Report to the Legislature

The Closure of Frances Haddon Morgan Center: Quality Assurance Report - Six Month Follow-Up

2ESHB 1087, C50 L11 Sec 205 (4)

October 15, 2012

Aging and Disability Services Administration
Division of Developmental Disabilities
P.O. Box 45310
Olympia, WA 98504-5310
(360) 725-3413
Fax: (360) 407-0955

TABLE OF CONTENTS

Executive Summary

The Closure of Francis Haddon Morgan Center: Quality Assurance Report – Six month follow-up is submitted per the Governor's Veto message. The Governor vetoed the section of SB 5459 requiring an annual mandated report on each person; however her message states, "I am directing the Department to share the various reports related to the quality of client transitions and community-based services …" This report summarizes the results of follow-up quality assurance data and information for clients who moved both to the community and residential habilitation centers.

BACKGROUND

In May 2011, the Washington State Legislature directed the Division of Developmental Disabilities (DDD) to close one of five state-run institutions for individuals with intellectual and/or developmental disabilities. Frances Haddon Morgan Center (FHMC) was closed by December 2011 and the fifty-two individuals who lived at the center have moved to community-based residences or other DDD institutions. The types of residences selected by these individuals include the following:

- **Residential Habilitation Center (RHC)** – RHCs are state-operated residential settings that provide habilitation training, twenty-four hour supervision, and medical/nursing services for clients who meet Medicaid eligibility and need active treatment services. An RHC may be certified as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) and/or licensed as a Nursing Facility. There are four remaining RHCs in Washington State: Fircrest School in Shoreline, Lakeland Village in Medical Lake, Rainier School in Buckley, and Yakima Valley School in Selah.
- **Supported Living/Other (SL/Other)** – Supported Living Services offer instruction and support to persons who live in their own homes in the community. Supports may vary from a few hours per month to twenty-four hours per day of one-to-one support. Persons pay for their own rent, food, and other personal expenses. DDD contracts with private agencies to provide Supported Living services. Other community-based residential supports offered by DDD include foster homes, group homes, adult family homes, companion homes, and staffed residential homes.
- **State Operated Living Alternative (SOLA/SL)** – SOLA programs offer supported living services and are operated by DDD with state employees providing instruction and support to individuals.

A previous quality assurance report, dated February 1, 2012, summarized the earliest information about the individuals who moved from FHMC and how they were adjusting to their new homes. This report is a follow up about these individuals now that they have had six months or more experience living in their new homes. The February 2012 Report is referenced throughout this document and can be found at http://www.dshs.wa.gov/ddd/RHC/.

How are former FHMC residents doing now?

All but two of the persons who moved as a result of the closure of Frances Haddon Morgan Center have remained in the same new homes. One individual moved to a single-level home from a two-story home because that setting better met her needs. However, she still is being supported by the same provider and continues to share her home with the same roommate. One individual passed away. Feedback from families, the individuals themselves, and other quality assurance data all indicate that these individuals are safe, happy, and secure. One family who selected a transfer to another institution is now considering a move to a community-based setting.

This quality assurance report summarizes select findings from three sources of information:

- An analysis of "Monitoring Movers Surveys" conducted at three to six months post move,
- Information from "Family/Guardian/Advocate Surveys" conducted at three or more months post move, and
- Incident reports and data about FHMC clients as compared to the timeframe prior to their move.

Detailed information about these three quality assurance processes is located in Appendix A. Anecdotal comments and links to videos about former FHMC residents who are successfully living in their own homes are also provided. Additionally, Appendix B of this report includes a series of personal stories about former FHMC residents.

Monitoring Movers Survey

The "Monitoring Movers Survey" is a three part interview process completed at one, three to six months, and twelve months after a move. The client and the staff that support the person are interviewed by a DDD quality assurance professional, who also makes observations of the person, their staff, and the home environment. This survey is administered to individuals who move from an institution to either community-based settings or RHCs. Details about this quality assurance protocol are provided in Appendix A.

All persons who moved from FHMC received a Monitoring Movers Survey visit at one month and then again at three to six months post move. Another quality assurance visit and "Monitoring Movers Survey" will be conducted at one year following each individual's move. The following analyses present complete data from the one month surveys (not all surveys were complete at the time of the February 2012 Report) and compares it to data gathered on the same individuals at three to six months post move.

- **Health Indicators –**
  (See pages 3-4 for a series of charts comparing the results of health-related questions)

  DDD Quality Assurance staff indicated that for the most part, individuals have access to needed medications and equipment, most have a primary care physician and dentist, and necessary health care appointments are being made and kept. At the time of their one-month quality assurance visit, one person in Supported Living only sometimes had access to specialized equipment that was in good condition, and one person who moved to SOLA did not yet have access to specialized equipment. All but two persons who moved to Supported Living had a primary care physician established by the one-month quality assurance visit, and all but two persons who moved to Supported Living and three persons

who moved to SOLA had a primary care dentist established by the one-month quality assurance visit.

By their three to six month quality assurance visit:

- Specialized equipment was in place for the two individuals who did not have access, but a need for specialized equipment was identified for one person who moved to SOLA and one person who moved to another RHC. These needs have since been addressed.
- One of the two persons who did not have a primary care physician at the one month visit now has one, but the other person did not have a primary care physician. He now has one.
- Three of the five persons who did not previously have a primary care dentist had one by the second follow up visit and a fourth now has one.

Chart 1a: Health Indicators – RHC

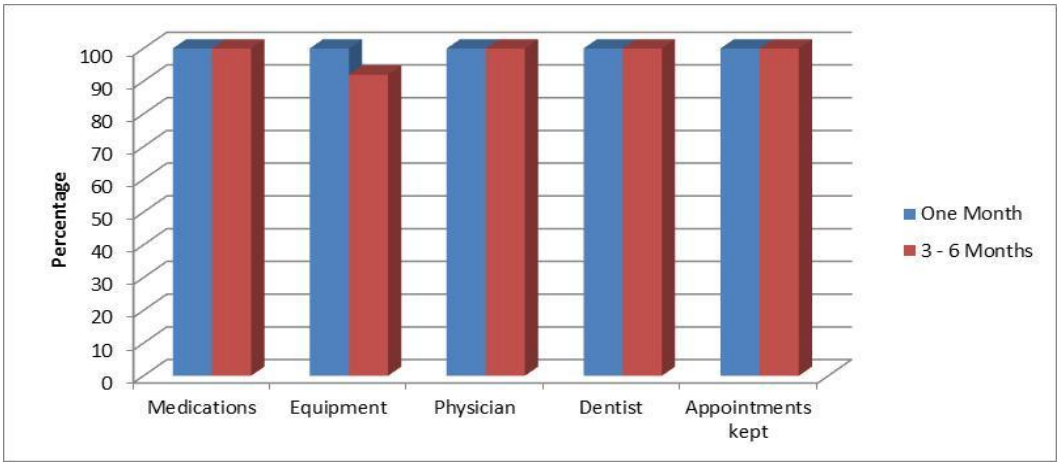


Chart 1b: Health Indicators – SL/Other

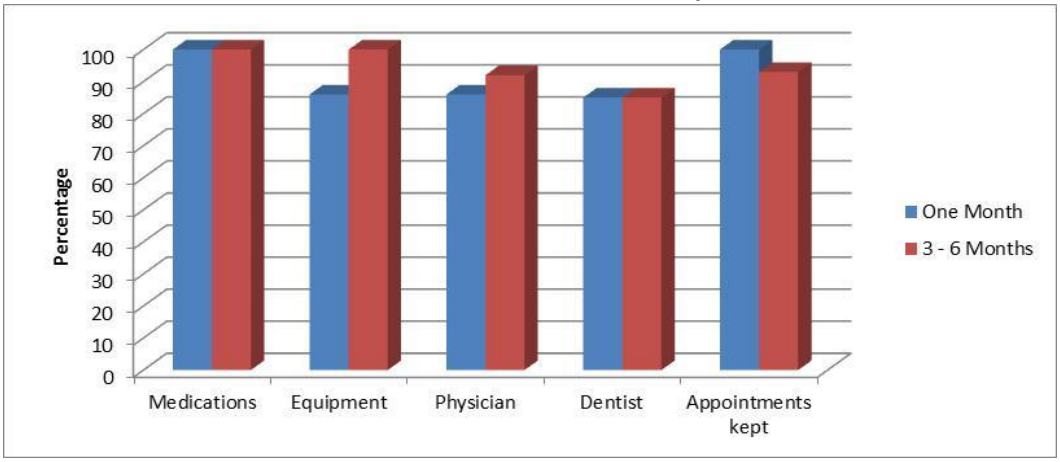
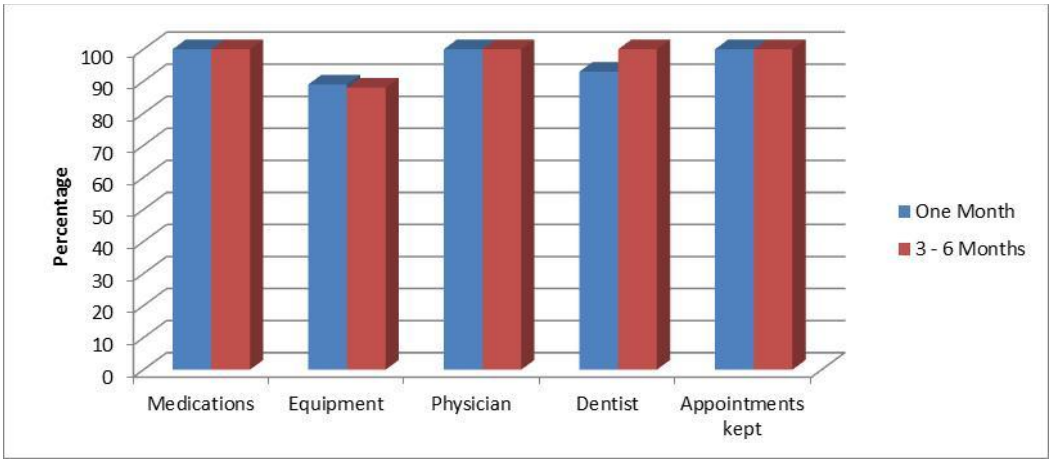


Chart 1c: Health Indicators – SOLA/SL



- **Welfare Indicators –**
  (see page 5 for a series of charts comparing the results of welfare-related questions)

  DDD Quality Assurance staff indicated that for the most part, staff at the new residences had all the information they needed when the individual moved. At the time of their one-month quality assurance visit, there were four individuals who moved to community-based settings whose support staff felt that they did not have all the information they needed at the time of the move. Prescribed diets were followed where required, except for one instance in each of the settings. All individuals had an adequate amount and variety of food, clothing, and appropriate personal hygiene in their new residence.

  By their three to six month quality assurance visit:

  - Support staff felt that they had received all the information needed except for two persons who moved to Supported Living. These issues have been addressed through extensive coordination with the providers, parents, client, and RCL staff.
  - Support staff was following the prescribed diet for one more individual, but the assessors continued to answer "No" for the two other individuals. Further follow up on these two situations indicated that neither was on a prescribed diet, but that they had some dietary issues that the provider is helping them address.
  - All individuals continued to have an adequate amount and variety of food, clothing, and appropriate personal hygiene.

Chart 2a: Welfare Indicators – RHC

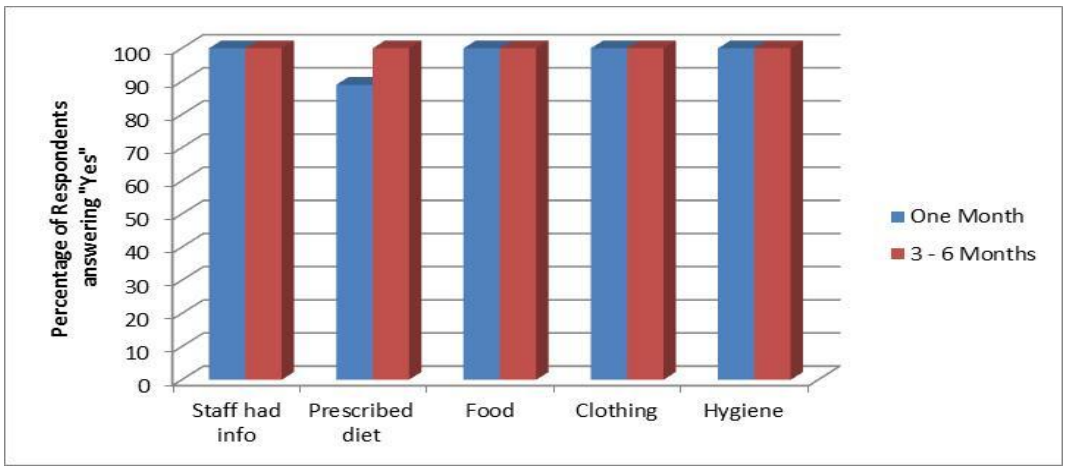


Chart 2b: Welfare Indicators – SL/Other

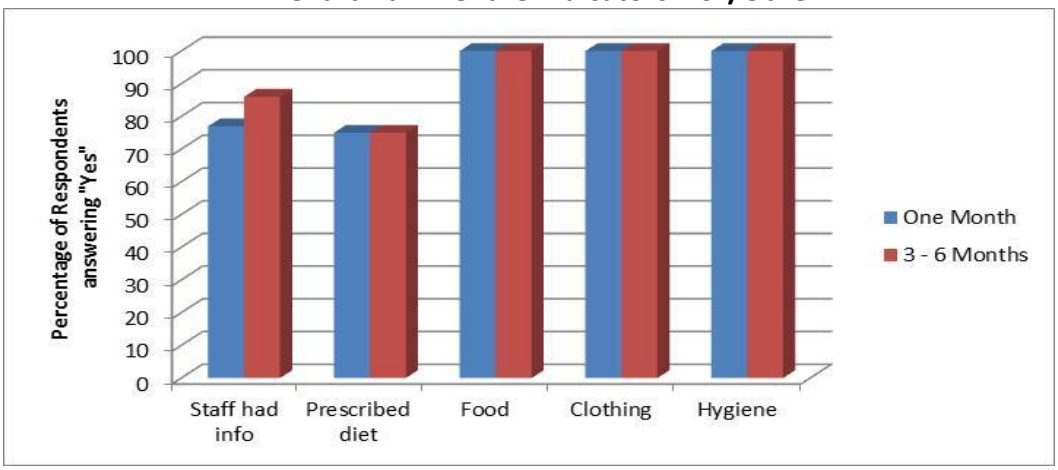
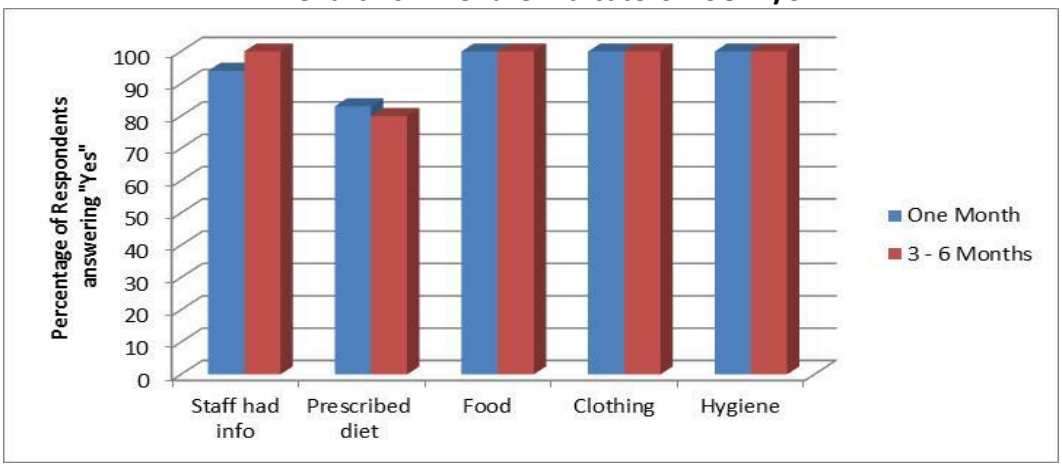


Chart 2c: Welfare Indicators – SOLA/SL

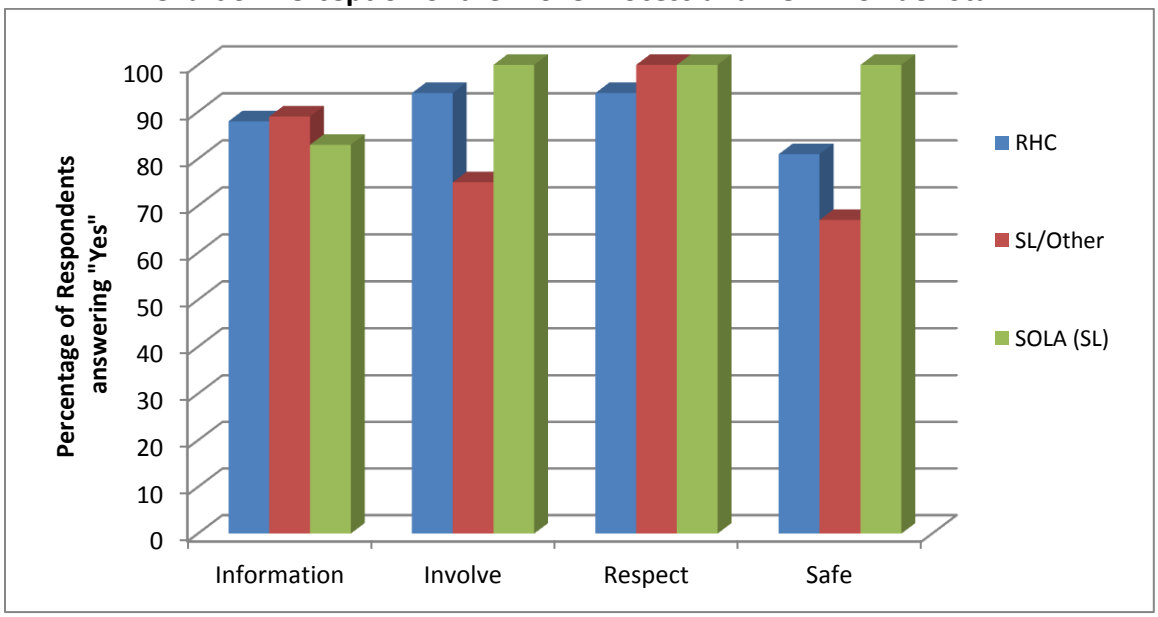


Family/Guardian/Advocate Survey

The "Family/Guardian/Advocate Survey" is a telephone survey conducted by Roads to Community Living (RCL) staff to obtain family perceptions about the moving process, the health and welfare of their family member, and overall satisfaction with the new residence. For this report, a telephone survey was also conducted with families of persons who moved from FHMC to another DDD institution. Details about this quality assurance process are provided in Appendix A.

At the time of the February 2012 Report, "Family/Guardian/Advocate Surveys" had been completed for thirty-one individuals. At that time, almost all felt that their family member was doing well, but often qualified this statement with "it's too early to tell." The following analysis describes 36 Family/Guardian/Advocate Surveys that were completed at least three or more months after the individual's move. Seven interviews were omitted from this analysis because they occurred prior to ninety days post move. Staff was unable to contact family/guardian/advocates for nine individuals (4 RHC, 2 SL/Other, 3 SOLA).

Chart 3: Perception of the Move Process and New Provider Staff



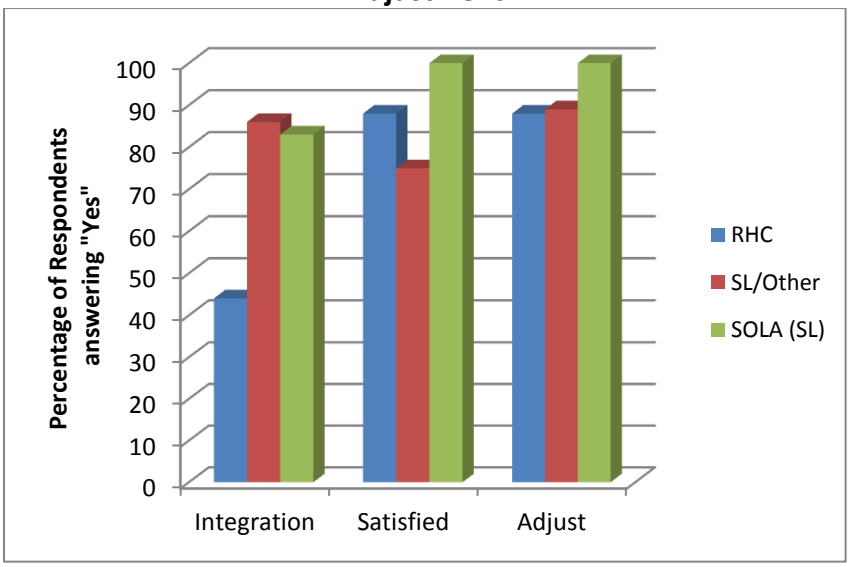
- Most families/guardians/advocates (81 percent) reported that they got enough information about move options and were involved in making the choice about where their family member would move to, and 14 percent responded "somewhat" to this question. Two families of individuals who moved to another RHC reported that they did not have information and choice.

- For the most part (86 percent), families/guardians/advocates reported that the new support staff involves them in important decisions with regard to their family member. Six percent responded “sometimes” and 9 percent responded “no” to this question.

- Except for two family/guardian/advocates of an individual who moved to another RHC, 96 percent of families/guardians/advocates reported that staff at the new residential placement always treats them in a respectful and courteous way.

- Most families/guardians/advocates (81 percent) feel that their family member is safe in his/her new home and an additional 14 percent responded “somewhat”. Two family/guardian/advocates of individuals who moved to another RHC responded, “no” to this question.

Chart 4: Perception of the Community Integration Opportunities, Satisfaction and Adjustment



- Most families of individuals who moved to community-based residences report that their family member is able to participate in activities in the community (76 percent responded “yes” and 18 percent responded “sometimes”), with the exception of one individual who moved to Supported Living/Other whose family responded “no.” Nearly 60 percent of the RHC families felt that their individual does not participate in activities in the community as often as they’d like, with 41 percent responding “sometimes” and 18 percent responding “no” to this question.

- Families, guardians, or advocates of the individuals who moved as a result of the FHMC closure reported high satisfaction with the move process and the services the individual is currently receiving. Eighty-three percent of families said that they were satisfied and another eight percent said that they were “somewhat” satisfied. Two additional

families who chose RHC and one family who chose SL/Other reported that they were not satisfied.

- Almost all families/guardians/advocates (89 percent) felt that their family member was adjusting well to their new residential setting. One family of an individual who moved to SL/Other felt that their family member was only "somewhat" adjusting to the new setting and three families/guardians/advocates of individuals who moved to another RHC felt that their family member was not adjusting well to the new setting.

Incident Reports

To date, nearly all moves have been successful. However, unusual, challenging or otherwise serious events may occur regardless of where an individual may reside, even with the most diligent oversight. The DDD Incident Reporting (IR) System provides comprehensive tracking and review. Field Services staff and RHC staff use an electronic incident reporting system to notify supervisors, resource managers and DDD Central Office about incidents that have occurred. More information about the DDD Incident Reporting System can be found in Appendix A.

As compared to the average monthly number of incidents per person for the twelve months prior to their move from FHMC, the rate of incident reports per person per month has actually decreased for most individuals. The rate of increase or decrease in incident reports is relatively consistent across all settings. This same pattern was evident during the reporting period for the February 2012 Report, through November 16, 2011, and continues to be evident through May of 2012. Incident reporting rates for FHMC former residents will continue to be monitored over time.

Chart 5: Incident Reports per Person per Month (average rate for 12 months prior to discharge versus average rate per month following discharge)

Placement Choice	**Increased:** Number of People whose rate of Incident Reports **Increased** (% people who chose that placement type)		**Decreased:** Number of People whose rate of IRs **Decreased** (% people who chose that placement type)		**No Change:** Number of People for whom there was **no change** in the rate of IRs (% people who chose that placement type)	
	Data through November 16, 2011	**Data through May 16, 2012**	**Data through November 16, 2011**	**Data through May 16, 2012**	**Data through November 16, 2011**	**Data through May 16, 2012**
RHC	5 (23.8%)	4 (19.0%)	16 (76.2%)	16 (76.2%)	0 (0.0%)	1 (4.8%)
SOLA (SL)*	1 (5.9%)	2 (11.8%)	4 (23.5%)	13 (76.4%)	2 (11.8%)	2 (11.8%)
Supported Living/Other	3 (21.4%)	2 (15.4%)	10 (71.4%)	8 (61.5%)	1 (7.1%)	3 (23.1%)
Total:*	9 (17.3%)	8 (15.7%)	30 (57.7%)	37 (72.5%)	3 (5.8%)	6 (11.8%)

Note: *Ten individuals had just moved to SOLA in November 2011 and thus were not included in the November 16, 2011 counts.*

The February 2012 Report discussed the tragic death of one individual who moved from Frances Haddon Morgan Center to a new community home and promised to provide further information when it was available. The person ingested liquid soap and was hospitalized for eleven days, appeared to have stabilized, and then was discharged. His condition became worse at home and his residential agency took him back to the hospital for further care. He died on the way to the hospital. The circumstances surrounding the death have been investigated by several entities and multiple actions have been taken:

- The Tacoma Police Department investigated the incident and the case was reviewed by the Pierce County Prosecuting Attorney. No criminal charges were filed.
- The provider agency that supported the individual immediately terminated four staff members. A Program Manager was suspended from regular duties and assigned to a non-supervisory role.
- DSHS Residential Care Services investigated the residential provider agency. The agency has completed all required corrective actions.
- The Department of Health conducted a review of the hospital that provided services to this individual. There were no findings involving the hospital.
- The Department of Health, Licensed Professionals program reviewed the actions taken by the accredited nursing assistant staff employed by the residential provider agency. Investigations regarding some of these employees are complete and some are still underway. Any actions taken will vary per individual employee.
- The Division of Developmental Disabilities implemented several statewide actions as a result of this incident. These actions were listed in the February 2012 Report. Several of these initiatives are discussed later in this report, regarding the benefits they have provided for all persons who have moved from institutional to community-based settings, both recently and in the future.

Case examples of individuals who are doing well after moving

(Names are changed)

Before moving to another RHC, "Susan" exhibited significant behaviors, including hurting herself and others, and destroying property. She frequently left the FHMC campus to surrounding city streets, undressed, and remained outside undressed even in very foul weather. At FHMC, "Susan" was not involved in a regular work program. Today, she works five days a week doing contract work for Comcast, and according to her team, she "is the best worker ever. She works very fast and she's extremely proud of what she does." She is benefiting from a larger, more enclosed campus and new incentive and self-management programs that have noticeably reduced her significant behaviors. She also participates in Special Olympics track and bowling, and spends more time with her family now that she lives closer.

"Don" moved to a home with support from a community residential agency. When asked what is going well, his mother replied, "He's adjusted beautifully ... he's quiet and peaceful; he's getting more at ease and independent." "When he wants something, he goes and gets it. He's free to do as he wishes." When she goes to visit him, "Don" opens the door for her. "Don" used to engage in temper tantrums and self-abusive behaviors; both have reduced noticeably since he's been in his new home. Don's mother has developed a great relationship with the agency and staff supporting her son. She feels like they don't hide anything from her. She's confident that the agency director will contact her if there's an issue and she can contact the agency director too – "It works both ways," she says.

"Linda's" mother said that her daughter's move to a SOLA home "is a step in a good direction. It's totally normal." "Now when she visits me, she wants to go back to her own home; before she didn't want to return to FHMC. She loves her home. This is the best feeling for me that she wants to be there." "Her behaviors have gotten calmer, maybe because she's happier." "Linda's" mother likes that her daughter is with the same staff that she knew from FHMC and they have great rapport. If there is anything new, she hears about it. "Linda" helps to mow the lawn and has more life skills now – she can do laundry, cooking, dishes, and vacuuming. She grocery shops, attends barbeques with other houses, and is getting to know her neighbors.

Case examples of individuals experiencing challenges after moving

(Names are changed)

As reported in the February 2012 Report, "Bob" moved to a community residence with support from a private agency. He had a pre-existing mental health condition and began to deteriorate at his new home. A brief psychiatric hospitalization occurred for a mental health evaluation, and he was discharged back to the residential provider. At the time of publication for the previous report, DDD staff, the contracted residential agency, and the family were working closely to enhance the plan around supporting this individual's mental health needs. DDD management was also coordinating with the DSHS Division of Behavioral Health and Recovery (DBHR) regarding system improvements for the provision of services to individuals with developmental disabilities.

> **Additional Actions Taken Since February:** Individuals with developmental disabilities are benefiting from improvements to the mental health service system that resulted from the coordinated efforts of DDD and DBHR management. DDD and the mental health provider for the county now have a strong working relationship. Intakes for services with the mental health provider for this county are now being conducted collaboratively between DDD and an agency staff person who has experience working with persons who have developmental disabilities. Common clients of DDD and this provider have been identified so that DDD can work collaboratively on care for these individuals as well. Additionally, DDD staff, the contracted agency, and the family continue to work closely to support "Bob". His positive behavior support plan was modified to include environmental modifications and alarms. A community psychiatrist at Mary Bridge Children's Hospital in Tacoma monitors his medications and behaviors closely to make medication adjustments as needed. This has helped stabilize "Bob's" behaviors. A speech language therapist developed a new communication system for "Bob" and provided visual support training for his support staff. As a result of the communication evaluation and training, "Bob's" communication has improved. He is practicing with an iPad to see if this device can better support his communication and independence at school and home. "Bob's" family continues to stay involved and visits regularly.

As reported in the February 2012 Report, "Carol's" move from FHMC was extensively planned as she was experiencing behavioral deterioration before she moved. For the first three to four weeks, she did better than expected. Then, a very noisy housemate moved in, causing her great distress. She destroyed her possessions and isolated herself in her room, and on one occasion she physically assaulted her family members when they came to visit.

> **Additional Actions Taken Since February:** "Carol's" treatment team first made medication changes and then moved her to a much quieter home to help her stabilize. She seems to be happier there and is slowly improving. She is socializing more and is able to tolerate having possessions back in her room. "Carol's" father regularly comes

to visit her and "Carol" calls home most weekends. However, she refuses to go to work or other activities and finds them very distressing and perhaps 'scary.' Incentives to get her out of her home and to have broader experiences are in place. She picks up her mail, and writes "thank you" notes to everyone that sends her cards or presents. "Carol's" current support team is consulting with her former team for further suggestions on how they can best meet her needs.

"Judy" has a history of eloping and running into streets causing great safety concerns. After moving into a home in the community, "Judy" tried to use her second floor bedroom window to leave her home and has threatened suicide.

Additional Actions Taken: "Judy's" support team of DDD staff, the contracted residential agency and the family, worked together to respond to "Judy's" immediate situation and need for supervision. The residential staffing changed from a person who slept in a room next to "Judy" to a person who was awake throughout the night. In addition, an environmental assessment was done of the home to identify any modifications that could improve physical safety. The environmental consultant, along with a behavioral specialist and DDD Case Manager, determined that it would be better for "Judy" to move to a one story home. "Judy's" residential staff was able to locate a desirable one story house and "Judy's" housing voucher was transferred to this new home to ensure affordability. A fence was also installed. "Judy" is doing well in her new home. She completed another year of high school and attended the prom with friends.

"Lyle's" parents are visiting him regularly at his new home at an RHC that is closer to where they live. "Lyle" has had a difficult transition. He is blind, which may in part explain why he is taking a longer time to adjust to his new environment. Although "Lyle" has a full time job on the facility campus, he struggles with noises, unknowns, and disruptions that cause him to become so upset that he has to go home from work. "Lyle" has also had what appear to be psychotic episodes.

Additional Actions Taken: The treatment team is working with a psychiatrist to identify medication changes, behavioral and visual impairment orientation approaches that will best help "Lyle" become more familiar with and comfortable in his new home and work settings.

Links to Videos

Several videos were completed to tell the story of individuals who have left institutional settings to live in the community. These stories give the perspective of family members who were involved with the process of moving their family member.

These videos are available on the DSHS website:

- This is Jenn's Story. Jenn moved from the Frances Haddon Morgan Center in Bremerton into her own home in Longview, Washington. She now lives closer to her brother and his family who have become more involved in her life.

- This is Christy's Story. Christy moved from Frances Haddon Morgan Center in July 2011 to a home in Puyallup. This video tells Christy's story about making the transition from FHMC to living in the community and includes the perceptive of her mother.

- This is Neil's Story. Neil moved from Frances Haddon Morgan Center in September 2011 to a State Operated Living Alternatives home. He now lives in the community with friends from the Morgan Center and with support from the staff he knew from FHMC.

What benefits has the Roads to Community Living project provided to former FHMC residents and others?

"Roads to Community Living" (RCL) is a federal "Money Follows the Person" (MFP) grant for adults and children who are considering moving back into the community from Residential Habilitation Centers (RHCs) or other institutional settings. The RCL grant provides additional supports and services to interested people and their families who decide to make this move. This can include helping a person and their family make a well informed decision regarding where to live, identify what supports are needed to live in the community successfully, and build collaborative partnerships with everyone involved in the person's life. Enhanced funding is available for one year after the person has moved into the community. These extra services are tailored to the individual and family's unique needs and desires.

The February 2012 Report included details about supports RCL staff provided to FHMC movers and their families. The RCL project is now working on a variety of activities that are benefiting the individuals who moved from FHMC, as well as others with developmental disabilities, by enhancing services available in the community. Appendix C of this report provides further details about these ten RCL projects.

- **Lessons Learned Project –** The Division asked independent facilitators to obtain feedback from stakeholders involved in or affected by the closure of FHMC. Nearly 130 stakeholders participated in the project. This information will help DDD plan for future moves from institutional settings and establishing new services in the community.

- **Eating Safety Project –** The one person who moved from FHMC and passed away had a history of "pica," or ingestion of inedible substances. Due to this incident, the Division contracted with two speech pathologists who have expertise in eating and swallowing disorders and who have extensive experience with individuals with developmental disabilities. Every person who moved from Frances Haddon Morgan Center to any location - community-based or another RHC – has been assessed for their risk of eating and swallowing problems, safety risks during eating, or any disorders that cause them to ingest non-food items.

- **Nursing Project –** The Division has engaged a Registered Nurse to review the health-related elements of each person's transition for those who moved to community-based homes. As a result of these health reviews, staff training needs have been identified, and a formalized checklist and protocol to address client health needs has been drafted. This checklist, when finalized, will better summarize participant health indicators and identify health and wellness outcomes.

- **Community Crisis Stabilization Services (CCSS) –** The Division of Developmental Disabilities is developing a framework of crisis and stabilization services to address the needs of clients, should they experience a crisis or need additional crisis services. The intent is to prevent unnecessary RHC placement. The Lakewood CCSS program is anticipated to open in October 2012 and will provide three youth placements of seven total planned crisis placements across the state.

- **Employment Project –** This project supports individuals to find meaningful jobs within one year of leaving the RHC, and will design a model that enhances employment opportunities for individuals leaving RHCs. The Employment Project involves fourteen individuals; 12 who moved from FHMC and two who either moved out of or are preparing to leave Fircrest School.

- **SOLA Housing Project –** Sixteen of the former FHMC clients moved into five Bremerton area homes and are supported by the SOLA program. They currently reside in market rate rentals and are thus prone to rent increases, limited ability to remodel, lease renewal dependent on the landlord, and other issues of typical rental properties. Projects are underway to obtain stable and affordable housing for these individuals that are tailored to their specific needs and are not subject to short-term lease.

- **Environmental Supports Project –** The Division contracted with Creative Housing Solutions to provide person-centered housing development and environmental adaptations consultation for four SOLA homes and three other community homes where 14 FHMC residents moved to. Safety features were recommended as well as environmental adaptations which would support each person's unique needs.

- **Assistive Technology and Communications Project –** The purpose of the RCL Assistive Technology Project is to develop a model process for assessing and evaluating the use of a variety of appropriate assistive technologies for individuals leaving, or who have left, RHCs. The University Of Washington Department of Rehabilitation Medicine developed an assessment tool and protocol for identifying activities for assistive technology evaluation and recommending appropriate assistive technologies to enhance independence on those activities. RCL also contracted with a speech/language pathologist who formerly worked at FHMC, to assess and recommend communication supports and to provide training to former FHMC residents.

- **Electronic Health Records Project –** The Division made the decision to implement a consistent electronic record keeping system for State Operated Living Alternatives (SOLA). The chosen web-based records system, Therap, is used by more than thirty other states and was developed for community-based programs that support persons with developmental disabilities. The RCL grant will assist with the transition from paper to computerized records, data and systems.

- **Appreciative Inquiry Project –** The closure of FHMC presented an opportunity to review the Division's "big picture" and how to apply and enhance other community-based services based on this knowledge. Roads to Community Living engaged Responsive Systems Associates to explore how the Division could better incorporate system values and markers of success into all aspects of the DDD system. The Appreciative Inquiry (AI) process is being used to learn from what is working well and how to extend that knowledge and practice to other areas within the DDD service system.

What's next?

Monitoring and quality assurance for the individuals who moved as a result of the FHMC closure will continue through regular quality assurance visits and data collection performed by both the Division of Developmental Disabilities and the Developmental Disabilities Council. Ongoing RCL projects and activities and other quality assurance efforts will continue throughout the duration of the grant. Examples of activities that will be ongoing include:

- **Monitoring Movers Surveys**
  All persons who moved from FHMC have received a "Monitoring Movers Survey" visit at one month and then again at three to six months post move. This survey process follows all individuals who move from an institution to either community or RHC settings. Quality assurance professional visits and observations of the person, their staff, and the home environment will occur again after former FHMC residents have lived in their new homes for a full year.

- **Money Follows the Person Quality of Life Surveys**
  The Washington State Developmental Disabilities Council (DDC) administers this federal survey to all persons enrolled for RCL funding who move from institutional-based to community-based residences. The survey is conducted independently from the Department of Social and Health Services. For former FHMC residents, a baseline survey was administered while they still resided at FHMC. Follow-up surveys will be administered at one year and at two years post move.

- **DDD Quality Assurance Processes**
  The February 2012 Report provided a thorough discussion of the Division's quality assurance processes. During the first year of residency in the community, the RCL project provides supports and enhances the regular DDD quality assurance activities. When that year is completed, regular DDD quality assurance systems will provide ongoing quality assurance and oversight to ensure the health and wellness of former FHMC residents as they continue their lives as members of our community.

Appendix A:
Quality Assurance Processes Discussed in this Report

In addition to quality assurance and oversight provided by the person's contracted residential provider agency, State Operated Living Alternatives (SOLA), or RHC regional and central office management, facility licensing reviews, Adult Protective Services (APS) and Residential Care Services Complaint Resolution Unit (CRU), individuals moving as a result of the FHMC closure are monitored by up to five additional quality assurance processes (see February 2012 Report).

The following quality assurance processes are discussed in this October 2012 report:

- **Monitoring Movers Survey -** The Monitoring Movers Survey is a three-part interview that is administered by quality assurance staff at one month, three to six months, and one year after an individual's move from an RHC to any other setting, including other RHCs.

    - **Part 1 – Staff Interview**
      The staff interview is administered to the program managers and direct support staff that assist the individual in their new residence. The individual's general health is reviewed; assuring that the individual has access to health care providers, preventive health screens are being completed, and health appointments are arranged and attended as necessary. Any medications or specialized equipment are reviewed to ensure that they are available and applied appropriately. If applicable, the individual's positive behavior support plan is reviewed to ensure that staff have received training specific to the individual, are familiar with the individual's support needs, and that the plan is being followed. The individual's social and community activities are reviewed to ensure that the person is an integral part of their local community and that relationships with family and friends are being maintained and strengthened.

    - **Part 2 – Client Interview**
      DDD quality assurance staff also visit with the individual. When possible, a structured interview is conducted with the individual to obtain information about the person's perception and satisfaction with services and supports received. Unfortunately, most of the persons who moved from FHMC were not able to complete the structured interview. Regardless, DDD quality assurance staff met with the individual and informally obtained input from the service recipient.

    - **Part 3 – Interviewer Observations**
      After each quality assurance visit, DDD staff formally record their observations of the safety of the individual's home and neighborhood, the condition of the home both inside and out, adequacy of the amount and variety of food and clothing for the individual, whether the individual was appropriately groomed, and whether staff

displayed dignity and respect, and interacted with the person in a way that encouraged the individual to make his/her own choices and decisions.

- **Family/Guardian/Advocate Survey -** One of the enhancements made by Roads to Community Living (RCL) staff to the quality assurance process for moves from RHCs is the development of a Family/Guardian/Advocate survey. Families of individuals who moved as a result of the FHMC closure are contacted via telephone by an RCL staff member to obtain their impression of the moving process, their observations of the health and welfare of their family member after the move, and satisfaction with services provided at the new residential setting. The division has adopted this survey for use with all FHMC moves. Regional DDD staff telephoned families of persons who chose to move to another RHC and administered a similar survey.

  Since a common theme among respondents from the previous round of interviews, as reported in the February 2012 Report was "It's too early to tell," this report analyzes data collected during interviews that occurred three months or more after their family member moved.

- **The DDD Incident Reporting System -** The DDD Incident Reporting (IR) System provides comprehensive tracking and review. Field Services staff and RHC staff use an electronic incident reporting system to notify supervisors, resource managers and to Central Office about incidents that have occurred. The DDD Central Office Incident Report Review Team meets monthly and represents a broad range of expertise. The team reviews and analyzes data pulled from the Incident Reporting Database with the goal of identifying the cause and ensuring appropriate follow-up. The IR Team reviews seven key indicators from RHCs, Regions and Community programs – overall monthly counts of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect, staff to client incidents, and client to client incidents – as well as evaluations of high profile single incidents. External investigations by Adult Protective Services (APS) and Residential Care Services (RCS) substantiate only a small number of these incidents as meeting the Revised Code of Washington (RCW) definition of abuse or neglect. DDD tracks trends and patterns as well as individual incidents of special concern. Action is taken as needed and traced by the IR Review Committee.

Appendix B:

Stories of Transition

– Originally authored by Grier Jewel, Washington State Developmental Disabilities Council

Albert

Fun to be around, active, creative, learns quickly, an all-around good guy … these are just a few of the words used to describe Albert by those who know him well. It's hard to imagine they're talking about the same person who, at age thirteen, was admitted to the Morgan Center for aggressive behavior and compulsive eating that made it impossible for his mother to keep him at home.

"He was huge," his mother says, recalling that he had lost a lot of weight that first year and staff had made progress in stabilizing what she refers to as his "flare ups." At one point, he was doing well enough to try a community placement. "It was a nice home," she says, "but there was no real plan in place. It just didn't work out."

With the closure of the Morgan Center, Albert's mother felt more comfortable with a State Operated Living Alternative (SOLA) than a private provider agency. She liked the fact that he'd have most of the same staff, two familiar housemates, and the same high school with teachers who know him. Whether it was due to good planning, familiarity, timing, or a combination of all three, Albert couldn't have responded better to the move.

"He was ready," SOLA staff explains. "He's matured. I can tell he wants to be independent." He helps around the house—cooking, setting the table, and doing laundry—sometimes initiating chores on his own, pleased and proud to have his own home. It's not all work, though. He goes swimming, plays basketball, and loves listening to music. "It was a great move," one of his support staff says, happy to see Albert "being a kid" and enjoying life.

Albert's high school transition teacher, agrees. He's seen a big improvement in Albert over the past few years, but even more so since the move. "I think he's happier now. There's lot less stress in his life having two roommates versus sixteen [at the Morgan Center]."

There's no doubt that living in the community is giving Albert a chance to mature and challenge himself in new ways. According to his speech therapist, Albert does best when the bar is set high. "He's one smart cookie," she says. "I think he's got real skill to go and work somewhere if a job could be found for him." To help improve his communication and control over his choices, he's been learning how to use an iPad. His speech therapist says the key has been to program it in ways that Albert can use it to make his views and choices known and to cause desired changes.

If his mother had one wish, it would be for even greater independence. "I would like to see him a little more out in the world and have more normalcy in his relationships. I'd like to see him have a girlfriend." It's difficult not to want more, considering how well he's doing. "I'm amazed," she says. These are two words Albert is sure to hear a lot from people as he shapes a life and future for himself in the community.

Carolyn[1]

In an ideal world, Carolyn would be living at home with her family. "But that's just not possible," her father says, pained by the reality of having a daughter with high needs in a system of limited community-based options for children. "It was tough trying to figure out where a fourteen-year-old could go." At the time, the Morgan Center was the best choice. It turned out to be a good one. To the relief of her family, Carolyn settled in and adjusted nicely.

No parent wants to upset the apple cart when things are going well; however, when the decision was made to close the Morgan Center, her father chose to see it as an opportunity rather than a setback. With the option to choose a community supported living provider, he'd be able to bring Carolyn closer to home.

"I called a lot of places and visited a lot of homes. Some just weren't a good fit, either because of the home or the other residents." Finally, after visiting a place just twenty minutes from the family home, he felt he'd found the right match: a large house in a nice neighborhood, staffed by a supported living provider he really liked.

Her family painted and decorated her room just the way they knew she'd like it—a pink princess-themed haven, with homemade curtains and a sign on the door: *Carolyn's Room*. She liked it so much that when it came time to go back to the Morgan Center after her first visit, she didn't want to leave. "Princess room," she said over and over, showing clear signs of not wanting to return to Bremerton. Her new staff was taken off guard.

"We were concerned about maintaining her trust," recalls Carolyn's supported living provider. "So we made arrangements for her to stay while we went back to collect her things." As far as transitions go, it couldn't have been easier. Starting a new high school the following month went just as smoothly. According to her father, Carolyn adjusts well to moving as long as she has a routine, so the ease of her transition didn't surprise him.

That's not to say life has been problem-free. Due to a reduction in medication while she was at the Morgan Center, Carolyn has had a recurrence of destructive behaviors that worry her parents; however, her father believes it's not related to the move. "It's a matter of building back up slowly and getting her stabilized on the medication."

Despite that one setback, he's pleased with the move. What makes it all worthwhile is being able to see his daughter as often as he wants, and to have her spend more time with her twin sister and

[1] Name has been changed.

stepmother. Their time together is now a regular part of their lives, rather than a special event. "It's the next best thing [to living at home]," he says, clearly happy to have Carolyn living so much closer. Aside from keeping her safe, that's all he's ever wanted.

Jemal

If asked to predict one of the biggest success stories to emerge from the closure of the Frances Haddon Morgan Center, chances are slim that anyone would have answered, "Jemal." And with good reason. Throughout most of the twenty-two years he lived at the Morgan Center, Jemal had racked up an impressive history of violent assaults that caused his transition team a great deal of concern.

"I was told he was one of their more troublesome clients," says an employee of the supported living provider chosen by Jemal's mother. He chooses his words carefully, partly out of wanting to protect Jemal's privacy, if not his dignity. "[Violence] was a big concern," he explains, recounting the many months he and the agency staff visited the Morgan Center as part of the transition process, getting to know Jemal, his history, and support needs.

The commitment of staff on both ends showed how much everyone wanted Jemal's transition to go well. A month prior to his move last October, he visited his new home several times, with the new provider agency staff assuming more responsibility with each visit. When it came time for moving day, Jemal settled right in. "He was perfectly fine," his staff recalls, marveling at how smoothly it went. "No negative reaction at all."

Despite his history of aggression, Jemal has not had a single incident in the seven-plus months since his move. Such a successful transition is due, in large part, to careful planning and continued one-on-one 24-hour staffing; however, the fact that Jemal is living in a smaller setting with more personal space and greater opportunities has clearly been a huge factor, one that's not gone unnoticed by his mother. "I think he felt more confined [at the Morgan Center]," she says. "He has more independence where he is now. He'll always need supervision, but he has more freedom [in the community]."

One of the reasons for his newfound freedom comes from Jemal's increasing ability to communicate with an iPad, programmed by a speech therapist for use at home and employment training. "He gets it," she said. "I push this button and someone listens to me." Having known him since his days at the Morgan Center, she gets excited just talking about the direction his life has taken. She's not alone. His job coach feels strongly that Jemal has a good chance of finding employment doing something he enjoys. "He's a hard worker, really goal-oriented, and he likes to finish his tasks. I think he'll be excellent."

"I'm just amazed," his mother says, remarking on Jemal's expanding possibilities, which include yet another first—sports—earning two spots at the Special Olympics state finals and his first overnight trip. "The move was a good idea. He's really happy. Whoa, it's good!"

Tom[2]

Tom's teacher remembers him from his first year in high school, when his violent outbursts reached a crisis level and he was admitted to the Morgan Center. Having returned to his hometown and former high school as a result of the Center's closure, the Tom that she sees today is not the same one she knew six years ago. Not by a long shot.

"He's a different person," she says. "He's calmer, more patient, and more appropriately verbal." What's been even more heartening for her to see is his continued improvement throughout the year since moving into the community.

His parents are cautiously optimistic. It's been a long journey. Although the frequency of his aggression had decreased significantly while at the Morgan Center, its closure intensified their worries. "We felt like Tom was in a good place," his mother says. "The move was a little scary."

Tom's mother and father chose the State Operated Living Alternatives (SOLA) option because it gave them comfort knowing that Tom would have familiar staff and housemates, as well as the fact that he would be attending his former high school. His transition team took their time preparing Tom for the move, including several visits over the summer to his new home so that he could get used to the house and neighborhood.

The planning and consistency paid off. Not only did Tom make a smooth transition into his new home and former school, he made good use of an opportunity for job training funded through a school-to-work program. His teacher and job coach created a tailor-made work experience that combined many of the things he loves—being outdoors, walking, and routine— in an environment that supports his strengths: retrieving balls on a local golf course.

According to his job coach, Tom has developed a rapport with regulars on the driving range that's "really sweet to see." Marveling that he returned to job training with even greater focus after a three-month break, she says, "He's able to adapt to change better than ever." She attributes his growth to "Consistency, consistency, consistency."

His parents are pleased with Tom's progress, though their feelings are tempered. "I worry," his father says, torn between wanting his son to have a normal life and wanting him to be safe. "But I guess there's risk everywhere. If he stayed, would he have been happy there?" he wonders, adding that he never liked the word *institutionalized*, or the stigma that comes with it. Despite concerns, his wish for Tom's happiness is undeniable. "I think it was a good move."

Tom is putting his own stamp on that statement. Shortly after graduating, he was offered a job at the golf course where he'd received training. It's his first paid job. For someone whose success and stability relies on consistency, he's showing everyone just how good some changes can be.

---

[2] Name has been changed

Appendix C:
RCL Projects

- **Lessons Learned Project**

  DDD asked independent facilitators to obtain feedback from stakeholders involved in or affected by the closure of FHMC. This information will help the Division plan for future moves from institutional settings and establishing new services in the community. The project obtained the perspectives of nearly 130 stakeholders: family members of former FHMC residents; former FHMC professionals (Human Resources, Physical Plant, and support staff); staff from newly developed State Operated Living Alternative homes; staff of other Residential Habilitation Centers; private community residential and employment providers that received FHMC residents; staff from DDD Central Office (including Roads to Community Living staff); DSHS Regions 2 and 3 DDD Field Services staff (which covers Western Washington, the area most affected by the closure and subsequent moves); and DSHS staff who worked with established closure work groups.

  The final report is in process of completion (anticipated October 2012) and will include conclusions and recommendations based on the analysis of stakeholder input. Some of the major concerns reported by focus group participants were the delays associated with the political decision-making process and the resulting hurried timelines, the human resources processes related to transitioning FHMC staff, and some 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.

- **Eating Safety Project**

  The one person who moved from FHMC and passed away had a history of “pica” or ingestion of inedible substances. Due to this incident, the Division contracted with two speech pathologists who have expertise in eating and swallowing disorders and who have extensive experience with individuals with developmental disabilities. Every person who moved from Frances Haddon Morgan Center to any location - community-based or another RHC – has been assessed for their risk of eating and swallowing problems, safety risks during eating, or disorders that cause them to ingest non-food items. The speech pathologists evaluated caregivers’ skills while in the residential settings to make sure that staff awareness and knowledge was present and safeguards and supports were in place. In situations where any concerns were identified, the speech pathologists worked directly with those caregivers and providers to increase staff skills, make environmental changes, develop and implement safety plans for individual clients, or make referrals for follow up medical-diagnostic assessments.

Numerous technical assistance sessions have been held around the state for residential providers and others who are interested in how to identify, follow up and recognize eating and swallowing challenges, warning signs and dangers of aspiration and choking. Basic orientation to eating and swallowing disorders, ingestion of non-edible substances and the consequences of such events is planned for all DDD case managers and residential providers on a statewide basis.

- **Nursing Project**

  In March of 2012, DDD engaged a Registered Nurse to review the health related elements of each person's transition for those who moved to community-based homes. As part of this work to date, over half of the FHMC clients who moved into the community were interviewed, the current state of their health was assessed, transition plans for individual clients were reviewed, and the transition processes at three RHCs were reviewed. As a result of these health reviews, staff training needs have been identified, and a formalized checklist and protocol to address client health needs has been drafted. This checklist, when finalized, will better summarize participant health indicators and identify health and wellness outcomes.

  Based on the findings of the project thus far, staff trainings will be created (primarily for staff working in Supported Living agencies, including SOLAs), that cover the following topics:

  - How to advocate for client health needs with medical professionals;
  - Medication sides effects and how to deal with them (such as constipation, weight gain, etc.);
  - Understanding commonly used medical and health related terms; and
  - How information you learn from daily life can help assess a client's health needs.

  This project is still operating. The rest of the 31 clients who moved from FHMC to community settings in 2011 will be visited and assessments of their health needs will be made. A report will be generated regarding each client. The information gathered will be used to develop more staff trainings and to refine existing health monitoring tools, and/or to create new tools and checklists related to client overall health and safety.

- **Community Crisis Stabilization Services (CCSS)**

  In 2010, Governor Gregoire proposed the creation of a sustainable system of care that would serve more people with developmental disabilities with a wider array of options near their families and local schools. Due to the closure of the FHMC and the 2011 Washington State Legislative amendment of RCW 71A.20, the Division of Developmental Disabilities was charged with developing a framework of crisis and stabilization services to address the needs of clients, should they experience a crisis or need additional crisis services. The intent is to prevent unnecessary Residential Habilitation Center placement. In March 2011, an initial workgroup convened to determine the scope and deliverables of the Crisis

Stabilization program. The workgroup determined that 7 (5 children, 2 adult) crisis beds would be opened and run by the state, and the workgroup developed initial draft policies and procedures for the Community Crisis Stabilization Services (CCSS) beds as well as the role and focus of the Community Crisis Treatment Teams to be developed in each of the 3 DSHS Regions.

Presently, DSHS-DDD is making preparations for a 3-bed CCSS home in Lakewood, Washington, and is exploring locations for two additional sites around the state. The Lakewood program has hired a manager as well as its clinical team who are participating in preparatory training/staff development and drafting Standard Operating Procedures for the facility. Another workgroup will convene in August 2012 to review and fine-tune the draft CCSS program policies and procedures, determine the program's role in the DDD continuum of care, and develop a "road map" for a common crisis approach for future implementation statewide. The Lakewood CCSS program is anticipated to open in November 2012 and will provide three youth placements of the seven total planned crisis placements across the state.

- **Employment Project**

The Employment Project supports individuals to find meaningful jobs within one year of leaving the RHC, and will design a model that enhances employment opportunities for individuals leaving RHCs. The Employment Project involves fourteen individuals; twelve who moved from FHMC and two who either moved out of or are preparing to leave Fircrest School.

This project worked collaboratively with King, Pierce, and Kitsap counties, as all fourteen participants were seeking employment in these counties. The project formed a statewide Steering Committee and three local workgroups in each of these counties. Washington Initiative for Supported Employment (WiSe) coordinated an employment plan for each participant. This included organizing a planning/action team, which depending on the individual, included people from county employment programs, residential agencies, DDD Case Management, RCL, county, the Division of Vocational Rehabilitation, schools (if appropriate), friends, family members, and community members. WiSe staff facilitated initial planning meetings and periodically brought teams together to review and update the plan as needed. Currently, the twelve individuals who resided at FHMC have employment providers, a planning team and plan, and have employment or are seeking employment. Three of the twelve individuals have paid jobs.

A final report of the first year of this project will be available in early fall 2012. Goals under consideration for the second year of the project include: further support of the eleven participants, who currently do not have jobs, to obtain employment; adding additional participants to this project; working with local communities to develop opportunities for individuals who present unique challenges for employment; disseminating lessons and

employment strategies; and developing recommendations for system improvement to enhance employment outcomes for individuals with significant disabilities.

- **SOLA Housing Project**

  Sixteen of the former FHMC clients moved into five Bremerton area homes, and are supported by the SOLA program. They currently reside in market rate rentals and are thus prone to rent increases, limited ability to remodel, lease renewal dependent on the landlord, and other issues of typical rental properties. Projects are underway to obtain stable and affordable housing for these individuals that are tailored to their specific needs and are not subject to short-term lease. In January 2011, the non-profit Inland Empire Residential Resources (IERR) organization began plans to acquire two three-bedroom houses in Bremerton and one four-bedroom house in the Port Orchard area. The accessible, affordable housing project will provide housing for ten of the individuals who are supported by SOLA. With the support of DDD, the project was fully funded in the fall of 2011 by the State Housing Trust Fund (HTF), the City of Bremerton, and IERR. However, with HUD budget cuts announced in December 2011, Kitsap County cut their $50,000 award for the Port Orchard house.

  With input from SOLA staff and clients, IERR found three suitable houses and purchased those homes in early May 2012. Through consultations with SOLA staff and clients and the project architect, a scope of work has been developed to remodel each house to meet the specific needs of the people who will reside there. IERR has hired a remodeling and construction professional to assist with pricing the work, including reviewing bids from subcontractors. The remodeling of the homes began July 22 and the goal is for the ten individuals to occupancy the three homes no later than the end of September 2012. Based on the remaining project funds and pricing home modifications, IERR will request additional funding, via an amendment process, from the HTF. In addition, IERR submitted another application to Kitsap County for $50,000. A second project is being proposed to acquire and remodel two additional homes for the remaining 6 SOLA clients. Grants are being sought, and the determinations whether to fund the new project should be made by March 2013.

- **Environmental Supports Project**

  The Division of Developmental Disabilities contracted with Creative Housing Solutions to provide person centered housing development and environmental adaptations consultation for four SOLA homes and three other community homes where fourteen FHMC residents moved to. Safety features were recommended as well as environmental adaptations which would support each person's unique needs.

  In addition, George Braddock, from Creative Housing Solutions, facilitated six workshops about person-centered housing development and environmental adaptations throughout Washington State for residential providers, families, state employees and other interested individuals. These presentations provided information about environmental supports for

individuals who have medical or behavioral challenges and who may not do well in conventional housing. Mr. Braddock also provided housing and environmental consultation for four individuals currently living in and planning to leave RHCs who will need environmental supports to be successful in the community.

Creative Housing Solutions is currently completing a housing "precedent study" to gather lessons learned from the housing arrangements developed for former RHC residents in the community. This study will identify locations and environmental modifications that will help provide the needed appropriate, safe, desirable and cost effective housing options for individuals transitioning from RHCs to community. The outcome will be check lists and housing templates that will inform the search for and development of safe, affordable housing. This study is anticipated to be complete in the fall of 2012.

- **Assistive Technology and Communications Project**

The purpose of the RCL Assistive Technology Project is to develop a model process for assessing and evaluating the use of a variety of appropriate assistive technologies for individuals leaving, or who have left, RHCs. The University Of Washington Department Of Rehabilitation Medicine developed an assessment tool and protocol for identifying activities for assistive technology evaluation and recommending appropriate assistive technologies (AT) to enhance independence on those activities.

Three of the project participants are former FHMC residents who all live together and receive supports from the SOLA program. These individuals received an assistive technology assessment and appropriate AT was recommended for some activities. This included an iPad which was mounted in a common area for all three individuals to schedule and cue for activities and to build communication. The individuals and their staff are receiving training in the use of these assistive technologies. Goals for the second year of this project include: follow up evaluation, training, and support for the three current participants; the inclusion of three additional former residents of FHMC who also receive supports from SOLA; and development of a protocol and assessment to evaluate AT remotely for individuals who live in rural areas or places without easy access to professional AT evaluations.

In addition to the above project, RCL contracted with a speech language pathologist who formerly worked at FHMC, to assess and recommend communication supports and to provide training to former FHMC residents. Nine individuals who live throughout Kitsap, King and Pierce received this consultation. Depending on the person, the recommended communication supports included schedules and picture supports, social stories, and/or the use of communication devices. These items are now in place and staffs of each of the nine individuals have been trained on the recommended functional communication systems. The iPad was recommended as a communication tool for four individuals, and three of these individuals have purchased or were loaned iPads. One of the three individuals purchased an iPad through RCL enhancement funding and is learning how to communicate

with his mother through this device. The fourth individual is currently waiting for administrative approval to purchase an iPad.

- **Electronic Health Records Project**

  While living at FHMC, residents experienced the advantages of computer based record keeping. For a variety of reasons, and with the diversity of providers involved, client service record keeping processes across the division are not standardized. Considering this, the Division made the decision to implement a consistent electronic record keeping system for State Operated Living Alternatives (SOLA). The chosen web-based records system, Therap, is used by more than thirty other states and was developed for community-based programs that support persons with developmental disabilities. Roads to Community Living (RCL) staff are assisting with the implementation of Therap in all SOLA homes across Washington State. In the next few years, SOLA residents will benefit by immediate access to electronically secure information and the ability to immediately recall and share information with health care providers and others as authorized.

- **Appreciative Inquiry Project**

  The closure of FHMC is one step toward the evolution of community-based supports for individuals with intellectual and developmental disabilities. The closure presented an opportunity to review the Division's "big picture" and how to apply and enhance other community-based services based on this knowledge. Roads to Community Living engaged John O'Brien and Connie Lyle O'Brien from Responsive Systems Associates, to explore how to how to better incorporate system values and markers of success into all levels of services within the DDD system. These values and markers are identified in the DDD Commitment Statement and include: health and safety, choice in life and services, respect, everyday relationships, competence and involvement in community life.

  Five separate stakeholder groups, including self-advocates, families and community advocates, residential providers, counties and employment providers, and DDD state staff, were interviewed about how to improve the DDD community support system. From these interviews, Appreciative Inquiry (AI) was recommended as a process to discover and learn from what is working well and how to extend that knowledge and practice to other areas within the DDD service system.

  The O'Briens facilitated two AI workshops, including a one day workshop with DDD Program Managers and a two day workshop with a cross section of stakeholders as mentioned above. Appreciative Inquiry workshop participants will use AI to further understand what's working and make improvements in areas of interest. Some areas of interest identified included: What makes a good transition for individuals moving from an RHC to the community, finding supportive guardians at no cost, assuring people have assistive technology, obtaining more hours in jobs for people with complex support needs, and bridging the gap between vocational and residential services. A follow up to this workshop

was held in September to determine what was learned and define next steps. Appreciative Inquiry workshops will be held with different groups throughout Washington during 2012-13 in an effort to better align practice with values of the DDD service system.