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Report to Congressional Requesters

February 1989

BOARD AND CARE

Insufficient Assurances That Residents' Needs Are Identified and Met

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The Honorable John Heinz
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Claude Pepper
Chairman, Subcommittee on Health
and Long-Term Care
Select Committee on Aging
House of Representatives

In response to your requests and later discussions with your offices, we undertook a review of board and care issues. This report contains information on (1) the size of the board and care industry, (2) characteristics and needs of board and care home residents, (3) how states are monitoring and regulating board and care homes, and (4) the role the Department of Health and Human Services has played in overseeing board and care. The report also recommends that the Congress direct the Secretary of Health and Human Services to conduct a comprehensive assessment of states' oversight of their board and care populations.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will provide copies to the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties and make copies available to others upon request.

This report was prepared under the direction of Janet L. Shikles, Associate Director. Other major contributors are listed in appendix IV.

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Many elderly and disabled adults reside in board and care homes; little is known nationally, however, about the residents' needs or the care they receive. The Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, and the Ranking Minority Member, Senate Special Committee on Aging, requested that GAO provide information on the size of the board and care industry, characteristics and needs of residents in board and care homes, and the role of the states and the federal government in monitoring the care these individuals receive.

Background

"Board and care" describes a wide variety of nonmedical community-based residential facilities—group homes, foster homes, adult homes, domiciliary homes, personal care homes, and rest homes. These homes, which may provide room, meals, and some protective oversight, are different from boarding homes, which only provide a place to sleep and eat.

In 1976, the Congress enacted the Keys Amendment to the Social Security Act, which required states to certify, to the Department of Health and Human Services (HHS), that all facilities in which a significant number of Supplemental Security Income (SSI) recipients resided or were likely to reside met appropriate standards. SSI provides a national minimum income to needy aged (65 or older), blind, or disabled individuals.

GAO did fieldwork in six states—California, Florida, New Jersey, Ohio, Texas, and Virginia. The state reviews included an examination of licensing procedures and policies and inspection reports. GAO also interviewed federal and state officials, board and care owners, and aging organizations and industry representatives.

Results in Brief

States continue to find serious problems in some licensed board and care homes, including physical abuse, unsanitary conditions, and the lack of medical attention. Situations have also occurred that have contributed to the death of board and care residents. Little is known, however, about the extent and magnitude of such problems. Given the situation in some licensed homes, this raises concern about the quality of care provided to residents of unlicensed homes that are not state regulated.

The objective of the Keys Amendment was to protect SSI recipients from being in substandard board and care facilities. Strong state regulations

and oversight activities are critical to the accomplishment of this objective, but HHS currently commits almost no resources to assure that state board and care programs are in compliance with the Keys Amendment and implementing regulations.

GAO also found that widespread confusion exists on such basic issues as what constitutes a board and care home, how to deal with unlicensed homes and the variety of different licensing requirements among the states, and how to use available sanctions to correct problems without hurting the people the law was intended to protect.

GAO's Analysis

Universe of Board and Care Homes Is Unknown

The total number of board and care homes operating in the United States is unknown. A 1987 industry survey identified about 563,000 board and care beds in 41,000 licensed homes serving the elderly, mentally ill, and the retarded. The actual number of homes could be significantly higher because there is confusion over the wide variety of board and care definitions, state criteria exclude some homes from licensing, and there are an unknown number of homes that remain unlicensed due to the lack of enforcement efforts. For example, it is unknown how many boarding home residents, estimated to be between 500,000 to 1.5 million, live in homes that should be defined as board and care.

Four of the six states in GAO's review believe they have licensed most board and care homes in their states. Ohio and Texas, however, had made very limited attempts to regulate homes. Estimates of the unlicensed homes for the two states totaled about 3,500. Data are not available on the number of unlicensed homes nationwide.

Residents Have Low Incomes and High Service Needs

Surveys of the board and care population have identified many residents who have physical limitations, have previously lived in an institution due to a mental disability, are unlikely to have friends or relatives visit them, and have low incomes. One recent survey of more than 6,000 residents in New Jersey, for example, showed that about 45 percent were on SSI, about 42 percent had a psychiatric care history, about 68 percent had a chronic illness, and about 71 percent were on medication.

State officials in GAO's review reported that board and care homes experience difficulty in meeting the needs of mentally ill residents. An additional problem is caused by the low incomes of residents, specifically those on SSI. In 1988 the federal SSI benefit was $354 per month for an individual. Even with state supplements to SSI, studies have shown that the total payment may fall short of covering the actual costs of care.

Serious Problems Exist in Some Licensed and Unlicensed Homes

State inspections of licensed homes over the past several years have identified a wide variety of problems. These range from very serious situations, in which residents have been subjected to physical and sexual abuse, to problems involving persistent unsanitary conditions, such as improperly stored food and trash. In some cases board and care residents had been denied heat, were suffering from dehydration, were denied adequate medical care, or had food withheld if they did not work. Situations have also occurred that have contributed to the death of board and care residents. Because none of the six states had aggregated inspection data, the magnitude of the problems is unknown. Officials believe that problems are concentrated in homes with low-income residents, specifically those living on SSI.

Given the situations identified in licensed homes, undoubtedly serious problems also exist in unlicensed homes. This was confirmed, for example, in Ohio when a state health department nurse found residents in unlicensed homes who were not receiving enough food or who had large lesions, bedsores, and unattended chronic infections.

Difficulties in Closing Poor Homes

All six states had legal authority to immediately close homes or suspend licenses when residents' safety or well-being was threatened. However, three of the six had only one sanction available for dealing with substandard homes—to deny or revoke a home's license—a time-consuming process that can take up to a year. The other three states had intermediate sanctions, such as fines or receivership. One difficulty in closing homes is the lack of alternative housing for residents, especially those who rely on SSI and other forms of public assistance.

HHS Has Limited Responsibilities Under Keys Amendment

While the Keys Amendment and implementing regulations require states to establish and enforce board and care standards and periodically inspect homes, HHS is only required to record that it has received the states' annual certifications concerning compliance. HHS has chosen to do

little more than note that certifications have been received. HHS has said there is little it can do to monitor state actions or sanction states not in compliance.

HHS regulations do require states to report deficient board and care homes to the Social Security Administration so that the agency can reduce SSI benefits of any recipient living in such homes. Only four states currently submit reports. HHS officials have stated that the penalty provision is not enforceable. In addition, reducing benefits of SSI recipients penalizes the recipients, not the facility.

Recommendations

In view of the problems identified in our review of board and care programs in six states, coupled with the size and vulnerability of the resident population, we recommend that the Congress direct HHS to

- conduct a comprehensive assessment of states' oversight activities for their board and care population. This assessment should determine the adequacy of (1) licensing and regulatory requirements, (2) resources committed to their enforcement, and (3) efforts to identify whether residents' needs are being met.
- report to the Congress findings and, if appropriate, recommendations as to (1) subsequent steps needed to assure the protection of board and care residents and (2) changes needed to the Keys Amendments to make it more effective.

Agency and Other Comments

HHS and the six states GAO visited generally agreed with the report's findings. HHS offered an alternative strategy for addressing the report's concerns. HHS stated that it should conduct an assessment of the health and safety conditions and quality of care in a sample of licensed and unlicensed homes and, if appropriate, recommend specific strategies to help assure the protection of board and care residents. GAO believes such an effort will be useful if HHS considers state oversight activities, including licensing requirements, resources committed, and resident needs.

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Abbreviations

AoA	Administration on Aging
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OAA	Older Americans Act of 1965
OHDS	Office of Human Development Services
OPPL	Office of Policy, Planning, and Legislation
SSA	Social Security Administration
SSI	Supplemental Security Income

Introduction

Board and care homes have been an integral part of providing residential care for disabled and elderly populations for many years. "Board and care" is a generic term used to describe a wide variety of nonmedical community-based residential facilities, including group homes, foster homes, adult homes, domiciliary care homes, personal care homes, and rest homes. These homes may provide room; meals; help with such activities as bathing, grooming, and dressing; and some degree of protective oversight below the level of nursing care. Concerned about the quality of care provided to residents in board and care homes, the Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, and the Ranking Minority Member of the Senate Special Committee on Aging requested that we obtain information on the industry.

Background

In the mid-1970s fires in boarding homes resulted in several deaths and injuries to residents. Allegations of abuse and exploitation of elderly and mentally ill residents were also reported. Together these events focused attention on board and care facilities and heightened congressional concern about the need for regulation of these homes. Until this time the Congress had been exploring different options for an appropriate federal regulatory role in board and care. One option had even included a proposal to develop federal regulations similar to nursing home regulations;[1] this proposal was later determined to be infeasible. Finally, in 1976 the Congress enacted the Keys Amendment to the Social Security Act, which permitted Supplemental Security Income (SSI) payments to persons in publicly supported community residences serving 16 or fewer residents. It required states to certify that all facilities in which a significant number of SSI recipients resided or were likely to reside met appropriate standards; this was intended to protect SSI recipients from living in substandard homes.[2]

SSI recipients receive monthly cash payments under a program established in 1972 by title XVI of the Social Security Act. Implemented in 1974, SSI was intended to provide a national minimum income in accordance with uniform requirements to needy aged (65 years or older), blind,

[1]The Center for the Study of Social Policy, Completing the Long Term Care Continuum: An Income Supplement Strategy (Washington, D.C.: The Center for the Study of Social Policy, 1988), p. 19.

[2]Neither the amendment nor the Department of Health and Human Services has defined "significant" number. The Department in publishing final regulations in November 1983, stated that it believed the states, which have responsibility for implementing the amendment, were in the best position to define the term.

or disabled persons.[3] As of January 1988 this federal benefit was $354 per month for an individual.

Under the Keys Amendment, states are required to establish, maintain, and insure enforcement of standards for any category of institutions, foster homes, or group living arrangements in which a significant number of SSI recipients reside or are likely to reside. These standards must cover such matters as admission policies, safety, sanitation, and protection of civil rights. The Department of Health and Human Services (HHS) was given responsibility for developing program regulations and for receiving annual certifications from each state indicating compliance with the amendment.

Objectives, Scope, and Methodology

At the request of the Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, and the Ranking Minority Member of the Senate Special Committee on Aging, we undertook a review of board and care issues. The objectives of our review were to provide information to the Congress on

- the size of the board and care industry,
- characteristics and needs of residents who live in board and care homes,
- how states are monitoring and regulating board and care homes, and
- the role HHS has played in overseeing board and care.

In conducting this review we obtained information from and interviewed responsible officials at HHS, industry associations (such as the American Health Care Association and the National Association of Residential Care Facilities), aging organizations, state agencies, and board and care homes. We also reviewed information in HHS files submitted by states on their standards and surveyed officials in 10 Social Security Administration (SSA) district offices to determine the number of states reporting deficient homes.

To address how states are monitoring and regulating board and care homes, we selected for review six states—California, Florida, New Jersey, Ohio, Texas, and Virginia. These states represent geographic diversity, both high and low numbers of licensed board and care homes, and different state licensing criteria and regulatory efforts regarding such homes. For each state we obtained information on its board and

[3]In 1988, an estimated 4.411 million individuals will receive SSI payments—1.446 million because they are 65 or older and 2.965 million because they are blind or disabled.

care regulatory program from various state regulatory, ombudsman, and board and care association officials. We reviewed documentation regarding regulations, policies, and licensing and inspection procedures as well as pertinent studies, inspection reports, and complaint investigations. We also accompanied state officials in visits to about 50 board and care homes.

We performed our review between March 1987 and September 1988 in accordance with generally accepted government auditing standards.

Board and Care Residents Have Physical Limitations, Mental Disabilities, and Low Incomes

A 1987 survey[1] of state licensing agencies identified about 41,000 licensed board and care homes with about 563,000 beds serving the elderly, mentally ill, and mentally retarded. This actually represents an undercount of the total number of beds and facilities because data are unavailable on the number of unlicensed homes in operation. Some facilities remain unlicensed (and therefore generally unknown to state agencies) because state criteria exclude them from licensure requirements. Other facilities meet a state's criteria for licensing but remain unlicensed due to lack of enforcement efforts. HHS has also indicated that there is little information on how many board and care residents are in boarding homes.

Surveys have determined that the board and care population includes many residents who have physical limitations or need protective oversight, have mental disabilities, need assistance with taking medication, have a very limited income, and are unlikely to have even monthly visits from friends or relatives. One recent survey of more than 6,000 residents in New Jersey, for example, showed that about 45 percent were on SSI, about 42 percent had a psychiatric care history, about 68 percent had a chronic illness, and about 71 percent were on medication.

States in our review reported that a common need for board and care residents is mental health services. An additional problem reported by state officials is the low income of SSI recipients, which makes it difficult to meet their basic needs. Most states (five of six in our review) provide income support in addition to the SSI benefit; however, even with these supplements, state cost studies have identified a gap between income and the cost of care for publicly supported residents.

The Total Number of Board and Care Homes Is Unknown

The National Association of Residential Care Facilities, which represents residential care facility owners and operators, conducted a mail survey[2] of 112 state regulatory agencies, asking them to report the number of licensed residential care facilities and beds as of January 1, 1987. The total reported was 41,381 homes, with 562,837 beds. Of this total, about 10,000 homes with about 264,000 beds were identified as serving the elderly only, and the balance served mentally ill, mentally retarded, or mixed populations.

[1]National Association of Residential Care Facilities (NARCF), 1987 Directory of Residential Care Facilities (Richmond: NARCF, 1987).

[2]NARCF, p. 5.

In responding to the survey one agency in each of four states indicated that not all the data requested were available (three provided the number of homes only), while one agency in each of 10 states did not respond. For 9 of these 14 agencies, the association used 1986 data from another source, although data on the number of beds were not available for three agencies.

The association qualified its estimates as incomplete due to the wide variety of definitions and sizes included in licensing, as well as the fact that some states were just beginning to license some homes. Nationally, a variety of titles and a wide range of size criteria are used by the states to identify their board and care programs. From the 1985 JRB Associates[3] study of state long-term care regulations, we identified at least 39 different program titles used by the states. The most frequently used were "Residential Care," "Foster Care," "Family Care," "Boarding Homes," and "Personal Care." Also, the study[4] identified size criteria used by 65 state programs for licensing. The minimum sizes ranged from 1 to 21 residents; 26 programs had maximum size criteria ranging up to 200 residents.

In addition, a 1982 HHS Inspector General report said there is widespread confusion over the distinction between boarding homes and board and care homes. The report noted that boarding homes are residences that simply provide their residents a place to sleep and eat, while board and care facilities also offer some form of protective oversight.

During 1981 congressional hearings,[5] HHS said that estimates for the boarding home population range from 500,000 to 1.5 million. However, HHS noted that it was unclear as to how many of these residents lived in homes that should be defined as board and care. HHS added that there is little reliable information on board and care residents.

During our state visits from July 1987 to January 1988, we obtained data on the number of licensed homes and beds for each state's board and care programs, as shown in table 2.1. In four of the six states, the association data overstated the size of their programs. Based on the data

[3]JRB Associates, Profile of State Regulations of Long Term Care Health Facilities (McLean, Va: JRB Associates, 1985), HHS Contract #282-83-2114, pp. 2-8 through 2-11.

[4]JRB Associates, pp. 2-24 through 2-27.

[5]Oversight Hearing on Enforcement of the Keys Amendment before the U.S. House of Representatives, Select Committee on Aging (Washington, D.C.: U.S. Government Printing Office, 1981), Comm. Pub. No. 97-296, pp. 6 and 11.

we obtained, the six states accounted for about 25 percent of the licensed board and care homes and about 38 percent of the licensed beds that were reported in the 1987 national survey.

Table 2.1: Number of Licensed Homes and Beds in the Six States' Programs

State	Homes	Beds
California	7,804	118,481
Florida	1,450	55,000
New Jersey	462	12,903
Ohio	162	5,303
Texas	168	5,244
Virginia	404	18,081
Total	**10,450**	**215,012**

No Data on Number of Unlicensed Homes

The 1987 estimate of over 500,000 licensed board and care beds is considered an undercount of the industry primarily because of the lack of data on the number of unlicensed facilities. Some facilities remain unlicensed because state criteria exclude them from licensure requirements. Others meet a state's criteria for licensing but remain unlicensed due to lack of enforcement efforts.

No nationwide data on unlicensed homes exist. Some studies have located unlicensed homes within a limited geographic area, such as Cuyahoga County, Ohio;[6] the state of Colorado;[7] or the state of Ohio.[8] The first two studies identified unlicensed homes by using telephone directories, consulting classified ads, and talking to hospital discharge planners and social workers. Contacts by mail, telephone, or in-person interview were made to obtain relevant information for those studies.

Ohio does not have an extensive regulatory program, and the purpose of the Ohio studies was to gather demographic data about unlicensed homes. In Cuyahoga County, data were obtained for 64 homes, with an average size of about four residents, whose operators agreed to be interviewed. The second Ohio study, in which a questionnaire was mailed to

[6]Sally Reisacher, A Study of Unlicensed Board and Care Homes in Cuyahoga County (Cleveland: Boarding Home Advocacy Program, 1985).

[7]Board and Care Research Center and the Colorado Long-Term Care Ombudsman Program, The Colorado Personal Care Boarding Home Registry (Denver: Medical Care and Research Foundation, 1985).

[8]Eleanor Warner and Claire Smith, Adult Care Facilities: An Undeveloped Resource for Ohio's Elderly (Cleveland: The Northeast Ohio Family Home Care Coalition and the Boarding Home Advocacy Program, 1985).

personnel in the 88 county departments of human services, identified 822 unapproved and unlicensed "board and care" homes. Further, the respondents reported that 251 homes, or about 30 percent, were known to be providing skilled nursing care to one or more residents. Colorado's study, made before the state required board and care licensing, was undertaken primarily to develop a boarding home registry. In the state, about 200 homes were identified whose operators agreed to be listed.

Board and Care Homes Are Typically Located in Cities, Average 23 or Fewer Beds, and Are Privately Run

Several HHS-funded multistate studies have obtained information on the characteristics of board and care homes, the most recent being that published in 1983 by the Denver Research Institute.[9] Based on visits to 602 licensed and unlicensed board and care homes in California, Colorado, Florida, Massachusetts, Minnesota, Texas, and Washington, Institute researchers reported that homes for the elderly tend to be larger (with an overall mean of 23 beds and state averages ranging from about 13 to about 40 beds) than those serving the mentally ill (17 beds and ranging from about 8 to about 24 beds) and the mentally retarded (9 beds and ranging from about 7 to about 10 beds).

Moreover, about 67 percent of the homes for the mentally ill and about 57 percent of the homes for the elderly were in urban areas, while about 51 percent of those for the mentally retarded were in suburban areas. Most board and care homes for the elderly (about 77 percent) and mentally ill (73 percent) were privately (family) owned. About 50 percent of the homes for the mentally retarded were owned by nonprofit corporations, including church/charitable organizations. The providers were predominantly women. At least 45 percent of the providers in homes for the elderly and mentally ill were 50 or more years of age.

Many Board and Care Residents Have Mental Disabilities; Many Also Rely on SSI for Support

Surveys have found that the board and care population includes many residents who have physical limitations or need protective oversight, are suffering from mental disabilities, and have a limited income. The Denver Research Institute survey of 2,933 residents in licensed and unlicensed board and care homes in seven states included only facilities in which at least 50 percent of the residents were receiving SSI and which predominately served one of three categories of residents: elderly, mentally ill, or mentally retarded residents.[10]

[9]Nancy D. Dittmar and others, Board and Care for Elderly and Mentally Disabled Populations (Denver: Denver Research Institute, 1983), HHS Contract #100-79-0117.

[10]Nancy D. Dittmar and others.

This study found that many residents had previously lived in some type of institution serving the mentally ill and had a median monthly income ranging from $422 for the elderly to $568 for the mentally retarded. Few residents had regular visits from family or friends, and many needed help managing money or taking medications. (See table 2.2.)

Table 2.2: Board and Care Resident Characteristics Reported by the Denver Research Institute in 1983

	Homes serving		
Resident characteristic	**Elderly**	**Mentally ill**	**Mentally retarded**
Average age	66.5	48.8	33.5
Percent female	57.8	51.3	45.9
Percent currently married	6.1	5.3	0.3
Percent with post-high school education	16.7	18.8	0.5
Employment:			
Percent employed	9.2	17.6	74.8
Percent unemployed and not looking due to age or incapacity	76.2	55.9	10.6
Percent that previously lived in:			
Institution for mentally ill	28.1	77.9	8.9
Institution for mentally retarded	5.3	5.2	62.0
Nursing home	20.3	12.6	5.5
Percent taking psychotropic medications	34.1	75.8	29.9
Percent with physical impairments restricting activity outside home	31.0	9.8	10.2
Financial status:			
Percent on SSI	51.3	63.7	78.1
Percent on Social Security	50.8	34.7	31.2
Percent with earned income	10.7	16.0	46.1
Median income	$422	$452	$568
Family/friends:			
Percent visited by family at least once per month	39.9	27.2	33.2
Percent visited by friends at least once per month	16.5	15.7	21.3
Percent that needed assistance with:			
Cleaning their room	56.1	35.3	34.8
Managing money	46.7	47.0	87.7
Taking medicine	42.7	53.7	47.5
Bathing	26.9	10.8	22.8

These findings are consistent with the profiles of the board and care population in our state reviews. For example, in New Jersey, a 1986 statewide needs assessment of 6,675 residents who agreed to participate

in the survey (6,259 resided in board and care homes) showed that about 45 percent of the residents were on SSI, about 42 percent had a psychiatric care history, about 68 percent had a chronic illness, and about 71 percent were on medication.

In Virginia, a 1985 state-funded study[11] found that about 50 percent of the recipients of the state SSI board and care supplement had been previously hospitalized in state institutions for mentally ill and mentally retarded individuals. In New Jersey, two studies found that in Camden County,[12] 31 percent of board and care residents were placed by mental hospitals, and in Essex County,[13] about 66 percent of such residents had a history of psychiatric hospitalization.

States Have Identified Some Residents' Health Needs

Based on state needs assessments and special studies, officials report that board and care homes have experienced problems in meeting the needs of some residents.[14] The 1986 New Jersey statewide needs assessment by county welfare agencies found that about 5 percent of the 6,675 residents surveyed had medical needs that were barely met or not met at all. A 1986 California survey of operators of 1,274 residential facilities for the elderly found that 9 percent of their residents required daily assistance with personal care needs and might have had chronic health problems requiring occasional attention from health professionals.

A commonly identified need of board and care residents was mental health services. According to a 1988 study in Virginia,[15] board and care operators and staff believed that many mentally disabled residents were not receiving needed support services. These included day support, vocational rehabilitation, and outpatient therapy services.

[11]Ernst & Whinney, Final Report: Auxiliary Grants Program Study (Richmond: Ernst & Whinney, 1985), p. 14.

[12]Camden County Board of Social Services, Camden County Boarding Home Pilot Project: Progress Report (Trenton: New Jersey Department of Human Services, 1986), p. 10.

[13]Essex County Department of Citizen Services, Essex County Boarding Home Pilot Project: Progress Report (Trenton: New Jersey Department of Human Services, 1986), p. 16.

[14]Each of the six states reviewed required some type of health certificate/assessment to be prepared by a physician or nurse either just before or after admission to licensed board and care homes. All six states required various additional procedures for identifying or monitoring residents' needs in their licensed homes. For a description of these state requirements, see appendix I.

[15]Report of the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Department of Social Services on Aftercare Needs of Mentally Disabled Clients in Adult Homes (Richmond: Commonwealth of Virginia, 1988), Hse. Doc. No. 17, p. 20.

Prior Virginia studies had also noted the lack of appropriate services. The 1986 study[16] concluded that Virginia's board and care homes are generally an unsatisfactory alternative for the state-funded mentally disabled. According to licensing officials, the regulations for homes for adults do not require a minimum level of mental health care. Operators, for example, are not required to have trained staff to handle mental health needs.

New Jersey surveyed operators for demographic characteristics and services needed by and provided to their residents. This study[17] projected that about 2,200 persons, or about 45 percent of all residents in the state's residential health care facilities, needed mental health services; about 400 of these persons, or 18 percent, were not receiving needed services.

Florida has recently established 140 mental health residential treatment facilities with about 2,600 beds to provide residential care and treatment to mentally ill persons. New Jersey serves most developmentally disabled board and care residents through a separate licensing program. New Jersey has also just started a separate community residence licensing program for the mentally ill, but given the limited funding level, most of these residents will remain in the general board and care population.[18]

Funding for SSI Recipients Is a Problem

Another commonly cited problem for board and care residents, specifically those on SSI, is their low income. Recognizing that the federal SSI benefit level was not adequate to cover basic services for residents of board and care, most states have provided additional income support through state supplements.[19] Five of the six states we visited provided SSI supplements for board and care; these are available, however, only to

[16]Staff Report of the Joint Legislative Audit and Review Commission on Deinstitutionalization and Community Services (Richmond: Commonwealth of Virginia, 1986), p. 53.

[17]Gerald R. Gioglio and Ronald Jacobsen, Demographic and Service Characteristics of the Rooming Home, Boarding Home and Residential Health Care Population in New Jersey (Trenton: New Jersey Department of Human Services, 1984), pp. 16-17.

[18]At least one state has established specialized board and care homes. California asks all homes, when applying for a license, to indicate which type of resident they will serve.

[19]All but eight states have federal- or state-administered supplementation designed to pay some of the additional cost of housing in a board and care arrangement. The amount of the supplemental monthly benefits ranged from $1.70 to $634.50 in 1987.

residents of licensed homes.[20] Even with these supplements, state cost studies have identified funding shortfalls for publicly supported residents.

A 1985 study[21] by Florida's licensing agency recommended increasing the combined monthly state and federal SSI benefit from $463 to $595, the adjusted operating cost per person. Two New Jersey studies found that homes in its board and care programs lost money on residents dependent on SSI. A November 1987 study,[22] funded by the New Jersey Association of Health Care Facilities, showed that the combined federal and state SSI rate for residential health care facilities' residents fell $6.68 per day below the average cost of $21.05 per day for 55 such facilities, or a monthly shortfall of about $200. The Department of Community Affairs funded a 1986 study[23] that found the 1983 average monthly costs were $39.85 more than the total 1986 SSI benefit available to residents of 20 Class C board and care homes. These studies concluded that, as a result of these revenue shortfalls, some homes were closing and others were refusing to admit SSI recipients, resulting in a shortage of available beds.

An additional problem is caused by the limited placement of residents in state SSI supplement programs. In 1987 the Florida legislature placed a budgetary cap on the state's supplement program, which limited the number of participants to 4,997. This cap created waiting lists in several districts. Ohio pays the board and care supplement to residents of county-certified homes; however, only half of Ohio's counties have certification programs.

California provides special supplements for developmentally disabled and mentally ill board and care residents in addition to a board and care supplement. Because of budget limitations, California capped funds for

[20]Texas provided no supplements. It has, however, established two funding programs covering about 1,100 board and care residents. The state subsidizes the provision of certain board and care type services to eligible adults of licensed personal or custodial care homes and certified adult foster care homes at the rate of about $19 and $8.35 per day, respectively.

[21]Inspector General's Office of Management Review and Evaluation, ACLF Descriptive Evaluation (Tallahassee: Department of Health and Rehabilitative Services, 1985), pp. 56-57.

[22]Urban Health Institute, Residential Health Care Facilities in New Jersey: A Study of Cost and SSI Reimbursement (Roseland, N.J.: Urban Health Institute, 1987), p. 1.

[23]Dropkin and Kitrosser, CPAs, A Study of Class C Boarding Homes in New Jersey (New Brunswick, N.J.: Dropkin and Kitrosser, 1986), p. S-2.

the mentally ill supplement program in 1986. This has limited participation to between 3,300 and 4,300 clients a year, or only about 11 to 14 percent of the approximately 30,000 mentally ill board and care residents.

State Regulatory Efforts Identify Serious Problems in Board and Care Homes

States establish their own requirements regarding the type and size of board and care homes that must be licensed. States also specify what types of services must be provided. Officials in four of the six states in our review—California, Florida, New Jersey, and Virginia—believed that they have comprehensive licensing criteria and enforcement activity. Ohio and Texas, however, had made very limited attempts to identify and license their homes. Estimates of unlicensed facilities for the two states total about 3,500.

State inspections focus principally on the adequacy of the physical condition and operational aspects of board and care homes. However, states have found residents in some homes subjected to physical and sexual abuse, in need of medical care, and living in unsafe and unsanitary conditions. State inspectors have found food and medications improperly stored, lack of heat, and residents suffering from dehydration and other physical problems. In some cases, residents were found dead in board and care homes. Because none of the states visited aggregated inspection data, the magnitude of the problems is unknown. Officials believe that these problems are concentrated in homes with low-income residents, specifically those living on SSI.

Because of the problems that continue to exist even in licensed homes, serious conditions may go undetected in unlicensed homes. In Ohio, investigations of unlicensed homes found residents who were not getting enough to eat; did not have adequate clothing to keep them warm; or had large lesions, bedsores, and unattended chronic infections.

Each of the states visited reported difficulties in using available sanctions to deal with problems of substandard board and care homes. One difficulty in closing homes is the lack of alternative housing for residents.

State Licensing Requirements Vary

The operators of board and care homes are licensed by state agencies, each of which uses its own requirements for size (number of residents) and the services to be provided. Nationally, the states have a wide range of size criteria for licensing their board and care homes. The 1985 JRB Associates study[1] of state long-term care regulations determined that 65 personal and domiciliary care programs (also known as board and care) had minimum size criteria ranging from 1 to 21 residents, with the most

[1]JRB Associates, Profile of State Regulations of Long Term Care Health Facilities (McLean, Va.: JRB Associates, 1985), HHS Contract #282-83-2114, pp. 2-24 through 2-27.

frequent minimum being 1 and 3 (14 programs each). Size criteria for licensing also varied among the six states we visited, with the minimum size ranging from one to six residents.

As part of its licensing requirements, each state may specify what types of services must be provided. The 1985 study[2] found that food preparation and assistance with medication were the most frequently required protective oversight services, followed by housekeeping and laundry. The most frequently required personal care services were bathing, grooming, and dressing. In the six states in our review, the above services were generally required, as shown in table 3.1. However, New Jersey also required each resident of a licensed residential health care facility to receive at least 12 minutes per week of medical supervision and health monitoring by a registered nurse.

[2]JRB Associates, p. 2-40.

Table 3.1: Board and Care Licensing Requirements in Six States

State	Program title	Size criteria (number of residents)	Minimum services required
California	Adult Residential Facilities	One or more	Need and services plan, room and board, basic supervision, laundry, planned activities, and assistance with self-administered medication, dressing, eating, and bathing.
	Residential Facilities for the Elderly	One or more, 60 years of age or with compatible needs	Room and board, basic supervision, laundry, planned activities, transportation to meet health needs, and assistance with self-administered medication, dressing, eating, and bathing.
Florida	Adult Congregate Living Facilities	Four or more unrelated to owner[a]	Housing, food services, 24-hour protective oversight, and one or more personal services, such as assistance with self-administered medication, eating, bathing, and dressing.
New Jersey	Class C & D Boarding Homes	Two or more unrelated to owner	Food, shelter, laundry, financial services, and one or more personal care services, such as assistance with dressing, bathing, transportation to health services, and medications.
	Residential Health Care Facility	Four or more unrelated to owner	Food, shelter, laundry, one or more personal care services, such as dressing, bathing, and supervision of medications, and at least 12 minutes per resident per week of medical supervision and health monitoring by a registered nurse.
Ohio	Adult Family Homes	One to five unrelated to owner, if at least one is SSI recipient	Accommodations and personal assistance; i.e., supervision as required and help in walking, bathing, dressing, feeding, or getting in or out of bed.
	Adult Group Homes	Six to 16 unrelated to owner, if at least one is SSI recipient	Law states accommodations only; personal assistance may not be provided.
	Rest Homes	Six or more	Accommodations and personal assistance—same as Adult Family Homes.
Texas	Personal Care Homes	Four or more	Food, shelter, and one or more services of a personal care or protective nature; personal care means supervision of or assistance with routine living functions, while protective services include assistance with walking, hygiene, medication, and meals.
Virginia	Homes for Adults	Four or more, if one is unrelated to owner	Room, board, supervision, and assistance with activities of daily living—bathing, dressing, feeding, and taking medication.

[a]Facilities providing personal services to fewer than four adults are Adult Congregate Living Facilities if they advertise to or solicit the public for residents.

Texas and Ohio Have Made Little Effort to License Homes

Officials in four of the six states in our review believed that, through their comprehensive licensing criteria, enforcement efforts, or investigation of complaints concerning unlicensed homes, they had identified and licensed most of their board and care homes. Ohio and Texas officials, however, said that they have made limited attempts to identify and license board and care homes.

Texas officials reported that the state has placed a low priority on identifying and regulating unlicensed board and care homes. An industry representative in Texas noted that the Department of Health had estimated that about 20,000 unlicensed beds were serving SSI recipients. Further, a March 1988 study estimated that about 1,500 unlicensed homes were providing personal care services in Texas. A Texas state official said that the department is understaffed and underfunded, with not enough staff to inspect licensed homes frequently.

The department investigates complaints about unlicensed homes that appear to be offering personal care to the residents. If the department determines that the facility should be licensed under its Personal Care Home program, the provider has to either obtain a license, change its operations to preclude licensing, or close. According to state officials, if the home continues to operate illegally, the state has the authority to close it but rarely does.

In Ohio, regulatory responsibilities are divided between the Department of Human Services and Department of Health. Several state officials and studies have cited Ohio's regulatory environment as confusing, weak, and ambiguous, which allows homes to operate without regulatory requirements or state or local oversight. For example, the Adult Family Home program, requiring licensure of homes with one to five unrelated adults, has no licensed homes because regulations have never been approved. Officials indicated that at least 2,000 unlicensed board and care type homes may be operating in Ohio. An Ohio official said that state budgets cannot finance the cost of staff required to conduct all of the investigations needed to fully implement regulation of board and care homes.

State Inspections Focus on Physical Plant

Licensing agencies in each of the six states required an initial inspection for a license and at least one inspection as part of the annual license renewal process. Inspections focused primarily on physical plant and operational aspects of the homes, though one state included social evaluations through resident interviews.

Two states used multidisciplinary teams to conduct the inspections, while four relied on one individual. One of the latter, California, uses consultants—physicians, nurses, and dieticians—working under contract to assist evaluators with inspections on an as-needed basis. Florida has established inspection teams of a licensing specialist, a fire protection specialist, and a dietician who must inspect each licensed adult congregate living facility at least once a year. Also, New Jersey inspections of residential health care facilities include an operational inspection, done by a nurse, and a building inspection, done by a building inspector. The operational inspection covers food, sanitation, medications, and general quality of care based on interviewing at least 10 percent of the residents. The Class C and D boarding home inspections also include resident interviews in the social evaluation component. (See table 3.2.)

Table 3.2: Inspections of Board and Care Homes in Six States

State	Program	Number of homes	Number of inspectors	Comments
California	Adult Residential Facilities	4,136	51[a]	Residential care evaluators inspect physical and operational aspects and may use consultants for specialized assistance.
	Residential Facilities for the Elderly	3,668	67[a]	Each evaluator may be responsible for both Adult Residential Facilities and Residential Facilities for the Elderly or may specialize, depending on the number of homes in each district.
Florida	Adult Congregate Living Facilities	1,450	32	Inspectors include 16 licensing specialists, 8 fire protection specialists, and 8 dieticians; 1 of each is on an inspection team. Officials reported inadequate staffing to cover homes.
New Jersey	Class C & D Boarding Homes	228	[b]	Inspections consist of social and physical evaluation components, which involve two evaluators for the larger homes. Officials report no staffing difficulty; estimate average of 3 to 4 visits per year to each home.
	Residential Health Care Facilities	234	6	Inspections consist of input from both an operational and a building inspector, of which there are five and one, respectively. No reported staffing difficulty; report average of 3.75 visits per year to each home.
Ohio	Adult Family Homes	0	0	Program currently not enforced.
	Adult Group Homes	59	2	Officials report inadequate staffing to identify unlicensed homes.
	Rest Homes	103	[b]	None.
Texas	Personal Care Homes	168	[b]	Officials stated that licensing and regulating homes was not a high priority in Texas.
Virginia	Homes for Adults	404	19	Officials noted that more inspectors would allow more time to work with operators to bring them into compliance.

[a]Budgeted positions.

[b]State licensing officials did not know how many inspectors they had for their board and care programs as their inspectors are responsible for several types of homes.

Officials in all states except New Jersey and California expressed concerns about the adequacy of oversight of their board and care industry. Most reported that they limited their regulating and monitoring of board and care homes because they lacked sufficient resources and staff. Ohio officials noted, for example, that having only two licensing specialists for its Adult Group Home program was insufficient to identify and license such homes statewide.

Serious Problems Persist in Some Board and Care Homes

In the six states we visited, our review of inspection reports and information provided by and discussions with state officials showed continuing problems in the quality of care residents receive. State and industry officials and ombudsmen believe that problems are concentrated predominantly in homes with low-income residents, specifically those receiving SSI. In one state in our review, we examined inspection reports for all 55 homes in one district. We found that homes serving predominantly publicly supported residents had about twice as many violations on the average as homes serving predominantly private-pay residents.

State officials gave us examples that showed, over the past several years, board and care residents being subjected to physical and sexual abuse and lacking needed medical care. Situations also occurred that contributed to the death of board and care residents. In these instances, state officials had initiated actions against board and care operators, such as closing homes or revoking licenses. The following examples are intended to illustrate the types of situations that have occurred in some board and care homes. However, because state licensing agencies do not aggregate their inspection data, we do not know the extent to which, or the kinds of homes in which, violations may be occurring.

- In one board and care home the state licensing agency accused the administrator of instructing the staff to feed a resident bread and water only and to discontinue her medication as the resident was bedridden and "dying anyway." The resident was bleeding rectally, unable to eat, drank very little liquid, and subsequently died. At another home, operated by the same administrator, staff notified him that a resident apparently was having a heart attack, complaining of shoulder, neck, and chest pains. No medical attention was obtained, and the client died the next day. The state suspended operations at the homes.

- In another board and care home, the state licensing agency accused the operator of failing to provide adequate medical care to a resident who suffered a heart attack and multiple falls. The resident was not bathed completely for over 3 weeks and was left lying on the floor in his own feces and urine for at least 2 days. The resident was suffering from decubitus ulcers and respiratory depression and had to be transported by a paramedic to the nearest hospital. The state suspended operations at the home.
- A licensing specialist found that the operator of a well-maintained licensed board and care home had sexually abused three female residents as well as his daughter. One resident, a 21-year-old retarded woman, became pregnant and had an abortion. Residents were also struck and coerced into giving the operator's son their personal spending money. They were forced to work, and food was withheld if they did not perform their duties. Also, they were threatened with physical harm if they told visitors about the abuse at the home. The state closed the home and revoked its license.
- In another small family-run board and care home, residents were forced to work in the home and on the farm, subject to physical abuse from the operators and their daughter. Residents were punished with a cattle prod. The state closed the home and revoked its license.

Also, February 1988 hearings before a commission on board and care facilities in one of the six states we visited identified further examples that residents are physically and sexually abused and subjected to unhealthy and abusive conditions. It was noted that during a 3-month period in 1987, 357 cases of abuse were reported, of which 180 were confirmed by investigating officials. In 73 percent of the confirmed cases the abusers were employees of the board and care facilities. Also, during these hearings, it was stated that an operator of a board and care facility pleaded guilty to a manslaughter charge and was sentenced to 4 years in prison. It was alleged that the operator had locked a mentally retarded resident in a closet, and the resident had died through the operator's criminal negligence.

Safety and sanitation problems were also found during annual state inspections or in response to complaints to state officials. They varied from dirty range hoods to a full spectrum of violations concerning food storage, plumbing, laundry, and personal cleanliness. Extensive follow-ups by the inspectors are often necessary to enforce compliance. Some examples we obtained from our review of facility files, discussions with state officials, or special reports follow.

- One home had a 2-year history of violations regarding the quantity, quality, and storage of food, as well as safety violations regarding smokers sharing a room with a resident on oxygen and the lack of a bathtub grab bar and night signal system. Other violations included greasy stove and hood, flies, cockroaches, and inadequate heat. Although $750 in fines had been paid, by February 1987 the operator was advised by the state inspector to pay another $1,500 in outstanding fines to avoid being sued in small claims court. Similar violations were noted throughout 1987 with additional fines being assessed.
- Another facility had cockroaches on the kitchen shelves, chemicals stored with condiments, and refrigerated and frozen foods stored in unsanitary conditions.
- From June to December 1987 another home had continuous violations regarding trash, dirty carpet, urine odor, insufficient and improperly labeled and stored food, improperly stored and dispensed medications, water temperature too hot, dirty and inoperable stove, incomplete resident records, no personnel records, no toilet paper, flies, and no heat.

In addition, state inspections found problems concerning personal health needs and care:

- In a small board and care home, a resident, rather than a staff member, was handing out the medications, and one resident mistakenly received insulin prescribed for another resident.
- In another small home, inspectors found improperly stored medications that were easily accessible to residents and evidence that medications were not being given as ordered. One resident should have used 24 tablets from her prescription by the time of the inspector's visit but had used only 11, while another should have used 27 tablets but had used 47.
- A home operator took a resident to the hospital for a physical ailment, where it was discovered that changes in the resident's psychotropic medication, which had been improperly administered by the home's staff, had contributed to the ailment.

Because of the types of problems found in licensed homes, serious problems may exist in some unlicensed homes. In Ohio, where most homes remain unlicensed, a registered nurse with the Department of Health investigates complaints concerning unlicensed homes. She has found elderly residents in homes with insufficient fire extinguishers and nonoperating smoke alarms, nonambulatory elderly residents on the second floor and in cellars, and elderly residents so hungry that they grabbed food

off each other's plates. She stated that her efforts have led to the closing of about 30 unlicensed homes.

Additional problems that she identified in unlicensed facilities in 1985 and 1986 include elderly residents with catheters hanging loose from their bodies with drainage tubings encrusted with residue indicating a chronic infection; an elderly lady with a heart rate of 30 beats per minute, who had not seen a doctor in 3 years, lying in urine and feces in bed; elderly residents who were chilled because they were improperly attired in light tops (light hospital gowns) without underclothing; elderly residents with heads encrusted with dirt, hair matted to their heads, and greasy hair; and elderly residents with large lesions and bedsores. While the nurse's findings have caused the Department of Health to close unlicensed homes and relocate the residents, under the current system such conditions are identified only if someone complains to the health department.

States Encounter Difficulties in Imposing Sanctions Against Poor Quality Homes

All six states visited had legal authority to immediately close homes or suspend licenses when residents' safety or well-being was threatened. Three of the states—Ohio, Texas, and Virginia—had only one sanction for dealing with substandard homes; that is, denying or revoking a home's license. Officials noted that closing homes is a difficult, time-consuming process. In Virginia the license revocation process can take over a year to complete. One long-term care ombudsman stated that closing substandard or unlicensed homes is difficult because they have no place to relocate the residents.

The other three states had intermediate sanctions, such as fines or receivership, to use against substandard homes. While one California official believed that fines were a good "attention getter" with some operators, California and Florida officials generally reported that fines had not been an effective deterrent due to the difficulties and time involved in collecting them. According to Florida officials, it often took more than a year before fines could be approved and collected. Another Florida official noted that this delay negates the primary effectiveness of the fines, since the more quickly the sanction follows the inspection, the more effective it is. In addition, an industry official noted that paying fines may prevent board and care operators from making needed improvements to the homes.

In commenting on our report, a New Jersey official said that in addition to its authority to place deficient homes in receivership, New Jersey has

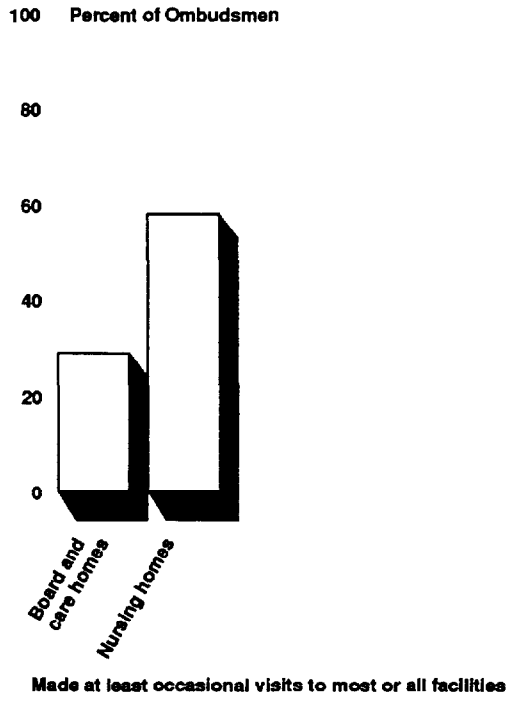
other enforcement approaches, such as filing disorderly persons complaints in municipal courts against repetitious and recalcitrant owners and operators. He said the state has sought and obtained criminal indictments as well as temporary and permanent injunctions, jailed two owners for violating permanent injunctions, and caused the demolition of an unsafe facility that they kept closing and the owner kept illegally reopening.

Limited Ombudsman Efforts Regarding Board and Care

In addition to their regulatory programs, the states operate ombudsman programs established under the Older Americans Act of 1965 (OAA) that have varying degrees of oversight over board and care homes. State ombudsmen are to investigate and resolve complaints and use the information they collect to advise public policymakers of industry conditions and needed changes in laws or regulations. In 1981, the Congress expanded the ombudsman program to include responding to complaints of residents of board and care homes, in addition to nursing homes. However, HHS stated that no additional funds were provided for these added responsibilities.

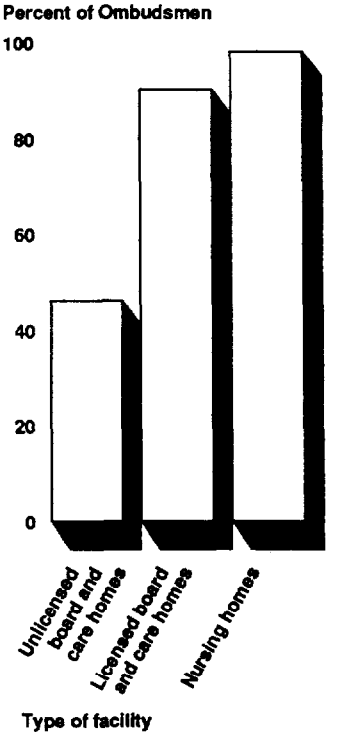
In 1987, the American Association of Retired Persons, in cooperation with the National Association of State Units on Aging, the Senate Special Committee on Aging, and others, surveyed all state ombudsmen. Preliminary results, based on responses from 48 of the 54 ombudsmen, indicated that most state ombudsmen believed it was just as important to visit board and care homes as nursing homes. However, about half believed that they had not been successful in maintaining a presence in those homes. As figure 3.1 shows, twice as many ombudsmen reported visiting nursing homes as compared to board and care homes.

Figure 3.1: Ombudsman Visits to Homes
(Fiscal Year 1986)



Moreover, less than half the ombudsmen reported having jurisdiction over unlicensed board and care homes (see fig. 3.2).

Figure 3.2: Ombudsman Jurisdictions
(As of February 1987)



Among the six states in our review, ombudsman activities and legal authority concerning board and care homes varied greatly. (See table 3.3.)

Table 3.3: Characteristics of Six State Ombudsman Programs

Characteristics	CA	FL	NJ	OH	TX	VA
Does ombudsman have legal authority to enter:						
Licensed board and care homes?	Yes	Yes	Yes	No	Yes	Yes
Unlicensed board and care homes?	Yes	Yes[a]	Yes	No	No	No
Does ombudsman respond to board and care complaints?	Yes	Yes	Yes	Yes	No	Yes
Does ombudsman have a toll-free hotline?	Yes	No	Yes	Yes	No	Yes
Total number of ombudsman staff:						
Paid	103	15	13	44	45	4
Volunteer	620	192	0	194	550	19

[a]With warrant or permission from owner.

HHS's Role in Board and Care Has Been Minimal

HHS's role in overseeing the board and care industry is extremely limited. HHS commits minimal effort to assuring that states have sent in their annual certifications as required by the Keys Amendment. These submissions certify that states have established standards for all board and care homes that have or are likely to have SSI recipients and that states are otherwise in compliance with the Keys Amendment. Under this procedure, both Texas and Ohio have certified their compliance with Keys even though state officials acknowledged that they may have thousands of unlicensed and unregulated homes and that many of these homes are likely to have SSI recipients.

The implementing regulations of the Keys Amendment require states to periodically inspect and report deficient board and care homes to the Social Security Administration so that the agency can reduce SSI benefits of any recipient living in such homes. Because this provision penalizes the recipient for the facility's failings, states have little incentive to report board and care violations to SSA. Our survey of the 10 SSA regional offices disclosed that only four states currently submit reports. States contacted by two SSA regional offices claim to have no "noncomplying facilities."

HHS has limited oversight responsibilities under Keys. HHS's concerns about the limitations of federal authority and the weakness of the amendment were noted at a 1981 congressional oversight hearing on board and care. HHS officials promised, at this hearing, to find a way to make Keys more effective and to develop legislative recommendations to accomplish this. However, HHS has not developed legislative proposals to revise Keys.

The Keys Amendment: HHS's Role in Board and Care Oversight Is Limited

The federal role and oversight of the board and care industry has primarily focused on the Keys Amendment. This amendment required states to

- establish, maintain, and enforce standards[1] for any category of institutions, foster homes, or group living arrangements in which a significant number of SSI recipients reside or are likely to reside;
- make the standards available for public review; and
- certify annually, to the Secretary of HHS, that they have complied with all of the amendment's requirements.

[1]Covering such matters as admission policies, sanitation, safety, and protection of civil rights.

The states are required by regulation to submit their annual compliance certifications and summaries of their initial board and care standards and any subsequent changes to the Assistant Secretary of Human Development Services. In addition, they are required to report to SSA all substandard board and care homes so that the agency can reduce the federal SSI payments by the amount of the state supplement paid to SSI recipients for "medical or remedial care."[2]

HHS Review of States' Compliance With Keys

During a 1981 congressional hearing on HHS's oversight of board and care, the HHS Undersecretary stated that "the primary responsibility for licensing rests with the States" and added

> ". . . there is really little that we can do to directly monitor their actions as to the extent to which the facilities conform to their requirements, or in fact, to sanction the States if in our judgement the reports are inadequate."[3]

Implementing regulations directed states to submit annual certifications and publish summaries of standards in the Annual Services Plan for the title XX social services grant program. However, the regulations did not provide for withholding funds from noncomplying states. Moreover, in 1981, the Congress converted title XX to a block grant program and amended Keys to remove any references to title XX.

HHS then attempted to resolve the issue by directing the Administration on Aging (AoA) to receive Keys certifications and tie them to OAA funds, but this proposal was opposed by members of the Congress, the aging community, and AoA. They feared that all senior citizens benefiting from OAA programs would suffer for the failures of a state licensing agency that probably had no connection to aging programs. Ultimately, HHS issued new regulations directing states to send their certifications and summaries of standards to the Office of Human Development Services (OHDS). Neither implementing regulations nor the Keys Amendment tied state certifications to any federal funds.

[2]By regulation, "medical or remedial care" means care directed toward the correction or improvement of a medical condition that has been diagnosed as such by a licensed medical practitioner and the care is provided by or under the direct supervision of a medical practitioner or other licensed health professional.

[3]Oversight Hearing on Enforcement of the Keys Amendment Before the U.S. House of Representatives, Select Committee on Aging (Washington, D.C.: U.S. Government Printing Office, 1981), Comm. Pub. No. 97-296, p. 18.

Currently, the Office of Policy, Planning, and Legislation (OPPL) in OHDS commits one-eighth of one person's time to reviewing state certifications and summaries of standards. As part of its review, OPPL checks state certifications for language confirming that states have set and are enforcing standards and for the appropriate state official's signature. OPPL sends an annual memo to state officials reminding them of the Keys requirements and follows up with states that have not responded.

In 1978, HHS issued regulations that specified procedures states must have for enforcing standards, as well as areas that standards must cover. However, OPPL does not rigorously examine the state submissions for any of these items, verify state claims on enforcement efforts, or solicit data on the number of inspections or actions taken. Ohio and Texas have certified their compliance with Keys even though officials of these states told us that as many as 3,500 homes may be unregulated and not following state standards. A Texas official acknowledged that it is likely that many SSI recipients are in their unregulated homes.

HHS Objected to Penalty Provision

The implementing regulations of the Keys Amendment require states to report deficient board and care homes to SSA so that it can reduce SSI benefits of any recipient living in such homes. The Congress[4] did not want SSI to become a source of funding for deficient homes. Specifically, SSA is to reduce the benefit by the amount of any state supplement for medical or remedial care.

At the 1981 hearing,[5] the HHS Undersecretary cited problems with the penalty provision stating that "penalizing a recipient for the failings of a facility seems not only inequitable, but also inadequate as a corrective measure." Further, he added that "clearly, States have no incentive to report such [board and care home] violations and [SSI supplement] payments to the Social Security Administration, and do not do so."

To invoke the penalty, SSA needs the states to report which homes are substandard. According to our survey of the 10 SSA regional offices, only eight states have either reported substandard homes or that they were closing such homes; only four currently submit such reports. About 300 homes have been reported as being substandard or being closed, all but a

[4]Unemployment Compensation Amendments of 1976 (Public Law 94-566) (Washington, D.C.: U.S. Government Printing Office, 1976), U.S. Senate Committee on Finance, Report No. 94-1265 to accompany H.R. 10210, p. 29.

[5]Oversight Hearing, p. 24.

few by one state. Two SSA regional offices have made contact with states to follow up on the reporting requirement. They found that most states claim to have no "noncomplying facilities."

To invoke the penalty, SSA also needs to determine which state SSI supplements reimburse medical and remedial care. For eight states that do not supplement SSI, SSA can not apply the penalty provisions. During the 1981 hearing, the Undersecretary stated that "generally boarding homes do not provide medical or remedial care, and State supplemental payments are not paid on that basis."[6] HHS advised us that reductions in SSI payments by an amount equal to any state supplementary payment for medical or remedial care are not possible.

"Completed" Eight-Point Program Left HHS Efforts Unchanged

In spite of HHS reservations about the Keys Amendment, the Undersecretary assured the Committee at the 1981 hearing that HHS did not support its repeal. Instead HHS officials agreed to find a way to make the amendment more effective, including the development of legislative recommendations. HHS has not questioned the part of the Keys Amendment that permits SSI payments to residents of public facilities with 16 or fewer residents.

The Undersecretary promised that HHS would begin to address the problems with Keys and federal oversight of board and care with a study by the Inspector General, which was issued in April 1982. Based on recommendations in this study, the Secretary developed an eight-point plan to strengthen the Department's board and care efforts. However, an OHDS policy director informed us that the promised legislative proposals never materialized.

HHS's eight-point program had three major purposes:

- To improve coordination of HHS board and care policy and activity.
- To improve HHS Keys enforcement efforts.
- To undertake efforts in technical assistance, including research and an information clearinghouse.

HHS Coordination Unit Temporary

To improve coordination, HHS established a Board and Care Coordination Unit to address the fragmentation within HHS and serve as a focal point for board and care efforts. During the 1981 hearing, the Undersecretary

[6]Oversight Hearing, p. 24.

noted that at least four HHS entities were directly involved in board and care—SSA, OHDS, the Office of Planning and Evaluation, and the Health Care Financing Administration (HCFA).

Several agencies detailed staff to the Board and Care Coordination Unit, which held meetings to report progress on the eight points. SSA, AoA, and HCFA were individually responsible for addressing Keys enforcement efforts. Members of the unit also coordinated the technical assistance efforts discussed later. HHS has since phased out the coordination unit, providing no staff or budget for it.

Keys Enforcement Not Improved

HHS also initiated efforts to tie Keys certifications to the HCFA "waiver" and "representative payees" programs. However, neither have helped to improve Keys enforcement. Established in 1981, the HCFA waiver program for home and community-based services permits states to use Medicaid funds to provide long-term care services to Medicaid beneficiaries who would otherwise have to be in nursing homes. The HHS Secretary directed that in applying for waiver programs, states must certify that facilities receiving such services meet state Keys standards. As of June 1988, HCFA had approved 119 waiver programs in 46 states. However, HCFA officials could not say how many of these waivers provide services to board and care residents.

SSA appoints representative payees to manage social security, as well as SSI, benefit checks when the beneficiaries are not competent to do so because of either mental or physical incapacity. Under this expanded enforcement effort, only operators in compliance with Keys could serve as payees. However, SSA implemented a policy that allowed noncomplying operators to serve as payees if an alternative payee cannot be found because it needs payees to help manage beneficiaries' funds. An SSA official recalled that several years ago SSA checked its computer files and found only one such payee who operated a substandard home. However, SSA relies on states to report substandard homes; without such reports, its policy is to assume that homes comply with state standards.

HHS Has Ended Technical Assistance Efforts

To improve regulation of resident care, HHS provided technical assistance to states and board and care homes. In 1983, the Office of the Assistant Secretary for Planning and Evaluation provided $150,000 to add board and care issues to the Project Share clearinghouse, which it had previously established to cover a wide range of human services issues. Project Share also administered OHDS contracts to develop two

"how-to" manuals discussing best practices, one on fire safety and the other on training operators. Funds are no longer provided to Project Share for board and care activities.

Through Project Share, OHDS also publicized model state legislation and fire safety standards developed by the American Bar Association and National Bureau of Standards, respectively. However, HHS has neither determined if states have used these studies nor measured the costs of enforcing and complying with these model standards. HHS officials explained that they considered their job completed when they distributed the studies.

AoA Has Small Role in Ombudsman Program

AoA administers funding for the state-run long-term-care ombudsmen programs, which were expanded in 1981 to include residents of board and care homes, as well as nursing homes. An AoA official told us that the agency leaves states as much discretion as possible in determining the extent of their ombudsmen's board and care efforts. Further, AoA has not attempted to summarize data on the extent of such efforts. In the OAA Amendments of 1987 the Congress directed AoA to study the impact of the ombudsman program on residents in board and care homes and report by December 31, 1989.

Conclusions, Recommendations, and Agency Comments

Currently, little is known about board and care homes. For example, the total number of board and care homes operating in the United States is unknown. Accurate data on the number of such homes have not been compiled because of the lack of a uniform definition of board and care as well as states' different size criteria for licensing board and care homes. A 1987 industry association survey of state licensing agencies identified about 41,000 licensed board and care homes with about 563,000 beds serving the elderly, mentally ill, and mentally retarded. However, the association qualified its estimates as incomplete due to the wide variety of board and care definitions and the fact that some states were just beginning to license board and care homes. HHS has indicated that there is widespread confusion over the distinction between board and care homes and boarding homes, which have an estimated population of 500,000 to 1.5 million.

While national data are lacking, state surveys have shown that the board and care industry serves many individuals who have physical limitations, have previously lived in an institution due to a mental disability, are unlikely to have friends or relatives visit them, and have low incomes. Because so many of these individuals are alone, they have no one to look out for their interests if they are mistreated, abused, or receiving poor quality care in a home.

Because of the vulnerability of the population served by the board and care industry, state regulations and oversight activities to assure that residents receive at least a minimal level of care are critical. However, two of the six states we reviewed had a significant number of board and care homes that were not regulated by the state. Therefore, little is known about the board and care population or the extent and seriousness of problems in those homes.

Inspections of licensed homes in some states have identified serious problems in some homes. Situations identified by state licensing agencies showed a wide range of problems, including physical abuse, unsanitary conditions, and the lack of medical attention to meet the residents' needs. Situations have also occurred that have contributed to the death of board and care residents. However, data are lacking on the extent and magnitude of such problems.

HHS has stated that states have the basic responsibility for regulating board and care homes. Because its oversight of board and care has been minimal, HHS has no assurances that the objectives of the Keys Amendment and implementing regulations are being achieved. States annually

certify to HHS such compliance, but HHS does not know if states are enforcing standards or have licensed and are inspecting all homes. Texas and Ohio, for example, have estimated that they have about 3,500 unlicensed homes, yet they certify to HHS that they are in compliance. Both states cite the lack of resources as reasons for not licensing all homes.

Although HHS funded the development of model standards over 5 years ago, it has not determined if states have adopted such standards. Such an assessment could provide useful information on the necessity and feasibility of establishing minimum national standards for board and care homes.

In addition, few states report deficient board and care homes to HHS. HHS had indicated that such reporting would not be beneficial because (1) the penalty provisions of the Keys Amendment are not enforceable and (2) reducing the benefits of SSI recipients is not an appropriate way to enforce state standards since this penalizes the residents for the homes' failures. State officials believe, however, that closing deficient homes, except in life-threatening situations, is not always feasible. This is because alternative housing for residents is often not available given the low incomes of many residents.

We believe it is important that HHS have information on the number of homes not in compliance with the Keys Amendment and the types of deficiencies noted. Such information would enable HHS to inform the Congress of the seriousness and extent of problems occurring in board and care homes. HHS has recognized the need for nationally representative data on board and care homes and their residents, stating that such a need will become more critical as the American population continues to age.

In summary, a number of important questions remain unanswered about board and care programs. These include:

- How many licensed and unlicensed board and care homes are operating throughout the country?
- What are the needs of and the quality of care provided to SSI board and care residents?
- How many board and care homes are not providing adequate care to residents?
- Should the federal government develop minimum standards for board and care homes?

- Are additional resources needed at the federal and state levels to help ensure quality care to residents?
- What should be the federal role in board and care?

Answers to these questions would enable HHS and the Congress to begin developing solutions to help ensure the effective implementation of board and care programs.

Recommendations

In view of the problems identified in our review of oversight of board and care in six states, coupled with the size and vulnerability of the resident population, we recommend that the Congress direct HHS to

- conduct a comprehensive assessment of states' oversight activities for their board and care population. This assessment should determine the adequacy of (1) licensing and regulatory requirements, (2) resources committed to their enforcement, and (3) efforts to identify whether residents' needs are being met.
- report to the Congress findings and, if appropriate, recommendations as to (1) subsequent steps needed to assure the protection of board and care residents and (2) changes needed to the Keys Amendment to make it more effective.

Agency and Other Comments

HHS said that the report provides a good overview of the board and care industry. HHS did not, however, agree with our recommendation, noting that we did not link the quality-of-care problems discussed in our report to the presence or absence of regulatory requirements. HHS offered an alternative strategy for addressing the concerns noted in the report. HHS stated it should conduct an assessment of the health and safety conditions and quality of care in a sample of licensed and unlicensed homes in a variety of regulatory climates. If the study documents a relationship between the conditions and care available to residents and the presence of specific regulations, HHS said it would recommend specific strategies to assure the protection of board and care residents as appropriate. HHS said that, if such a relationship cannot be established, its proposed study should be able to point to the variables that do seem to be related to quality so that they can be further pursued. (See app. II.)

HHS also recognized the long-term need for nationally representative information on board and care homes and their residents, which it believes will become more critical over time as the overall aging of the American population continues. HHS noted that alternative approaches

to obtaining such information are being discussed within the Department.

Since the states have major responsibility for board and care homes, state oversight is critical. We believe that the HHS alternative strategy will be useful if state oversight activities, such as resources committed, licensing requirements, and resident needs, are included in the study of board and care homes. An assessment that does not address these issues will not be sufficient. As noted in our report, states are establishing their own requirements regarding the types and size of board and care homes that must be licensed and the services that must be provided. In some states the majority of board and care homes remained unlicensed in accordance with state regulations. As a result, regulatory protections afforded board and care residents can vary significantly. Further, it is the extent of enforcement, which requires a commitment of resources, that brings home operators into compliance with regulations.

All six states we visited said they agreed with the report's contents. Four state licensing agencies provided written comments on the report. (See app. III.)

The Virginia Department of Social Services commended our study and supported the report's recommendations. The department identified areas where federal assistance would be useful in dealing with short-term board and care issues. These included (1) funding for the development and enforcement of board and care regulations; (2) funding for training, technical assistance, and consumer education of board and care operators and staff; and (3) an HHS technical assistance component to help states with their regulatory efforts. The department noted that many of the problems that regulatory agencies face are related to insufficient funding for the care board and care residents need, which cannot be addressed without more extensive study.

The Ohio Department of Human Services said there are significant problems in providing appropriate housing for the low-income elderly. The department said that (1) if the states are to fully implement the provisions of the Keys Amendment, federal financial assistance is essential; (2) there are literally thousands of board and care homes in several states that appear to be unlicensed or unregulated; and (3) state budgets cannot finance the cost of staff required to conduct all of the investigations that are necessary to fully implement regulation of these facilities.

We did not assess the impact of additional federal funding for state regulatory efforts. Therefore, we are not in a position to comment on the state's proposals for additional federal funding.

Technical comments provided by HHS and the states to clarify agency responsibilities and regulations were incorporated where appropriate.

Description of States' Requirements for Assessing Resident Needs

In Florida, administrators or home operators must determine whether needs can be appropriately met in their homes based on an initial medical examination performed by a physician or nurse practitioner. Further, 1987 legislation allows board and care homes to provide "limited nursing services" upon obtaining a special license requiring resident assessments by a state-employed registered nurse three times a year.

The Ohio Rest Homes program requires semiannual physician examinations of residents. The Texas Personal Care Homes program requires an initial health screening of residents and annual follow-up by a physician or registered nurse. The Virginia Homes for Adults program requires operators to assess resident needs upon admission and at least annually thereafter. Virginia is also developing a uniform needs assessment tool, which it plans to integrate into an interagency information system covering a variety of residents and social service programs.

California requires its residential facilities for the elderly to determine an applicant's compatability with other residents upon admission, as well as to keep an up-to-date needs appraisal. The state also requires its adult residential facilities to maintain up-to-date care plans showing how they will meet resident needs, as well as what those needs are, and county or regional agencies provide case management and conduct quarterly needs assessments for residents covered by its supplemental services programs, which cover all developmentally disabled and about 14 percent of mentally ill residents.

In 1986, New Jersey's county welfare agencies completed a one-time needs assessment for board and care residents. Currently, the local agencies must conduct needs assessments on new residents only, though officials regularly visit most homes and must review each home twice a year. In addition, they provide information and referral to help residents obtain needed services.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

NOV 30 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Board and Care: Limited Assurance That Residents' Needs Are Being Met." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of Department of Health and Human Services on the General Accounting Office Draft Report, "Board and Care: Limited Assurance That Residents' Needs Are Being Met"

Overall, the Department finds the report to be thoughtfully prepared and to provide a good general review of developments in the board and care area.

GAO Recommendation

The General Accounting Office (GAO) recommends that the Congress direct the Department of Health and Human Services to:

> "conduct a comprehensive assessment of state's oversight activities for their board and care population. This assessment should determine the adequacy of (1) licensing and regulatory requirements, (2) resources committed to their enforcement, and (3) efforts to identify whether residents' needs are being met."
>
> "report to the Congress findings and, if appropriate, recommendations as to (1) subsequent steps needed to assure the protection of board and care residents; and (2) changes needed to the Keys Amendment to make it more effective."

Departmental Comment

The Department does not concur with this recommendation as currently stated. The GAO report has documented instances of residents living in unsafe and unsanitary conditions without appropriate care. However, it does not link the incidence of these conditions to the presence or absence of particular regulatory requirements. In fact, the GAO report points out the difficulties in ascertaining the extent of problems in board and care homes and the role of regulation in mitigating them.

HHS recommends an alternative strategy for addressing the very real concerns stated in the GAO report.

(1) The Department should conduct an assessment of the health and safety conditions and quality of care in a sample of licensed and unlicensed homes in a variety of regulatory climates.

(2) If this study is able to document a relationship between the living conditions and care available to board and care residents and the presence of specific regulatory requirements, the Department would recommend specific strategies for assuring the protection of board and care residents as appropriate.

(3) If such a link cannot be established, this study should also be able to point to the variables which do seem to be related to quality so that they can be further pursued.

The Department also recognizes a longer-term need for nationally representative information on board and care homes and their residents which is available on a regular basis. This need will become more critical over time as the overall aging of the American population continues. Alternative approaches to obtaining such information are now being discussed within the Department.

Comments From State Licensing Agencies

STATE OF NEW JERSEY

THOMAS H. KEAN
GOVERNOR

DEPARTMENT OF COMMUNITY AFFAIRS
DIVISION OF HOUSING AND DEVELOPMENT
WILLIAM ASHBY COMMUNITY AFFAIRS BUILDING
101 SOUTH BROAD STREET – CN 802
TRENTON, N. J. 08625-0802

ANTHONY M. VILLANE JR., D.D.S.
COMMISSIONER

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General Accounting Office
441 "G" Street, NW
Room 6858- HRD
Washington, DC 20548

Dear Mr. Thompson:

Thank you for the opportunity to review the draft of the GAO report on board and care issues and to offer these comments.

We would like to commend your organization for undertaking such a worthy endeavor. The board and care industry provides a very necessary service in this aging society, and for too long, it has been expected to do so on skimpy resources and with little or no national attention. From our perspective, we did not uncover any misstatements or factual errors in the report. However, we do believe that there have been serious omissions regarding sanctions, remedies and enforcement approaches that have been utilized in our enforcement of the Rooming and Boarding House Act of 1979, that warranted mention in the report since it seems that other states are seeking effective enforcement remedies.

Since October of 1980, the New Jersey Department of Community Affairs, Division of Housing and Development, Bureau of Rooming and Boarding House Standards, has enforced the Rooming and Boarding House Act of 1979 and the Regulations which govern these standards.

Over the last eight years, over 212 rooming and boarding homes have been closed by the Bureau and over 1700 residents have been relocated to safer and more secure facilities. Sixty-three (63) of these facilities were closed as a result of an inspection which revealed conditions which presented a clear and imminent danger to the health and safety of the residents. These facilities were closed within 48 hours after these conditions were discovered and in each case, the residents were relocated either to other boarding homes, or to hospitals or nursing homes depending upon the resident's needs. These actions were taken despite the contention that there were no places to

put these residents. In over 150 cases, the Bureau has denied or revoked licenses of operators and/or owners of rooming and boarding homes for a myriad of justifiable reasons.

There are other examples of innovative enforcement approaches used in New Jersey. For instance, New Jersey has filed disorderly persons complaints in municipal courts against repetitious and recalcitrant owners and operators; we have sought and obtained criminal indictments, temporary and permanent injunctions, and two owners have served time in jail because they had violated a permanent injunction. On one occasion, the Bureau successfully caused the demolition of an unsafe facility that the Bureau kept closing down and the owner kept illegally re-opening.

Vigorous enforcement of the law against undesirable owners and operators places a tremendous strain upon the support systems that are designed to assist the deinstitutionalized who live in these homes to integrate into the community. But, New Jersey has demonstrated that if the commitment is there inters of resources and priorities, then these residents can be housed in safer and more decent boarding and rooming homes.

We believe that the above comments should be included in your final report and they are being offered for your consideration.

Sincerely,

William M. Connolly AIA
Director

3361H

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HEALTH FACILITIES EVALUATION
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MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER

October 21, 1988

Lawrence H. Thompson
Assistant Comptroller General
The United States General
Accounting Office
Washington, DC 20548

Dear Mr. Thompson:

I have reviewed your draft report of which 1 copy is being returned to you.

The report appears to accurately describe the board and care operation in New Jersey and probably nationwide.

Some of our specific comments are listed below:

1. The licensing requirements for residential health care facilities in New Jersey require medical supervision, as well as health monitoring by a nurse. I am not responding on behalf of other board and care facilities operated, or licensed by other New Jersey agencies. We agree that additional time for monitoring the health needs of residents is required.

2. We have long range plans to establish a deficiency profile for residential health care facilities.

3. We are seeing a contraction of the number of beds in New Jersey through voluntary closure and revocation actions this year.

Feel free to contact me if additional information is required.

Sincerely,

Solomon Goldberg

Solomon Goldberg, D.D.S.
Director
Licensing, Certification
and Standards

SG/dv
Enclosure

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COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

October 26, 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

The Virginia Department of Social Services commends the General Accounting Office for its Draft Report on Board and Care. The Department supports the report's recommendation for further study of this issue and offers its full participation and cooperation.

In response to your request for comments and because the time factor associated with the proposed study will delay long range recommendations the Department has identified additional recommendations for interim improvements. The ideas which follow were selected because they would require relatively modest assistance in relation to the potential benefits to residents of Board and Care facilities.

1. Development of Regulations
The study indicated that the states are experiencing some problems with either the quality or the lack of licensing standards. Direct funding assistance provided for up to two years could help states to rectify these problems. States without a proper statutory base could be offered an additional year to establish that base before undertaking the development of regulations. This objective could possibly be achieved by providing the states with the equivalent of two additional staff persons plus a modest allowance for incidental expenses.

2. Enforcement of Regulations
Ongoing assistance on a matching formula for states to expand their enforcement staffing if it is inadequate or to add special expertise to regulatory programs (e.g.

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consulting staff with a background in medical care, dietetics, etc.), would also increase resident protection.

3. Provider and Consumer Training
Provider training, technical assistance and consumer education are important keys to quality service in Board and Care facilities. It is well established that many operators and direct care staff are poorly prepared to provide adequate care despite good intentions. Turnover among direct care staff increases the importance of assisting homes to meet their training needs. Direct funding to all states performing licensure could encourage them to develop programs to address this need.

4. Federal Technical Assistance to States
The Department of Health and Human Services could also establish a small technical assistance component (two to four well qualified persons) to help states with their regulatory efforts. This would especially be useful for: technology transfer; regulatory program assessment/consultation; and, research /recommendations on specific issues which need to be addressed in regulations--- as opposed to trying to develop an entire set of model regulations. Examples of such specific issues where the proposed component could provide guidance in rule-making include: staff qualifications or training; staff ratios for particular population groups; space requirements; building code requirements; types of persons inappropriate for board and care homes or special protections that should be in place if persons with such conditions are to be admitted or retained, etc.

The Virginia Department of Social Services recognizes that many of the problems regulatory agencies currently face are directly related to insufficient funding for the nature and extent of care many Board and Care residents need. The Department also understands that this root cause probably cannot be addressed without more extensive study.

While we support long range improvements based on a more comprehensive study, we do encourage you to consider short term strategies that would, in the meantime, allow for substantial

progress in providing quality care and much needed protection to those individuals residing in Board and Care facilities.

Cordially,

Larry D. Jackson
Commissioner

/cwl

cc: Carolynne Stevens

Richard F. Celeste
Governor

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

December 13, 1988

Lawrence Thompson
Assistant Comptroller General
United States General Accounting
Washington, DC 20548

ATTENTION: HUMAN RESOURCES DIVISION

Dear Mr. Thompson:

Thank you for your letter of October 7, 1988 in which you forwarded copies of the General Accounting Office report on board and care homes. I do appreciate the opportunity to review the report and submit comments for your consideration.

Over the past several years the board and care industry in the state of Ohio has undergone great scrutiny from several departments of the state as well as various advocacy groups throughout the state. There is no question that in Ohio, as well as the rest of the country, there are significant problems in the provision of appropriate housing to low income elderly. Legislation was enacted in the state of Ohio in 1980 requiring the licensure of various categories of board and care homes by the Ohio Department of Human Services. Part of that legislation was temporarily suspended until 1983, however, as resources within the state budget have prohibited the department from fully implementing all the requirements of that statute.

During this past year, legislation was introduced in the Ohio House of Representatives which, if enacted, would greatly alter the adult system in our state. Soon, however, our legislature will adjourn the current session, and this legislation is not expected to pass out of committee. We fully expect the legislation will be revised and reintroduced in January when the next legislative session begins.

From a technical aspect, the data contained within your report appears to be accurate with respect to the state of Ohio. My only comment with respect to your recommendations would be that if the states are to fully implement the provisions of the Keys Amendment, federal financial assistance is essential. As your report indicates, there are literally thousands of these homes in several states which appear to be unlicensed or unregulated. State budgets cannot finance the cost of staff required to conduct all of the investigations which are necessary to fully implement regulation of these facilities.

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Lawrence Thompson
Page 2

Again, thank you for the opportunity to respond to this report and I look forward to hearing from you in the future.

Sincerely,

PATRICIA BARRY
Director

PB:hc

Major Contributors to This Report

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