SUMMARY

California's Commission on State Government Organization and Economy (the "Little Hoover Commission") has a long-standing interest in improving those long term care services which are funded and/or regulated by the state. In addition to this study of community residential care facilities, which are licensed and monitored by the State Department of Social Services' Community Care Licensing division, the Commission also has issued this year an in-depth study of skilled nursing facilities (nursing homes), which are licensed and monitored by the State Department of Health Services' Licensing and Certification Division.

In the course of doing these studies, the Commission has become concerned for the safety and well-being of Californians who need long term care services and who rely on the state to protect their interests. It is the Commission's intent, in advocating the recommendations contained in this report and in our report on skilled nursing facilities, to identify ways in which chronically disabled Californians may receive appropriate care at a reasonable cost. At an absolute minimum, these citizens must be protected against abuse and exploitation.

This report is specifically concerned with three major client groups residing in community care facilities: the developmentally disabled, the mentally disabled, and the elderly. Our findings and recommendations have to do with three primary aspects of community residential care: the system for providing services, monitoring and enforcement, and funding. Our recommendations would affect state, regional, and local entities and in many cases require authorization by the Legislature.

CALIFORNIA SYSTEM FOR PROVIDING COMMUNITY CARE SERVICES TO DEVELOPMENTALLY DISABLED, MENTALLY DISABLED, AND/OR ELDERLY RESIDENTS

Summary of Findings

We found that physical and sexual abuse and harassment of community care residents occur with alarming frequency and severity. Yet, the Community Care Licensing offices (which we refer to simply as "CCL") appear powerless to take timely action either to stop such abuse or to prevent its continuation in the same facilities. At the same time, CCL does nothing to acknowledge, reward, or encourage excellence in providing community care services.

We found that the Department of Developmental Services is more advanced in defining client services and goals and in

setting policy and rates for all therapeutic and supportive services provided to developmentally disabled individuals residing in community care facilities than are the affected state departments and advocates for the mentally disabled and elderly. This disparity is a sign that community care is not integrated into the overall long term care system in California. Yet, community care is not viable as a free-standing and independent service; residents need to be monitored and to have access to social and health services.

We found that the mentally disabled and elderly need the same level of monitoring and personal contact that is provided now only to the developmentally disabled through case management services offered by regional centers. Placements of elderly individuals in community care facilities -- whether they are placed there by themselves or by family members or conservators -- is rarely a matter of public record. Consequently, volunteers in the State Long Term Care Ombudsman Program do not know where elderly community care clients are living and, thus, cannot visit them unless complaints are received.

We found that, because the facility administrators are not required to be "certified," no training or experience requirements are imposed on them. In the early days of family care as an alternative to institutionalization in state hospitals, social workers did certify community care providers. In our judgment, certification of the service providers, in addition to licensure of the facilities, affords a highly desirable level of quality control. At present, only community care providers serving the developmentally disabled are certified through a mechanism utilized by the regional centers for approving the providers as "vendors."

We found that CCL lacks a data base and information systems that are needed for efficient program management. There is, for example, no licensee tracking system. Thus, service providers whose licenses have been revoked in one county may be licensed in another county, their prior records having escaped notice. There also is no information systematically available to prospective residents on the quality or cost of care in the facilities in their areas. Neither do community care administrators receive information regarding the availability of services which their residents need and may have publicly subsidized access to.

We found that the public at large -- including physicians -- is unaware of the distinction between skilled nursing and community care facilities. This leads to inappropriate placements: individuals receive either more or less care than they actually need. A related problem is that lack of public awareness seems to correspond with lack of neighborhood acceptance of community care facilities and residents.

Finally, we found that community care facilities serving six or fewer residents are treated the same as facilities serving 500 residents or more. We believe that the small facilities actually comprise a community care "subsystem," which can be administered and regulated more effectively if defined and treated as such.

Summary of Recommendations

Legislative Changes

We recommend that the Legislature make the following changes in state law:

1. Amend the Torres-Felando Long Term Care Act (Chapter 1453/Statutes of 1982 (AB 2860)) to specify that community residential care shall be included in the array of services referred to generically as long term care.

2. Restrict the authority of Community Care Licensing to evaluation of facilities only. In other words, delete all references to evaluation of program activities by licensing personnel.

3. Authorize the Department of Developmental Services (DDS), the Department of Mental Health (DMH), and the Office of Long Term Care (O/LTC) to develop in regulations the program goals, provider standards, and service definitions for community residential care services provided to the developmentally disabled, mentally disabled, and elderly, respectively. These state units also need authorization to certify community care administrators who meet their respective standards. We further recommend they be authorized to create, in conjunction with related volunteer organizations in each community, a system of "ratings." Each community residential care facility should receive a rating based on its record in meeting licensing and certification requirements.

4. Require community care administrators serving the developmentally disabled, mentally disabled, and elderly to be certified by DDS, DMH, or O/LTC, respectively, based on the regulations specifying program goals, provider standards and service definitions developed pursuant to #3 above.

5. Require CCL to consult with DDS, DMH, and O/LTC regarding proposed changes in licensing regulations, prior to circulating such documents to the public. Require CCL to obtain statements signed by the directors of those entities attesting to their review of the proposed changes. Require CCL to attach these statements to the proposed regulations, including any comments

on or opposition to specific proposed changes, prior to their distribution before public hearings.

6. Authorize the development and provision of case management services to all developmentally disabled, mentally disabled, and/or elderly individuals residing in community care facilities.

7. Require the Health and Welfare Agency (HWA) to identify all conflicts in existing and emerging law pertaining to the authority of CCL and the authority of DDS, DMH, and/or O/LTC with respect to community care facilities, and propose appropriate legislative changes.

8. Require HWA to establish procedures whereby the program goals, provider standards, and service definitions developed in regulations by DDS shall be reviewed by DMH and O/LTC -- and vice versa. The intent is to assure that all affected departments will be advised of advances in services for categorically-defined client groups.

9. Amend the Torres-Felando Long Term Care Act to specify that community long term care agencies shall keep records on clients placed in community care facilities.

10. Require regional or county representatives of DDS, DMH, and O/LTC to develop records on community care facilities in each catchment area, however defined for each client group category. This consumer information is to be made available to prospective community care residents and/or their family members or other representatives. The records shall include facility ratings. We recommend further improving information available to consumers by requiring CCL to ask the Public Utilities Commission to require telephone companies to list community care facilities by client group, in each new edition of their telephone directory yellow pages.

11. Authorize CCL to develop a "small facilities subsystem." Part I of this subsystem shall consist of licensed "cluster administrators," who manage the recordkeeping, purchasing, and activity planning in up to 10 small facilities, among other specified responsibilities. Part II of the "small facilities subsystem" shall consist of designating model houses for one-year periods and providing for visits to these model houses by administrators of other small facilities. Part III shall consist of CCL's awarding certificates of excellence to small facility administrators who qualify on the basis of cleanliness and/or food and meal quality.

Administrative Changes

Among changes that can be accomplished through administrative action and require no legislative changes, we recommend that:

1. Community Care Licensing halt all activity related to developing "client-specific" licensing regulations. As we have indicated, the Departments of Developmental Services and Mental Health and the Office of Long Term Care should be responsible for establishing standards and goals for community care as a service utilized specifically by the client populations they serve.

2. The Health and Welfare Agency require all state departments that make decisions affecting residents in community care facilities to establish advisory task forces to review and comment on the recommendations contained in this report. Advisors should be representative of the clients themselves, client advocates, and service providers.

3. Community Care Licensing ask the Public Utilities Commission to require telephone companies to list community care facilities, by client group, in every new edition of the telephone directory yellow pages.

MONITORING OF COMMUNITY RESIDENTIAL CARE SERVICES AND ENFORCEMENT OF RELATED LAWS AND REGULATIONS

Summary of Findings

We found that the number of unlicensed community care facilities appears to be increasing, thereby posing a danger for unsuspecting community care clients. Budget cuts have led to CCL's decision to target its investigative resources on responding to complaints in licensed facilities, leaving unlicensed facilities unmonitored altogether. Local law enforcement agencies seem unaware of the problem.

We found that facility administrators are better protected against punitive actions taken by CCL than residents are protected against abuse and exploitation by administrators. Because the mentally disabled and elderly are seen less frequently than the developmentally disabled by social workers or other client advocates from outside a facility, these two groups especially are at the mercy of those community care administrators who are or become abusive.

We found that the existing monitoring and enforcement system lacks a 24-hour, 7-day-a-week emergency response mechanism. The Commission believes the state must have the capacity to respond in a timely manner to crises in community care facilities.

We found that the rights of residents to have privacy and to make life style decisions are all but ignored as a focus of monitoring and enforcement activities in community care facilities.

We found that more "sets of eyes" are needed in order to assure the well-being of community care residents. Volunteer ombudsmen are trained to mediate complaints the elderly may have regarding their care or the way they are treated by facility administrators. This low-cost monitoring by volunteers has not been consistently made available, however, to developmentally or mentally disabled community care residents.

We found CCL's operational philosophy to be ambiguous. That is, CCL has avoided committing itself to enforcement of laws and regulations, rather than technical assistance to facility administrators, as its primary responsibility. CCL has not developed standard criteria or procedures, for example, regarding the need for immediate closure of a facility.

We found CCL's screening of applicants for licensure to be inadequate. Not only are applicants not screened for their ability to handle finances or to assure the availability of English-speaking persons in the facilities, but they are not required even to know what the regulations specify regarding their facilities or the care needs of the residents.

We found that CCL's enforcement activities are not credible. Facilities ordered to close under court injunctions continue to operate without negative consequences. Fines assessed are often subsequently waived. Coordination with local law enforcement agencies is minimal, contributing to the perception many community care administrators share that they have little to fear in the way of punishment for violating the law.

We found that the Legislature's elimination of the post-licensing visit (within 90 days after licensure of a community care facility) represents the loss of a useful technique to prevent community care administrators from establishing inappropriate routines within facilities.

We found that CCL's investigative resources are inadequate. Nine non-supervisory investigators to review and investigate complaints of abuse or neglect in a 57,000-facility system (of which 22,000 are residential facilities) cannot complete even all the paperwork involved in preparing a desirable number of cases for prosecution. Furthermore, investigators often must do without the assistance and opinions of medical experts in determining the causes and/or the seriousness of the various client conditions they observe. Also, CCL investigators historically have been denied permission in <u>every</u> case to carry weapons into community care facilities in which administrators have threatened bodily injury to investigators or residents, or both.

We found that some licensing staff are assigned to evaluate the same facilities year after year. We believe this lack of rotation can lead to the evaluators' reluctance to cite violations.

We found that separating community care licensing from health facilities licensing has led to community care residents' loss of access to needed health services.

Finally, we found that community care facilities are allowed to locate in geographic proximity to each other in some communities to the point of forming undesirable concentrations. This problem exacerbates the general perception of community care residents as "undesirable neighbors."

Summary of Recommendations

Legislative Changes

We recommend that the Legislature make the following changes in state law:

1. Relocate the State Long Term Care Ombudsman Program from the Department of Aging to either the Attorney General's Office or the Department of Consumer Affairs. Also, the Legislature should expand the authority of the program to include recruitment and training of volunteers to monitor developmentally and mentally disabled clients as well as the elderly.

2. Authorize CCL to establish an emergency telephone "hotline" in Sacramento, to be accessible 24 hours a day, 7 days a week. CCL should then be responsible for contacting the appropriate office or individual in the local community in which the crisis has occurred. We further recommend that CCL require licensees to post the "hotline" telephone number in an obvious place in each licensed facility.

3. Require CCL to create an automated licensee-tracking system, using Social Security numbers as the primary identifier.

4. Require CCL to create a uniform accounting system for use in specified categories of community care facilities.

5. Require community care facilities licensed to serve 25 or more residents to establish resident and/or family member councils for the purpose of giving residents greater voice in decisions affecting their daily lives. Such resident councils should be made a condition of licensure for all facilities of the specified capacity.

6. Recombine Community Care Licensing with the Department of Health Services' Licensing and Certification Division and consider relocating the licensing function in the Attorney General's Office.

7. Restore funding and authority to reinstate community care post-licensing visits within 90 days of licensure.

8. Authorize an increase in the number of investigators. Restore funding and authority to locate approximately half of the investigators from CCL's Audits and Investigations Bureau in southern California.

9. Require CCL to notify placement agencies of a community care facility which has been cited or closed down for serious, potentially life-threatening deficiencies in the quality of care. When records of placement agencies which have referred clients to the offending facility are not available, we recommend that the Legislature require CCL to notify DDS, DMH, and O/LTC. These agencies would be responsible for alerting their county or regional counterparts to CCL's charges and actions.

10. Require CCL to notify clients and their families or other representatives whenever the community care facility in which the clients are residing is being cited or closed for serious deficiencies.

11. Authorize CCL to establish an emergency fund, possibly using revenue from increased fines, for use in providing for the relocation and care of residents when CCL closes community care facilities on short notice.

12. Clarify the definition of "unlicensed facility" to mean any facility that is (a) providing services allowed only in licensed facilities; (b) housing residents who demonstrate the need for services which only licensed facilities are authorized to provide; or (c) representing itself as a facility in which services authorized only in licensed facilities are being provided.

13. Authorize local police and sheriffs' departments to issue citations to owners of unlicensed facilities. These citations would resemble traffic tickets and the fines would equal fines for other violations of licensing laws and regulations. The revenue from these fines would remain in the community to offset the costs of an aggressive effort to close down unlicensed facilities or to force their owners to seek licensure.

14. Provide for automatic increases in fines assessed for specified violations. Specifically, fines should increase annually (or semi-annually, as the case may be) by the same percentage as the approved cost of living increase for SSI/SSP recipients.

15. Require CCL to treble fines for repeat violations. This provision should apply to administrators of unlicensed facilities as well as for other violations.

16. Authorize CCL to retain 50 percent of revenue from assessed fines in order to establish an emergency resident relocation fund and/or to support an increased level of enforcement activity.

17. Require all community care licensees to be bonded for a minimum of $1,000, and require that such bonds be written to cover the payment of assessed fines in the event a licensee fails to pay the fines or does not pay on time. Require CCL to revoke the license when the amount owed for fines exceeds the amount of the bond.

18. Authorize CCL to place a community care facility into receivership. (This would exclude small facilities which are also the administrators' private homes.)

19. Authorize CCL to establish a "crisis team" that it could send for limited and specified periods to operate community care facilities that are experiencing administrative failures.

20. Allow private citizens to recover legal fees in successful lawsuits against abusive or otherwise unsatisfactory community care facility administrators by authorizing attachments of administrators' property as the source of funding to cover these costs.

21. Require boarding houses (residences where meals are available, but care and supervision are prohibited), to register with Community Care Licensing.

22. Authorize volunteers in the State Long Term Care Ombudsman Program to enter boarding houses, as time and other resources permit, to determine whether clients needing care and supervision have been inappropriately placed in boarding houses.

23. Specify that any public employee (or a private, non-profit organization's employee who is paid from public funds) shall be immediately dismissed for referring an individual in need of community residential care to an illegal (unlicensed and/or uncertified) community care facility, or to an unsafe community care facility (one in which actions against an administrator are pending, due to substantiated charges of abuse or neglect of the residents).

24. Require CCL to give local governments an opportunity to comment on community care licensing applications when the new facility would be located within 300 feet of an existing community care facility, OR a skilled nursing facility, OR a boarding house. This requirement should not apply, however, to the small facilities (six beds or fewer).

Administrative Changes

Among changes that can be accomplished through administrative action and require no legislative changes, we recommend that:

1. CCL tighten applicant screening procedures by (a) not accepting incomplete applications, (b) revising the application form to include the applicant's plan for assuring the availability of English-speaking staff in each licensed facility, (c) requiring applicants to sign release forms authorizing CCL to obtain certain specified information about them, (d) requiring applicants to supply similar release forms signed by each of their employees who will provide direct services to residents, and (e) requiring applicants to sign statements that they have read and understood the pertinent regulations.

2. CCL and representatives of the Departments of Developmental Services and Mental Health and the Office of Long Term Care include monitoring of financial records in all routine visits to facilities. We recommend that these agencies encourage administrators found to be having bookkeeping problems to employ an outside bookkeeper to maintain the facility's accounts in accordance with CCL's uniform accounting system. All facility administrators should be encouraged to have a certified public accountant conduct an annual review of the books and prepare an annual report.

3. The State Long Term Care Ombudsman Program train volunteers specifically in the mediation of problems related to a breach of community care residents' rights to have privacy and to make decisions affecting their daily lives.

4. CCL arrange for licensing evaluators to be trained to gather evidence for use in investigations and prosecutions.

5. CCL rotate personnel assignments to prevent evaluators from reviewing the same facilities year after year.

6. The Health and Welfare Agency analyze the circumstances under which permission to bear arms has been granted to investigators from departments other than Social Services. On the basis of this analysis, we recommend that the Health and Welfare Agency

develop criteria to assist the affected department directors in deciding on a case-by-case basis when a situation warrants granting permission to investigators to carry weapons.

7. CCL investigators notify the Department of Social Services' Legal Division immediately upon determining that one of its investigations could lead to criminal prosecution. At that point, the Legal Division should assign an attorney to advise investigative staff regarding what additional information will be needed, if any, in order to prosecute the case.

8. The highest community care licensing official arrange quarterly meetings with the directors of Developmental Services, Mental Health, and Long Term Care and the State Long Term Care Ombudsman to discuss problems in the long term care system that require coordinated action by some or all of those entities.

9. CCL organize advisory groups composed of representatives of all client groups, advocates, and service providers to advise CCL regarding monitoring and enforcement problems they are aware of and to recommend remedial actions CCL could take.

10. CCL establish criteria regarding abusive or other life-threatening conditions that indicate a need for immediate corrective action, including possible facility closure. Such criteria should not remove CCL's discretion so much as limit the need for discretion to situations which are not covered by defined criteria.

11. CCL sponsor seminars twice a year for local law enforcement agencies, including district and city attorneys and fire marshals. These seminars would afford opportunities to create joint strategies for addressing enforcement problems identified by CCL and to share information on successfully prosecuted cases around the state.

12. CCL prepare a manual on the responsibilities of local law enforcement agencies, as prescribed by existing law. This manual should include information on how communities can access state-level investigative resources.

13. CCL prepare handbooks for use by new licensees and residents. The handbooks would state in clear, nonlegal language what the law requires of service providers in order to be licensed. The handbooks would also state in clear, nonlegal language the rights and responsibilities of residents in community care facilities. We further recommend that the Departments of Developmental Services and Mental Health and the Office of Long Term Care prepare, for inclusion in the handbooks, clearly-written statements of the program goals, provider standards, and client services that make up the framework within which community residential care is to be offered.

FUNDING

Summary of Findings

We found that the primary funding source for community residential care services for the elderly and developmentally and mentally disabled is SSI/SSP. Thus, federal and state funds are used in roughly equal proportions. The cost of the licensing program, however, is paid 100 percent from the state general fund.

Supplementary payments from state funds are available to the developmentally disabled, but not to the mentally disabled or elderly. These supplements are intended to buy a higher level of care for clients who have been assessed as needing additional "specialized services." Thus, the adequacy of funding for community residential care services varies from client group to client group.

We found that the "rate" for community residential care services is not regulated. For clients supported by public funds, the rate is virtually equivalent to the existing SSI/SSP grant level (minus the small sums reserved for the clients' personal and incidental needs). Residents with private resources pay whatever the market will bear.

Because budget reductions so far have not resulted in lower SSI/SSP grant levels, the funding for direct services in community care has remained relatively stable and, in fact, has risen by whatever cost of living increases have been approved for SSI/SSP recipients. Funding for monitoring and enforcement, on the other hand, has been cut. We found that reducing support for monitoring and enforcement has also diminished the effectiveness of these activities.

Summary of Recommendations

Legislative Changes

We recommend that the Legislature adopt the following two guiding principles in allocating any new revenue that may be generated pursuant to adoption of our funding-related recommendations:

** New revenue should not replace General Fund support dollar-for-dollar -- at least not until additional revenue potential has been identified and realized. Rather, new revenue should be used to increase monitoring and enforcement effectiveness and improve the quality of service.

** There should be no increase in rates paid to facility administrators unless the increase is buying a higher quality or level of service. Across-the-board rate increases (other than cost of living adjustments) cannot be justified.

With those two guiding principles in mind, we recommend that the Legislature make the following changes in state law:

1. Require community care licensees to pay annual licensing fees. Require CCL to structure licensing fees in such a way as to offer incentives for compliance with licensing laws and regulations. Add a $2 per bed annual fee to support the State Long Term Care Ombudsman Program.

2. Authorize the State Long Term Care Ombudsman Program to establish an "Ombudsman Foundation." The Foundation would be eligible to receive tax-deductible contributions for the purpose of supporting local volunteer ombudsman programs for the elderly and developmentally and mentally disabled clients residing in both skilled nursing and community care facilities.

3. Require CCL to notify DDS, DMH, O/LTC, and all licensees of the federal rules governing supplemental funding from private sources to maintain SSI/SSP recipients in community residential care facilities. CCL should also develop standard agreements for the use of facility administrators. Require DDS, DMH, and O/LTC to organize aggressive efforts at the county or regional level to solicit private contributions to support increased levels and quality of service provided to community care residents.