74th OREGON LEGISLATIVE ASSEMBLY - 2008 Special Session **MEASURE: HB 3617 A**
STAFF MEASURE SUMMARY **CARRIER:**
House Committee on Human Services and Women's Wellness

REVENUE: No revenue impact
FISCAL: May have fiscal impact, statement not yet issued

Action:		Do Pass as Amended and Be Printed Engrossed and Be Referred to the Committee on Ways and Means by Prior Reference
Vote:		7 - 0 - 0
	Yeas:	Cowan, Gelser, Gilliam, Kotek, Maurer, Olson, Tomei
	Nays:	0
	Exc.:	0
Prepared By:		Rick Berkobien, Administrator
Meeting Dates:		2/5, 2/6, 2/7, 2/8

WHAT THE MEASURE DOES: Creates the Quality Care Fund for the Dept of Human Services (DHS) to provide training, licensing activities and ensure quality in long-term care facilities, residential care facilities and adult foster homes. Defines "residential facility" to include an assisted living facility but to exclude a residential treatment facility or residential treatment home. Creates the Database of Quality of Care Violations to list names and other information of caregivers who have committed substantiated abuse and violations of quality care against clients for incidents during or after 2003. Requires the database be available on the Internet and accessible by the public. Stipulates the length of time a name remains on the database and criteria for having a name removed from the database. Redefines "abuse." Clarifies that measure applies to adults with developmental disabilities. Requires a facility to regularly notify residents and others of the database and how to access it. Requires DHS to report to each Legislative Assembly on fees and civil penalties assessed against facilities. Requires a facility, when a caregiver has committed abuse, to notify each resident and others of the abuse. Requires DHS to establish different licensing fees for long-term care facilities, residential care facilities and adult foster homes. Direct licensing fees into the Quality Care Fund. Requires DHS to adopt rules, using objective criteria, for establishing civil penalties, which may not exceed $500 for each violation or as otherwise required by federal law. Limits amounts of civil penalties, except for situations where death, serious injury, rape occur, to an aggregate not to exceed $6,000. Specifies that DHS impose a penalty of not less than $2,500 per violation against a facility where abuse occurs resulting in death, serious injury, rape, and similar abuses. Requires DHS, when adopting criteria for assessing civil penalties, to take into consideration prior violations, financial benefits realized by the facility, gravity of violation, severity of incidence, and facility's history of correcting violations. Allows DHS, if it finds a facility is responsible for abuse resulting in a resident's death, to impose a penalty of $500 to $1,000 for each violation. Clarifies that DHS can impose penalties for violations that do not constitute abuse. Allows DHS to assess civil penalties for various violations related to licensing, and to establish a process and criterion for imposing penalties. Establishes that sections of the bill become operative on July 1, 2008. Allows DHS to take actions to carry out sections of the bill. Declares an emergency effective upon passage.

ISSUES DISCUSSED:
- Need for consumer protection of individuals in caregiving situations
- Individuals and types of facilities affected by bill
- Difficulty in proving "substantiated complaints" against caregivers or facilities
- Type of abuse situations that would be entered into database
- Other information that may or may not be entered on database
- Whether or not the measure violates Constitutional due process provisions
- Studies on the number of people with disabilities who have been victims of assault by people they know

EFFECT OF COMMITTEE AMENDMENT: Defines "residential facility" to include an assisted living facility but to exclude a residential treatment facility or residential treatment home. Deletes technical assistance and adds training and licensing activities to purpose of fund. Adds substantiated complaints of abuse and violation of quality of care standards, as defined by rule and for those incidences on or after 2003, as additional reasons a caregiver may be listed on database. Designates the database as the Database of Quality of Care Violations. Stipulates the length of time a name remains on the database and criteria for having a name removed from the database. Redefines "abuse." Clarifies that

measure applies to adults with developmental disabilities. Deletes provisions that modify the information that DHS should maintain in the database. Modifies biennial fees that some facilities pay for licensing. Requires DHS to adopt rules, using objective criteria, for establishing civil penalties, which may not exceed $500 for each violation or as otherwise required by federal law. Limits amount of civil penalties, except for situations where death, serious injury, rape occur, to an aggregate not to exceed $6,000. Specifies that DHS impose a penalty of not less than $2,500 per violation against a facility where abuse occurs resulting in death, serious injury, rape and similar abuses. Requires DHS, when adopting criteria for assessing civil penalties, to take into consideration prior violations, financial benefits realized by the facility, gravity of violation, severity of incidence, and facility's history of correcting violations. Allows DHS, if it finds a facility is responsible for abuse resulting in a resident's death, to impose a penalty of $500 to $1,000 for each violation. Clarifies that DHS can impose penalties for violations that do not constitute abuse. Allows DHS to assess civil penalties for various violations related to licensing, and to establish a process and criteria for imposing penalties.

BACKGROUND: In November 2007, *The Oregonian* newspaper ran a series of investigative stories on the care of individuals with developmental disabilities in residential programs. The stories highlighted abuse and neglect of these individuals including deaths of residents in questionable circumstance, physical abuse, theft from residents, and other poor caregiving.

The Department of Human Services licenses and oversees approximately 8,000 caregivers in 1,200 adult group homes and foster homes. Approximately 4,200 adults with developmental disabilities reside in these programs. Many states maintain a database of caregivers who are guilty of resident abuse. Oregon currently does not maintain a database, which advocates note allows caregivers, who have been fired from one job to easily find employment in another facility.