STATE OF CALIFORNIA EDMUND G. BROWN JR., *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY
11th & L BUILDING, SUITE 550, (916) 445-2125
SACRAMENTO 95814

SUPPLEMENTAL REPORT

ON THE STATE

DEVELOPMENTAL DISABILITIES PROGRAM

STATE OF

CALIFORNIA

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December 1977

Honorable Edmund G. Brown Jr.
Governor, State of California

Honorable James R. Mills
President pro Tempore, and to Members of the Senate

Honorable Leo T. McCarthy
Speaker, and to Members of the Assembly

In January 1976, this Commission issued a comprehensive report entitled, "A Study of the Administration of State Health Programs." Two chapters dealt with state programs for developmental disabilities (DD) and offered specific recommendations for improving the sadly deficient and wasteful programs.

Now, almost two years later, the situation has been improved very little. In fact, the deficiencies in programs, staffing and facilities have persisted so long that the Department of Health's Licensing and Certification Division has taken action against its sister program by rescinding the certification for four state hospitals to be eligible for federal funding. Similar decertification is threatened against the other five state hospitals receiving that category of funding.

Up to $60 million a year in federal monies is thus in jeopardy, all because the current and immediate past administrations have failed to take action to comply with the very specific recommendations of this Commission, a Senate Select Committee and other concerned parties. The tragedy of this irresponsibility is that its victims are among the Californians who are least able to help themselves.

Hardly a day passes when the headlines don't include another situation which causes this Commission deep concern. Among the most recent is in Los Angeles County, where the Board of Supervisors threatened to sue the state to secure adequate services at Metropolitan State Hospital. Although this facility does not serve DD patients, who are the subject of this supplemental report, the situation there illustrates the shameful chaos which permeates the state health delivery system, and which this Commission has sought for so long to eliminate.

This Commission finds the present status of the state hospital system in general and the DD program in particular to be a disgrace. These deplorable conditions persist despite continuing assurances by the Department of Health that the problem areas are being corrected and the programs are being improved to a level which Californians can find acceptable.

It seems inconceivable to us that these tragic situations continue to exist. We strongly urge a greater intensity of action by both the Administration and the Legislature to solve these problems. Among the conclusions commencing on Page 25 of this report, the Commission repeatedly recommends the following:

1. State hospital physical plant safety should be brought into compliance with licensing and accreditation standards.

2. Without delay, improved staffing standards should be implemented in all state hospital programs to assure proper care of patients and to maximize their ability to return to their communities for residential or home care, supplemented by services which provide for medical, social and vocational rehabilitation.

3. The state should strengthen its commitment to investment in an adequately funded system of community facilities and services, to reduce to a minimum the need for institutional care and to speed the process of normalization of patients suffering developmental disabilities.

This Commission must re-emphasize its commitment to implementation of our January 1976 recommendations on enhancing the DD program's effectiveness, as well as all recommendations for upgrading the state hospital system as a whole. As we have said before, this Commission will not relax its efforts until the level of care in the state's health delivery system meets the standards expected in a society which calls itself civilized.

This is the Commission's fourth and final supplemental report in the current series dealing with state health programs. The first report dealt with licensing and certification activities, the second with state hospitals, and the third with administration of the MediCal program. The Commission intends to conduct a further review in the Fall of 1978 to evaluate what further progress has been made by them and the effect of the upcoming reorganization of state health agencies under Senate Bill 363. As usual, public hearings will be held to determine whether meaningful reforms have been undertaken in this most crucial of state services.

Respectfully,

NATHAN SHAPELL
Chairman

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SUPPLEMENTARY REPORT ON

STATE PROGRAM FOR DEVELOPMENTAL DISABILITIES

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I. Summary of January 1976 Findings and Recommendations.*

The operations of the regional centers which serve developmentally disabled (DD) clients are not adequately supervised by the DOH, whose staff is too small to fulfill this function properly. The legal status of regional centers as private corporations contributes to lack of administrative control of fiscal transactions; inconsistent personnel practices and lack of affirmative action programs; a wide diversity of program standards, and priorities; lack of uniform reports of service statistics; deficient management of contracts; and lack of effective outreach to low-income and minority clients.

As a result, regional center operations are marred by misuse of funds, mismanagement and conflict of interest in contract services, fraud by vendors, abuse of patient rights, excessively high salaries, financial exploitation by physicians, and unfair hiring practices.

Conflicts and disagreements over service priorities have developed due to failure of the DOH to provide a clear statement of goals, objectives, priorities, and standards for the operations of regional centers. Regional centers vary widely in priorities for services to clients. Evaluation of programs and audits of fiscal practices by the state are severely deficient. Gaps in

*
Report available by writing Department of General Services Publications, P.O. Box 1015, North Highlands, CA 95660. Enclose check or money order for $6.00 payable to "State of California, Document Section." The Commission supplemental report on State Hospitals (April 1977) dealt with the state hospital portion of the DD program.

community services still persist.

As private agencies, regional centers are faced with severe limitations in coordinating a complex public and private system of services and in assuring the development of services in the community which are needed but unavailable.

There are so many agencies involved in serving DD clients that no accurate assessment has yet been made of the numbers of clients and services provided, the size and description of waiting lists, or the numbers of potential clients who are receiving no service whatsoever. It is hoped that a survey now being conducted by the Department of Rehabiliation will produce much needed statistics in this area.

Rates and fees for services contracted by regiona centers are established independently and vary significantly. Services supplied by state hospitals for the DD are poorly coordinated with the services of the regional centers. Patients discharged by state hospitals are not always accommodated by regional centers for continuing and comprehensive care in the community setting. Lack of availability of community residential facilities and services forces continued hospitalization of patients who are ready for community-based care.

State hospital and Area Advisory Boards have had little impact on planning and coordination of services for several reasons--lack

of staff support, failure to include DD services in statewide health planning, and the lack of initiative by the DOH to develop an effective statewide planning system for meeting the full spectrum of needs of the DD population.

Availability of out-of-home residential care in community programs is severely limited for a number of reasons--inadequate rates of reimbursement under Medi-Cal, an allocation policy to regional centers which provides no incentive against state hospitalization, and licensing standards for community facilities which are more demanding than those applied to state hospitals.

The Commission recommendations included:

1. Integrate services provided to DD clients in state hospitals and through regional centers based upon a logical plan of geographic regionalization.

2. Undertake a comprehensive management study of regional center operations.

3. Immediately establish uniform policies for regional centers in order to:

   a. Prohibit private practice by full-time staff or the use of regional center facilities by their private patients.
   b. Eliminate conflict of interest in contracts by board members and prosecute those engaged in such conflicts.
   c. Adopt state personnel job descriptions and salary schedules by all regional centers.

d. Comply with the affirmative action policies of the state.

e. Perform audits in a timely fashion.

f. Enforce tighter controls over contracts with vendors.

4. Place regional centers under the direct operation of the DOH an develop publicly operated community residential care.

5. Strengthen the numbers and competence of DOH staff in order to assure adequate supervision over regional center operations.

6. Review the rights of clients and make improvements in grievance and appeal procedures.

7. Review and standardize rates or reimbursement for various levels of residential care and contract services.

8. Pay needy families to maintain clients in their home when this is in the best interest of the client

9. Ensure that the DOH comply with licensing standards for fire, life safety, seismic, staffing and patient care.

10. Apply licensing and certification standards for state hospitals in the same manner as for private facilities.

11. Have an independent review made by specialists of all treatment modalities in use by state hospitals.

12. Evaluate the state hospital patient discharge system and develop policies to maximize community placement.

13. Conduct an investigation into private practice by professionals employed full-time by the State.

II. Response to the Commission's Report

Santa Ana Hearing -- November 1976

At the Commission's first follow-up hearing November 18, 1976 in Santa Ana, DOH Chief Deputy Director Raymond Procunier, Deputy Director Don Miller, and Associate Deputy Director William Keating, M.D. in charge of state hospital programs indicated full agreement with the Commission's findings and recommendations. Procunier testified: "It was immediately apparent to me that everything that was said in the report was true and there should have been nervousness and excitment about responding--that I didn't find" (in the DOH). He also said, "By January 1, 1977 we will have the results of a recent study and by March 1, I will have it in the Governor's hands--the recommendations on how to staff those places (the state hospitals)." He said "it is my responsibility to take him

(the Governor) a definite, well staffed-out, defendable program and say this is what we need to run the state hospitals the way they are supposed to be run. And then he has a decision to make." In addition, Procunier said, "We now have a plan and are involved in implementation of fire and life safety regulations." Keating told the Commission: "I agree with your report. I agree with the fact that work needs to be done. I agree that these programs need to be upgraded so that they serve."

In January 1977, the DOH's official written response to the Commission's report reiterates substantial agreement with the findings and recommendations.

Legislation

Significant legislation was enacted in 1977 to carry out many of the reforms long sought by this Commission. Governor Brown signed Senator Alfred Alquist's SB 18, mandating implementation of the 1973 state hospital staffing standards by June 1980. Although the improved staffing levels are urgently needed, the Commission regrets that the Governor waited so long to take such action until the situation reached crisis proportions. It is to the Legislature's credit that they saw the need and passed Senator Alquist's similar staffing bills in two previous years,

only to have them vetoed by the Governor.

In other major legislative action after the Commission's report, Assemblyman Frank Lanterman secured the Governor's signature on a package of bills designed to strengthen programs for DD. Dealing with many issues raised by the Commission, these bills call for:

1. Mandating the legal right to treatment and habilitation services to every DD person who is a patient in a state hospital, community care facility or at home.

2. Adoption by June 1980 of staffing standards in state hospital DD programs sufficient to assure maximum person growth and development.

3. Compilation by regional centers of a roster of state hospital patients who could be placed in the community, provided that residential placement and supportive services were made available

4. Creation of a State Council for Developmental Disability to develop a state plan; to implement and monitor the plan; to allocate certain federal funds to regional centers; to evaluate and report on programs contained in the state plan; and to review and comment on other plans proposed by state agencies to serve DD clients. The Council is also charged with producing an annual report; with reviewing state agency regulations related to service to the developmentally disabled; with providing testimony to

legislative committees; and with monitoring appeals procedures and arbitration of disagreements between regional centers and state agencies.

5. Revision of the responsibilities of Area Boards to make them primarily responsibile for advocacy and assurance of compliance with laws affecting DD persons.

6. Elimination of conflict of interest in regional center operations; mandatory reporting of the status of clients, cost of services, and review of performance; specifications of procedures for terminating contracts.

7. Revision of rates for residential care, supportive services in the home and contract services.

8. Development of procedures for arbitration for vendors; fair hearings of appeals; evaluation of patient progress; and judicial review.

Sacramento Hearing - September 1977

The new State Council on Developmental Disabilities and the Association of Regional Centers Contract Administrators (ARCCA) presented testimony at the Commission's second follow-up hearing, September 15, 1977 in Sacramento. The Council indicated that the Commission's 1976 report gave impetus to legislation which created the Council with sufficient funds to provide for staff

and to sign contracts for pilot projects. The Council's first report to the Governor and the Legislature is due in March 1978.

ARCCA testified that many of the problems discussed in the Commission's report are beginning to come under control. The Association has recently appointed several statewide committees to look at administrative practices, ethics and to evaluate program effectiveness.

ARCCA informed the Commission that it recently undertook a legal review of existing statutes relating to the respective responsibilities of the regional centers and the DOH. This review specifies major conflicts in the interpretation of these responsibilities. A document has been prepared by the organization for review by the department. (This will be discussed in a subsequent section of this supplemental report.)

The California Nurses' Association reiterated its general agreement with the Commission's findings and recommendations relative to DD programs in state hospitals. CNA indicated an opinion that state hospital programs have not yet attained compliance with either licensure or accreditation standards and urged that the Commission continue to press the administration to supply the resources necessary to accomplish these goals.

Richard Walden representing the American Civil Liberties Union of Southern California, also expressed concern about the state's failure to meet licensing and accreditation standards for hospital programs for DD. He reported lack of progress thus far by the State Council for Developmental Disabilities in providing a strong program of patient rights in all treatment settings and in the development of specific advocacy and grievance procedures.

Several witnesses representing patient groups testified in strongly negative terms about the present status of programs for developmental disability in both state hospitals and regional centers. They emphatically denied that significant progress has been made since the issuance of the Commission's 1976 report, with which they concur.

Dr. Michael Levine, former Acting Executive Director of the Fairview State Hospital, testified that the DOH admitted in April 1977 that state hospitals are not in conformity with fire, life safety, federal or state certification standards. In spite of these statements, certification of Fairview by the Joint Commission on Hospital Accreditation was granted. He said certification was based heavily on review of clinical charts. But at Fairview, he added, charts of patients include programs which the hospital is not staffed to provide. In addition, he said notations are made in the charts that services have been provided when, in fact, they have not.

Dr. Levine said standards recommended for accreditation are for one staff person for five to eight patients. But at Fairview, he said, the ratio is one staff person for 15 to 20 patients. There are only seventeen teaching positions at the hospital for one thousand children eligible for educational services; only four physical therapists for 600 patients; no audiologist and only one speech therapist.

Dr. Levine added that Fairview's staffing level is insufficient to accomplish more than custodial care. Patients are admitted to the hospital without any prospect of providing services necessary to assure their improvement. He said that of the patients hospitalized at Fairview, 80 percent remain unchanged, 10 percent make some gains, and 10 percent actually lose ground following admission.

III. Current Status of DD Programs.

A report on the Attorney General's investigation of operations of regional centers was released in September 1977. The investigation was initiated by this Commission in 1975. The report contains the following findings, based upon audits of the Department of Benefit Payments and on-site visits which the Attorney General's staff made to eight centers. Several of these corroborate January 1976 findings of the Commission:

1. Diversion and comingling of funds to parent corporations in violation of the law.

2. Exploitation by physicians employed full-time by regional centers by conducting private practice in center facilities to augment their salaries.

3. Absence of independent boards of directors in some regional centers to oversee funds appropriated for operations.

4. Conflict of interest in awarding DD patient service contracts to members of boards of directors.

5. Misrepresentation of professional credentials on the part of some regional center staff and excessive compensation for professional positions.

6. Irregularities in management of property and inventory.

7. Failure to recover fees from third-party payers.

8. Failure to monitor contracts with vendors.

These findings, although developed from sample of eight regional centers, nevertheless indicate the validity of the Commission's allegation that the DOH has not exerted sufficient management controls over regional center operations.

The Attorney General made these recommendations:

1. Establishment of automous private corporations for management of DD funds.

2. Elimination of advance payments to regional centers and installation of a system of monthly payments to the centers.

3. Centralized control of contracts with vendors signed by the regional centers.

4. Production of a manual by the DOH to guide all aspects to the operations of regional centers.

5. Employment of better qualified Community Program Analysts to provide proper DOH technical assistance to the regional centers.

6. Creation of incentives to maximize third-party collections for services provided through the regional centers.

7. Implementation of stronger inventory controls by the DOH over property and assets of the regional centers.

8. Legal action against irregularities in place of simple audit exceptions.

The Association of Regional Center Contract Administrators (ARCCA) and DOH plan to issue responses to the Attorney General

report in the latter part of November 1977, not in time to be reported here.

However, ARCCA in response to the reports of the Commission and the Attorney General, has already conducted a survey of regional centers to determine the current status of most issues raised. The highlights of responses to the October 1977 survey indicate:

1. By July 1, 1978, in conformity with AB 3804, Program Policy Committees will be appointed to serve as governing boards to each center. Some difficulty is being experienced in seating knowledgeable professionals and state employees on these boards, dur to the conflict-of-interest provisions of the new law.

2. Responsibility for program decisions are made by the boards of trustees of the centers but these decisions are being interferred with by directives from the DOH and the community program analysts, who are described as lacking authority and professional knowledge.

3. Salary schedules now in use by regional centers have all been reviewed and approved by the DOH.

4. All centers have submitted affirmative action plans to the DOH. The department does not intend to respond, however, pending the outcome of the Bakke decision before the U. S. Supreme Court because of possible legal implications on the methods employed in affirmative action programs.

5. Conflict-of-interest has been completely eliminated on the part of the staff, but nine centers continue to have

potential conflict-of-interest. Each affected board has requested waivers, and complete compliance is planned for July 1, 1978.

6. All regional centers have stepped up efforts to improve outreach programs to better serve ethnic minorities and low-income clients.

7. Three centers have waiting lists for initial contact. Eight have waiting lists for services due either to lack of funds or service resources. Services provided directly by the centers, defined in AB 3804, include case finding, intake and assessment, prevention, individual program planning, coordination, referral annual review of status, purchase of service, advocacy, community organization and program development.

8. Contracts are made for a variety of specific services, such as case management, respite care, genetic counseling, family planning and behavioral intervention.

9. The centers are now at work with the staff of the DOH to develop uniform systems of collecting financial and client service information. The existing DOH data processing system for DD clients does not produce the kind of information to improve program analysis and management.

10. The primary lack of resources in the community is residential care, especially small family care homes, independent living facilities, skilled nursing facilities for DD clients and facilities capable of providing behavior intervention. Also lacking are adequate transportation, training and employment

development, and respite care. The services of medical specialists are also difficult to arrange because of low fee schedules. Resources which are now available are reaching their maximum capacity.

11. Lack of resources derive from poor planning, low rates of reimbursement, lack of funds for services development, lack of viable sponsors for new services and bureaucratic red tape.

12. Relationships of regional centers to state agencies vary from poor to excellent. Relationships are best with public health and crippled children's services.

13. Relationships between regional centers and state hospital programs also vary by location. Some view state hospitalization as an inappropriate alternative; others consider state hospitals to be part of a continuum of residential care and a good source of specialized treatment.

14. Removal of patients from state hospitals, when indicated, is impeded by lack of both residential facilities and supportive services. Rates must be made more realistic for community care and services, and confidence in continued funding must be assured.

15. Eighteen regional centers have been audited by Department of Benefit Payments in 1976-77. Three have not been audited since 1974-75.

Meanwhile, the status of state hospital programs for DD clients

was included in a preliminary report of a 1977 task force led by Louis Simpson, M.D., a psychiatrist, who was asked by the Governor to review conditions at state hospitals. In his report to the Governor, Dr. Simpson said, in reference to the Commission's January 1976 report: "I strongly recommend that you read it and I strongly endorse the recommendations in the report." Dr. Simpson points out that the majority of patients in state hospitals are developmentally disabled persons.

The only way that the population of state hospitals can be reduced, he writes, is to find adequate alternatives for out-of-home residential care of the developmentally disabled by paying adequate rates for nursing homes and board-and-care facilities to take care of the developmentally disabled. Needed along with this is the development of community services such as day care centers, homemakers services for patients, and volunteer programs in both nursing homes and board-and-care facilities. Dr. Simpson also recommended the development of residential care facilities in the community operated by public entities, and training programs for small board-and-care operations.

He endorsed this Commission's recommendation for establishment of a regional program to plan and coordinate effective and cost-efficient programs for DD clients and to manage the total resources of state hospital programs and regional centers

within a defined geographic region. He noted that the regional centers in minority communities are understaffed and are not being allowed to develop programs which are responsive to the unique communities they serve.

Finally, Dr. Simpson urged an immediate evaluation of controversial treatment methods in state hosptials for the developmentally disabled. He felt that some of the methods seem "diabolical" to him.

IV. State Health Department Regulation of Regional Centers. Continuing and serious disagreements prevail on the question of the rights and responsibilities of regional centers and the relationship which they bear under law to the DOH. The Association of Regional Center Contract Administrators (ARCCA) agrees DOH has the right and responsibility to enforce accountability for the legal performance of programs of the regional centers. But ARCCA asserts that the regional centers have a right as private corporations to determine the methods they will use to meet these objectives.

ARCCA strongly resists any infringement of the legal rights of private corporations. Sharp exception is taken to several specific contractual requirements contained in the master contract of the DOH with the regional centers:

Item 8 specifies that contracts made between regional center and private vendors shall be guided by a policy that the purchase of services can be made only from those facilities and service providers which have been approved by the DOH in accordance with regulations provided by that department. ARCCA recommends deletion of this approval requirement, countering that a private corporation under law has a right to set its own standards independent of the DOH.

Item 14 demands that all hearings of the boards of directors of a regional center be held as open meetings. ARCCA objects

to this, pointing out that private corporations are not bound to this policy. ARCCA does, however, recommend that meetings on major policy be made open to the public.

Item 15 refers to the DOH's Regional Center Operations Manual, which sets forth DOH's requirements for regional centers to fulfill their contractual obligations. ARCCA contends that the manual contains many requirements not supported by the law and recommends that the use of the manual not be dictated in the master contract.

Item 16 relates to the DOH's right to perform full audits and require complete fiscal disclosure of each regional center and the vendors with whom they contract. ARCCA indicates that this requirement is an abridgment of their rights as a private corporation.

Item 18 of the contract relates to the levels of salaries, wages, and consulting fees. DOH sets forth standards for personnel practices in the regional centers. ARCCA recommends that these standards be deleted, contending that private corporations reserve the legal rights to adopt their own personnel practices, salary levels and consulting fees.

Item 27 stipulates the rates of reimbursement for travel and per diem expenses. The ARCCA expresses a desire to delete this requirement, stating that private corporations have the right to

set standards for reimbursement in these areas as they see fit.

Section 34-39 of the contract relates to nondiscrimination in employment and the use of state approved standards for affirmative action programs. ARCCA contends that a private corporation cannot be bound by state regulations relating to affirmative action.

ARCCA representatives also lodged criticisms of the administration of DD programs:

1. The State Council on Developmental Disabilities has so far failed to develop productive relationships with regional centers. The council has not consulted effectively with experienced regional center staff or board members in fulfilling its new statutory responsibilities. The process of developing a state plan by the council has so far virtually excluded input from ARCCA.

2. The DOH field staff includes some who are inexperienced and ill-prepared to understand the basic needs of the regional centers. Regulations are promulgated which are arbitrary, unreasonable and inconsistent. Appeals by the regional centers for relief of unworkable requirements demanded by the state are usually ignored. The DOH's response to ARCCA's positions on the statutory basis for state regulations of centers remains unsatisfactory to ARCCA.

3. The DOH operations manual reflects a failure to

accommodate geographical and regional realities. These call for greater flexibility and consideration of regional differences in community attitudes and resources available to regional centers.

The Chief Deputy Director of the Department of Health has responded in writing to the demands made by the ARCCA. He indicated his intention to support all of the conditions contained in the contract, and to enforce the standards outlined in the operations manual. He expressed a desire to continue to negotiate on disagreements, but pointed out that any regional center which did not wish to comply with the contractual requirements was free not to sign a contract with the state. He quoted legal opinions from his department which indicated complete disagreement with the legal opinions reflected in the ARCCA document. He also indicated that state responsibilities require control over sole-source contractors which are more stringent than contracts let out to bid.

V. State Hospital Decertification

In discussing the licensure of state hospitals, at this Commission's November 1976 hearing, the DOH Deputy Director, Don Miller, admitted that, under certain conditions which prevail in the state hospitals licensure would be denied if they were being operated as private facilities. Approximately eight months later, that very action occurred. At the time of this writing, the DOH Division of Licensing and Certification has denied certification for Agnews, Fairview, Napa and Pacific, four of the nine state hospitals receiving federal Medi-Cal funding. The division indicates that unless compliance can be assured, they intend to decertify the other five state hospitals in January 1978--Camarillo, Patton, Porterville, Sonoma and Stockton.

The programs under way to correct fire, life safety, and environmental defects appear to be progressing at a rate which is satisfactory to both accreditation and certifying authorities. The implication of the loss of license by state hospitals is loss of an estimated $60 million of federal support to the operations of state hospital programs. Presumably, the state will be forced to tap the General Fund to make up the deficit.

Serious legal questions are created by keeping patients confined in unlicensed state hospitals. For example:

- Does such confinement represent denial of the

constitutional guarantee of equal protection under the law?

- What is the State's legal liability in the event of injury or loss of life resulting from environmental or staffing deficiencies?

- Is the state liable for physical and emotional deprivation of patients in face of standards of care which are so deficient as to result in denial of licensure and failure to provide services essential for the welfare of patients?

- Is the state open to legal sanctions for violating licensing requirements?

- Can the Division of Licensing and Certification demand closure of state hospitals which fail to comply with licensing requirements, as it can with private facilities?

- What alternatives must be provided by the state in the event of widespread reduction of state hospital programs?

VI. Conclusion

The continuing crisis in state hospitals is the direct result of failure by successive administrations to implement the numerous recommendations made by the Legislature and this Commission.

Beginning with the recommendations four years ago of the Senate Select Committee on the Phase-out of State Hospital Services (Senator Alfred Alquist, Chairman) and repeated by this Commission in 1976, these actions have been urged repeatedly:

1. State hospital physical plant safety should be brought into compliance with licensing and accreditation standards.

2. Without delay, improved staffing standards should be implemented in all state hospital programs to assure proper care of patients and to maximize their ability to return to their communities for residential or home care, supplemented by services which provide for medical, social and vocational rehabilitation.

3. The state should strengthen its commitment to invest in an adequately funded system of community facilities and services, to reduce to a minimum the need for institutional care and to speed the process of normalization of patients suffering developmental disabilities.

The Commission finds the present status of state hospital programs for DD to be inexcusable.

Assurances have repeatedly been made by the DOH before hearings of the committees of the Legislature and of this Commission that state hospital standards would be rapidly improved. Testimony has been presented over and over again by officials of the department that they completely agree with the detailed specific criticisms of state hospital programs and nearly all recommendations for corrective action.

Yet, in November 1977, four years after the issuance of the Senate Committee report, and nearly two years after this Commission's report, most state hospitals face the imminent prospect of loss of licensure. The Commission finds that this crisis could have been averted by prompt and responsible administrative action. The fact that it wasn't leaves us with a sense of deep frustration bordering on despair.

The creation of a new Department for Developmental Services presents an opportunity to bring fresh, committed, and professionally qualified leadership to the state and to implement sorely needed reforms in state hospital and community programs. But the Commission remains deeply concerned about the present status of community services for the developmentally disabled. Regional centers, the administrative heart of community services, are plagued with deficiencies which result in denial of essential services.

The reports of the Attorney General have confirmed this

Commission's past criticisms of the operations of the regional centers, although it is clear that serious deficiencies in management are not present in all regional centers. The continuing tension which prevails between regional centers and the State Health Department is symptomatic of recurrent, severe administrative dysfunction.

This Commission is convinced that deficient administration of regional center programs is a major problem, though not universal. We believe that persistent challenges by regional centers of the authority of the state is directly related to their status as private corporations.

In this respect the Commission has asked the Attorney General to provide answers to two pertinent questions:

1. Does the master contract between the DOH and the regional centers contain any requirements which do not conform to existing law?

2. Is there, in California law, a class of corporation other than a non-profit charitable corporation, which functions as a public corporation and is thereby more responsive to the public interest and the taxpayer?

This request is made out of this Commission's firm conviction that it is inappropriate to administer over $100 million of tax monies for community programs for DD exclusively through

private corporations without adequate controls and safeguards.

The taxpayer has a right to full disclosure of exactly how tax funds are used and to demand that the administration of community programs be conducted openly and in conformity with state regulations designed to assure full accountability and protection of patient rights.

At the same time, the Commission feels that the Department of Health has not yet succeeded in providing competent, consistent and equitable technical assistance to the regional centers. We note, though, that DOH's development of a master contract and a manual for regional center operations is a commendable start toward stronger administrative controls.

Our current review of regional center operations has confirmed our stand that the administration of community programs for developmental disability should be vested in a government agency--the Department of Health--and that the delivery of services of various types should be accomplished under contract by public and private organizations without discrimination.

Contracts to vendors, whether they are private or public entities, should be drawn to assure full public disclosure and accountability for compliance with reasonable fiscal and service performance standards.

The Commission also feels that the development of essential community services and facilities where they are lacking is the primary responsibility of the DOH, not the private sector.

VII. Recommendation

The Commission again refers the Governor and the Legislature to the recommendations made in its report of January 1976 and urges immediate implementation of those proposals which would serve to improve the deliverly of essential health services.