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Executive Director

# COMMUNITY RESIDENTIAL CARE IN CALIFORNIA

## Community Care as a Long Term Care Service

December 1983

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## Community Care
## As A Long Term Care Service

A Report
of the

COMMISSION ON CALIFORNIA STATE GOVERNMENT

ORGANIZATION AND ECONOMY

December 1983

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Governor of California

Honorable James Nielsen
Senate Minority Floor Leader

Honorable David A. Roberti
President pro Tempore of the Senate
and Members of the Senate

Honorable Robert W. Naylor
Assembly Minority Floor Leader

Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and Members of the Assembly

Dear Governor and Members of the Legislature:

As you know, the Little Hoover Commission in August 1983 issued an exhaustive study discussing living conditions in nursing homes and presenting recommendations for improvement. During that study, we received testimony which indicated that problems in community care facilities are even more severe than in nursing homes. Upon receiving the details of four specific facilities which had abused its residents, the Commission initiated a thorough investigation of the living conditions provided in community care facilities.

During the months in which we conducted our investigation, this Commission made unannounced visits to community care facilities and received extensive testimony on numerous other facilities guilty of subjecting their residents to severe abuse, neglect, and generally unhealthy and uncaring conditions. Daily throughout this State, residents of community care facilities are being severely abused, beaten, fed spoiled food, forced to live with toilets that don't work, generally subjected to a demeaning existence and left unattended. In fact, some residents are actually killed in facilities each year. The most disturbing fact is that most of the citizens of this State, as well as most of our elected officials, are generally unaware of these conditions.*

Conditions such as these leave no question that it would be unthinkable and immoral for government to allow such facilities to operate, let alone place individuals into them. And yet, these facilities continue to operate, and thousands of residents continue to be subjected to these horrors. Moreover, where the State has taken action

*On page 21 of this report, we provide a sample of the specific conditions.

against some very bad facilities by taking away their licenses, many of them have continued to operate without a license, thereby not even being subject to an annual inspection or the minimum health standards.

California currently has 22,000 community care facilities licensed to provide "non-medical" residential care to 151,000 children and adults unable to live without care or supervision. These numbers alone are staggering and do not lend themselves to traditional government monitoring and enforcement techniques.

In response to these special problems, our Commission, in addition to conducting public hearings, held three all-day workshops in which we brought both elected and appointed government officials; facility operators; residents and family members; local enforcement officials; and consumer advocates together to work with our commissioners, staff and project consultant towards the objective of developing new approaches and recommendations to solve the problems. Our study findings include the following:

- Community residential care is not viable as a free-standing system of care and supervision; it can work only in conjunction with periodic review of individual residents by trained social and health service professionals.

- Elderly residents of community care facilities, in particular, are subject to abuse because they are rarely monitored by outsiders. System goals and client services are more advanced for the developmentally disabled than for the elderly or mentally disabled.

- In the existing community care system, certification of administrators is neither mandated nor authorized by State law.

- Small facilities (six or fewer residents) comprise a community care "subsystem" that should be maintained apart from the larger facilities.

- Data base and information systems do not adequately monitor facilities and residents, or assist consumers.

- The number of unlicensed community care facilities is increasing at an excessive rate; neither State nor local enforcement agencies are making any meaningful effort to stop it.

- The existing enforcement system lacks protections for residents in emergencies.

- More "sets of eyes" are needed to assure that residents are adequately cared for and not abused.

- The system for screening individuals applying for facility licenses is inadequate; staff working in facilities are not screened for criminal histories, there are no educational requirements to receive a license, and operators are not even required to know what the State regulations require.

- State coordination with local law enforcement agencies is virtually non-existent.

- Current investigative resources are inadequate in number, expertise, and geographic allocation.

- Budget constraints reduce the effectiveness of monitoring and enforcement activities.

- More flexibility in paying for residential care is desirable for all client populations. More money should be made available for community residential care only for changes that would upgrade the quality of care.

To improve the system for providing community care to residents of these facilities and to ensure that the State adequately protects these individuals, the Little Hoover Commission has developed over thirty detailed recommendations for legislative reform, reorganization of certain State functions, operational improvements, and sources of new revenue to support certain activities. Included in our recommendations are the following:

1. Integrate community residential care into the long term care system. Coordinate policy development, coordinate the definition of services, and extend case management services to the elderly and the mentally disabled.

2. Stregthen the "small facilities" subsystem by creating cluster administration of these facilities. Identify and reward "model houses" to help educate operators and serve as incentives.

3. Recruit and train volunteers to monitor residents.

4. Create an automated licensee information system.

5. Revise applicant screening so that it is more meaningful.

6. Recombine community care licensing and health facilities licensing and relocate the licensing function in the Attorney General's Office.

7. Structure coordination of enforcement activities.

8. Clarify definition of unlicensed facilities and create a citation system similar to traffic tickets, to assist in taking action against them.

9. Increase fines for licensing violations; triple the fines in cases of repeat violators.

10. Require all licensees to be bonded.

11. Authorize CCL to place a facility in receivership.

12. Establish a "crisis team" within CCL to step in and operate extremely bad facilities temporarily.

13. Encourage private action against unsatisfactory facilities by allowing recovery of legal fees through attachments of administrators' property.

14. Impose an annual licensing fee to support increased monitoring.

15. Authorize the establishment of an Ombudsman Foundation.

The members of this Commission believe government has a legal and moral responsibility to protect and ensure that the residents of community care facilities live in safe and healthy conditions. At the same time, we recognize that government today must provide services with very limited resources. Therefore, we have attempted to design our recommendations to increase and improve the services and protection government provides community care residents without significantly affecting the cost of operations.

Respectfully submitted,

JEAN WALKER, Chairwoman
Community Care Facility Study
Subcommittee

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## 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 <u>and</u> 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, nonprofit 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.

# I. INTRODUCTION

The Commission on California State Government Organization and Economy -- more familiarly known as the Little Hoover Commission -- is committed to improving California's provision of long term care services and has issued earlier reports on related programs. Most recently (August 1983), the Commission completed a study of the nursing home industry.

The Commission's primary objective in issuing this report is to identify ways of reforming the community residential care system to enable it to assure better protection of the residents and to improve the quality and level of services without dramatically increasing public costs.

Community residential care in its present form is an unsatisfactory instrument of public policy. This report is concerned with state government's responsibility, in generating an alternative to institutionalization, to take the necessary steps that assure the safety and well-being of the individuals affected by that action.

## Background

It sounds like a relatively simple idea: instead of keeping individuals suffering from chronic disabilities in acute care hospitals or skilled nursing facilities, let's remove them from those high-cost institutions and assist them in finding appropriate places to live "in the community." More humane, more

rehabilitative, less costly. But, as it turns out, it is also more administratively complex and difficult than anyone anticipated.

Community residential care is not the monolithic structure its label implies. Community residential care services are available to more than 150,000 Californians in 22,000 facilities that have bed capacities ranging from one to 550, or more. The types of clients include abandoned or abused or orphaned children (foster care), developmentally and mentally disabled individuals of all ages, elderly persons, alcoholics, drug abusers, and paroled or court-assigned wards of the Youth Authority.

Depending on which category, or "label," applies best to any given individual, substantial differences can ensue in such variables as: source of funding for residential care services; monthly rate; availability of assessment interviews, placement assistance, and follow-up visits (case management services); and access to such generic community services as job training, recreation, or transportation. The perceptions of community residential care's purposes, efficacy, or deficiencies can diverge to surprising degrees, depending on whether one's point of view is that of regulator, provider, or purchaser of services, client advocate, state bureaucrat, or budget analyst.

Community residential care can be thought of, for example, as an industry which evolved as a market response to a public purpose: government is community care's biggest customer. Yet, it is a "regulated" industry in name only. The caregivers are

indeed licensed by the state, and their facilities must meet minimum standards. But qualifications for community care licensees themselves have not been specified, nor have standards for care been determined.

The units of state government that are the focus of this study are:

- The Community Care Licensing Division (referred to throughout as "CCL") in the Department of Social Services. CCL licenses all community residential facilities.
- The Department of Developmental Services (DDS). DDS monitors the operations of regional centers, which approve facility administrators before case managers are allowed to place developmentally disabled clients in community residential care.
- The Department of Mental Health (DMH). DMH monitors the operations of county mental health departments whose efforts to assist mentally disabled clients find community residential care placements vary substantially from county to county.
- Office of Long Term Care (O/LTC). The Office of Long Term Care has been established pursuant to the Torres-Felando Long Term Care Act (Chapter 1453/Statutes of 1982 (AB 2860)). O/LTC is expected to be the driving force in creating a comprehensive system of long term care services -- including community long term care agencies -- for California's elderly.

- Health and Welfare Agency (HWA). The Secretary for Health and Welfare is directly responsible to the Governor for general policy formulation in social and health services and for sound management of each department and office within the Health and Welfare Agency.
- The State Long Term Care Ombudsman Program in the Department of Aging. The Ombudsman Program has pioneered the development of local volunteer programs to recruit and train volunteers to provide client-monitoring of the elderly in nursing homes and community care facilities.

## METHODOLOGY

In February 1983, the Little Hoover Commission hired Deanna J. Marquart, principal in the policy analysis consulting firm, Troubleshooters, as a project consultant to conduct a study of community residential care. The initial phase of the project began with a literature search and review of existing documents and analyses. On May 25 and 26, the Commission held a hearing in Los Angeles as an additional and updating step in the information-gathering process. In conjunction with this hearing, several Commissioners made unannounced visits to selected community care facilities.

During July and August, the Commission sponsored three workshops on community residential care, each one focused on a different client group: developmentally disabled, mentally disabled, and elderly. Participation in the work groups was limited

to 25 persons each; invitations were sent to pertinent organizations representative of the clients themselves, the care providers/facility administrators, advocates, law enforcement officials, and state departments and agencies. Comments and recommendations from the hearing and these workshops were used in the development of many of the recommendations the Commission is advocating in this report.

## II. CALIFORNIA'S SYSTEM FOR PROVIDING COMMUNITY CARE SERVICES TO DEVELOPMENTALLY DISABLED, MENTALLY DISABLED, AND/OR ELDERLY RESIDENTS

### A. Major Findings

1. Abusive, Unhealthful, Unsafe, and Uncaring Conditions Are Intolerable

2. Fragmented Administration Inhibits the Integration of Community Residential Care into the State's Overall System for Long Term Care

3. Advocates Seek Case Management Services for the Elderly and Mentally Disabled Comparable to Case Management Services Now Provided Only to the Developmentally Disabled

4. System Goals and Client Services Are More Advanced for the Developmentally Disabled than for the Mentally Disabled or Elderly

5. Caregivers for the Developmentally Disabled Are "Certified," But Caregivers for the Elderly and Mentally Disabled Are Not "Certified"

6. Small Facilities (Six or Fewer Residents) Comprise a Community Care "Subsystem" That Should Be Maintained Apart from the Larger Facilities

7. Data Base and Information Systems Are Inadequate to Support Efficient Program Management

8. Provider Training Is Not Required

9. Excellence in Providing Community Residental Care Services Goes Unacknowledged and Unrewarded

10. Lack of Community Awareness and Acceptance Causes Developmentally and Mentally Disabled Residents to Be Perceived as "Undesirable Neighbors"

### B. Recommendations for Improving Community Residential Care Services

1. Integrate Community Residential Care into the Long Term Care System

   a. Clarify Roles

b. Coordinate Policy Development

c. Coordinate Definition of Services

d. Extend Case Management Services to the Elderly and Mentally Disabled

e. Improve Consumer Information

2. Strengthen the "Small Facilities Subsystem"

a. Create Opportunity for "Cluster Administration" of Small Facilities

b. Designate Model Houses

c. Award Certificates for Excellence

## A. Major Findings

### 1. ABUSIVE, UNHEALTHFUL, UNSAFE, AND UNCARING CONDITIONS ARE INTOLERABLE

The first finding of this study is the most shocking: California is tolerating the operation of numerous community care facilities in deplorable conditions. The residents are subjected to physical and sexual abuse, neglect, and generaly unsafe living conditions. As one representative of the community care industry observed, "the conditions are far more severe than ever existed in nursing homes fifteen years ago. It's a snake pit out there."

The unfortunate difference is that few people, particularly government officials, are aware of the unconscionable conditions which thousands of community care residents, most of whom cannot care for themselves, must live in each day.

Members of the Little Hoover Commission visited facilities and saw first-hand the dirt, the neglect, and the emptiness. And during two days of public hearings, we listened to one individual after another describe his or her personal "horror story." There is no way to relate adequately the variety and number of stories we heard and conditions we observed. Below is only a sample:

#### Facilities Do Not Provide Care for Residents

1. Bedridden patients lie in their own excrement.

2. Residents suffer from decubitus ulcers (bedsores) to the point of requiring hospitalization. In one case, the facility's staff did not know what it was, so they simply exposed the resident's decubitus ulcer to sunlight each day. Eventually, the resident had to be hospitalized, at which time surgery and skin grafts were required.

3. In one facility, a resident was finally hospitalized after gangrene had gone undetected for too long. The individual had several toes amputated.

4. Many facilities employ non-English speaking staff who are unable to communicate with residents. This condition is particularly dangerous when residents are suffering from or develop medical problems and staff cannot so much as read and understand the instructions on prescription labels.

5. Residents are repeatedly fed boiled cabbage and chicken livers or hot dogs as their primary diet. Actual meals served often do not resemble the posted menus.

Threats and Physical and Sexual Abuse

1. Residents are threatened with retaliation, ranging from going unfed to being hit, if they report how they are being treated to licensing staff or volunteer ombudsmen.

2. When one resident became ill with diarrhea and was incontinent, the operator chose to teach him a lesson by taking him into the backyard, undressing him, and washing him down with a garden hose.

3. Residents are forced to have sexual relations with operators or staff. In one case, an elderly female resident was told that if she didn't go along with the operator's demands, she would never see her family again.

Unhealthy and Unsafe Living Conditions

1. During one of our Commission's unannounced visits to facilities, we observed:

   - Only two toilets were operative for 45 residents; neither was clean.

   - Although the residents in the facility were described by the operator as "sometimes violent," a large saw was discovered in an unlocked hall closet.

   - Medications were "stored" in open cabinets in the same room in which ice cream was kept in a locked freezer.

   - Four of the five fire alarms were inoperative.

   This facility was described by the Deputy Director of the Department of Social Services as an "average" facility.

2. In unlicensed facilities, residents sometimes sleep in one large room where mattresses are lined up next to each other on the floor.

Privacy Denied to Residents

1. Residents are denied privacy when family or others visit them at the facility.

2. Facility staff listen to conversations at a bedroom door.

3. Ombudsmen are banned from entering a facility and visiting residents, although they have legal access.

4. Residents are subjected to interrogation about what was said after visitors leave.

5. Operators and staff take ombudsmen's business cards away from residents.

Residents Denied Personal Dignity

1. Residents are limited to one roll of toilet paper per two residents per month.

2. Owners and staff prohibit residents from taking a nap, going to bed, turning a channel on the TV, running water to clean dentures, or turning on a light without their approval.

3. Private pay residents are given different meals from residents receiving SSI/SSP.

4. Residents are treated like children. For example, in one facility they were required to clean their plates in order to receive dessert.

5. One resident's clothes were ripped off because she was undressing too slowly.

6. One woman was threatened with having all her hair cut off, because it took too long to wash it.

7. Residents are refused the right to make telephone calls.

The description of the above conditions is not meant to indicate that all community care facilities are unhealthy, unsafe, or abusive. This Commission recognizes that a significant number of community care facilities provide very good living conditions on limited revenues.

Based on this study, our Commission has concluded that there is no single cause for the above conditions. Although we believe significant improvements can be made in the monitoring and enforcement system, we do not necessarily believe, for example, that these intolerable conditions exist because the Community Care Licensing Division of the Department of Social Services is not doing its job. Given the number of facilities, the lack of program standards or required qualifications for licensees, and reductions in state general fund support for licensing and enforcement activities, the department's task is in fact overwhelming.

## 2. FRAGMENTED ADMINISTRATION INHIBITS THE INTEGRATION OF COMMUNITY RESIDENTIAL CARE INTO THE STATE'S LONG TERM CARE SYSTEM

Community residential care is not viable as a free standing system of care and supervision. It can work only in conjunction with periodic review of individual residents by trained social and health service professionals who are capable of assessing the care needs of those individuals over time. In short, community residential care needs to be fully integrated into the array of services referred to generically as "long term care."

Implementing a system of community residential care involves more than maintaining a system of facilities licensing. In order to assure the provision of adequate services and a safe environment for residents, a network of supportive and therapeutic services must be developed, maintained, and coordinated. There are

inherent difficulties in coordinating such a complex service delivery system.

The most glaring problem is the disparity between the relatively diverse services available to the developmentally disabled and the lack of supportive and/or therapeutic services available to the mentally disabled and elderly. This disparity results from there being three completely independent service planning groups. The Department of Developmental Services (DDS) and its "satellites" (regional centers, State Council on Developmental Disabilities, and related advocacy organizations) have developed standards and goals for community residential care services for their clientele, apart from licensing requirements, and created a mechanism for selecting service providers.

DDS calls this mechanism "vendorization." It means a community care provider has been approved by the regional center as able and willing to meet the needs for service that are unique to developmentally disabled individuals. The developmentally disabled program planning network promotes provider training in techniques of behavior modification that are effective in teaching developmentally disabled persons to become proficient in such activities of daily living as eating a meal in the company of others, participating in games and other group activities, and performing household chores.

The organizational structure that has facilitated these advances in programming for the developmentally disabled in community care fails to facilitate similar advances for the mentally

disabled and elderly. Ideally, when statutes, regulations, policies, and procedures affecting one client group are refined and improved, similar processes would be triggered automatically for the client groups who are also in community care but whose presence there occurs under separate statutory and administrative auspices. That this does not occur is evidence that community residential care is not integrated into existing long term care systems -- except for the developmentally disabled.

Because service planning for the three distinct client groups is not coordinated, there is a tendency to perceive Community Care Licensing (CCL) in the Department of Social Services (DSS) as having the primary administrative responsibility for community residential care -- as if community residential care were a definable "program" in and of itself. To some extent, the affected state departments appear to share this perception.

In addition, facility administrators are not generally included in planning improvements in the provision of services. It is rare for the administrators to function as members of a "treatment team," rather than merely as "operators" of community care facilities. At the opposite extreme is the responsibliity assigned to administrators of residential facilities for the elderly (RFF's). The regulations pertaining to this category of licensure require RFE administrators to assess the care needs of residents and assure that appropriate services are secured. The service providers, in this case, are being expected to fill the gap that is created by the lack of a state-level system for the

elderly that is comparable to the state-level system for the developmentally disabled.

## 3. ADVOCATES SEEK CASE MANAGEMENT SERVICES FOR THE ELDERLY AND MENTALLY DISABLED COMPARABLE TO CASE MANAGEMENT SERVICES NOW PROVIDED ONLY TO THE DEVELOPMENTALLY DISABLED

One reason that the severe conditions described earlier can persist in many community care facilities is that mentally disabled and elderly clients are rarely monitored by outsiders. Case management is not routinely available to the elderly, nor comprehensively available to the mentally disabled.

"Case management" is actually an array of services provided directly to clients. It includes, but is not limited to, the following components:

1. Assessment of the client's physical, environmental, financial, and psychosocial needs and resources.

2. Determination of the need for placement assistance and ongoing case management services, especially periodic monitoring.

3. Development of an individual care plan to meet the client's immediate and long-term needs. This plan is prepared with the participation of the client and other relevant persons (for example, family members and doctors). The plan covers not only an individual's needs for income and health services, but also for emotional support, reassurance, social contacts, recreational activities, and supportive living arrangements.

4. Service procurement. Case managers locate, make arrangements for, and sometimes actually purchase services to be provided to individual clients.

5. Regular and timely reassessments of each client's progress and condition.

County mental health departments do monitor mentally disabled residents in community care facilities, but not as frequently as developmentally disabled clients are visited, or over as long a term. Few standards have been developed in the mental health system pertaining to the goals for clients in community residential care. Furthermore, the mental health system lacks a certification device similar to "vendorization." Consequently, mental health case workers are powerless to affect the conditions in which they find their clients living.

Assessment of individual clients has to be performed by qualified professionals who have the capacity to determine the health and social service needs of the clients. Elderly and mentally disabled clients badly need assessment and periodic reassessment, as their conditions tend to fluctuate rather often.

Assessment, while desirable, is admittedly an art at this point, not a science. The most advanced assessment system is that used for developmentally disabled clients. Nevertheless, assessment instruments currently in use for this client group sometimes do not adequately take into account behavioral problems and medical needs. Inaccuracies in client assessments, just as often as <u>no</u> client assessments, lead to "inappropriate placements" -- meaning clients receive either too little or too much care. The difference is, in a case management system, <u>re</u>assessments create the potential and the mechanism for correcting initial errors.

During our hearing, the Commission received testimony from four local ombudsmen who investigate and attempt to resolve complaints in community care facilities in San Diego, Orange, Napa, and Santa Cruz Counties. Each of these individuals stated that one of the most serious problems in community care facilities today is inappropriate placement.

Inappropriate placements result in many of the conditions the ombudsmen must investigate. For example, ombudsmen see numerous cases of residents who are bedridden patients lying in their own excrement. The facility administrator in such cases obviously is unqualified and incapable of caring for such individuals. These types of residents should be in nursing homes.

As discussed earlier, assessment of prospective residents by administrators of residential facilities for the elderly (RFE) is the law, but is it actually being done -- or, when it is, is it effective? RFE administrators are not required to meet any qualifications that would make them suitably able to judge the mental, physical, or functional capacities of prospective residents. Furthermore, an administrator has a financial incentive to "keep the beds full," whether or not the elderly individual could be truly appropriately received into the administrator's facility.

The degree of resident participation and choice in his or her total residential care arrangement is closely connected with the availability of case management services that emphasize individualized care and service planning. Case managers in the system for the developmentally disabled point out that assisting clients

in choosing an appropriate community care facility is complicated by the fact that a client has the right to choose where he or she is going to live. A community care resident cannot be forced to accept a recommendation for placement. The principle is a good one and is intended to promote and support the programmatic goal of increasing client independence. Sometimes, however, it is hard to reverse a placement decision that is not in the client's best interests if, for whatever reason, the client chooses to remain in an inappropriate facility.

Nevertheless, case management offers many client benefits as a system. Services for an individual are tailored to meet his or her needs by the case manager, who also maintains more constant contact with the client. Consequently, there is another set of eyes periodically observing the conditions in a facility. However, it is also true that certain problems inhere in adding case management services to the community care system and they would need to be resolved. The problems are: (1) purchasing power is generally limited to the SSI/SSP rate; (2) options under this constraint are limited; (3) developmentally disabled clients have supplemental public funding available for specified purposes while others do not; and (4) there is presently little or no information available to prospective residents on quality of care and/or which facilities have good or bad records with respect to licensing violations.

## 4. SYSTEM GOALS AND CLIENT SERVICES ARE MORE ADVANCED FOR THE DEVELOPMENTALLY DISABLED THAN FOR THE MENTALLY DISABLED OR ELDERLY

California lacks a comprehensive concept of what the community residential care system is supposed to do. Lacking such concept, the state entities with statutorily authorized missions to serve specified client groups have defined their own clientele's need for community residential care services. Once again, the state-level system for the developmentally disabled has established service definitions compatible with the clients' needs for service, whereas the state-level systems for the elderly and mentally disabled have not intervened in the program development of community residential care to any significant degree.

From testimony at the May 1983 hearing and papers produced at the three summer workshops, the Commission has identified several elements of community residential care in which separate goals and client services should be defined differently for each client group. These are: standards development, compliance monitoring and enforcement, provision of health and supportive services within facilities, resident participation in facility decision-making and in the community, individualized care and service planning, resident or client tracking, availability of meaningful activities, and the qualifications of providers.

Participants in the summer workshop concerned with the developmentally disabled felt that the broad service goals estab-

lished by Community Care Licensing (CCL) are in some cases inadequate for developmentally disabled clients. Furthermore, there are areas of conflict between the requirements of the Lanterman Act and those of the Community Care Licensing regulations pertaining to services for the developmentally disabled (for example, prone restraints). When conflicts arise, the delineation of authority needed to resolve such issues is unclear. The results are confusion among facility administators and deficiencies in the
provision of services to residents.

System Goals/Service Outcome Goals. "System goals" should define what community residential care is supposed to be and do for the residents, without reference to categorical disabilities. "Service outcome goals" should clarify the developmental, rehabilitative, or functional conditions that community residential care services are intended to promote. These vary from client group to client group. Therefore, The Departments of Developmental Services (DDS), Mental Health (DMH), and the Office of Long Term Care have to be responsible for developing service goals for the developmentally disabled, mentally disabled, and elderly, respectively.

Within client groups, service goals will vary from individual to individual. Thus, sensible goal-setting for each client can be achieved only in a case management system utilizing individual client assessment.

## 5. CAREGIVERS FOR THE DEVELOPMENTALLY DISABLED ARE "CERTIFIED," BUT CAREGIVERS FOR THE ELDERLY AND MENTALLY DISABLED ARE NOT "CERTIFIED"

Licensing is concerned to a great extent with a licensee's physical plant, certification with the caregivers, or facility administrators. In the existing community residential care system, certification of administrators is neither mandated nor authorized by state law.

The regional centers have developed a form of certification for caregivers serving the developmentally disabled. The regional centers require administrators to be "vendorized," meaning they are approved by a given regional center to serve developmentally disabled clients. Case managers place their clients only with vendorized administrators, who also are eligible for supplemental funding to the extent each administrator is able to provide "specialized services." Thus, administrators have a financial incentive to seek vendorization. This system helps to screen out providers who are not qualified or able to provide quality care.

Before 1973, when the state Community Care Licensing Act was passed, the process of releasing state hospital patients into community placements involved the "certification" of community care providers by the same social workers who would also continue to follow the progress of or changes in those patients (see Appendix A for more detail). When board and care homes were first being actively sought (primarily for the chronically mentally ill) as an alternative to institutionalization -- starting

around 1940 and continuing through the early 1970's -- this ongoing personal contact constituted a less formal quality control mechanism than licensing.

The impact of licensing on quality is unclear. Among social and health service professionals, there is a sense that the humanitarian motivations which were once thought to be the cornerstone of effective care and supervision are simply not relevant in the "bricks and mortar" system of licensing.

Regional centers created vendorization as a quality control mechanism that allows them to set standards that exceed licensing requirements for service providers who are interested in meeting the specialized care needs of the developmentally disabled. County mental health departments presently lack a comparable device. Certification of administrators serving the elderly is not feasible at present, as there is no administrative entity available to perform this function.

## 6. SMALL FACILITIES (SIX OR FEWER RESIDENTS) COMPRISE A COMMUNITY CARE "SUBSYSTEM" THAT SHOULD BE MAINTAINED APART FROM THE LARGER FACILITIES

Throughout the period of this study, the Commission has received comments from diverse sources on the special set of problems that is associated with small community care facilities -- private homes serving six or fewer residents. Of 22,000 community residential care facilities throughout the state, 18,000 (82 percent) are licensed for six or fewer residents.

Of that total of 18,000 small facilities, approximately 4,000 are housing the elderly and developmentally and mentally disabled clients, while 14,000 serve foster care children.

Before 1946, community residential care was provided predominantly by churches or charitable organizations in large facilities or by families in their own homes as recruited, certified, and supervised by social workers (see Appendix A for more detail). When CCL began licensing community care facilities in the mid-1970's, the system took on a new aura of entrepreneurship.

Unlike most proprietors, administrators of board and care homes do business in relative isolation. They are protected from the standard market forces that might otherwise drive out the abusive administrators by the disabilities and fears of the very clients they serve. This situation apparently brings out the worst in certain care providers and, as things stand, residents in small facilities are inadequately protected against abuse, exploitation, and grimness.

The "family setting" of the small facilities represents a tradition in therapeutic environments thought originally to be particularly appropriate to mentally ill patients who no longer need hospitalization, but who do still need care and supervision. When the Community Care Licensing Act was passed, these small facilities came under the auspices of the same regulatory system that evaluates rest homes for as many as 550 "well elderly," orphanages for comparable numbers of children, and other large non-medical care facilities.

It is "nonmedical care" that places all these quite disparate care options into the single category "community care" for purposes of licensing. The efforts of government to reduce the high costs of professional long term care for various disabilities have led to this categorization and have thereby stimulated the demand for increasing numbers of community care beds. Individuals without medical training, but with their own homes to offer as a resource, have come forward to supply this care.

This trend can be expected to continue, given recent changes in federal funding for long term care (effective October 1, 1983). The new policy is to eliminate day-rate reimbursement to hospitals in favor of paying a specified maximum for a diagnostically defined condition. This change will cause hospitals to place convalescing patients in skilled nursing facilities (SNFs) in order to reduce their own costs per day. In turn, the SNFs will want to place their clients -- those whose conditions have stabilized -- into community care, to make room for placements that hospitals will soon be paying for at a higher rate than SNFs now receive.

The point of this is that it is desirable now and will remain desirable for the foreseeable future to keep community residential care decentralized and to utilize the family care setting. The large number of facilities available, the scattered site distribution of these facilities, and the diversity in levels of care available are all characteristics of the "small facilities subsystem" that make it compatible with the necessity of reducing the costs of long term care.

Problems may arise, however, when options for improving the quality of care are considered. At that point, it will be important to exempt the small facilities from traditional means of regulating quality -- such as educational requirements of service providers -- and, instead, to create "networks" within which small facilities can function and be supervised. This is desirable for two reasons: (1) many community care residents prefer to live in the family-setting environment in small facilities, and (2) the lack of extra staffing requirements and provider qualifications makes this care option available at low cost, relative to all other options.

With the clarification of rules and requirements for the family-setting care option, the rest of the community residential care industry can mature without disrupting the "small facilities subsystem." In the industry as a whole, caregiving specialties and concomitant training programs should be allowed to emerge in order that more levels of care can be integrated into the overall long term care system.

## 7. DATA BASE AND INFORMATION SYSTEMS ARE INADEQUATE TO SUPPORT EFFICIENT PROGRAM MANAGEMENT

There is no requirement for community residential care facilities to report costs or utilization and no system-wide automated management information system. Thus it is not possible to determine such facts as the following:

- Prior Experience of Providers. Although all applicants for licensure must provide fingerprints which are checked against the Department of Justice's criminal records, there is no system for checking an applicant's prior record of service as a community residential care provider. There are known cases of individuals whose licenses have been revoked in one county for serious code violations (such as neglect or abuse of residents) who are subsequently licensed in a different county; this can occur without the licensing agency's being aware of it.

  Also, there is at least one known case of a delicensed nursing home administrator who is currently operating several community residential care facilities. This discovery was made through personal observation rather than through systematic record checks.

  Finally, only the applicants are screened via the fingerprint check, while staff (i.e., employees of the licensees) in the larger facilities are not screened by the state at all.

- Consumer Information on Quality of Care. Not only do licensing personnel have systematically inadequate information on caregivers, but so does the general public. There is no systematic generation or distribution of information regarding the quality of care in available facilities by area. Current law and regulations require CCL to maintain a facilities rating system. The basis for

ratings is to be the extent to which facilities have been found to be in compliance with health and safety standards. CCL, however, has never implemented the required facilities rating system.

Furthermore, CCL state and district offices make no systematic effort to gain press attention to changes or improvements in community residential care. The general public (to say nothing of doctors!) is unaware of what the difference might be between a community care and a skilled nursing facility. For example, even the telephone book does not provide a useful listing of facilities. Generally, facilities are grouped together under a heading such as "rest homes," or "retirement homes," which frequently combine nursing homes with community care facilities or even room and board houses. This information gap alone undoubtedly contributes to widespread "inappropriate placements" throughout the residential care system statewide.

- The annual cost of public subsidies for community residential care. Based on the SSI/SSP rate, basic payments for foster care children, and assuming 60 percent of licensed capacity for adults is occupied by publicly-supported residents, we estimate a minumum of $583 million in public funding will go into direct service costs during 1983-84.

  Facilities are not required to report charges to clients with private income. Consequently, the costs incurred by

these individuals are unknown. Private-pay residents often pay more, but even if they pay only the SSI/SSP rate, at least another $181 million is going into community residential care from private sources. (This estimate assumes a 90 percent occupancy rate. CCL has no data on utilization, however, so the actual occupancy rate may be considerably lower than we have assumed here.)

The above estimates do not include the costs of case management or administration. They also exclude substance abusers, supplemental funding for "specialized services," county supplements for foster care, and residents in unlicensed facilities. Thus, community residential care may be a nearly $900 million a year industry in California.

The lack of cost data retards efforts to make community residential care more efficient. Without knowing how much we are spending now and what benefits might accrue to the residents as a result of more expenditures, any reorganization of rate-setting, reimbursement, or purchase of additional services would have to be made on the basis of intuition rather than analysis.

- Information to Facility Administrators. Lack of knowledge about the special needs of residents and about resources and services available in the community are critical impediments to adequate service provision. Providing information to community care facility administrators regarding community events, activities, and services that residents

in their facilities would be eligible to participate in could result in more active lives for community care residents.

- Client Tracking. An effective system for tracking residents is lacking for all three client groups. Without information on prior placements, case managers and other service professionals attempting to devise an appropriate care plan for a client have no way of knowing where the client has been, which services have been provided in the past, or what was successful or unsuccessful. The resulting interruptions in service to a client may be damaging to an individual's prospects for rehabilitation and greater self-sufficiency.

  Monitoring elderly residents is particularly difficult because far more of the elderly than of developmentally or mentally disabled either place themselves in community care facilities or are placed there by family members. Because there is no reporting system or client tracking system into which to feed client characteristics, volunteers from programs such as the Long Term Care Ombudsman have no way of finding out where self-placed elderly residents are living.

## 8. PROVIDER TRAINING IS NOT REQUIRED

Given that the service providers in community residential care are not required to meet minimum qualifications, it is not

surprising that training often is not available to them. Yet, provider training would have the most immediate and beneficial impact on the quality of life for community care residents.

At present, only RFE administrators are required to fulfill training standards: 20 hours of continuing education per year, the content of which is unspecified and left to the administrator to decide. Regional center case managers cite as critical the gap between the expertise of program planners and that of providers as a primary factor in inadequate service delivery. Mental health professionals at the Little Hoover Commission workshop this summer pointed to four deaths of mentally disabled residents which were linked to the unskilled application of management of assaultive behavior techniques.

While it is clear that the majority of community care providers and staff are inadequately trained for their responsibilities, the actual type of training these persons should receive is undetermined. Priorities need to be set. Should the administrators be trained first, for example, in the improved management of safe and clean facilities or improved provision of care to residents?

That administrators are increasingly organizing themselves into associations suggests they are interested in upgrading their personal professionalism, as well as their political influence and public image. As discussed earlier, our perception is that administrators of small facilities need to be involved in a supervised "network" of small facilities. This arrangement may or

may not include formal training, but it would afford more opportunities for small facility administrators to learn from each other how to upgrade the quality of care they provide.

In the larger facilities, on the other hand, we believe that at least those supervising the care given to residents should be professional administrators and/or health service specialists. Thus, they should be required to meet traditional educational or training requirements commensurate with their professional status and level of responsibility in a community care facility.

## 9. EXCELLENCE IN PROVIDING COMMUNITY RESIDENTIAL CARE SERVICES GOES UNACKNOWLEDGED AND UNREWARDED

One of the most common complaints heard from community care administrators is that they hear only "bad news" from the state -- that is, when their facilities are out of compliance with laws or regulations. News stories, too, tend to focus on cases of criminal abuse in community residential care, causing the industry as a whole to suffer the loss of public confidence that follows.

Because we think it is important to the safety and well-being of all community care residents that certain deficiencies in the existing system be corrected, we too will be reporting to a great extent on what is now wrong with service delivery, enforcement, and funding. But we consider it equally important to acknowledge that there are community care administrators who provide quite satisfactory care at a low cost and, in some cases, operate truly

model facilities which deserve to be commended and imitated. In addition, if excellent facilities were identified and publicized as such, the medical profession and the general public would be better able to make intelligent selections.

## 10. LACK OF COMMUNITY AWARENESS AND ACCEPTANCE CAUSES DEVELOPMENTALLY AND MENTALLY DISABLED RESIDENTS TO BE PERCEIVED AS "UNDESIRABLE NEIGHBORS"

Community care residents are frequently perceived as "undesirable neighbors." This is particularly true of developmentally and mentally disabled clients. The public policy thrust to achieve savings by moving patients out of state hospitals and into the community could benefit from a public relations effort, not only to promote understanding and acceptance but also to recruit volunteers to help generate activities, job opportunities, or family homes.

Representatives of all three client groups have decried the lack of community involvement and support for community care residents and programs. Since the deinstitutionalization movement began, mentally and developmentally disabled clients and their service providers have often experienced resistance from within neighborhoods when attempts were made to establish residential facilities or homes. While neighborhood acceptance is still an issue for these two client groups, an even greater need exists to reintegrate disabled individuals into the community at large. Community residential care clients need access to commu-

nity resources such as parks, recreation programs, the Y's (YMCA and YWCA), schools, public transportation, and libraries.

## B. Recommendations

### 1. INTEGRATE COMMUNITY RESIDENTIAL CARE INTO THE LONG TERM CARE SYSTEM

We recommend that the Legislature 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.

Community residential care is not viable as an independent system of care. All adult community care clients need access to health and social services, some more frequently than others, some for longer periods than others. In order for community care to be efficacious as a low-cost residential service for chronically disabled individuals, it must be compatible with and integrated into the overall long term care system that is now emerging in California.

Specifically, administrative improvements at the state-level should include clarification of roles, coordination of policy development, coordination of service definitions, and improvement of information available to consumers. The integration of community residential care into the long term care system also should have the specific result of extending case management services to the elderly and mentally disabled.

a. Clarify Roles. We recommend that the Legislature revise state laws in order to clarify the role that the Community Care Licensing Division is to play in the long term care system vis-

a-vis the state departments with responsibilities for developing appropriate goals, standards, and services for specified client groups.

We recommend that CCL continue its narrow focus on facilities licensure, based on physical standards. We further recommend that any authority CCL now has in statute to evaluate programmatic aspects of community care facilities be deleted from the law. Most urgently, we recommend that CCL be prevented from distributing its recently drafted "client-specific" regulations for public review and comment.

We recommend that the Departments of Developmental Services and Mental Health be statutorily authorized to develop program goals, provider standards, and client service definitions for community residential care services provided to the developmentally disabled and mentally disabled, respectively. These departments -- not CCL -- should formulate appropriate implementing regulations for their respective program goals, provider standards, and client service definitions. We further recommend that state laws be amended to require that service providers for these two client groups be certified by the regional or county representataives of these departments in order to be eligible to receive placements of publicly subsidized individuals.

We recommend that the Office on Long Term Care -- whatever its ultimate organizational status and/or placement in state government turns out to be -- be mandated to develop program goals, provider standards, and client service definitions and

related regulations for community residential care services provided to the elderly. We further recommmend that Chapter 1453/-Statutes of 1982 be amended to require the Community Long Term Care Agencies, as they are phased in, to certify administrators of residential facilities for the elderly, based on these goals, standards, and service definitions.

Finally, we recommend that CCL develop procedures for reporting violations of programmatic and service standards which licensing evaluators observe during their visits to community care facilities. We further recommend that the State Long Term Care Ombudsman advise all volunteer programs to refer locally unresolved quality of care complaints to the appropriate program agency rather than to CCL. Such violations and complaints should be investigated by the Departments of Developmental Services or Mental Health or the Office of Long Term Care, as appropriate. We recommend that these agencies develop criteria and procedures for decertification of community care facilities, whenever necessary to protect the well-being of the residents.

b. Coordinate Policy Development. We recommend that changes in licensing regulations developed by CCL pursuant to our proposed restrictions on facilities licensure be discussed with and reviewed by the Departments of Developmental Services and Mental Health and the Office of Long Term Care before public hearings are held on such regulations and/or before they are submitted to the Office of Administrative Law for review and

approval. We further recommend that the Legislature require CCL to obtain statements signed by the department directors, attesting to each department's having reviewed the proposed changes in regulations. These statements should include the departments' comments on or opposition to the changes CCL has proposed and be attached to the copies of regulations which are distributed to the public before hearings are held.

We recommend that the Legislature require the Health and Welfare Agency to identify all conflicts in existing and emerging law between responsiblities assigned to CCL and those assigned to affected state departments regarding community residential care and propose appropriate legislative changes.

c. Coordinate Definition of Services. We recommend that the Legislature require the Health and Welfare Agency to establish a process whereby the program goals, provider standards, and client service definitions developed in regulations by the Department of Developmental Services will be reviewed by the Department of Mental Health and the Office of Long Term Care, and vice versa. The intent of this provision is to assure that all affected departments keep apace of advances in services for categorically-defined client groups as such advances evolve.

We do not mean to imply here that all services available to one client group should necessarily be available to all other client groups. This Commission does believe, however, that all the component programs in the community care system need to be advised on a regular and systematic basis of new developments and experimental approaches in providing community care services.

We further recommend that the Health and Welfare Agency require the departments to create advisory processes that solicit recommendations and comments on proposed changes from affected clients, service providers, and client advocates.

d. Extend Case Management Services to the Elderly and Mentally Disabled. To the extent that community residential care is eventually assimilated into the overall long term care system, the elderly and mentally disabled will indeed receive case management services comparable to those available now only to developmentally disabled community care clients. These services include: individual assessment, care and services planning, placement assistance, periodic follow-up monitoring, and mediation with service providers. This change is so critical to the diminishment of abuse and exploitation of community care residents, however, that we feel we must specify it.

Based on the experience documented by the multipurpose senior services demonstration project (MSSP), case management that emphasizes community placements results in more efficient utilization of existing services. All MSSP clients are identified as "frail elderly" and are eligible for skilled nursing services funded under MediCal. The average cost in MSSP for providing social and health services to clients in community settings is approximately $900 per client per month. This cost includes case management and compares quite favorably with the average $1,150 per client per month in nursing homes, which is the cost of skilled nursing services only.

Providing case management services to the elderly and mentally disabled may require additional funding at first, but there is reason to expect that at least a significant portion of new costs will gradually be offset by reduced expenditures.

As the long term care system evolves, all clients, regardless of categorical disability, should receive case management services at whatever point they enter the system -- that is, whether as a state hospital patient, a recipient of in-home supportive services, or a community care resident.

In support of this goal, we recommend that Chapter 1453/-Statutes of 1983 be amended to require Community Long Term Care Agencies to indicate in their planning process how they intend to keep records on clients placed in community residential facilities.

e. Improve Consumer Information. We recommend that the Legislature transfer the existing mandate to implement a facilities rating system from CCL to the Departments of Developmental Services and Mental Health and the Office of Long Term Care. We recommend that this statutory requirement be further amended to specify that the county or regional counterparts of these departments shall create such rating systems in conjunction with related volunteer organizations in each community.

The rating of each community residential care facility should be based on the facility's record in meeting both licensing and certification requirements, including an administrator's having received certificates of excellence (see our recommendations for the "small facilities subsystem").

We further recommend that regional centers, county mental health departments, and community long term care agencies be required to make their facility ratings available to prospective residents, and/or their family members or other representatives. Prospective community care residents are entitled to have the evaluative summary a rating represents before selecting a facility.

Finally, we recommend that the Department of Social Services' Community Care Licensing Division ask the Public Utilities Commission (PUC) to require all telephone company offices in California to list licensed community residential care facilities for the elderly and developmentally and mentally disabled in the yellow pages by client group.

## 2. STRENGTHEN THE "SMALL FACILITIES SUBSYSTEM"

We recommend keeping small facilities as a viable care option and improving the quality of life for the residents housed in them.

There is a legitimate place for nonprofessional care and supervision, particularly in the small, family-setting facilities. However, these facilities need to be brought into a "network" of small facilities that develops apart from the professionalizing changes now beginning to take place in community care. Once this has been accomplished, the rest of the industry can mature, diversify by offering ever more specialized services and levels of care, and become professionalized. Decentralized

administration and monitoring of small facilities would allow Community Care Licensing to devote its own monitoring and enforcement activity to regulating conditions and programs in larger facilities, wherein the majority of community residential care clients reside.

Enhanced decentralization of services administration and monitoring of quality control in the small facilities can perhaps best be achieved by making room in the system for new entrepreneurs. Currently, only the facility administrators are the entrepreneurs, while the state bears the entire burden of setting standards, improving services, developing new programs, monitoring for quality control, and investigating complaints.

Blending public purposes with market forces has already yielded what appears to be a generally adequate statewide supply of community residential care services. Now, there is a need to create opportunities for entrepreneurs other than caregivers to enter the industry so as to improve quality control, diversify services available to clients, and build community acceptance and support.

We believe that the three programs outlined below would produce the very desirable results we have just discussed. <u>Therefore, we recommend implementation of all three of these programs. However, we believe these proposals should be implemented at first on a two-year pilot project basis only.</u>

## a. Create Opportunity for "Cluster Administration" of Small Facilities (Six or Fewer Residents)

Throughout our discussion of this recommendation, we will refer to the small facility operators as "managers," rather than as administrators, to reduce the confusion of talking about the "cluster administrators."

By "cluster administration," we are referring to there being one administrator for up to a maximum of 10 small facilities. Obviously, restrictions on geographic proximity would have to be specified. The responsibilities of the cluster administrator would include, but not be limited to, the following:

- Selection of cluster house managers that meet the cluster administrator's expectations (informal "certification")
- Budgeting and recordkeeping for all facilities in the cluster
- Management of pooled resources for purchasing to reduce overall costs -- for example, food, transportation, tickets to community events
- Monitoring of quality of care in each cluster house
- Being responsible for making sure violations cited by Community Care Licensing are remedied by cluster house managers within time frames set by CCL
- Soliciting residents in order to maintain the highest possible occupancy rate per licensed capacity in each cluster house
- Soliciting volunteer participation in organizing and helping to carry out planned programs and activities
- Soliciting contributions of money, goods, and services to improve the quality of life in the cluster houses
- Developing mechanisms to assure resident participation in decision making within each cluster house

Co-licensure. Community Care Licensing would license the cluster administrators and co-license each cluster house manager participating in a licensed cluster administrator's program. If a cluster house manager were to leave a particular cluster, he or she would have to be relicensed. Similarly, if the cluster administrator leaves, all house managers in the cluster would have to be relicensed whenever a replacement cluster administrator became available.

As a condition of co-licensure, all applicants would be required to sign an agreement to accept SSI/SSP clients to the extent beds are available.

Incentives. The financial incentives for participation by small facility managers in a cluster would consist of a $50 per month bonus for the first resident. This payment would derive from licensing fees collected by CCL, as discussed in our funding-related recommendations later in this report. CCL would administer the payments to cluster administrators; the administrators, in turn, would pay the bonuses to the house managers. As added benefits, the cluster house managers would be relieved of responsibility for many administrative tasks and would have the advantage of operating a facility in a dynamic environment rather than in the relative isolation of a free- standing private home.

As for the cluster administrator, he or she would receive $35 per month per resident (that is, for each additional resident after the first, for whom the house manager would receive $50).

The cluster administrator would keep client records for all the cluster houses as the basis for submitting monthly claims to CCL and would distribute the payments upon his or her receipt of them.

In addition, the cluster administrator would charge the house managers modest fees for handling all administrative duties for the entire cluster. A house manager would be willing to pay for such services, presumably, only if the cluster administrator is able to reduce the house managers' costs or reduce their workload or both.

Positive Screening Bonus. Being able to attract individuals with both administrative skills and experience in community organizing or social services is important to the success of this approach. Encouraging applicants to assume the risk of creating the new entrepreneurial function of cluster administrator necessitates providing a one-time, first-year-only bonus to individuals who possess desirable qualifications. We suggest a $500 bonus to be offered in two equal payments: $250 after the second quarter of operation, $250 after the fourth quarter. To qualify as a cluster administrator, an applicant would need to have at least two years of experience in one or more of the following or related areas:

- Program, or project, management
- Administration of a specified task or unit within an organization
- Nursing
- Humanitarian endeavors

- Long term care ombudsman program
- Social work
- Case management
- Military service (eight years of experience: screening for training in maintaining orderliness)

In order to collect the bonus, a cluster administrator's record during the first year of operation would have to be "clean:" (1) no citation issued to any house manager in the affected cluster for abuse or neglect of a resident, and (2) all deficiencies cited by CCL would have to have been corrected within the time frame set by CCL.

As an additional screening and quality control device, a cluster administrator should be required to provide a $3,000 certificate of deposit as evidence of his or her ability to assume liability for whatever consequences may ensue should substandard care be given in that cluster. The administrator should be allowed to collect the interest on the deposit, but the state would be entitled to recover losses from the deposit for clients who have been financially exploited or physically abused or injured in a cluster house.

We recommend that CCL be restricted to licensing not more than 20 cluster administrators per year during the two-year pilot project phase. This approach would eliminate the need to identify geographic boundaries for a pilot project and would limit costs to funds available. It would also allow CCL to take advantage of implementing the cluster model wherever qualified indi-

viduals are ready and willing to participate. At the same time, a potential 40 cluster administration pilots would be adequate for purposes of evaluating the efficacy of this proposal.

In our funding-related recommendations, we have identified licensing fees as a possible source of revenue to support this program.

b. Designate Model Houses

The basic idea in this recommendation is to provide all small facility licensees with the opportunity to see and experience the operation of a facility which, in the judgment of Community Care Licensing, exemplifies high quality and manifests the intentions of licensing laws and regulations.

CCL district office evaluators would select model houses on the basis of two criteria: (1) cleanliness and orderliness of the home, and (2) meal quality, including nutritional value, preparation, and taste. The designation of model houses would be for one-year periods, with two-year intervals required between designation of the same facility.

Additional Community Care Licensing Responsibilities. CCL would be responsible for distributing information and organizing events, as follows:

1. Notification to Licensees. CCL would distribute the names of the selected model house administrators, their addresses and telephone numbers to all small facility administrators in the district, and make this list available as well to all newly licensed administrators throughout the year.

2. Notification to Model House Administrators. CCL would distribute to the model house administrators the names, addresses, and telephone numbers of all small facility administrators in the district, including new licensees.

3. Notification to Local Media. CCL would issue press releases to explain the model house program and to announce the selection of each year's group of model house administrators. Where possible, CCL would also facilitate the preparation by local media of feature stories on excellent facilities.

4. Sponsorship of Annual Event. CCL would sponsor an annual event (luncheon or tea, most likely) to honor the "outgoing" model house administrators and to recognize each group of newly selected model house administrators. Among licensees, the event would be open only to model house administrators just concluding and those beginning their year of designation as model facility administrators. Case managers in the area who are responsible for placing their clients in the best facilities available should also be invited. The purposes of the event would be to acknowledge the outstanding administrators and to give them an opportunity to share experiences and, for outgoing administrators, to advise the new model house administrators regarding how to organize a successful facility tour and meal.

Responsibilities and Incentives for the Administrator. As a model house administrator, a licensee would arrange up to 20 visits per year by administrators of other small facilities. The visits would include an inspection tour and a meal.

As an incentive to organize such visits, CCL would pay the administrator $25 per visit. Each visitng administrator would sign a voucher, which the model house manager would then submit to Community Care Licensing. Thus, the total bonus available to a model house administrator for acting as standard-bearer for a year would be $500. There also would be the added intangible benefits of enhanced prestige and respectability. These qualities, of course, would contribute to an administrator's reputation and attractiveness as a service provider and thereby enhance his or her income potential.

In our funding-related recommendations, we have identified licensing fees as a possible source of revenue to support this program. If the number of model houses designated per year is restricted to a specified percentage, the costs can be predicted and controlled.

c. Award Cerficates for Excellence

We recommend that CCL recognize quality in community residential care services by awarding to administrators certificates of excellence for cleanliness and orderliness, and/or certificates of excellence for food quality (nutritional value, preparation, and taste).

Restrictions. In order for them to be meaningful as means of defining and recognizing excellence in the maintaining and administering of community care facilities, the certificates awarded each year should be restricted to not more than 20 percent of all small facilities per district.

An additional restriction should be that "Model House" administrators would be ineligible to receive certificates (only during the year in which they are designated as model house administrators).

## III. MONITORING OF COMMUNITY RESIDENTIAL CARE SERVICES AND ENFORCEMENT OF RELATED LAWS AND REGULATIONS

### A. Major Findings

1. Unlicensed Facilities Continue to Operate
2. Resident Protections in Emergencies Are Secondary to Facility Administrators' Right to Due Process
3. Residents Lack Protected Rights to Privacy and Participation in Facility Decision Making
4. More "Sets of Eyes" Are Needed to Assure That Residents Are Adequately Cared for and Not Abused
5. Operational Philosophy Is Ambiguous: Enforcement First, or Technical Assistance?
6. Applicants Are Screened for Criminal Histories Only
7. Enforcement Mechanisms Do Not Deter Willful Violations of Laws and Regulations
8. Coordination with Local Law Enforcement Agencies Is Lacking
9. Post-licensing Visits Have Been Eliminated
10. Complaints and Emergencies Need More Attention
11. Investigative Resources Are Incomplete
12. Potential for Collusion Needs Preventive Remedy
13. Coordination with Health Facilities Licensing Is Lacking
14. Geographic Restrictions on Community Care Facility "Grouping" Do Not Prevent Concentration

### B. Recommendations

1. Increase and Strengthen Monitoring
   a. Recruit and Train Volunteers to Monitor Residents
   b. Establish Emergency Response Capability
   c. Make Applicant Screening More Meaningful
   d. Create an Automated Licensee Information System

e. Standardize Cost Accounting

f. Empower the Residents to Be Monitors

2. Make Enforcement Activities More Effective

a. Recombine Community Care Licensing and Health Facilities Licensing. Study and Consider Relocating the Licensing Function in the Attorney General's Office.

b. Utilize Licensing Personnel More Effectively

c. Develop Criteria for Granting Permission to Bear Arms

d. Structure Coordination of Enforcement Activities

e. Develop Criteria for Seeking a Temporary Suspension Order (TSO) and Procedures for Notification and Relocation of Residents

f. Sponsor Enforcement Seminars

g. Prepare Handbooks for New Licensees and Residents in the Community Care System

h. Clarify Definition of Unlicensed Facilities and Create Citation System That Resembles Traffic Tickets

i. Increase Fines for Licensing Violations

j. Require All Licensees to Be Bonded

k. Authorize CCL to Place a Facility in Receivership

l. Establish a "Crisis Team" within Community Care Licensing

m. Encourage Private Action Aginst Unsatisfactory Community Care Facilities by Allowing Recovery of Legal Fees through Attachments of Administrators' Property

n. Require Boarding Houses to Register with the State and Authorize Long Term Care Ombudsmen to Enter These Facilities

o. Authorize Immediate Dismissals of Placement Officers Who Make Illegal or Unsafe Placement Referrals

p. Restrict Geographic Concentrations of Community Care Facilities

## A. Major Findings

### 1. UNLICENSED FACILITIES CONTINUE TO OPERATE

One of the most significant monitoring and enforcement problems in community residential care is the increasing number of unlicensed facilities. Witnesses who testified before our Commission stated that this problem is growing at an excessive rate. In some cases, they are facilities that continue to provide care and supervision, but simply do not seek license renewal. In other words, these administrators appear to have "dropped out" of the licensed system of community care rather than continue to be monitored and evaluated by CCL. However, they continue to provide care and supervision as if licensed.

In other cases, facilities are operated by individuals who are either unaware that licensure is required or they are indifferent to the requirement. Or, at the other extreme, facilities that have been closed down by CCL continue operating.

During our hearing, we received testimony on several instances of abuse and neglect in unlicensed facilities. For example, the Los Angeles Deputy District Attorney testified that an unlicensed facility that had been ordered to cease and desist its operation simply moved to a new location and kept operating. One resident in this particular facility developed such severe decubitus ulcers that he required hospitalization. But rather than hospitalize him, the facility simply kept the windows open "because the rotting of the body was so bad...." The resident eventually died in the facility.

Budget reductions have caused the Community Care Licensing Division to target complaints and violations in licensed facilities as the top priority for investigation and prosecution. This makes sense as a scarce resource policy decision, but quality assurance and client protection are diminished as a result. Local law enforcement agencies have historically considered the policing of community care facilities to be a low priority. Policing the operation of unlicensed community care facilities unfortunately receive an even lower priority. In addition, many police departments also face "scarce resource" problems of their own and have cut back on whatever their limited efforts had been in the past.

## 2. RESIDENT PROTECTIONS IN EMERGENCIES ARE SECONDARY TO FACILITY ADMINISTRATORS' RIGHT TO DUE PROCESS

A major weakness in the existing community residential care system is the lack of protections for residents in emergencies. When CCL seeks a temporary suspension order (TSO) in response to life-threatening conditions discovered in a facility, there often is not available even so much as a list of the residents' family members to be contacted in emergencies. This was the case recently, for example, when CCL obtained a court order to close a large community care facility in Turlock.

If a complaint about the quality of care is made against a facility, the administrator has the right to protest CCL's actions and continue operating the facility until a hearing is

held to resolve the complaint. On the other hand, where placement agencies do exist, they can be prevented from removing their clients until there is a hearing. This may take weeks, during which time the clients remain in the facility, possibly in continued jeopardy.

There is unfortunately abundant evidence in the existing system of severe abuse and exploitation of board and care residents. Beyond the trauma of abuse, life for a large number of residents is inactive and completely lacking in therapeutic substance. The clients are not institutionalized in the sense that they are not (usually) locked inside the facility, but neither are they engaged in activities or therapy intended to promote their independence. In short, community care residents are very much at the mercy of an unmonitored system of providing residential services.

Because licensing is a regulatory program, not an array of direct services to be provided, the protections against capricious or arbitrary actions apply to the regulated entities -- the facility administrators -- and not to the residents. A contested license revocation involves complex legal proceedings which assure service providers access to due process under the law but which, except in the most extreme cases when clients would die unless transferred to a hospital, do not provide for protective services for the clients.

County-level budget reductions have all but removed adult protective services from county welfare departments. Such

changes leave especially the elderly and mentally disabled community care residents without someone to intervene on their behalf when a crisis occurs.

The existing monitoring and enforcement system also lacks a 24-hour, 7-day-a-week emergency number to call when dangerous or life-threatening conditions are discovered and require an immediate response from government agencies. The need for such a "hotline" was seen in Los Angeles on a Sunday in March 1983. The police department there discovered a number of mentally disabled community care residents who had been abandoned by the facility operator. The police contacted the city's health department.

The city health department staff found five residents who had not eaten in almost two days; the only water available was from either the bathtub or garden hose. Once the city health official had fed and taken care of these residents, he attempted to contact Community Care Licensing, but discovered that there was no way to get in touch with the state licensing agency in an emergency. Instead, he would have to wait until 8:00 Monday morning.

This Commission believes the state must have an emergency hotline to assure a timely response to crises in community care facilities.

## 3. RESIDENTS LACK PROTECTED RIGHTS TO PRIVACY AND PARTICIPATION IN FACILITY DECISION MAKING

The right of residents to participate in decision making that affects their quality of life is basically ignored in licensing regulations. There also is no statutory requirement for such mechanisms as resident councils or other means of giving the residents a voice in decisions that determine their care and circumstances of daily living.

Again, there is substantial evidence that community care residents are often victims of harassment and are denied basic dignities. One volunteer ombudsman for the elderly has reported, for example, that some facility administrators serve lower quality meals to their SSI/SSP residents than to the private-pay residents, referring to the former as "welfare cases." Administrators have been known to cut hair against the residents' will, insist on undressing the residents and/or watching them bathe, locking the residents' bedroom doors to keep them out (or in) during the day, not allowing residents to change the t.v. channel without permission.

These actions are not, strictly speaking, against the law, but they do go against the grain of what most elected officials would hope for in planning and maintaining a system of community care.

## 4. MORE "SETS OF EYES" ARE NEEDED TO ASSURE THAT RESIDENTS ARE ADEQUATELY CARED FOR AND NOT ABUSED

Where trained volunteers are available to respond to complaints or, even better, to maintain personal contact with individuals in community care, the whole system benefits from having extra "sets of eyes" to observe with increased frequency the conditions in which community care residents are living. Even conscientious administrators state there is no doubt they pay more attention to what is supposed to be going on in their facilities when they know evaluators -- whether from CCL or from a volunteer program -- may drop in at any time.

Many community care residents need regular intervention and advocacy, but large numbers are not monitored or visited at all. Annual inspections by Community Care Licensing evaluators cannot be expected to ensure that residents receive, on a daily basis, even the minimum services and protective oversight required by law. The inadequacy of this centralized monitoring effort is compounded by the lack of expertise among evaluators concerning especially the health and therapeutic needs of residents with specific disabilities.

Various efforts are being made throughout California to organize volunteers to visit clients residing in community residential care homes. Volunteers in the Long Term Care Ombudsman Program for the elderly are trained to monitor the well-being of the residents, to negotiate and consult with service providers if care improvements are needed, and to report unsafe or unhealthful

conditions to the nearest Community Care Licensing office. This program, which relies on a paid volunteer coordinator (usually part-time) to recruit and train volunteers within a given community, is perceived by both clients and service providers to be helpful and effective in resolving complaints.

Although "mandated" to include community care facilities in what started out to be a nursing home ombudsman program, the local ombudsman programs do not have adequate fiscal resources to extend their services comprehensively to community care residents. Volunteers to monitor developmentally and mentally disabled community care residents do exist in places, but they lack the statutory authority that the long term care ombudsmen have to gain entry to any community residential care facility.

Volunteers actually provide services to administrators as well as residents. Because they visit a large number of facilities in a given area, they are able to suggest or sometimes even organize activities for participation by the residents. They help to create a network of service providers by sharing information. As an adjunct to licensing, this monitoring is effective in reducing the isolation in which community residential care services tend to be provided.

## 5. CCL's OPERATIONAL PHILOSOPHY IS AMBIGUOUS: ENFORCEMENT FIRST OR TECHNICAL ASSISTANCE?

Trying to encourage voluntary compliance with laws and regulations, but effectively forcing compliance when necessary, requires a delicate balance of consultation and policing. The licensing function would seem to demand a primary emphasis on enforcement and a secondary emphasis on technical assistance. Evidence that CCL has not established these priorities, however, consists in there not being standard criteria for facility closure -- that is, in every case, it is a "judgment call."

## 6. APPLICANTS ARE SCREENED FOR CRIMINAL HISTORIES ONLY.

One way to characterize current applicant screening procedures is to say they are "negative." That is, they serve to screen people out on the basis of their deficiencies. Current applicant screening processes are inadequate in the following specific ways:

- Criminal record checks are run on applicants for licensure, but not on staff who will be providing the direct services (if different from the licensee).

- There is no automated licensee tracking system for data regarding the personal histories of individuals who, for example, have had their licenses revoked in one county, but apply for licensure in another county.

- There are no educational or experiential requirements which applicants for various categories of licensure must meet.

- Applicants are not required to assure the availability at all times of an English-speaking caregiver who can read prescription labels and other instructions pertaining to a resident's care.

- Incomplete applications are accepted, resulting in there being excessive staff time devoted to assisting applicants with filling out forms.

- Applicants are not required to know what the regulations specify regarding their facilities or the care needs of residents.

- Community Care Licensing does not routinely request credit checks on applicants.

"Positive screening criteria," such as education or experience requirements, would make licensure of community care facility administrators selective on the basis of their qualifications to provide community residential care services. Lacking such standards, the licensing system presently has no basis for the recruitment of community care administrators.

## 7. ENFORCEMENT MECHANISMS DO NOT DETER WILLFUL VIOLATION OF LAWS AND REGULATIONS

For whatever reasons, CCL has not come up with an array of enforcement mechanisms that deter community care facility administrators from ignoring regulations and/or breaking the law. As mentioned earlier, administrators of unlicensed facilities continue to operate those facilities even when the facilities are ordered closed under court injunctions. Fines assessed for violations of law and regulations are routinely reduced or even waived. Consequently, there is little perception among administrators that violating laws and regulations will have punitive consequences or that whatever punitive consequences may ensue will be onerous.

## 8. COORDINATION WITH LOCAL LAW ENFORCEMENT AGENCIES IS LACKING

So far as we have been able to determine, the Santa Ana Police Department is the only municipal police department in California that has established a special unit to investigate and prosecute violations of the law in community residential care facilities. There seems to be a general lack of knowledge on the part of local law enforcement agencies of conditions in community residential care or procedures for closing seriously substandard facilities. There is little coordination between CCL and law enforcement agencies, except by the investigators on a case-by-case basis. This lack of cooperative effort contributes to the

perception many community care administrators must have that they have little to fear from the police.

As previously stated, local police departments and district attorneys consider community care facilities a low enforcement priority. When a police department does investigate a facility, state licensing investigators are often excluded from the investigation. Moreover, licensing investigators do not have access to the evidence until the police department closes the case. By that time, the case is too old for an effective investigation.

This situation is illustrated by a case at a facility in Pasadena, where a resident was killed in December 1982. The police still list the case as open. Consequently, the state licensing investigators cannot initiate any work in the meantime, although there is no indication that the case is receiving active attention by the local police.

In July 1983, the Orange County Board of Supervisors reported on cases of illegal activity and negligence of residents in community care facilities to State Attorney General Van de Kamp and requested that his office investigate the situation. Evidently, the combined efforts of CCL and city or county investigators were not sufficient in that case to reduce the incidence of serious problems.

## 9. POST LICENSING VISITS HAVE BEEN ELIMINATED

Due to budgetary considerations, CCL has been forced to eliminate post-licensing visits which previously were scheduled to

occur within 90 days after licensure. New licensees tend to be less familiar with what is expected of them and less confident in establishing routine operating procedures. Early enforcement of regulations helps to minimize long-term problems. With budget cutbacks, however, newly-licensed facilities now are not visited by evaluators until their first renewal deadline is within 120 days of coming due.

## 10. COMPLAINTS AND EMERGENCIES NEED MORE ATTENTION

Although CCL has been able to hasten investigators' response to complaints of abuse and neglect, it still takes up to 30 days for an investigator to arrive on the scene once a complaint has been received by the Audits and Investigations Bureau. The Bureau advises, however, that it hopes to cut response time in the near future to a maximum of 15 days, with "immediate" response capability in the most serious cases. All of CCL's nine investigators (plus two supervisors) are located in Sacramento, exacerbating the response time problem in the southern part of the state.

In addition, CCL's capacity to respond to emergencies is restricted to taking legal actions intended to close dysfunctional facilities. This may be an appropriate enforcement response to the administrators, but it penalizes the residents rather harshly as well. CCL needs ways of smoothing the transition for the residents when facility administration either is turned over to new operators or is completely terminated (in which case, the residents must move).

## 11. INVESTIGATIVE RESOURCES ARE INCOMPLETE

Nine non-supervisory investigators just simply aren't enough investigators to reduce the incidence of abuse in 57,000 community care facilities scattered throughout the state (22,000 residential and 35,000 day care facilities). Investigations are technical processes that require personnel trained in gathering and reporting evidence. The paperwork involved in completing an investigation that can win a conviction in the case of wrongdoing must be painstakingly accurate.

Furthermore, CCL investigators need more timely and more consistently available assistance from nursing and medical experts in determining the causes and/or the seriousness of various client states. Although CCL does employ a few registered nurses, this is by coincidence rather than the result of allocated medical positions. Because CCL is faced with increasing numbers of cases involving medical issues, it is imperative that it have access to this expertise. Currently, CCL has great difficulty in taking action against facilities with residents suffering from decubitus ulcers and other medical problems, because it lacks appropriate staff who can make those judgments.

Finally, there is the question of whether CCL investigators should be armed when circumstances would seem to warrant it. Although the Director of Social Services has the statutory authority to give permission to CCL investigators on a case-by-case basis to carry weapons, the investigators' requests have so far been denied. From our perspective, any facility in which the

administrator has threatened an investigator with bodily harm is no place for a disabled client. In such cases, investigators need to be prepared to protect the residents and themselves. Investigators from other departments do occasionally carry weapons; in those departments, prior approval by the department director is required in each case.

## 12. POTENTIAL FOR COLLUSION NEEDS PREVENTIVE REMEDY

A familiar problem in all regulatory programs is the potential for collusion between regulators and regulatees. More innocently, and no doubt more common, is the gradual "capture" of the regulator's good will by a winsome administrator. Licensing evaluators sometimes are responsible for inspecting the same facilities over a number of years. This situation can lead to an evaluator's reluctance to cite violations in a facility which is administered by someone who is basically cooperative and with whom he or she has become friendly over time. Currently there is no standard procedure for rotating CCL evaluators to ensure that they maintain meaximum objectivity when inspecting a facility.

## 13. COORDINATION WITH HEALTH FACILITIES LICENSING IS LACKING

The complete separation of health and community residential care facilities licensing appears to have led to the loss for community care clients of access to health services. The "clean" conceptual distinction between "medical" and "nonmedical" care, which served as the basis upon which community care licensing was

separated from health facilities licensing and moved into a different department, turns out not to be quite so easy in the "real world." As we have pointed out several times already, there are residents in community care facilities who should be in skilled nursing facilities. Licensing evaluators are the only government agents who make routine visits to all facilities; yet, they lack the expertise to make judgments regarding the level of care required by individual residents.

## 14. GEOGRAPHIC RESTRICTIONS ON COMMUNITY CARE FACILITY "GROUPING" DO NOT PREVENT CONCENTRATION

Lacking community acceptance, a tendency has developed for community care facilities to locate in near proximity to each other, usually in rundown areas. This problem exacerbates the general perception of community care residents as "undesirable" or "devalued," obviously impeding their re-entry into life patterns that are as nearly normal as possible. Also, because the sudden visibility of disabled individuals in a neighborhood is alarming to the original residents, this practice of grouping community care facilities impedes community acceptance of the program. Thus, a cycle of rejection is established.

At present, Community Care Licensing gives cities an opportunity to comment on the possibility of licensing a new community care facility only if the applicant's facility is within 300 feet of an already licensed facility. However, a facility may be more than 300 feet from another one and still result in a close

grouping of facilities. Also, a facility may end up being next door to an unlicensed facility, but more than 300 feet from a licensed one. In this case, the city would not even have an opportunity to comment.

## B. Recommendations

### 1. Increase and Strengthen Monitoring

Better monitoring of community care facilities is needed primarily for the sake of the residents -- to protect their well-being and rights. Better monitoring will also upgrade the quality of care provided in these facilities, and that will help to make community care a bona fide long term care service.

We recommend the six-part strategy outlined below in order to increase and strengthen monitoring.

a. Recruit and Train Volunteers to Monitor Residents. The State Long Term Care Ombudsman Program in the California Department of Aging (CDA) has pioneered the development of local ombudsman programs in California. In 1982, new legislation (Chapter 1457, Statutes of 1982 (AB 2997)) extended the authority of the ombudsman to enter nursing homes to encompass community care facilities as well. The ombudsman program has been successful not only in reducing the isolation of elderly residents in long term care, but in generating information about conditions and quality of care in the facilities.

We recommend that the State Long Term Care Ombudsman be organizationally relocated in the Attorney General's Office -- or other state agency, such as the Department of Consumer Affairs. We believe the Ombudsman needs to be located in an agency which has legal staff, is familiar with complaint handling, and has expertise in enforcement.

We further recommend that similar programs be initiated to serve developmentally and mentally disabled residents. For example, the State Long Term Care Ombudsman could be responsible for the recruitment and training of new volunteers to fulfill new monitoring responsibilities with respect to clients other than the elderly.

The monitoring of the elderly should continue to be funded out of federal Older Americans Act funds, while the state should support an administrator for either the expanded or newly initiated programs to include local volunteer ombudsman services, or their counterparts, for the developmentally and mentally disabled.

The primary benefits of moving the ombudsman function into the Attorney General's Office would be to (1) promote better coordination of enforcement resources and strategies, and (2) heighten the effectiveness and credibility of the enforcement process by associating it with the highest-ranking peace officer in the state. Under current provisions of the Older Americans Act, however, transferring the ombudsman program to the Attorney General's Office may not be compatible with our recommendation to recombine the licensing of health and community care facilities and relocate <u>that</u> function in the Attorney General's Office as well. If it is not, we would recommend locating the State Long Term Care Ombudsman Program in the Department of Consumer Affairs.

As the elderly would benefit directly from these changes, we do not anticipate that the federal Administration on Aging would object to the use of Older Americans Act funds (or deny a waiver, if one is required) to continue support of that portion of a newly constituted State Long Term Care Ombudsman Program which is charged with monitoring specifically the elderly.

As discussed in our funding-related recommendations, we believe an "Ombudsman Foundation" could raise at least a significant percentage of the amount of money that would be needed to cover the new costs of significantly expanding the Long Term Care Ombudsman Program.

b. Establish Emergency Response Capability. We recommend that the Legislature authorize CCL to establish a telephone "hotline" in Sacramento. CCL should assure that someone is available 24 hours a day, 7 days a week to respond to crises discovered in community care facilities. CCL should then be responsible for contacting the appropriate office or individual in the local community in which the crisis has occurred. Furthermore, we recommend that CCL require licensees to post the "hotline" telephone number in an obvious place in each licensed facility.

c. Make Applicant Screening More Meaningful. Applicant screening may be the single weakest link in the existing community care system. As community residential care matures as a proprietary industry, we expect to see the industry itself begin

to devote more money and time to increasing the professionalism of facility administrators. Eventually, there will surely be acceptable minimum qualifications that at least certain categories of community care providers will have to meet -- this to protect the interests and image of the administrators as much as to promote a higher quality of care.

In the meantime, we recommend tightening applicant screening procedures in the following simple ways:

- Do not accept incomplete applications.
- Revise the licensing application form to include the applicant's plan for assuring the availability of English-speaking staff in each licensed facility.
- Require applicants to sign a release form authorizing Community Care Licensing to obtain information on past employment, credit, driving, and criminal justice records.
- Require applicants to obtain signed releases for the information specified above from all of the applicants' employees who will be providing direct services to the residents.
- Require applicants to sign a statement that they have read and understood the community care licensing regulations that pertain to their category of licensure.

d. Create an Automated Licensee Information System. We recommend that the Legislature require Community Care Licensing to create an automated licensee information system to keep track of administrators who move around, both inside and outside California. Using Social Security numbers, CCL should develop the capacity to identify applicants for licensure who have been cited for serious violations in other locations, or whose licenses have

been revoked elsewhere. It is unnecessary to lack this rudimentary data base in an age of revolutionary information processing techniques and equipment.

Certain lower cost enforcement approaches depend for their efficacy on the ease of discovery of past records. For example, a facility administrator who is in jeopardy of losing his or her license and being heavily fined for violations of various laws and/or regulations could be given the option of signing an agreement not to operate a community care facility or ever again to apply for licensure. Unless it is possible to retrieve a record of such a transaction, however, this otherwise desirable enforcement device is so weak as not to be viable.

The reintegration of Community Care Licensing with the Department of Health Services' Licensing and Certification Division, which we recommend, would be expedient with respect to sharing information. An automated licensee information system could be combined with the Consumer Information System our Commission has recommended be developed for nursing homes. With such a system, delicensed nursing home administrators, for example, could not operate community care facilities -- at least not without submitting to a period of probationary licensure. But, unless the Community Care Licensing and Licensing and Certification Divisions share a data base, the state has no way to control entry into the community care industry by historically unscrupulous service providers.

e. Standardize Cost Accounting. We recommend that the Legislature require Community Care Licensing to establish a uniform accounting system with account numbers that are applicable to specified categories of licensed facilities. We further recommend that CCL, 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. Representatives of these agencies should take advantage of such opportunities to encourage facility administrators who are having recordkeeping problems to employ an outside bookkeeper to maintain the accounts in accordance with the uniform 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.

Absent standard-format reports on costs and expenditures in community care facilities, funding adequacy will remain a matter of speculation and opportunities to achieve economies and/or improved program effectiveness will escape notice.

We favor eventually requiring community care facilities to report cost and utilization data annually. Because the community care system still lacks such rudimentary components as service definitions and clarification of administrative roles, however, we feel a recommendation to require cost and utilization reports at this time is premature.

f. Empower the Residents to Be Monitors. We recommend that the Legislature amend state community care licensing laws to require the establishment of resident and/or family member councils in the larger facilities (25 or more residents). In smaller facilities, we recommend that volunteers coming in as monitors should be trained by the State Long Term Care Ombudsman Program to help community care residents negotiate remedies with administrators whenever a resident's right to make his or her own decisions has been ruptured.

The right of community care residents to become and/or remain as independent as possible requires that mechanisms be created to protect the right of residents to make decisions regarding the quality of their own daily lives. To the extent residents and/or members of their families are exercising this right, the residents themselves will be empowered to monitor and correct conditions in the facilities where they are living.

## 2. Make Enforcement Activities More Effective

Based on the comments and recommendations the Commission received during the May 1983 hearing in Los Angeles and the summer 1983 workshops in Sacramento, we recommend implementation of the changes proposed on the following pages. They are intended to make the state's enforcement activities more effective in producing a reliable and safe system of community residential care.

a. Recombine Community Care Licensing with Health Facilities Licensing. Study and Consider Relocating the Licensing Function in the Attorney General's Office. We recommend that Community Care Licensing and Health Facilities Licensing be recombined. Additionally, we recommend consideration of relocating this function in the Attorney General's Office. Licensing is a law enforcement function. Locating this function in the Departments of Health Services and Social Services has contributed to the ambiguity of operational philosophy observable in both licensing units. That is, the general posture of these two departments is to be helpful to the public. In the case of licensing, however, being "helpful to the public" demands being effective enforcers of laws and regulations. Placing the licensing function in the Attorney General's Office would reinforce that this primary responsibility is to be discharged by licensing staff.

Prior to 1976, Community Care Licensing was a branch of the Licensing and Certification Division of the Department of Social Services. Community Care Licensing was transferred to the Department of Social Services in order to strengthen the emphasis on licensing of facilities that provide nonmedical care. That emphasis seems to have been achieved, but at the expense of community care residents' having lost adequate access to health care.

Thus, an important benefit to be had from reuniting the two licensing efforts is that medical expertise would be more readily available to community care licensing staff. Also, the opportunities to "educate" health facilities licensing staff to the

strengths and weaknesses of community residential care would aid in the process of bringing community care into the overall long term care system.

There currently is very little coordination between Community Care Licensing and local law enforcement, except on a case-by-case basis during a criminal investigation. In the stronger "enforcement environment" of the Attorney General's Office, the reconstituted licensing unit would be credible in the role of enforcer and, consequently, would have enhanced opportunities to team up with local law enforcement agencies to close facilities that are not safe or otherwise are not suitable as residential facilities.

Finally, we recommend that the Legislature restore funding and authority to CCL to reinstate post-licensing visits within 90 days of facility licensure. This preventive enforcement activity can save the costs of license revocation proceedings later on and prevent unnecessary misery and abuse for unsuspecting residents.

b. Utilize Licensing Personnel More Effectively. We recommend that CCL make the following personnel management changes to strengthen its enforcement capacity:

- Licensing evaluators should be trained in investigative skills to enable them to gather evidence which will be utilized in prosecuting more cases successfully.
- The number of investigators should be increased, and the new positions should be established in a southern Cali-

fornia location. The ability to respond to complaints and to coordinate with local law enforcement agencies in the case of serious violations is too constrained under the present arrangement.

- Evaluators should be given rotated assignments; that is, they should not be evaluating the same facilities year after year. This would reduce the potential for collusion or simple reluctance to cite violations when the facility administrator is perceived by the evaluator to be a colleague and friend.

c. Develop Criteria for Granting Permission to Bear Arms. We recommend that the Health and Welfare Agency gather the necessary information from each affected department to facilitate the analysis of circumstances under which permission to bear arms has been granted to investigators going into community care facilities. On the basis of this analysis, we recommend that the Health and Welfare Agency develop criteria to assist the department directors (and the Attorney General, if our recommendations are adopted) in deciding on a case-by-case basis when a given situation warrants granting permission to investigators to carry weapons.

d. Structure Coordination of Enforcement Activities. We recommend that CCL undertake to structure the coordination of enforcement activities as follows:

With the Department's Own Legal Division: CCL's Audits and Investigations Bureau should notify the Department of Social Services' Legal Division immediately upon determining that one of its investigations could lead to a criminal prosecution. The Legal Division should assign an attorney at that point to advise investigative staff regarding additional information that will be needed, if any, to prosecute the case.

With Other State Departments: The track record of interdepartmental "coordinating committees" is not encouraging. Still, the need is clear for the Departments of Developmental Services and Mental Health and the Office of Long Term Care to know what CCL is doing that affects community residential care -- and vice versa. We recommend that the top official in the Community Care Licensing Division (or in the newly formed licensing unit which we have recommended be placed in the Attorney General's Office) meet quarterly with the directors of Developmental Services, Mental Health, and Long Term Care, and the State Long Term Care Ombudsman. These meetings should be concerned with problems in the long term care system, solutions to which will require the cooperative effort of all or most of the affected state agencies. This group would have the necessary authority to assign short-term task forces composed of staff from each department or agency to recommend ways of resolving conflicts or problems identified by one of the departments or agencies.

With Advisory Committees: At both the state and district office levels, we recommend that CCL organize advisory groups composed of representatives of all client groups, advocates, and service providers. These groups should have an opportunity, first, to review and comment on the recommendations in this report. On an ongoing basis, they should be asked to advise CCL regarding problems they are aware of at the individual resident and/or facility level and to recommend remedial actions CCL could take.

With Local Law Enforcement Agencies: District and City Attorneys and most local police departments seem to have little awareness of the community residential care program: how it differs from skilled nursing facilities, the requirement for licensure, the rising incidence of abuse, or the investigative activities of CCL and the Departments of Developmental Services and Mental Health. If the licensing function is transferred to the Attorney General's Office, linkages with local law enforcement will be strengthened. Regardless of the organizational placement of licensing, however, we recommend that CCL sponsor seminars and prepare informational handbooks written especially for local law enforcement agencies.

With Placement Agencies: Any time CCL substantiates a complaint, it cites the offending community care facility. When the offense is serious -- one reflecting potentially life-threatening deficiencies in the quality of care -- we recom-

mend that the Legislature require CCL to notify placement agencies.

To the extent that a daily census is available in each community care facility indicating the source of the placement referral for each resident, we recommend that the Legislature require CCL to notify every affected placement agency. When such information is not available, we recommend that the Legislature require CCL to notify the Departments of Developmental Services and Mental Health and the Office of Long Term Care when charges of abuse, neglect, or other serious mistreatment of residents have been substantiated. These state agencies would then be responsible for alerting their county or regional counterparts to CCL's charges and actions.

e. Develop Criteria for Seeking a Temporary Suspension Order (TSO) and Procedures for Notification and Relocation of Residents. We recommend that CCL develop specific criteria regarding abusive or life-threatening conditions in a community care facility that indicate when CCL should seek a temporary suspension order (TSO) with the intention of revoking the license. Such criteria should not remove CCL's discretion, but rather limit the need for discretion to situations which are not covered by defined criteria. This would help to eliminate criticism of CCL as "arbitrary" or "biased" in license revocation proceedings and, more important, establish more effective protection of residents in unsafe facilities.

We further recommend that the Legislature require CCL to establish procedures for taking a more direct role in notifying residents and their families or conservators of impending punitive actions against facilities. At present, CCL requires the administrators to notify family members. We find this procedure yields inadequate protection of and assistance to residents. We agree that CCL's primary responsibility is to regulate facilities and not to provide direct services to residents. In the case of a TSO or license revocation, however, we recommend that CCL recognize that the licensee is not adequately meeting the needs of the residents and take steps itself to notify family members, conservators, and/or local placement agencies of the residents' immediate need to relocate.

Finally, we recommend that the Legislature authorize CCL to establish an emergency fund, possibly out of increased fines (see our recommendations related to fines), to provide for the relocation and care of residents when CCL closes facilities on short notice.

f. Sponsor Enforcement Seminars. We recommend that Community Care Licensing sponsor seminars twice a year for local law enforcement agencies. The seminars would allow CCL to educate peace officers, district and city attorneys, and fire marshals regarding the incidence and distribution of violations -- especially abuse, exploitation, and unlicensed facilities that continue to operate. The seminars would afford opportunities to create joint strategies for addressing the problems identified by CCL and to share information on successfully prosecuted cases around the state.

In keeping with this cooperative approach, we recommend that Community Care Licensing prepare a manual on the responsiblities of local law enforcement agencies as prescribed by law. The manual should include information on how to access state-level investigative resources when specialists or additional investigators are needed at the community level.

g. Prepare Handbooks for New Licensees and Residents in the Community Care System. In addition to manuals for law enforcement agencies, as discussed above, we recommend that CCL prepare simplified handbooks that state in clear, nonlegal language what exactly the law requires of community residential care providers. Currently, CCL provides new licensees only with copies of licensing regulations and periodic updates on administrative or policy changes at the state level. Residents and their families also need handbooks regarding their rights and responsibilities 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.

h. Clarify Definition of Unlicensed Facilities and Create Citation System That Resembles "Traffic Tickets". We recommend that the Legislature amend state law to include a three-pronged definition of unlicensed facilities, as follows:

"Unlicensed facility" means any facility without a license that:

(a) Is providing services allowed only in licensed facilities;

(b) Is housing residents who demonstrate the need for

services which only licensed facilities are authorized to provide; or

(c) Is representing iself as a facility in which services authorized only in licensed facilities are being provided.

This clarification would make it easier for district and city attorneys to prosecute administrators of unlicensed facilities, thereby affording greater resident protection.

As an incentive for aggressive action by local law enforcement to close unlicensed facilities or to encourage such facilities to seek licensure, we recommend that the Legislature authorize police and sheriff departments to issue traffic ticket-like citations to administrators. Police and sheriff departments would retain all fines collected pursuant to these citations. The fines should equal fines for other violations of licensing laws and regulations.

i. Increase Fines for Licensing Violations. If fines are to deter willful violations of law and regulations, they must be high enough to make noncompliance a financial hardship for the administrator. Currently, the maximum fine for noncompliance with a plan of correction prepared by a licensing evaluator is $50 per day. The actual rate of assessment is determined by CCL according to the seriousness of the violation.

Provision should be made for keeping fine levels commensurate with their purpose as incentives for compliance. We recommend

that fines increase automatically every year at the same rate SSI/SSP grant levels are adjusted for cost of living increases. The current maximum fine was set in 1979, when the regulations for assessing civil penalties first took effect. If that maximum had been adjusted at the same rate as SSI/SSP grants, the maximum fine now would be $73.25 per day (and, effective January 1, 1984, it would be $75.90 per day).

We further recommend that fines for repeat violations be trebled. This should apply to citations issued to administrators of unlicensed facilities as well as for other violations.

In 1982, Community Care Licensing assessed 878 civil penalties. If each penalty were $50 for one day, the amount collected would have been $43,900 (assuming the fines were not later waived). At $73.25 for one day, the same number of penalties would have generated $64,314 -- a difference of $20,414, or 46.5 percent.

We recommend that Community Care Licensing retain in its own budget 50 percent of the total fines revenue to support enforcement activities; we further recommend that the remaining 50 percent be used to support monitoring efforts by volunteers. This would give CCL a greater incentive to be aggressive in assessing civil penalties. Furthermore, funding for monitoring by volunteers could be increased.

j. Require All Licensees to Be Bonded. We recommend that the Legislature amend state law to require all community care

licensees to be bonded for a minimum of $1,000 (or more, as required by Title 22, Section 80345, depending on the amount of clients' money an individual administrator routinely administers). Bonding companies will charge administrators an average of $30-$55 every three to five years for preparation and management of the bond.

We further recommend that changes in law specify that the bond has to be written to cover civil penalties. That is, when a licensee refuses to pay assessed fines for violations of law or regulations, or fails to pay the fines on time, Community Care Licensing will have the right to collect the fines from the bonding entity. When the amount owed for fines exceeds the amount of the bond, we recommend that the Legislature require CCL to automatically initiate license revocation proceedings.

The bonding entity (either a bonding company or a community care administrators association) would require collateral from applicant facility administrators: cash, savings certificate, or letter of credit from a bank. This demonstration of capacity to assume financial liability would serve as an applicant screening device, at no additional cost to the state and at a reasonable additional cost to facility administrators.

k. Authorize CCL to Place a Facility into Receivership. Community Care Licensing currently lacks statutory authority to place a community care facility into receivership. Because license revocation is a harsh action and an often contested (and

therefore protracted) process, a receivership option would be highly desirable.

We recommend that the Legislature amend state law to give Community Care Licensing this authority, except in the case of small facilities which are also the private homes of the administrators. CCL's authority should include a wide choice of receivers; a mechanism whereby residents can request, or petition for, receivership; and wide discretion for CCL to invoke receivership and determine the duration of receivership in any given situation.

1. Establish a "Crisis Team" within Community Care Licensing. We recommend that the Legislature authorize CCL to develop an internal "crisis team" that could be sent to facilities that are experiencing administrative failures, but which CCL considers redeemable. A crisis team would be particularly valuable in the areas around the state where the supply of community care facilities is barely adequate or not adequate. It would also give CCL an opportunity to fulfill the technical assistance mission it perceives itself to have, yet with enforcement as the unmistakable motivation and goal.

Another possible benefit is that, through the crisis team's actual operation of a facility for a time, CCL might learn of difficulties caused by law or regulation that could be changed, thereby removing barriers to high quality performance.

Having this internal capacity and the option of invoking receivership would greatly enhance Community Care Licensing's ability to take corrective actions short of facility closure. Corrective actions are preferable in that they do not entail displacement of the residents in community care facilities.

m. Encourage Private Action Against Unsatisfactory Community Care Facilities by Allowing Recovery of Legal Fees through Attachments of Administrators' Property. We recommend that the Legislature amend state law to allow private citizens to recover their legal fees for bringing civil suits against abusive or negligent community care administrators. Recovery of legal fees should be authorized through the mechanism of attaching the administrators' property.

n. Require Boarding Houses to Register with the State and Authorize Long Term Care Ombudsmen to Enter These Facilities. We recommend that the Legislature amend state law to require owners of boarding houses -- residences where meals are provided, but no care or supervision -- to register their facilities in the nearest Community Care Licensing office. Notification of this requirement would be difficult, but perhaps the addresses of SSI/SSP residences that are not licensed as community care facilities could serve as the initial source of information regarding the present location of boarding houses. SSI/SSP computer tapes are available to the Department of Social Services for purposes such as these.

We further recommend that the Legislature amend state law to authorize volunteers in the State Long Term Care Ombudsman Program to enter boarding houses, as time and other resources permit. They would be trying to determine, on the basis of the recommended three-pronged definition of unlicensed facilities, whether a client needing care and supervision has been inappropriately placed in a boarding house.

o. Authorize Immediate Dismissals of Placement Officers Who Make Illegal or Unsafe Placement Referrals. We recommend that the Legislature amend state law to 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 or unsafe community care facility. An "illegal" facility is an unlicensed and/or uncertified facility; an "unsafe" facility is one in which actions against an administrator are pending, due to substantiated charges of abuse or neglect of the residents.

We recognize that placement officers are often under pressure to make referrals quickly. We recognize also that the available referral options may be less than ideal. Nevertheless, if community residential care is to become a respected and unfeared alternative to institutionalization, clients must be confident that the assistance offered by public agents in locating an acceptable residence is dependable.

p. Restrict Geographic Concentrations of Community Care Facilities. Existing law provides that CCL must give local governments an opportunity to comment on applications for community care licensure when the new facility would be located within 300 feet of an existing community care facility.

We recommend that the Legislature amend state law to specify that CCL will 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)). This approach would substantially increase the local option to express concerns about the undesirable concentration of certain kinds of commercial development within any given area.

# IV. FUNDING OF COMMUNITY RESIDENTIAL CARE

## A. Major Findings

1. Sources of Funds Are Mixed

2. Adequacy of Funding for Direct Services Varies by Client Group

3. Rates and Payment Arrangements Vary by Client Group

4. Budget Constraints Reduce the Effectiveness of Monitoring and Enforcement Activities

## B. Recommendations

1. Impose Annual Licensing Fees to Support Increased Monitoring and Enforcement Activities and New Programs for Small Facilities

2. Authorize the Establishment of an "Ombudsman Foundation"

3. Launch an Aggressive Campaign to Solicit Private Contributions for Increasing the Levels and Quality of Service Provided to Community Care Residents

## A. Major Findings

### 1. SOURCES OF FUNDS ARE MIXED

Federal and state funds support community residential care and, in the case of clothing allowances and other foster care supplements, county funds support residential services as well.

Federal Funds. During the period 1969-80, the mentally disabled client population in state mental hospitals declined by an average 61 percent throughout the United States (IV-1). During that same period, the average annual cost of keeping an individual in a state mental hospital rose from $5,600 to $32,800 -- a 485 percent increase. Most states, including California, responded predictably to this strong fiscal impetus to shift the cost of caring for specified populations from state general funds for state hospitals to the federal Supplemental Security Income (SSI) program for entitlements to individuals. Today, SSI remains the main source of payment to community residential care providers.

In addition, P.L. 97-35 allows states to seek waivers from the Secretary of the U.S. Department of Health and Human Services to broaden the definition of "medical assistance" under Medicaid

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IV-1. U.S. Administration on Aging, "Board and Care Homes and the Keys Amendment," Washington, D.C. (undated).

to include home and community-based services. California has requested and received such waivers in order to prevent unnecessary institutionalization, as in the multipurpose senior services demonstration project, which serves elderly clients. Conceivably, then, community residential care will continue to be paid for increasingly with federal funds.

State Funds. The largest single category of state support for community residential care for the three groups targeted in this report is the State Supplementary Payment (SSP) portion of the SSI/SSP payments to individuals. In addition are the supplementary funds available to developmentally disabled residents for "specialized services," as discussed earlier. In the Short-Doyle program for mentally disabled clients, there are instances of contracting by counties directly with community residential care service providers, using state and county funds.

Licensing. Licensing costs are borne 100 percent by the state General Fund.

## 2. ADEQUACY OF FUNDING FOR DIRECT SERVICES VARIES BY CLIENT GROUP

We estimate the cost to the public for providing community residential care services for foster care children, the elderly, and developmentally and mentally disabled clients will be at least $583 million in 1983-84. This amount represents direct service costs only. That is, it excludes administration, licensing, and case management costs.

There is no way to evaluate whether that amount is too much, too little, or about right. While community care facility administrators would disagree with us that $15 per day may be adequate, it is nevertheless true that some undeterminable number of community care residents are in fact living in safe, healthful conditions at the current level of funding.

Administrators receive most of any increase in SSI/SSP payments approved by the federal and state governments. Thus, while inflation may arguably have caused cost increases over the last ten years that exceed the cost of living adjustments granted to funding recipients, administrators have been able to offset such increases at least to some extent with public funds.

The question of adequacy is less easily dismissed in the case of licensees who have only recently purchased the home or facility in which they intend to provide residential care services. The cost of housing has increased so dramatically that administrators could not realistically expect to amortize that cost completely out of public subsidies for community care residents. The effect of this particular cost increase is ambiguous: it may inhibit entry into the community care industry by individuals who are otherwise inclined to provide this particular service, or it may mean that these administrators solicit clients who are able to pay much higher rates than SSI/SSP clients can pay.

Because of the assumptions we have made, we believe our estimate of $583 million in annual expenditures may be lower than the actual public cost of community residential care, even though it

is substantially higher than all other estimates we have seen. In any case, the major funding issues have less to do with the adequacy of the total amount available than with whether adequate funding is available on an individual-by-individual basis to purchase the level of services required to fulfill a given client's plan of care and treatment.

We believe that more money should be made available for community residential care only for changes that would upgrade the quality of care. On this basis, we contend that across-the-board rate increases for service providers cannot be justified.

## 3. RATES AND PAYMENT ARRANGEMENTS VARY BY CLIENT GROUP

Rate-setting for community residential care is subject to all the complexities, inequities, and other imponderables that beset other social and health services paid for by the government and provided only to eligible individuals. In the last two years, three major studies have been written regarding rates alone for foster care and residential care for the developmentally and mentally disabled. Yet another rate-setting study is currently being prepared by the State Council on Developmental Disabilities.

An effective rate-setting mechanism should accommodate variations in the cost of client services. Rates should vary according to differences in client needs and the cost of meeting those needs. Behavioral problems of clients in rural settings, for example, may demand more or less urgent attention (with their

concomitant costs) than for those in urban settings. Furthermore, to be effective, a rate-setting mechanism must be administered by an entity that has a reasonably accurate, reliable, and preferably flexible method of developing rates. None of these conditions adheres in the existing system.

In the precursors of licensed community residential care -- for example, family care homes for mentally ill patients released from state hospitals -- the responsible state department authorized payment directly to the providers. Rate maximums were set in statute and amended annually on the advice of the Department of Finance.

Licensing community care facility administrators to solicit residents, without government oversight or regulation of rates to be charged, and empowering individual clients to purchase their own community residential care services with SSI/SSP entitlements considerably loosened government's control of rates. Reining it back in would not be easy.

In effect, the SSI/SSP rate sets the board and care rate for the majority of board and care residents. Similarly, the government-approved SSI/SSP cost of living adjustment (COLA) determines the annual price increase. In order for providers to pass on cost increases that exceed the SSI/SSP COLA, they must charge those residents with private resources more than the $459 per month that SSI/SSP clients can pay ($478 after January 1, 1984). Some facilities -- in Orange County, for example, -- charge their private-pay residents as much as $2,500 per month

for board and care -- an amount which is more than double the average Medi-Cal payment for skilled nursing care.

Equity. Rates are equitable if they support similar levels of service for similarly disabled individuals. The simplicity of that statement is defied by variations in existing capacity to assess disability and to respond with accurate levels and types of appropriate services, availability of supplemental funding, restrictions imposed by the funding source, and arrangements for making payments to service providers.

Community care administrators who are approved -- "vendorized" -- by a regional center to provide residential care for developmentally disabled clients, for example, are eligible to receive payments directly from the regional center to supplement SSI/SSP-based rates. Such differential funding is limited to approved vendors, and rates are based on the level of staffing and/or the provision of "specialized services."

Advocates for the developmentally disabled have successfully made the case for differential rates for residential care. Should similar provisions be made for the mentally disabled and the elderly? The Legislature apparently found that inequity compelling enough to authorize differential funding for the mentally disabled (Chapter 1194, Statutes of 1979, (SB 951)), but was constrained by insufficient revenue from ever appropriating the required funds.

The characteristics of the developmentally and mentally disabled client groups vary from each other; yet, the desirability

of having access to differential funding for the mentally disabled is evident.

Developmental Services programs have time to plan for placements, and Developmental Services clients demonstrate physical, developmental, and behavioral characteristics which are measurable. Consequently, there is a reasonable basis upon which to establish an appropriate rate commensurate to need and to a long-range treatment program.

Mentally disabled clients, on the other hand, have the potential for drastic changes in behavior, degree of disability, and placement needs over a relatively short time. The volume of initial placements and subsequent changes in placement is greater for this client group.

Such differences suggest that more flexibility in paying for community residential care is desirable for all client populations. In most cases, the SSI/SSP-based rate is adequate to support individuals in need of basic residential services. Due to individual client differences or changes, however, that rate sometimes is not adequate to purchase an appropriate level of additional care. In that situation, it is patently inequitable to supplement funding available to persons with one set of disabilities and who purchase services in the same system in which persons with others sets of disabilities are denied supplemental funding.

## 4. BUDGET CONSTRAINTS REDUCE THE EFFECTIVENESS OF MONITORING AND ENFORCEMENT ACTIVITIES

Budget reductions in recent years have diminished the state's capacity to monitor community residential care and to enforce the laws and regulations pertaining to this program. Because monitoring and enforcement activities are supported 100 percent by the state General Fund, the funding for these activities has been "raided" in order to support other of the legislature's or administration's priorities.

We do not object to reducing the cost and size of state government. In this case, however, we believe evidence of abuse and neglect of community care residents and of substandard conditions in facilities is sufficient to justify increasing expenditures on enforcement. The cuts in support for investigation and facility evaluation make placement in a community care facility a frightening specter rather than a welcome and affordable alternative to higher levels of care.

Currently, licensees pay no fee for the privilege of gaining access to the community care market. Revenue from modest fees could be used to defray the considerable costs of monitoring and enforcement.

## B. Recommendations

Except for the "private pay" residents in community care facilities, the support for community care now comes entirely from public sources. We believe it is possible to diversify the funding base in ways that will also serve to strengthen enforcement and integrate community care with the overall network of long term care services.

We support two guiding principles for the use of new funds:

- New revenue should not replace General Fund support dollar-for-dollar -- at least not until additional revenue potential can be identified and realized. Rather, new revenues 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) make no sense in this program.

## 1. Impose Annual Licensing Fees to Support Increased Monitoring and Enforcement Activities and New Programs for Small Facilities

Early in the development of community care as an alternative to institutionalization, community residential care services were not considered to be appropriate as a profit-making venture. Providers were recruited to perform a humanitarian service. The much smaller payments to service providers at that time were expected to cover only the actual costs incurred in meeting the residents' basic needs and not to supplement the household income.

The contemporary community care program has to be viewed as a unique cottage industry -- that is, for the small facility administrators -- as well as a care alternative for the residents. Many administrators are in the business of providing residential care because they have a house to use as a resource in making a living. Their primary motivation, in fact, may be to earn income and not necessarily to provide care and supervision for chronically disabled individuals.

There is no reason to believe that the quality of care is necessarily diminished because the provision of services has become more proprietary. On the other hand, it is certainly appropriate to collect a fee from licensees in exchange for granting them the right to offer residential care services on an open market. We recommend that such fees be imposed.

We further recommend that licensing and renewal fees should be structured to offer incentives for compliance. We suggest the following:

- Basic licensing and annual renewal fee: $100
- Additional increments of $25 per 25 additional beds up to 100 beds per facility, but with small facilities exempt from the first increment. Thus:

| | |
|---|---|
| up to 6 beds | $100 |
| 7 to 32 beds | 125 |
| 33 to 58 beds | 150 |
| 59 to 84 beds | 175 |
| 85 to 100 beds | 200 |

- Additional increments of $100 per 100 additional beds, up to a maximum annual fee of $500. Thus:

| | |
|---|---|
| up to 200 beds | $300 |
| 201 to 300 beds | 400 |
| 301 or more beds | 500 |

- For each civil penalty assessed during the prior year (per violation, not per day), $10 should be added to the annual licensing fee
- "Model House" administrators' licensing renewal fee should be <u>reduced</u> by $10
- Recipients of certificates of excellence should receive one-time <u>reductions</u> of their licensing fees at the rate of $10 per certificate

The revenue from licensing fees based on this or a comparable schedule would be more than enough to implement the "cluster administration" and "model house" pilot projects recommended earlier.

Finally, we recommend that the Legislature consider including an additional $2 per bed annual licensing fee to support the State Long Term Care Ombudsman Program. This would allow expansion of the program's volunteer work in community residential care facilities. Because this fee would be state revenue, it could be used to expand the ombudsman program into facilities serving client groups other than the elderly without conflicting with existing federal law.

2. Authorize the Establishment of an "Ombudsman Foundation"

The Long Term Care Ombudsman Program needs access to the traditional fund-raising methods available to all volunteer organizations. Just as many school districts throughout California have created foundations as fund-raising arms to support their academic programs, we recommend that the Legislature authorize the State Long Term Care Ombudsman Program to form a foundation that is eligible to receive tax-deductible donations in support of monitoring activities to be performed at the local level by volunteers.

It is unlikely, at best, that the Legislature will appropriate $2-3 million in state general funds to monitoring by volunteers in community residential care facilities. It is at least possible that enough support could be solicited from private sources to begin to expand this program. The effort alone would have the benefit of increasing public awareness of long term care services and the importance of maintaining an official "presence"

in the facilities where such services are provided. The future quality of care will depend to a great extent on the success, or lack of it, of monitoring by volunteers.

In addition, as mentioned earlier, 50 percent of the fines collected by Community Care Licensing could justifiably be dedicated to supporting the ombudsman program (as part of the overall monitoring and enforcement effort).

### 3. Launch an Aggressive Campaign to Solicit Private Contributions for Increasing the Levels and Quality of Service Provided to Community Care Residents

The federal Social Security Act requires that private contributions to individual SSI/SSP recipients to supplement the costs of maintaining them as residents in community care facilities must be treated as "income." The resulting action in such cases would be that the Social Security Administration would reduce the grants to the affected SSI/SSP recipients to reflect this additional income. Congress has not authorized this provision of federal law to be waived upon the request of individual states.

Federal law does not, however, prohibit private contributions altogether. A friend or family member may give money directly to the facility administrator (rather than the resident) to purchase the services of a visiting nurse, for example, or someone to clean the resident's room, or to enable the resident to attend a concert or ball game or movie periodically. So long as the money (or in-kind contribution, such as tickets to community events) is not used to supplement "support and maintenance" costs, such

supplements are allowed under existing law. Specifically, "support and maintenance" refers to housing, food, and clothing.

We recommend that the Legislature require CCL to advise the Departments of Developmental Services and Mental Health, the Office of Long Term Care and, of course, all licensees of the rules under federal law that apply to supplemental funding from private sources for maintaining SSI/SSP recipients in community residential care facilities. We further recommend that CCL develop standard format agreements for facility administrators to use in negotiating with friends or family members of residents to specify the nature and amount of contributions to be made.

We also recommend that the Legislature require the Departments of Developmental Services and Mental Health and the Office of Long Term Care to organize efforts at the county or regional level to encourage facility administrators to actively seek additional funding for incrased levels of service. In addition to residents' friends and family members, we believe other private sources of supplemental funding exist. For example, churches or charitable organizations may be willing to serve as "sponsors" -- that is, to contribute money, time, transportation, and/or other resources in support of either an individual or a particular facility. Cluster administrators, as we recommended with respect to the "small facilities subsystem," might be expected to identify and solicit such community resources for the house managers in their clusters.

In keeping with the spirit of the times, this Commission believes that government's role in the community care system includes assisting facility administrators to help generate revenue from nontraditional sources, rather than to seek higher payments from public funds. Increasing the levels and quality of service to community care residents will require an aggressive effort to solicit support in various forms from the private sector. It is in all our best interests for government to make this effort.

# APPENDICES

# APPENDIX A

## Historical Derivations of the "Small Facilities Subsystem"

Over the period of this study, we discovered there had been a network of "family care homes" prior to implementation of the Community Care Licensing Act. These homes were "certified" by social workers from the Department of Mental Health. This model has been highly praised by former participants in it: both social workers and family members of the mentally ill.

Family care homes constitute the original version of what we refer to in this report as the "small facilities subsystem." We are including this material on the historical development of this care alternative in order to clarify the distinctions we have tried to make between the large, professionally-run community care institutions and the small, home-setting community care facilities we call the small facilities subsystem.

### Community Care Traditions

Community residential care derives from two major traditions. The first originated in the mid-19th century and consisted primarily of three institutional arrangements our society has historically maintained for dependent populations: orphanages, almshouses, and state hospitals.

The second tradition began in the 1940's as an alternative to placement in these institutions. Progress in medical science and changes in family structure converged to create a need for a therapeutic environment outside institutions.

History (A-1). A principle of English law, parens patriae, provides that the sovereign, or state, has a duty to oversee dependents who have been abused, neglected, or abandoned, or are for some other reason unable to care for themselves. Since the middle of the 19th century, this legal principle has prevailed in America as well, and it has influenced the development of community residential care in California.

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A-1. The historical summary presented here is derived from material in Purposes and Functions of Community Care: An Orchestra without a Conductor, by Dale Carter, et al. The Purposes report was prepared and issued by Steven Thompson Associates in 1980. We recommend that readers interested in a more thorough rendering of community care's history (in California and elsewhere) refer to this 1980 report.

With its population increasing rapidly in the mid-1800's, California found its duty to oversee dependents also expanded as a result of social problems such as gambling and public drunkenness. The high percentage of unattached males and foreigners in California at the time of the gold rush were also thought to contribute to the instability of family life that led to increasing the state's obligations. Also, the seasonal character of mining and agriculture meant that large numbers of people were without jobs for long stretches during the year. Many became dependent on government subsidies during those times.

Early public records show that, in 1853, those deemed "unsafe to be at large" due to insanity were institutionalized in the insane asylum at Stockton. This asylum was authorized by state law as the first such facility in California to be built and operated by the state. In 1855, the Legislature began appropriating funds to locally-operated public and private institutions that provided out-of-home care for various classes of indigents.

In 1860, the state initiated subventions through the counties for the support of out-of-home care for indigents. Until well into the 20th century, out-of-home care consisted of large facilities -- orphanages, almshouses, and state hospitals -- where people without personal resources and with different sorts of problems were housed and fed. Efforts to habilitate or rehabilitate such persons were not monitored by government and were often motivated and prescribed by religious beliefs and practices.

Impetus for Alternatives to Institutionalization. In 1946, the National Institute of Mental Health began making federal funds available for removing mentally ill patients from state hospitals and placing them in community residential facilities. In California, the Bureau of Social Work was established in the then Department of Mental Hygiene to accomplish this transition.

In 1955, when the California State Senate created its Interim Committee on the Treatment of Mental Illness, there were 36,000 mentally ill patients in state hospitals. By 1980, there were 6,000 -- a nearly 85 percent reduction.

The first legislation to emerge from the Interim Committee's work was the Community Mental Health Services Act of 1957, better known as the Short-Doyle Act. By 1967, subsequent legislation had been enacted to increase counties' fiscal incentive to utilize community care for mental health clients. At that time, community mental health programs represented 24 percent of statewide public mental health expenditures. By fiscal year 1971-72, community mental health spending had grown to 65 percent of the total.

"Family Care Homes" (A-2). Prior to 1973, when the Community Care Licensing Act was passed, the Department of Mental Health

(DMH) had field offices which recruited, trained, and certified "family care homes" as the need arose. The process allowed for exclusive use of the homes by the mental health program and was based on a goal-related relationship negotiated by the providers of the residential services and the DMH social workers. The responsibility for the success or failure of a placement was a joint one.

The basic purpose of family care in California was to foster the client's ability to assume responsiblity for himself or herself in dealing with the obligations of family and community life. Some of the patients selected for family care placements were from the hospital classification of "continuous treatment." The outlook for their full recovery was not hopeful, but they had responded to institutional treatment and training to such an extent that hospital doctors felt they could adjust to living under supervision in a home and profit from the individual attention which came with family life. Family care was also used for patients who had made major progress during periods of intensive hospital treatment. These patients were placed in homes as a therapeutic measure, with the purpose of hastening their full recovery and rehabilitation.

Starting in 1946, mental health social workers began to develop family care homes. They evaluated the qualifications of applicants, examined the physical facilities, and recommended certification of suitable homes. They provided continuous social work services to clients residing in family care homes, to their relatives, and to the family care home owners. The social workers conducted an annual review of each home prior to recertification.

Family care was both custodial and therapeutic. Even those who had shown no improvement in the hospital sometimes found in the family life milieu certain therapeutic aids the hospital was not able to provide.

In this system, social workers placed the greatest emphasis on the family caregivers' personal qualities. The caregivers needed to be: (1) sympathetic and tolerant people who were not easily upset or irritated; (2) well-adjusted; (3) firm, yet fair and essentially kind; (4) stable and sensible; and (5) able to

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A-2. This description of "family care homes" is based on material that was prepared by T. Richard Middlebrook, Chief, Office of Long Term Care, State Department of Mental Health.

relate to a patient on the level at which he or she could function, yet not lose sight that, with patience and interest, the patient could improve and become more willing to take part in family and community life. In other words, the potential quality of inter-personal relationships became the highest priority criterion in selecting family care homes for mentally ill persons.

Adoption of such a criterion was neither a product of random selection nor a matter of personal preference on the part of social workers. Rather, social workers found the personality of the caretaker was the single most reliable predictor of whether family care would succeed. The patient's improvement was directly related to the interest, help, and understanding they received from the families with whom they were living.

In some homes, it was the husband and father who seemed to be the most potent therapeutic aid; in another, the wife; and, in some instances, the younger members of the family seemed to mean the most to the patient. But in every case, the recognition of the therapeutic potential of those personalities was the most important part of the social workers' evaluation and certification of the home.

"Certification" in such a model is a highly subjective process. As a means of selecting appropriate family care homes, it assumes that social workers have been adequately trained as professionals and are sufficiently mature as adults to exercise good judgment. The objectives were also conceived in subjective terms: certification was perceived as a process of cultivating humanitarian motivations; prestige and a sense of social worth were considered to be the rewards that served as incentives to families to offer the service. The payments to families were meant to cover the actual cost of caring for a particular patient and <u>not</u> to provide additional household income.

<u>Licensing</u>. In the licensing model, community residential care is developing as a business, as well as an alternative to care in institutions. Just as the public purpose in providing community residential care has increasingly emphasized cost savings as well as humanitarian considerations, the private interests of the small facilities administrators have increasingly come to include making a living. Under these circumstances, monitoring and enforcement efforts must be carefully conceived and implemented in order to protect the best interests of the residents.

# APPENDIX B

## Data Summaries

## Table 1

COMMUNITY RESIDENTIAL CARE FACILITIES
Licensed Capacity
As of June 30, 1983

| | Beds | Facilities: 6 Beds or Fewer | Facilities: 7 Beds or More | Total |
|---|---|---|---|---|
| **Adults** | | | | |
| Small Family Homes | 10,578 | 2,317 | | 2,317 |
| Large Family Homes | 1,715 | | 154 | 154 |
| Group Homes | 35,621 | | 1,865 | 1,865 |
| Elderly (RFE) | 51,706 | 1,719 | 574 | 2,293 |
| Social Rehabilitation | 7,841 | | 319 (a) | 319 |
| Subtotals | 107,461 | 4,036 | 2,912 | 6,948 |
| **Children** | | | | |
| Small Family Homes | 4,303 | 1,105 | | 1,105 |
| Foster Family Homes | 23,774 | 12,668 (b) | | 12,668 |
| Large Family Homes | 70 | | 8 | 8 |
| Group Homes | 9,890 | | 959 | 959 |
| Subtotals | 38,037 | 13,773 | 967 | 14,740 |
| **Adults and Children** | | | | |
| Small Family Homes | 811 | 175 | | 175 |
| Large Family Homes | 59 | | 6 | 6 |
| Group Homes | 2,751 | | 124 | 124 |
| Subtotals | 3,621 | 175 | 130 | 305 |
| TOTALS | 149,119 | 17,984 | 4,009 | 21,993 |

Source: State Department of Social Services

Notes: (a) A small, but undetermined number of these facilities may be licensed for six or fewer beds.

(b) A small, but undetermined number of foster family homes would actually be licensed to care for more than six children.

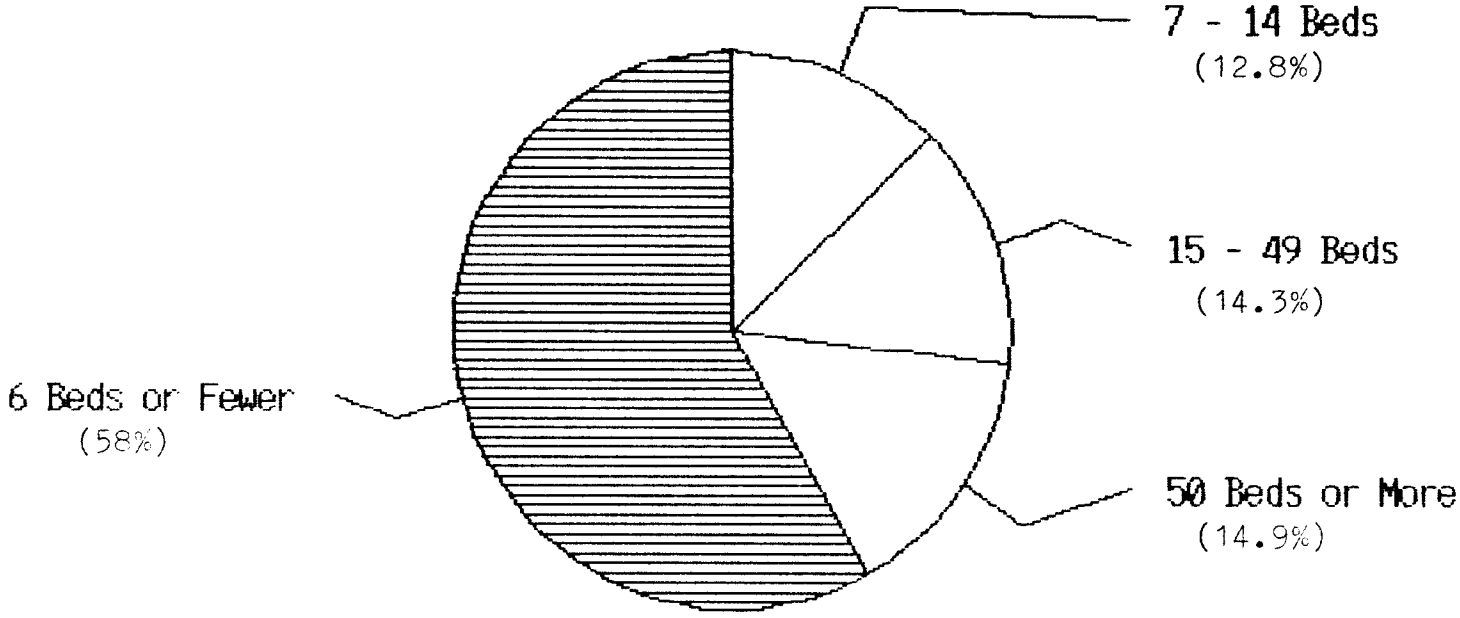
**Table 2**

DEVELOPMENTALLY DISABLED INDIVIDUALS
Residing in Community Care Centers As of October 1983

| Facility Size | Number Residents | Percentage of Total |
|---|---|---|
| 6 Beds or Fewer | 9,249 | 58% |
| 7 - 14 Beds | 2,034 | 12.8% |
| 15 - 49 Beds | 2,272 | 14.3% |
| 50 Beds or More | 2,369 | 14.9% |
| TOTALS | 15,924 | 100% |

Source: State Council on Developmental Disabilities

# DEVELOPMENTALLY DISABLED RESIDENTS




Source: State Council on Developmental Disabilities

Notes: This chart depicts the data presented in Table 2. Thus, the percentages shown above indicate the percentages of the total 15,924 developmentally disabled individuals who were residing in community care facilities as of October 1983.

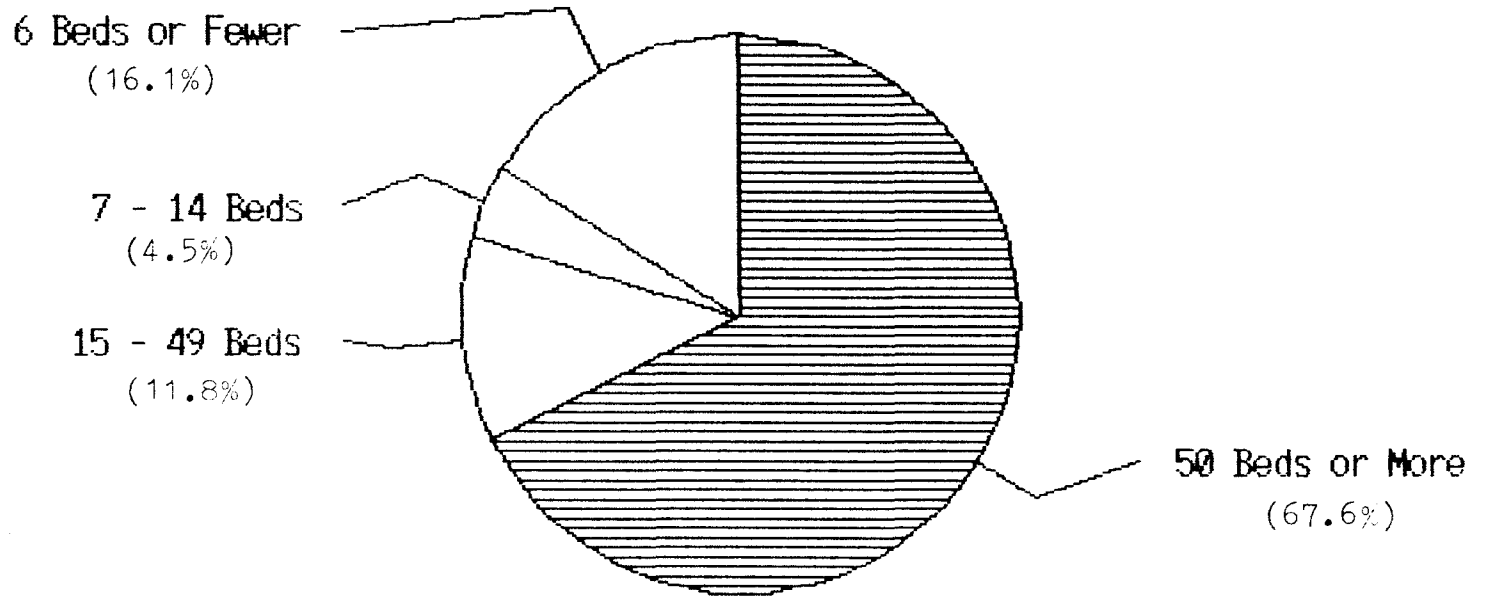
**Table 3**

ELDERLY INDIVIDUALS
Licensed Capacity in Comunity Care Facilities
As of September 26, 1983

| Facility Size | Number of Beds | Percent of Total | Number of Facilities | Percent of Total |
|---|---|---|---|---|
| 6 Beds or Fewer | 8,775 | 16.1% | 1,719 | 68.2% |
| 7 - 14 Beds | 2,429 | 4.5 | 219 | 8.7 |
| 15 - 49 Beds | 6,446 | 11.8 | 322 | 12.8 |
| 50 - 99 Beds | 7,051 | 13.0 | 97 | 3.8 |
| 100 - 199 Beds | 15,049 | 27.7 | 115 | 4.6 |
| 200 - 299 Beds | 7,863 | 14.4 | 33 | 1.3 |
| 300 - 399 Beds | 2,072 | 3.8 | 6 | 0.2 |
| 400 - 499 Beds | 2,545 | 4.7 | 6 | 0.2 |
| 500 - 599 Beds | 2,161 | 4.0 | 4 | 0.2 |
| TOTALS | 54,391 | 100.0% | 2,521 | 100.0% |

Source: State Department of Social Services

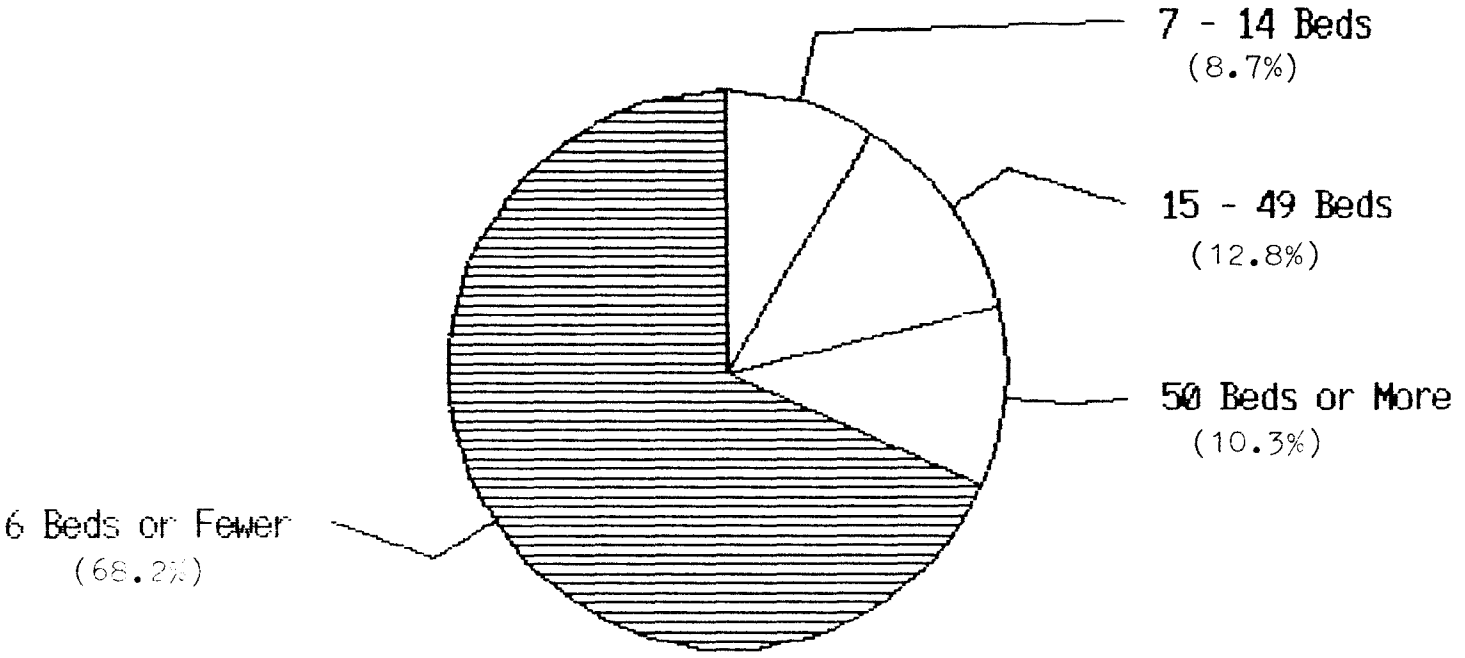
# LICENSED BED CAPACITY: ELDERLY




Source: State Department of Social Services

Notes: This chart depicts the data presented in Table 3 pertaining to the number of beds available for the elderly in licensed community care facilities, as of September 26, 1983. The total number of beds is 54,391.

# RESIDENTIAL FACILITIES FOR THE ELDERLY




Source: State Department of Social Services

Notes: This chart depicts the data presented in Table 3 pertaining to the number of facilities licensed to provide community care services for the elderly, as of September 26, 1983. The total number of facilities is 2,521.

**Table 4**

COMMUNITY CARE LICENSING
Staffing Levels 1980/1 - 1983/4

| | 1980-81 | 1981-82 | 1982-83 | 1983-84 |
|---|---|---|---|---|
| Evaluators | 147.5 | 180.0 | 169.0 | 198.0 |
| Other Field Operations | 91.6 | 119.5 | 113.0 | 121.5 |
| Investigators | 10.0 | 10.0 | 10.0 | 12.0 |
| Auditors | 7.0 | 7.0 | 5.0 | 5.0 |
| County Liaison | 18.0 | 18.0 | 12.0 | 8.0 |
| Central Operations | 34.0 | 33.0 | 35.0 | 35.0 |
| TOTAL | 308.1 | 367.5 | 344.0 | 379.5 |
| Attorneys Assigned to Licensing from DSS Legal Division | 7.0 | 7.0 | 7.0 | 9.0 |

Source: Community Care Licensing, State Department of Social Services

Notes: The fluctuations in CCL staffing levels reflect primarily either caseload transfers from counties or the State Department of Education to CCL or mandated enhancements in monitoring with respect to child day care programs. In short, the increased staffing level in 1983-84 does not indicate an increase in monitoring and enforcement activities related to the community residential facilities that are the subject of this report.

## APPENDIX C

**Participants in Little Hoover Commission's Community Care Workshops in Sacramento (Developmentally Disabled: July 25, 1983; Elderly: August 4, 1983; Mentally Disabled: August 18, 1983)**

**Community Care Workshop -- Developmentally Disabled**
**July 25, 1983**

| Name | Representing |
|---|---|
| Virginia Carlson | Regional Center of Orange County |
| Jake Donovan | State Department of Developmental Services |
| Nancy Fleischer | Protection and Advocacy, Sacramento |
| David Foster | Community Care Licensing, State Department of Social Services |
| Joyce Fukui | Community Care Licensing, State Department of Social Services |
| Carolyn Gaffney | Sonoma County Citizen Advocacy |
| Charles Galloway | Assembly Office of Research, Sacramento |
| Mary Guinn | Alta Regional Center, Sacramento |
| Andy Manale | State Council on Developmental Disabilities |
| Judy McDonald | California Association of Rehabilitation Facilities |
| Fred Miller | Community Care Licensing, State Department of Social Services |
| Lonnie Nolta | Developmental Disabilities Advocacy Services |
| Jay Ortiz | State Department of Developmental Services |
| Burns Vick | Developmental Disabilities Advocacy Services |

| | |
|---|---|
| Ralph Zeledon | State Department of Developmental Services |
| Doris Zepezaver | Central Valley Regional Center |

**Community Care Workshop -- Elderly**
**August 4, 1983**

| Name | Representing |
|---|---|
| Ingrid Azvedo | Governor's Advisory Task Force on Long Term Care |
| William Benson | State Long Term Care Ombudsman Program |
| Louise Broderick | California Association of Residential Care Homes (CARCH) |
| Kristin Casey | Long Term Care Ombudsman/Napa County |
| Liza Clavecilla | Community Care Licensing, State Department of Social Services |
| Amy Dean | Office of California State Senator Nicholas Petris |
| Richard Feingold | Palmcrest North, Long Beach |
| Edward Feldman | Nursing Home Abuse Unit, Los Angeles County District Attorney's Office |
| Diana Fields | Long Term Care Ombudsman/Napa County |
| Paul Goss | California Association of Health Facilities (CAHF) |
| Eunice Graham | California Association of Residential Care Homes (CARCH) |
| Muriel Greensaft | Long Term Care Ombudsman/Orange County |
| Hannah Handman | Freda Mohr Multiservice Center, Jewish Family Service of Los Angeles |

| | |
|---|---|
| Mary Hinschliff | Long Term Care Ombudsman/Santa Cruz County |
| Eileen Jackson | Long Term Care Ombudsman/Sacramento County and California Nurses Association |
| Derrell Kelch | California Association of Homes for the Aging (CAHA) |
| Harry Kendall | California Association of Residential Care Homes (CARCH) |
| Sandra King | Jewish Family Service of Los Angeles |
| Ralph D. Knight | Northern California Presbyterian Homes |
| Jean Lundstrom | Saddleback Community Hospital |
| Harold Mays | Arden Memorial Convalescent Hospital, Sacramento |
| Bill Ruppert | State long Term Care Ombudsman Program |
| Frances Schmidt | California Association of Residential Care Homes (CARCH) |
| Charles Skoien | California Association of Residential Care Homes (CARCH) |
| John Vidra | Community Care Licensing, State Department of Social Services |

**Community Care Workshop -- Mentally Disabled**
**August 18, 1983**

| Name | Representing |
|---|---|
| George Bukowski | State Department of Mental Health |
| Liza Clavecilla | Community Care Licensing, State Department of Social Services |
| Michael Coonan | Patient Rights Advocate, Sacramento County |

| | |
|---|---|
| Sharon Dorsey | California Association of Residential Care Homes (CARCH) |
| Robert Goulet | State Department of Mental Health |
| Diane Lockhart | State Department of Mental Health |
| Hon. Zoe Lofgram | Santa Clara County Supervisor, 2nd District |
| Lori McMahon | Mental Health Department, Sacramento County |
| Richard Middlebrook | State Department of Mental Health |
| Tom Rossebo | California Association of Residential Care Homes (CARCH) |
| Kathy Scheidegger | Community Care Licensing, State Department of Social Services |
| Charles Skoien | California Association of Residential Care Homes (CARCH) |
| Helen Teischer | California Alliance for the Mentally Ill |
| Mary Trounstine | Neighborhood Association, San Jose |
| Kerry Williams | Mental Health Advocacy Project, San Jose |
| Kitty Wong | The Manor, Santa Monica |

## APPENDIX D

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APPENDIX E

A Schematic To Show of Whom Actions or Changes Would Be Required in Order to Implement the Commission's Recommendations

| | Legislature | CCL | DDS | DMH | O/LTC | Ombudsman | HWA | Other |
|---|---|---|---|---|---|---|---|---|
| SERVICE PROVISION | | | | | | | | |
| Clarify Roles (p. 46) | X | X | X | X | X | X | | Licensees |
| Coordinate Policy Development (p. 48) | X | X | X | X | X | | X | |
| Coordinate Definition of Services (p. 49) | X | | X | X | X | | X | Advisory Committees |
| Extend Case Management Services to Elderly and Mentally Disabled (p. 50) | X | | | X | X | | | |
| Improve Consumer Information (p. 51) | X | X | X | X | X | | | Community Volunteer Organizations |
| Strengthen the "Small Facilities Subsystem" (p. 52) | X | X | | | | | | Cluster Administrators/Model House Administrators |
| MONITORING AND ENFORCEMENT | | | | | | | | |
| Recruit and Train Volunteers to Monitor Residents (p. 80) | X | | X | X | | X | | Attorney General or Dept. of Consumer Affairs |
| Establish Emergency Response Capability (p. 82) | X | X | | | | | | Local Entities |

APPENDIX E
(continued)

| | Legislature | CCL | DDS | DMH | O/LTC | Ombudsman | HWA | Other |
|---|---|---|---|---|---|---|---|---|
| Make Applicant Screening More Meaningful (p. 82) | | X | | | | | | |
| Create Automated Licensee Information System (p. 83) | X | X | | | | | | |
| Standardize Cost Accounting (p. 85) | X | X | X | X | X | | | Licensees |
| Empower Residents to Be Monitors (p. 86) | X | X | | | | X | | Licensees (25 Beds or More)/ Residents |
| Recombine Community Care and Health Facilities Licensing/Relocate in Attorney General's Office (p. 87) | X | X | | | | | | Dept. of Health Services/Attorney General |
| Utilize Licensing Personnel More Effectively (p. 88) | X | X | | | | | | |
| Develop Criteria for Granting Permission to Bear Arms (p. 89) | | | | | | | X | Attorney General (potentially) |
| Structure Coordination of Enforcement Activities (p. 89) | | X | X | X | X | X | | DSS Legal Division/Advisory Committees/ Placement Agencies |

APPENDIX E
(continued)

| | Legislature | CCL | DDS | DMH | O/LTC | Ombudsman | HWA | Other |
|---|---|---|---|---|---|---|---|---|
| Develop Criteria and Procedures - Temporary Suspension Orders (p. 93) | X | X | | | | | | |
| Sponsor Enforcement Seminars (p. 94) | | X | | | | | | Local Law Enforcement and Fire Officials |
| Prepare Handbooks for New Licensees and Residents (p. 95) | | X | X | X | X | | | |
| Clarify Definition of Unlicensed Facilities/Authorize Local Citations (p. 95) | X | | | | | | | Local Police and Sheriff Departments |
| Increase Fines for Licensing Violations (p. 96) | X | X | | | | | | |
| Require All Licensees to Be Bonded (p. 97) | X | | | | | | | Licensees |
| Authorize CCL to Place Facilities into Receivership (p. 98) | X | X | | | | | | |
| Establish a "Crisis Team" within CCL (p. 99) | X | X | | | | | | |
| Encourage Private Action Against Unsatisfactory Facility Administrators (p.100) | X | | | | | | | Private Citizens |
| Require Boarding Houses to Be Registered/Authorize Ombudsman Access (p.100) | X | X | | | | X | | Boarding Houses |

APPENDIX E
(continued)

| | Legislature | CCL | DDS | DMH | O/LTC | Ombudsman | HWA | Other |
|---|---|---|---|---|---|---|---|---|
| Authorize Immediate Dismissal of Placement Officers for Making Illegal or Unsafe Referrals (p.101) | X | | | | | | | Placement Agencies |
| Restrict Geographic Concentrations (p.102) | X | X | | | | | | Local Governments |
| FUNDING | | | | | | | | |
| Impose Licensing Fees (p.113) | X | X | | | | | | Licensees |
| Authorize Establishment of "Ombudsman Foundation" (p.115) | X | | | | | X | | |
| Launch Aggressive Campaign to Solicit Private Contributions (p.116) | X | X | X | X | X | | | Licensees |

## ACKNOWLEDGEMENTS

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The Commission received written testimony and comments from many people whose interests in community residential care vary, depending on their standing in the system as service providers, client advocates, or government monitors or administrators. To the extent that it was consistent with the Commission's findings, we have incorporated much of their material into the final report.

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DEANNA J. MARQUART
Sacramento
December 1983