# SENATE BILL REPORT
# SB 6564

As of February 9, 2016

**Title**: An act relating to persons with developmental disabilities.

**Brief Description**: Providing protections for persons with developmental disabilities.

**Sponsors**: Senators O'Ban, Fain, Keiser, McAuliffe, Hobbs, Conway, Angel, Frockt and Warnick.

**Brief History:**
**Committee Activity**: Human Services, Mental Health & Housing: 1/26/16, 2/04/16 [DPS-WM].
Ways & Means: 2/08/16.

## SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

**Majority Report**: That Substitute Senate Bill No. 6564 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators O'Ban, Chair; Miloscia, Vice Chair; Darneille, Ranking Minority Member; Hargrove and Padden.

**Staff**: Kevin Black (786-7747)

## SENATE COMMITTEE ON WAYS & MEANS

**Staff**: Mark Eliason (786-7454)

**Background**: The Developmental Disabilities Administration (DDA) is a subdivision of the Department of Social and Health Services (DSHS) which provides assistance and support for persons with developmental disabilities in Washington. Programs offered by the DDA include residential provider services, residential services, and various non-residential services including case management, child development services, employment services, and Medicaid personal care.

DDA clients receive a functional assessment which is updated annually to determine whether the client qualifies for funded DDA services and determine the level of service.

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*This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.*

Separate subdivisions of DSHS investigate abuse, neglect, exploitation, and abandonment for children and vulnerable adults. Complaints and referrals are screened for investigation and may result in reports to law enforcement, investigation, an offer of protective services, findings, and referrals.

Adult Protective Services (APS) is a division of the Department of Social and Health Services (DSHS) which investigates allegations of abuse, abandonment, exploitation, or neglect relating to vulnerable adults. APS may conduct a fatality review when a vulnerable adult dies and the DSHS has reason to believe that the death may be related to abuse, abandonment, exploitation, or neglect.

**Summary of Bill (Recommended Substitute As Passed Committee)**: DDA must develop a process to determine which of its clients who receive an annual developmental disabilities assessment are at highest risk of abuse or neglect. Nine factors are listed for DDA to consider. Clients who are identified as highest risk must receive visits from DDA at least once every three months. At least 50 percent of these clients must receive an unannounced visit from their DDA case manager within a calendar year, replacing a scheduled visit, at the discretion of DDA. A client may refuse to allow an unscheduled visit to take place, but this fact must be noted.

During annual assessments, DDA must meet with the client in person. If the client is receiving personal support or supported living services, the case manager must ask to view the client's living quarters and note his or her observations in the service episode record.

APS must conduct a fatality review whenever a vulnerable adult, including an adult with a developmental disability, dies and DSHS has reason to believe that the death may be related to abuse, abandonment, exploitation, or neglect. In the event of a death or near fatality of an adult who is a client of DDA or who has been a client of DDA within one year, or an adult who has been the subject of an abuse or neglect report within one year, DDA must report the death to the Developmental Disabilities Ombuds. APS may conduct a fatality or near fatality review at its discretion, or at the request of the Developmental Disabilities Ombuds. Protections and procedures are established for APS concerning fatality and near fatality reviews. Referrals for fatality or near fatality reviews may also be made by other agencies or mandatory reporters, including law enforcement, medical providers, the Department of Health, the Long-Term Care Ombuds, and others. DSHS must convene a multidisciplinary workgroup to establish guidelines defining the participants, procedures, and standards for near fatality and fatality reviews concerning persons with developmental disabilities, including the participation of Disability Rights Washington, the Developmental Disabilities Council, and the Developmental Disabilities Ombuds.

An Office of the Developmental Disabilities Ombuds is created. The Department of Commerce must contract with a private, independent nonprofit organization to provide developmental disabilities Ombuds services. The Developmental Disabilities Omubds must have powers and duties including:

- providing information on the rights and responsibilities of persons receiving DDA services or other state services;
- investigating administrative acts relating to persons with developmental disabilities;

- monitoring procedures implemented by DSHS and DSHS facilities relating to persons with developmental disabilities, and recommending changes to procedures;
- carrying out activities related to fatality and near fatality reviews; and
- submitting an annual report concerning the work of the Ombuds, including recommendations.

The Developmental Disabilities Ombuds must consult with stakeholders to develop a plan for future expansion into a model of individual Ombuds services akin to the Long-Term Care Ombuds, and report its progress and recommendations by November 1, 2019. Conflict of interest provisions, confidentiality rules, liability protection, and other rules and procedures are established relating to the Developmental Disabilities Ombuds.

**EFFECT OF CHANGES MADE BY HUMAN SERVICES, MENTAL HEALTH & HOUSING COMMITTEE (Recommended Substitute As Passed Committee)**: The bill was extensively changed during the amendment process. Please see the bill summary.

**Appropriation**: None.

**Fiscal Note**: Available.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: Ninety days after adjournment of session in which bill is passed.

**Staff Summary of Public Testimony on Proposed Substitute As Heard In Committee (Human Services, Mental Health & Housing)**: PRO: This bill builds on an effort started last year to bring help to adults who need more robust care and protection than they are currently being provided. There have been shocking cases of abuse which could have been discovered earlier or prevented if these protections had been in place. A system must be created to identify persons who are most at risk, and to review those cases. There should be prioritization by risk factors. We agree Ombuds oversight is needed, although we prefer having a separate Ombuds office. Thank you for addressing some of the concerns we brought forward last year. Current case management ratios are 100 to 1 in this area. Isolation is a huge risk factor for this population. The Ombuds must have appropriate training. Clients of DDA should receive the support and protection they need to lead healthy and fulfilling lives. DDA case managers are only resourced to provide one visit per year. Smaller caseloads would help to detect problems. We should be considerate of parents and their desire for privacy as well. Language should be included indicating when the fatality review will occur. Investigations of near fatalities will depend upon reporting.

OTHER: I support the direction this is going, but recommend some amendments. The use of measures like unannounced visits should be tailored to apply to clients who have risk factors raising concern. There are other ways besides unannounced visits to investigate legitimate concerns. Some clients value their privacy and would not appreciate unannounced visits. The Ombuds should have proper training and clarity about its role. Supported living providers are already regulated and inspected by the state. Supported living should not be defined as a "facility." Limited resources should be focused on the highest risk cases. Please don't make this an unfunded mandate. Social workers support unannounced visits if they are

funded. There should be more scrutiny over the role of the Long-Term Care Ombuds. Significant funds and training would be required to build this capacity.

**Persons Testifying on Proposed Substitute As Heard In Committee (Human Services, Mental Health & Housing)**: PRO: Senator O'Ban, prime sponsor; Diana Stadden, Arc of Washington; Donna Patrick, Developmental Disabilities Council; Evelyn Perez, Bill Moss, DSHS; Noah Seidel, Self Advocates in Leadership.

OTHER: David Lord, Disability Rights WA; Melissa Johnson, Community Residential Services Assn.; Matt Zuvich, WA Federation of State Employees; Loren Freeman, Freeman & Associates; Patricia Hunter, WA State Long-Term Care Ombuds.

**Persons Signed In To Testify But Not Testifying on Proposed Substitute As Heard In Committee:** No one.

**Staff Summary of Public Testimony on First Substitute (Ways & Means)**: PRO: We need an ombudsman for individuals with intellectual and developmental disabilities.

OTHER: Unannounced visits are important. Please provide funding for this and do not make this requirement an unfunded mandate.

**Persons Testifying on First Substitute (Ways & Means)**: PRO: Donna Patrick, Developmental Disabilities Council.

OTHER: Matt Zuvich, Washington Federation of State Employees.

**Persons Signed In To Testify But Not Testifying on First Substitute:** No one.