

House Committee on Early Childhood and Human Services

Date: 3/5/25

Testimony in support of House Bill 3168

Chair Hartman, Vice-Chairs Nguyen and Scharf, and Members of the Committee,

Thank you for the opportunity to provide this written testimony in addition to the verbal testimony provided on Tuesday, March 4<sup>th</sup> in support of House Bill 3168. My name is Shaun Notdurft. I am a Direct Support Professional, providing person-centered community-based support for adults who experience developmental disabilities. I have been working in group homes with the Oregon Supported Living Program in Eugene since April 1, 1993. On June 27, 1996, we voted to go Union with SEIU 503. We are one of only three DD providers in the state who are unionized (excluding the state-operated group homes).

In my nearly thirty-two years working in the field, I have seen many changes and have experienced a tremendous amount of history. I have not just shown up for shifts, I have advocated for advancing the quality of our supports; I have contributed to support plans; I have done countless hours of research into the ethics and efficacy of various support perspectives; and, I have worked to support some amazing people. I believe that both the time on the job and my extra efforts delving into the mechanisms and philosophy of what I do uniquely qualifies me to testify in support of this bill, as well as myriad other aspects of this adventure, where I have the privilege of assisting vulnerable people fully access their community as equal members, build independence, and lead a self-directed life.

I work with individuals who were incarcerated in the Fairview institution. They experience challenges in society yet are so engaged and have overcome so many unjust perceptions. This is due to their character and ferocious will, and due to dedicated support from people like myself to ensure that there is an opportunity for success. I do not remove obstacles; I assist in the navigation of them – as the individuals we work with are at their own helm. There are, however, conditions that apply. Based on their care assessment and support plan, the three men I support are required to have 1:1 staffing in the community. Though they have made mistakes in their history, 1:1 support is not for the safety of the community but to support them – they are not a threat to anyone. The support we provide is crucial not only to protect these individuals from being victimized but also to prevent challenges to their mental health and from their lived trauma spiraling into a cascading crisis that could jeopardize their ability to remain in the community. I take this responsibility very seriously and strive to deliver support in a casual, non-intrusive manner that facilitates both their autonomy and success.

In order to accomplish this, certain staffing levels are required. If adequate staffing is not present, the men I support are stuck at home. This, as you would correctly imagine, is simply another form of institutionalization that we call warehousing; essentially, house arrest. Fortunately, the three men I support receive funding as allocated by the Legislature into the Rate Model (which, as a side note, is wholly inadequate and outdated). Having funding dedicated to staffing levels ensures quality support and adventurous community engagement. It is imperative.

I want to pivot to something that is important here. There are bad actors in this field, hence the writing of HB 3168. There are countless stories of providers pocketing money meant for staffing as they warehoused the people supported. This bill is important and should be passed. I would, however, suggest some amendments. First, nothing is manifested without enforcement and oversight. Providers will send in glowing reports, and heave sighs about how difficult their existence is... I bet each of you has seen this. Documentation, with oversight and investigatory validation is essential. Talk to the workers, not just the operators. In addition, there must be safeguards for truly well-meaning good actors. There are times when staffing levels are incredibly low: COVID-19 outbreaks, for instance. Or a particularly difficult home to work in or a behavioral/medical crisis that sends turnover into a tailspin. There must be a reporting mechanism that can describe the "Why;" a description of the circumstance that results in the provider not meeting the staffing levels expected. It may be as simple as a dearth of applicants, since this field tends to be high-stress and pays lower than many other jobs. It would probably be a good idea to include a requirement to report how the unused funds will be allocated, such as bonuses for relief staff, overtime pay, and other incentives, as well as a plan for increasing staff. The emphasis, however, must remain on safe staffing levels, site specific, at all times.

Finally, I would like to touch on worker safety. Being understaffed can be quite risky. It contributes to stress, burnout, and fatigue. People who feel incarcerated for no reason are likely to communicate frustrations, and this can manifest physically. In many cases, this is directed at the staff attempting to assist them. Staffing expectations exist partly due to this, and to our ethical duty to quality of life.

Not only will HB 3168 help with this, it also could expose bad actors in the field. I imagine a mechanism by which good actors can mentor bad actors, and through oversight and enforcement there is either improvement or sanctions. I think of the articles I read in the Rogue Valley Times regarding PCL, a large provider, where workers were getting injured on the job. I read their accounts and immediately realized that the state-required (and created) training, Oregon Intervention System, is not being trained and applied similarly between providers. The workers there were placed into a harmful environment, and it was clear to me that the provider did not ensure quality training standards or supervisory guidance. Workers were thrown into

working alone with barely any training, and experienced harm. The person supported is not at fault for any resulting behavior when it is the support that failed, due to both a lack of staffing and a lack of essential oversight both at the provider and the state level. I understand that this bill does not address training quality, that is a separate issue.

To double down on the intent of this bill, however, I would strongly assert that having staffing levels and a plan in place addressing worker safety is an integral component of my job, and my employer's responsibility to provide. If I am working alone unsafe, then the three men I support are also inherently at risk. I truly believe that together we can be successful in this amazing life of supporting others to live theirs. Funding is crucial to this end. But without rules of how funding must be applied, the fundamental responsibility cannot be met, and workers will be in preventable unsafe work environments.

The money in question is already allocated to the provider who has applied for it. I simply ask that HB 3168 make the intended use of the expenditure enforceable. Please amend this Bill to include oversight and accountability and have the mechanisms to ensure it is followed, along with reporting templates to report unavoidable inconsistencies and a plan of action to address the issue. I am fortunate to work for one of the good providers, and it is time that Oregon has consistent expectations for all providers.

I am willing to add more context, personal stories, and answer any questions you may have. I have dedicated over half of my life to this field, and I am seeking profound change. The people I support deserve it, and so does Oregon.

Thank you for your time and consideration of this important bill.

Sincerely,

Shaun Notdurft, DSP