From somebody who could answer his phone, not get into trouble, be independent during the day, who basically had his little job and was happy and jovial...to a person who is locked in his room, by himself, doesn't get out very much. He used to have the run of the whole Morgan Center. And now he is trapped... How cruel and heartless the state of Washington is."*

> *"I'm glad people aren't there. It is closed; it's amazing! Celebrate your successes."*
>
> *DDD Central Office Staff Member*

For those participating in the focus groups, basic attitudes about whether or not the FHMC should be closed had not shifted from before the closure. Staff of FHMC and family representatives who were against the closure of FHMC before the decision was made by the legislature, remained opposed to the closure. For the others, there was a range of positive expressions of accomplishment. *"It went spectacularly well, given the circumstances." "Most people are transitioning well" despite needed areas for improvement. "An 'A' for effort, for everything...chutzpah, passion, effort,"* said a DDD Central Office staffer.

Conclusions and Recommendations

On June 15, 2011, the bill directing the closure of the Frances Haddon Morgan Center was signed into law. As directed by the timelines required by the law, the majority of individuals living at FHMC were placed in new residences within a four to five month period, with the final individuals moving out on November 16, 2011. As directed, the facility was closed by December 31, 2011.

This was fast by any standard, given the complexities in disparate human needs, obligation based upon the union contract, creation of new community residences, and the interest in trying to create something families would want and support despite their broad opposition to closure. In addition, a member of the reflections group provided the insight that at the same time FHMC closed, all plant operations in DSHS Western WA were being reorganized, DSHS was coping with budget cutbacks of around 10%, reorganization was taking place in all Western Washington business operations, reduction and consolidation of six Regions to three was occurring, and a hiring freeze was in place. All of these events could be expected to impact the closure process. The magnitude of these simultaneous changes were referred to by one individual as a "a perfect storm."

It is a challenge to close any residential institution such as FHMC. Conflicting beliefs about the efficacy and legitimacy of institutions, communication consistency across the multiple and varied organizations and staff involved, different funding mechanisms for hospitals and community settings, "bundled services" of the institution versus availability of multi-provider services in the community, intentions to honor family choice, inflexible event horizons, and finding common agreement between union and management, are some of the more difficult areas to navigate. In the closure of FHMC, once the decision was made by the legislature, it was closed over a period of only six months despite deep concerns and opposition from family and many staff.

From the perspective of nearly all professionals involved, people worked very hard to bring about the closure in a way that was professional. *"Things could be better in the future, but people did step up and do the best they could,"* was a summary comment that rang true with the statements across the many stakeholders that participated in this review.

By most accounts of the stakeholders, the vast majority of FHMC residents moved successfully to new residences. Families, even those who were still voicing grave concerns and unhappiness over the closure of FHMC, for the most part expressed satisfaction with the new placements.

Indeed, many expressed their surprise at how well the move turned out for their family member. A Quality Assurance Report following the closure also noted that the vast majority of placements were "successful and well received by individuals, their families, and their new support providers."[8]

The widely differing roles and interests of stakeholder groups and the inherent controversy and complexity accompanying the closure of *any* institution, resulted in a complex set of experiences and perspectives for the stakeholders who participated in this study. There is no simple way to draw conclusions and recommendations from such divergent viewpoints. There are as many perspectives as there were people involved. For clarity, the researchers read and arranged the feedback into theme areas, and from those themes patterns and interpretations emerged. These were developed and were tested in a day of meetings with a "Reflections Group" of current or previous leaders from the Central and Regional DDD offices, RCL, and FHMC.

Themes

The decisions that led to the closure of FHMC was characterized by uncertainty and delay, followed by haste to meet timelines. The many years in which closure was contemplated by executive and legislative branches created uncertainty and delayed action related to the closure. Once the decision was made by the legislature, closure of FHMC happened quickly and caught many off guard.

> *"Many of the comments that were made by stakeholders we ourselves have already identified. Everybody needed more time in this closure process. We could have done a better job with more time. It was hard for Central Office too, for the same reason—there were deadlines set in the political process."*
>
> *Reflections Group Member*

The changes and delays created the conditions that led to many of the other problems identified by the stakeholders as chaotic. In the minds of many stakeholders, the actual process of closure lacked order and careful planning—yet much preplanning had occurred. Where preplanning had occurred, changes often that rendered planning obsolete, leaving the impression with many stakeholders that there was no plan at all. For example, initially two SOLA residences were planned; by November, literally just before closure was completed, it

[8] From Washington State Department of Social & Health Services (2012, February 1). *The Closure of Frances Haddon Morgan Center: A Quality Assurance Report*, p.1..

became known that five would be needed. Those responsible for planning and developing the residences had the daunting and nearly impossible task of identifying the community and residence, preparing the community, making required modifications on the residence, selecting staff and residents, and planning with FHMC staff, families and residents for the transition. For many stakeholders, these conditions led to disorder, rampant communication issues, and in the words of one, with *"never any time to stop the process and talk about the issues."*

Human resources and labor issues created extreme challenges to an orderly closure process. Next to the impact on residents themselves, the closure of FHMC had the biggest impact on the facility staff, many of which were to lose their jobs in the process. Rather than "jumping ship," many direct support staff made the decision to not leave their jobs, and all carried the stresses of their potential job loss while working harder to both do their existing jobs and the additional work created by the closure itself. Changing, misinterpreted, or insufficient information about what staff could do about their situation, limited access to options for transfer, and burdensome processes within the management-labor agreement caused significant issues at FHMC during the closure process.

> *"...Even though (closure) pointed out things could be better in the future, people did step up and do the best they could..."*
>
> *Reflections Group*

The human resources issues also affected the recipient RHCs, SOLAs, DDD Regions, and community service providers in many ways, for example being asked to hold positions for staff that were transferring from FHMC, and losing access to staff who had been primary contacts for getting information from FHMC.

Any problems in the transitioning process seem to have been exacerbated by accompanying problems with communication, particularly with knowing who to go to for a definitive answer. All stakeholder groups reported issues in communication, perhaps as the dominant theme. Given the many stakeholder perspectives, this would probably be true in any activity the magnitude of an institutional closure. What is particularly noteworthy is that for implementing staff and for parents, there seemed to be nobody to go to for the definitive answer to questions they felt were necessary to move forward. There seemed to be no clear chain of command, particularly if the issue cut across agencies. For example, many issues were reported between direct support staff of FHMC and other RHCs, as staff members struggled to move residents from one institution to the other.

Direct support staff members transitioning from FHMC to community residences (SOLA) were not adequately trained for the changes in their jobs. A small community residence

requires that staff perform a broader range of tasks than in an institutional setting. A SOLA home in a neighborhood does not have immediate access to on-site medical staff, facilities and physical plant personnel, psychologists, or others who provide services within an RHC. Because of that, SOLA managers and staff had to quickly become more self-reliant. SOLA staff that previously had been able to call together a team in a few minutes to address any situation involving a resident in crisis now found themselves without a community crisis response team. In addition, of SOLA staff that transitioned from FHMC, many were accustomed to the practices that were acceptable in an institution, but not as acceptable in a community setting. Those who had spent years working in RHCs needed to learn about the nuances of working within community settings. This training was needed when it became clear that some staff would transition to SOLAs, and prior to having FHMC staff provide information about community options to families of residents.

The community SOLA placements were made in areas lacking important auxiliary services to meet the needs of former FHMC residents. Many former FHMC residents moved into SOLA homes in Kitsap County. However, regional case resource managers knew that this area did not have a strong relationship with auxiliary services, such as mental health. Many families also voice persistent concerns over gaps in service supports that they believed were available at FHMC but are not available in the Bremerton SOLA homes. Other stakeholders validated the gaps that family members perceived in medical and behavioral supports. *"A real concern that people have identified appropriately,"* said a member of the Reflections Group. The consensus seemed to be that some political processes led to creation of the SOLAs in Bremerton. Most stakeholders commenting on this issue seem to agree that the SOLAs in Kitsap are not connected to the needed range of community services. *"People made political promises that we couldn't deliver on."*

Many families believe that the transition of their family member worked out well--beyond their expectations—despite their early opposition to the closure. The fear expressed by so many family members was that their sons/daughters would not be safe, either in the transition itself, or over time at the new residences. The feedback identified concerns with the closure process endangering individuals with unique needs that might not be understood by the receiving staff, the absence of comprehensive services in the community, and the concern about the effect of such a dramatic change on their sons/daughters. But for the overwhelming majority of FHMC residents, the transition happened smoothly in the minds of their family members, as summed up by one parent: *"I felt very badly about the closure. I couldn't believe this. My daughter learned a lot there and I was very disappointed. But things have changed for me. I really feel good because she seems so happy here (at the new residence). The main thing is, she is happy so I am happy. I'm very protective..."*

Recommendations

Stakeholders made many recommendations during the focus groups and interviews. These suggestions were often steps that *had* been taken during the closure of FHMC, such as checklists to guide individual transitions. This suggests that there were established processes that did not get translated to action on a consistent basis. Those involved in every critical step of the closure process might well say, "We thought we did that." How do we explain this apparent gap between the intentions of leadership and the experiences of so many stakeholders? Imposed timelines probably represents the single most important reason, forcing choices that were not ideal. The following recommendations should be part of a "transition blueprint" for transitioning residents from RHCs.

Pre-establish a facility closure process. The national movement to downsize or close institutions, application of federal laws and court precedent, and the support of advocates in Washington—including the current governor—suggest that the legislature can be expected to continue to downsize or close RHCs in Washington State over the next several years. If that is true, then both the residents and staff of the remaining RHCs, as well as the DDD and community staffs affected by the action, would benefit from planning that occurs well before the next facility downsizing or closure. Several recommendations, therefore, address needs in this area.

1. Create an experienced transition team that has administrative control of the entire process. Roles are complicated in residential facility transitions and in particularly when

on the scale of a facility closure, because of differences in both agency practices and service models.

2. Identify a resource person (a "super press secretary") who can be called to get immediate answers to questions. Appoint one person with cross-agency authority over state programs and agencies to be in charge of the closure so that there is accounting for final decisions, and who can be the "go-to guy" to avoid confusion. Assign this person solely to the project, rather than having it as an add-on to other job responsibilities.

3. Identify a person skilled in communications to craft the message of the project management team, maintaining consistency and clarity to all stakeholder groups and to the communities that are impacted by the closure.

4. Develop a communications plan that includes meeting with stakeholder groups at many points in the process.

5. Create an online resource site that has authoritative and timely information about the closure policies and plans, to ensure transparency in the process for all concerned. Be committed to keeping this up to date, accurate, and as detailed as possible. The closure website should have contact information and answers to frequently asked questions (FAQs), and be regularly monitored and updated with authoritative information. It should be used to log incoming problems, and subsequent updates about those problems.

6. Review the system's resources for alignment prior to beginning the closure process, including areas such as transportation, environmental resources, housing, mental health, and human resources. Many problems that were documented within the focus groups were created by different systems within the state not meshing well with each other.

7. Precede transitions of more individuals with significant mental health, medical, or other needs for professional auxiliary services with bridge-building with the providers of important auxiliary services. Availability of services should not be discovered *after* the community home is created and residents move to a community.

8. Take time to develop a comprehensive preliminary plan for facility closure in advance of a closure decision to ensure more realistic timelines once any closure decision is made by the legislature.

9. Establish role clarity for agencies (e.g., DDD regions versus FHMC staff), individual staff persons, and work groups. For each work group, leadership should develop a "team charter" clearly establishing the group's purpose, expected results, responsibilities, leadership, membership, authority, accountability, boundaries, decision-making process, record-keeping expectations, meeting mechanics, and resources available to the team.

10. Review and renew checklists generated from previous closures, to guide future activities and decisions. For example, develop a generic checklist that summarizes all of the possible items (e.g., medication, communications equipment) that must be with the resident when they arrive at their new home.

Establish a stronger management-labor-human resources partnership to support staff transitions. DDD and FHMC human resources personnel, FHMC management, receiving homes and RHCs, and FHMC staff all experienced significant issues related to staff transitions. Issues related both to difficulty getting rapid, clear, and unchanging answers to human resources questions, and dissatisfaction with the process itself.

1. Review language in collective bargaining agreements to identify and remove potential barriers or challenges to a smooth transition for RHC employees. Participants reported that they felt that the language of the agreement worked well when only a few staff were being laid off, but was a problem when trying to close an entire facility. One participant suggested, "*When they begin developing the collective bargaining agreement for the next biennium maybe they could look at the language to make it less complex for HR.*"

2. Develop HR experts who are experienced with facility closure or lay-offs to act as mentors or to be used on temporary assignment during the time of crisis or change.

3. Establish consistent, clear and complete responses to questions that may arise related to HR processes prior to future closures. Begin by developing responses to questions similar to those asked during the FHMC closure, to eliminate the inconsistencies experienced during that closure.

Expand community resources. While the community system has many resources in place in most parts of the state to support successful community living by individuals with intellectual/developmental disabilities, the influx of former FHMC residents, most of whom carried a label of autism, placed strain on some community resources and heightened the issues related to some other resources that were limited or missing.

1. Continue to work on expanding community resources at all times, so all communities might be better prepared to support individuals with intellectual/developmental disabilities, whether they are already living in the community or transferring from an RHC.
    - Work with the state mental health agency to identify and support strategies for expanding capacity in communities across the state to serve individuals with significant intellectual/developmental disabilities and co-occurring mental health disorders.
    - Insure that needed services, including crisis stabilization, doctors/dentists, and behavioral health/mental health services are available within the communities where residents are moving, prior to the actual moves.

2. For RHCs serving school-aged children and youth, work with local school districts very early in the process or even well before the closure decision to help to prepare them for the arrival of new students with significant needs.

3. Provide a housing consultant—knowledgeable about establishing community residences to assist in:
    - Identifying appropriate properties for development of a SOLA home, and to work with the neighborhood to accept the home
    - Pre-qualifying the property to ensure it will be appropriate for the individuals planned for living there
    - Reviewing new homes prior to any actual moves to ensure that the homes are ready for its residents.

4. Provide funding for hiring staff, training and technical assistance to community providers prior to the actual move so that new homes are ready to serve their residents when they arrive.

Define and clarify the process for ensuring "person centered" living transitions for individual residents. Although the stated intentions were to ensure person-centered

transitions, the perception was that consistently it was not achieved, based on differing feedback across many diverse stakeholders.

1. Provide information and support to families of RHC residents, starting well before a closure decision, to help families adjust and prepare for the eventual move.

2. Establish a centralized transition team that includes persons primarily connected to the community to support all individual transition teams to have the information and resources they need to make good transition decisions.

3. Organize information about the resident to include the most current, accurate guidelines for providing support. "Essential Life Planning," developed by Michael Smull and Susan Harrison Burke, may offer a useful system to support smooth transitions from an RHC to the new community placement.

4. Establish a timeline for resident moves that better reflects the needs of each person and family, with fewer residents moved on the same day or week. At FHMC, in one instance, 10 persons had to move in a single day. Fundamentally, this will require work with legislators to ensure that timelines established in law are realistic.

5. Sensitize, train and/or educate staff across systems, to identify likely points of disagreement or divergence in their systems so that these staffs are able to work together more seamlessly on behalf of individual residents. One objective of this training would be to ensure that there is a common language used between the staff of the institution and receiving facilities.

6. Prior to actual moves, clarify the roles of the family, and staffs from the RHC, county, Region, and community providers so that everyone is able to work most efficiently and in alignment with each other.

The closure of the Frances Haddon Medical Center ended with a sense of "mission accomplished" for most of those leading the closure effort. For all the diverse stakeholders most affected by the closure, there was much to criticize about the process, the compromises made in "person-centered" actions,

> *"I don't want to lose sight of the significant event that occurred here: we still accomplished the closure of the institution with six weeks to spare, even with the systems sometimes working against us."*
>
> *Reflections Group Member*

communications, and other aspects of the closure. Family members, even those who praised the outcomes for their sons/daughters, for the most part continued to believe the closure was a mistake and even a betrayal by the state. Many former FHMC staff that maintained their employment with the state still spoke with anger about both the process and result.

Closing an institution is difficult by any measure. However, decisions made by the legislature related to timing, constraints presented by state systems not aligning well, limited community resources, and barriers in collective bargaining agreements exacerbated the burden of the task. While replacing institutions with more effective and person-centered community services is a noble goal, the process by which it occurs can wound both employees and residents. As noted by one of the members of the Reflection Group, there are issues that are yet to arise from the closure of FHMC. The job of closure is not yet complete.

We encourage DSHS to adopt a strategy that moves this goal along, irrespective of the timing of legislative decisions related to closure, by developing closure plans for the remaining RHCs, or portions thereof, and taking action now to expand available community resources to support both community residents and those returning from an RHC.

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Appendix A: Biographical Sketches

Larry Rhodes, Ph.D.

B.A., M.A., Sacramento State University
Graduate Diploma, University of Stockholm
Ph.D., University of Oregon

Larry Rhodes is a consultant and researcher in the area of community and organizational development. He is a partner and Vice-President of Collective Alternatives, which has developed a nationally accredited community college curriculum used throughout Georgia for training community support persons. Larry has worked internationally both in the field of disabilities and in community development, authoring numerous articles and co-authoring a book on supported employment. He is retired from the University of Oregon's College of Education, where he was a Senior Research Associate and Assistant Professor. His Ph.D. from the University of Oregon is in severe disabilities, with specialization in program evaluation, employment and training.

Joyce Dean, M.Ed.

A.B., Summa Cum Laude, University of Rochester
M.Ed., University of Illinois

Joyce Dean was a Senior Research Assistant at the University of Oregon's College of Education for over 30 years, and Senior Partner of the consulting firm, Dean-Ross Associates, since 1993. Her emphasis in both positions has been on researching and applying the principles and practices of Quality Management to not-for-profit and government agencies. Her role at the university included planning, directing, coordinating, and/or evaluating numerous federal and state projects related to designing and improving organizations providing human services. She has served as a consultant and trainer in more than a dozen states, in several Pacific Islands, and in Australia. In her role as an evaluator, she has designed project evaluation plans, developed performance measures and instruments, compiled and analyzed data for determining the effectiveness of project methods. Her expertise in the field of quality derives from both formal training—including training by W. Edwards Deming, Peter Scholtes, and Donald Wheeler—and experience working with a wide variety of community organizations across the country. Ms. Dean is the author of the book *Quality Improvement in Employment and Other Human Services*, published by Paul H. Brookes Publishing as well as individual chapters, articles and manuals.