

LITTLE HOOVER COMMISSION

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TWO YEARS *of* PROGRESS
TOWARD
EFFICIENT *and* EFFECTIVE
GOVERNMENT

LITTLE HOOVER COMMISSION

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LITTLE HOOVER COMMISSION, 1988-89:

TWO YEARS OF PROGRESS TOWARD

EFFICIENT AND EFFECTIVE GOVERNMENT

TABLE OF CONTENTS

	<u>Page</u>
Progress Report	1
Summary of Studies	
California's Big Gamble: The Lottery	9
Boards and Commissions: California's Hidden Government	12
The Trashing of California	14
Homeless Help: It Takes More Than A Roof	16
Nursing Homes: Inadequate Care, Inadequate Oversight	20
Board and Care: Homes For The Forgotten	27
Crime and Violence in California's Schools	34
California's State Public Defender	37
California's Fragmented Approach to Drug Programs	40
The Road To Nowhere: California's Highway System	42
California's Workers' Compensation System	46
Appendix A: Commission Membership	50
Appendix B: Chronological List of Reports	51

PROGRESS REPORT

In the past two years, the Little Hoover Commission has led the way in improving conditions for residents of nursing homes and board and care facilities, played a meaningful role in the state's overhaul of workers' compensation and solid waste management systems, and pushed for changes in transportation policies and the process for creating boards and commissions.

Between January 1988 and December 1989, the Little Hoover Commission conducted 22 hearings and issued 12 reports. Cumulatively, those reports contained 68 findings and 112 recommendations to improve state government operations. From those recommendations, the Commission either sponsored or supported 60 pieces of legislation, more than half of which were enacted into law by the mid-point of the 1989-90 legislative session.

Formally known as the Commission on California State Government Organization and Economy, the Little Hoover Commission is an independent, bipartisan watchdog agency that was created in 1962. The Commission's mission is to investigate state government operations and, through reports and recommendations, promote efficiency, economy and effectiveness.

By statute, the Commission is a balanced, 13-member, bipartisan board composed of five citizen members appointed by the Governor, four citizen members appointed by the Legislature, two Senators and two Assembly members.

The Little Hoover Commission holds hearings about once a month on topics that come to its attention from citizens, legislators and other sources. But the hearings are only a small part of a long and thorough process:

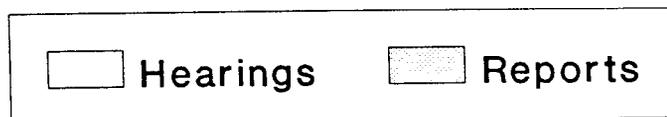
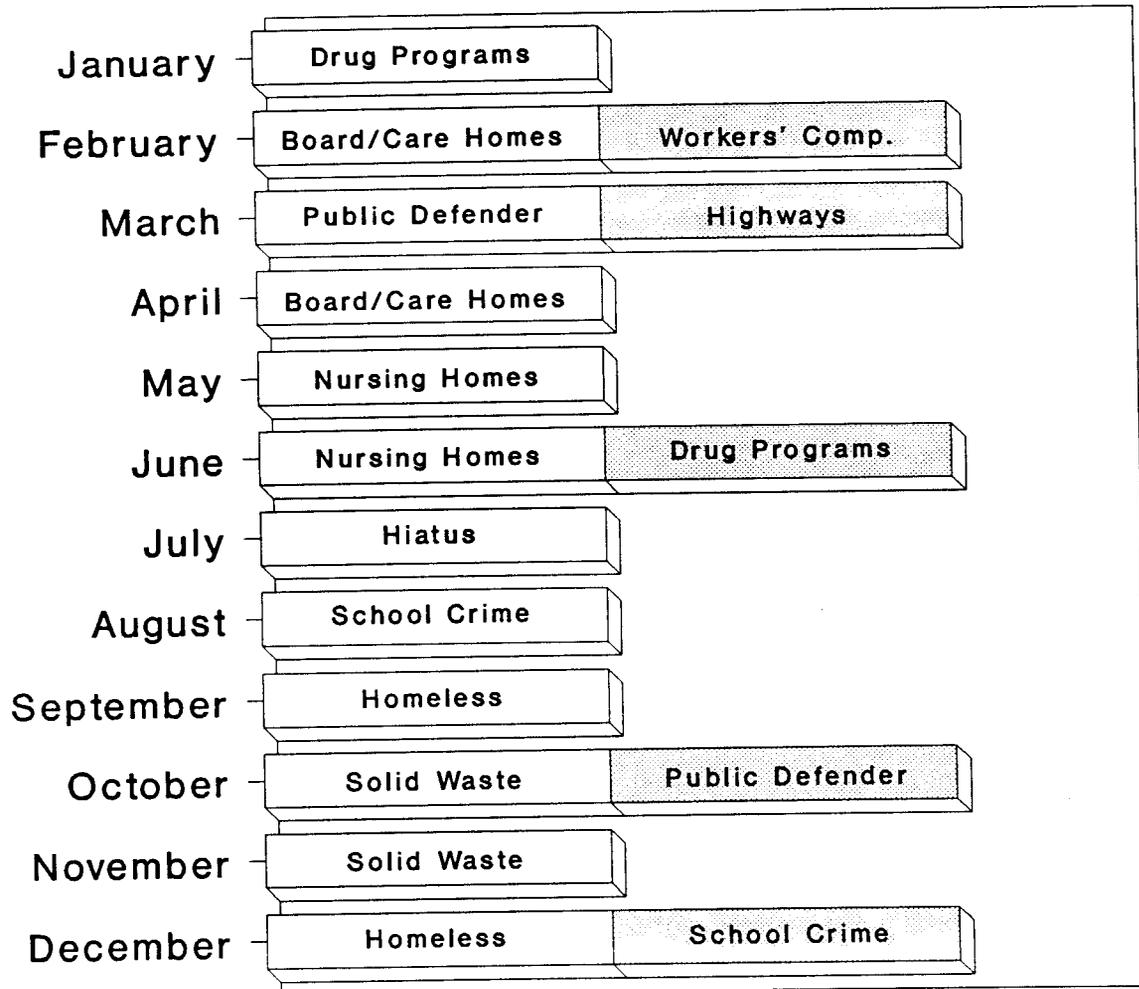
- * At least three months of preliminary investigations and preparations come before a hearing is conducted.
- * Hearings are constructed in such a way to explore identified issues and raise new areas for investigation.
- * Two to six months of intensive fieldwork is then undertaken before a report--including findings and recommendations--is drafted, adopted and released.
- * Legislation to implement recommendations is sponsored and lobbied through the legislative system and to the governor's desk.
- * New hearings are held and progress reports issued in the years following the initial report until the Commission's recommendations have been assimilated and the Commission is satisfied that the targeted state program is working efficiently and effectively.

From December 1962 through December 1989, the Commission issued 98 reports ranging from narrowly focused studies, such as "A Review of the Cost Savings Associated with Conversion of Guadalupe College into a Women's Prison," to in-depth probes of whole categories of services, such as "Children's Services Delivery System in California."

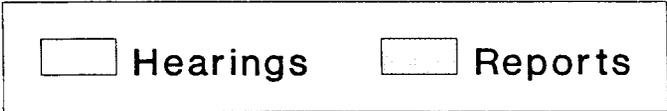
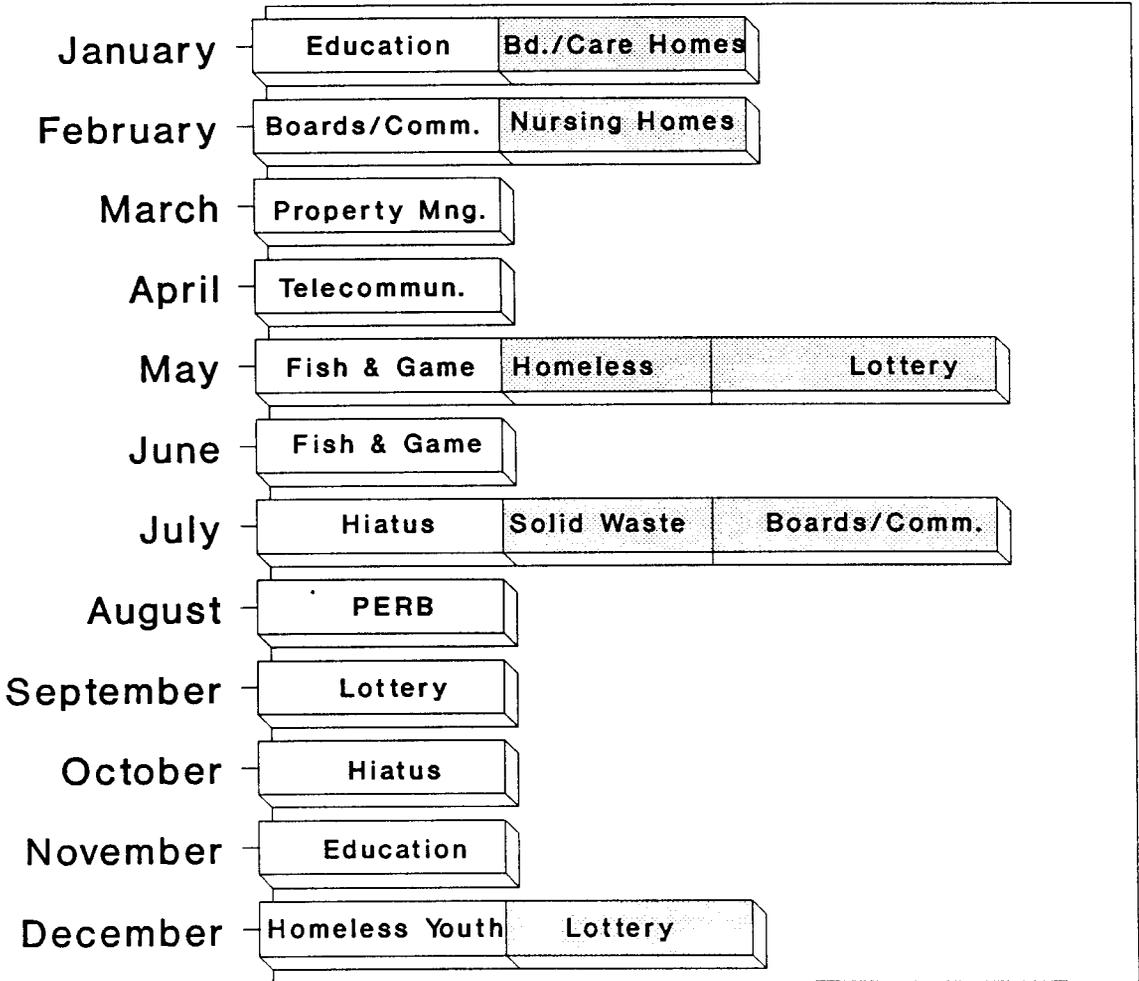
The Commission also monitors its own track record, issuing biennial reports that assess the status of recommendations and to ensure that remedies are pursued long after the original reports are filed away. The biennial report for 1988 through 1989 sums up a solid record of achievement for the Commission, particularly in the area of making state government services more accessible and effective for California's citizens.

The charts on the next two pages show the Commission's activities during the two-year period, including hearings held and reports issued (please see Appendix B for a chronological listing of reports by title).

Little Hoover Commission 1988 Activities



Little Hoover Commission 1989 Activities



A report by report summary is contained in the next section, but some general conclusions can be reached:

- * The Commission since the early 1980s has pursued improved living conditions for those in nursing homes and residential care facilities. Its most recent investigations show that the state still lags in monitoring these two distinct types of facilities, strictly enforcing fine and citation systems and taking steps to ensure a high quality of care for residents. But laws have been passed that should bolster residents' rights, provide more information about facilities to the consumer, tighten oversight and improve care-giver training.
- * In the area of solid waste management, the Commission's report came at the peak of concern over the state's rapidly vanishing landfill capacity and perceptions that the state's lead agency on waste was a stumbling block rather than promoter of solutions to this problem. With the Commission's active support, an omnibus reform measure was passed in 1989 that should produce a change in approach to solid waste management in the coming years.
- * The Commission added its weight to the long-term efforts to overhaul the Workers' Compensation System, which is one of the most expensively run in the country yet has the lowest benefits for workers in any industrial state. An omnibus reform measure, with the Commission's support, was finally written into law in late 1989. Time will tell if the reform is able to achieve the efficiency and effectiveness sought for this program.

In addition, one of the areas investigated by the Commission continues to be on the front-burner of legislative concern. The Commission's early 1988 assessment of the state's handling of its transportation needs has proven correct: The state has lost the ability to meet citizens needs because it has run out of funding to continue approved transportation projects.

Although some small legislative steps have been taken to meet problems identified in the Commission's transportation report, the bulk of the issues addressed by the Commission are reflected in Proposition 111 on the June 1990 ballot. This measure was placed on the ballot only after a wearying year of compromise that has brought together a broad-ranging coalition of interests. In essence, it will raise gasoline taxes, revise the state's spending limit and modify formulas for state spending on education.

But also included in Proposition 111 are many of the innovative techniques backed by the Little Hoover Commission in its report, such as traffic congestion management techniques, regional approaches to transportation needs and speeding the time-frame for projects once they have been approved.

Another area where the Legislature is just beginning to pursue remedies recommended by the Little Hoover Commission is on the proliferation of state boards and commissions. Going into 1990, bills were being sponsored to set sunrise and sunset criteria for the creation of any new bodies and to institute a review of the need to merge functions of existing bodies.

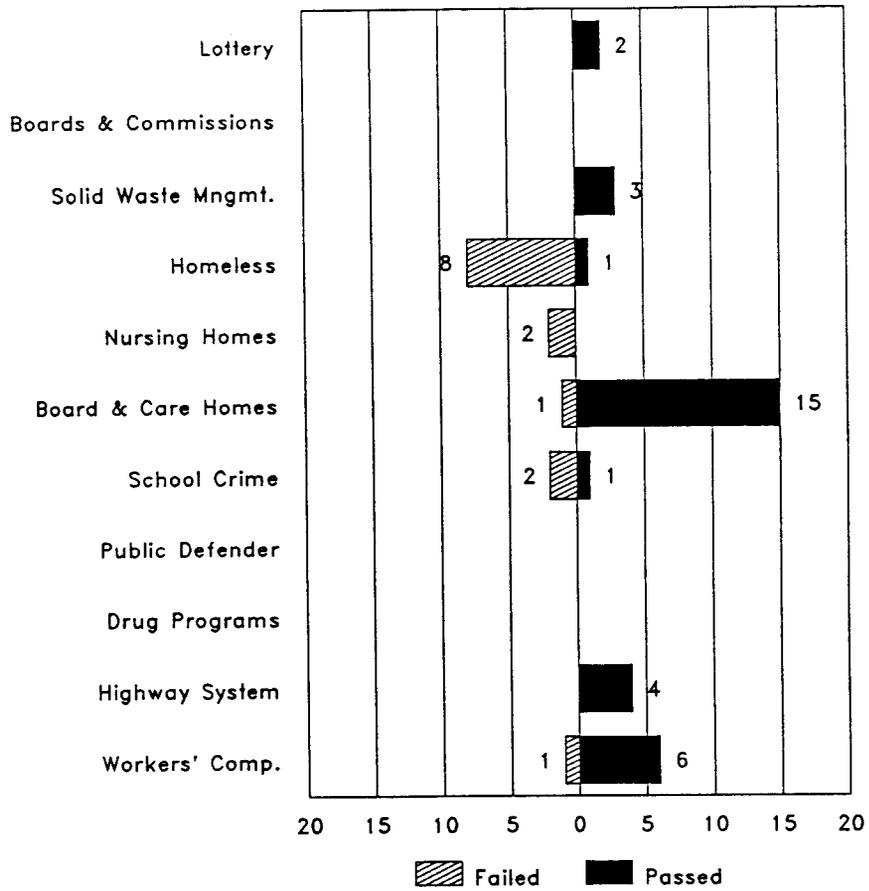
Finally, it can also be noted that the Commission found in reviewing the operation of the State Lottery that the bulk of the Commission's recommendations from an earlier study had been

implemented and that the Lottery had basically matured into a well-functioning state entity, with only minor fine-tuning required.

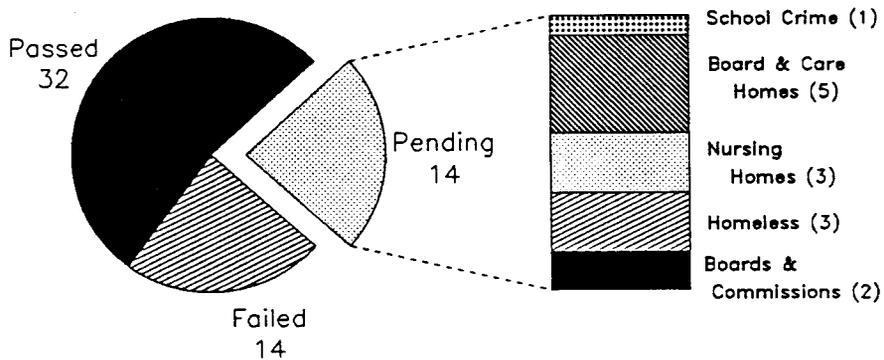
At least part of the Little Hoover Commission's success in seeing its recommendations implemented came from a strong emphasis on working with legislators and pursuing bills through the entire legislative process. The results of this renewed commitment to legislative legwork can be seen in comparisons of statistics for the successful passage of Commission sponsored or supported bills: In 1984, the Commission saw six of its measures signed into law. In 1989, 20 measures sponsored or supported by the Commission became law.

The chart on the next page reflects the Commission's legislative activities stemming from reports issued in 1988 and 1989.

LEGISLATIVE SUCCESS On 1988 And 1989 Reports



Note: As shown below, 14 bills were pending at the end of 1989.



As the chart shows, the Commission sponsored or supported 60 measures directly arising from the reports issued in 1988 and 1989. Of those, 32 were signed into law while 14 failed passage by the Legislature or were vetoed. Fourteen measures remained pending as the 1990 Legislature began its deliberations. This translates into a success rate ranging from 53 percent to 77 percent depending on the fate of the pending measures.

In addition, the Commission pursued legislation arising from previous years' reports. For instance, AB 226, which established a professional review program for accountants and was a recommendation to improve school audits from an earlier education report, was signed into law in 1989. The Commission has sponsored or supported three bills arising from its Children's Services Delivery System report, but all were vetoed. (It should be noted that many recommendations from this 1987 report became law through the Commission's efforts prior to 1988.) Finally, the Commission successfully sponsored a measure to require the Legislative Counsel to track all reports required by the Legislature to ensure that agencies complete and file them.

The Commission also continued in its role as a state watchdog in 1988 and 1989. The Commission continued its practice of holding annual hearings to prod the state into better management of its property holdings as a followup to its comprehensive 1986 study. And the Commission reviewed the bidding procedure for the state's plan to improve its telecommunications system.

Overall, the Little Hoover Commission in 1988 and 1989 aggressively fulfilled its mandate of working to improve state operations so that citizens are more effectively and efficiently served by their government.

**1988 And 1989
Study Summaries**

California's Big Gamble: The Lottery

The Little Hoover Commission issued two letter reports dealing with the California State Lottery in 1989, one concerning a specific Lottery policy and the other looking at the general operations of the Lottery.

The May 1989 letter report addressed the convoluted situation that had evolved around unclaimed, low-tier Lotto and instant game prizes. At various points, the State Lottery Commission had adopted and/or modified policies to sweep these unclaimed prizes into, first, the Education Fund and, second, into the game prize fund. The Little Hoover Commission letter report assessed the Lottery's policy and urged changes.

The December 1989 letter report was a followup review of a report issued almost three years earlier. This review found that, in general, the Lottery has matured well since voters approved its creation in 1984 and that fine-tuning rather than a major overhaul is needed.

In the original January 1987 report, the Commission cited problems with the then-new Lottery in three major areas: procurement procedures, relationships with contractors and financial accountability. The 1989 review showed that most of the recommendations to resolve these problems had been enacted or were in the process of taking place.

There were two problem areas where the Little Hoover Commission continued to find fault in 1989: budgetary oversight and the monitoring of contracts. In addition, the Commission identified new areas of concern: research and development procedures, and methods of evaluating advertising efforts.

Findings and Recommendations (May 1989)

The Little Hoover Commission's May 1989 letter report contained two findings and two corresponding recommendations.

FINDING #1: The purpose of the Lottery Act and the intent of the people would be better served by mandating the allocation of unclaimed low-tier Lotto prizes to the State Education Fund. The flip-flopping of the Lottery Commission over the years on this issue show the degree of ambiguity of existing law when it comes to instant prizes. But Lotto prizes are different in nature and the law is clear that unclaimed money should be used for education.

Recommendation: The Governor and the Legislature should amend the Lottery Act to clarify that unclaimed low-tier prizes should be placed in the Education Fund.

FINDING #2: The Lottery Commission's rule making process does not provide adequate time for public input. The Lottery Act allows the Lottery to move quickly on rule changes so that it may compete effectively and react to changing market conditions. In the absence of these needs, however, the Lottery Commission has taken action without adequate public notice and input.

Recommendation: The Governor and the Legislature should amend the Lottery Act to require that the Lottery Commission, when issuing rules that do not concern the operation of the games or prizes, provide at least 30 days' notice to the public.

Findings and Recommendations (December 1989)

The Little Hoover Commission December 1989 letter report contains four findings and four corresponding recommendations.

FINDING #1: The Lottery is exempt from external budgetary oversight. Under the law setting up the Lottery, the Lottery's operations are not reviewed by the Department of Finance, the Department of General Service or the Office of Administrative Law. Thus, the Lottery is responsible for developing, recommending and approving its own budget without normal checks and balances.

Recommendation: The Governor and the Legislature should require that all Lottery funds be classified as "special funds" subject to review by the Department of Finance, Legislative Analyst and the State Legislature.

FINDING #2: The Lottery does not have the operational flexibility necessary to effectively deal with future project development issues. Current state procurement practices, which require payment to a contractor only on receipt of a deliverable, do not allow the expenditure of funds on research and development, nor do they allow contractors to retain rights to the products. This acts as a powerful disincentive to companies that might otherwise bid on contracts that would allow the Lottery to use innovative and modern techniques in its operations.

Recommendation: The Governor and the Legislature should enact legislation to allow the Lottery to contract for research and development activities.

FINDING #3: The Lottery currently does not have an adequate system for evaluating the effectiveness of its advertising and promotional expenditures. The Lottery has a five-year growth plan based on the assumption that advertising and promotion efforts will attract new players and increase the revenues available for education. The Lottery, however, has no mechanism for determining the cost-effectiveness of its advertising and promotional campaign choices. Thus funds may be used unwisely and revenue goals may not be achieved.

Recommendation: The Lottery should implement a "return on investment" analysis of its advertising and promotional expenditures.

FINDING #4: The Lottery has not adequately monitored contract performance. The Lottery has not yet been able to institute procedures that would allow it to monitor contract performance and promptly execute prepared contracts and purchase orders. As a result, purchases and programs may be delayed and contractors may not be performing needed tasks.

Recommendation: The Lottery should immediately strengthen contract monitoring procedures.

Legislation

The Little Hoover Commission was involved in two bills during 1989 that stemmed from a recommendation in the May 1989 report.

Bill	Little Hoover Role	Outcome
AB 429 (Moore) Requires California State Lottery to pay all unclaimed Lotto prizes directly into the Education Fund.	Sponsor	Amended into SB 906
SB 906 (Dills) Omnibus California State Lottery cleanup and reform bill; includes provisions for some unclaimed low-tier prizes to be paid to Education Fund.	Support	Chapter 917, 1989 Statutes

Conclusion

The Little Hoover Commission's early recommendations when the Lottery was still in its developmental stages in 1987 were for the most part implemented. The Commission added to these recommendations in two 1989 letter reports. While a portion of the Commission's concerns have since been addressed, there are still some remaining recommendations. Other bills may be developed in future years to carry out unfulfilled recommendations, particularly from the December 1989 report.

Boards and Commissions: California's Hidden Government

A Little Hoover Commission letter report in July 1989 revealed the existence of more than 400 boards, commissions, authorities, associations, councils and committees in state government. The 361 organizations that responded to the study survey accounted for \$1.9 billion of the 1988-89 state budget and contained 3,650 members appointed by the Governor, the Legislature or some other mandated entity. These bodies operate to a large degree autonomously and outside of the normal checks and balances of representative government.

The letter report concluded that the state's boards and commissions are proliferating without adequate evaluation of need, effectiveness and efficiency. This lack of control may cost the state not only dollars, but also wasted resources, duplicated efforts and the adoption of policies that may run counter to the general public's interest.

The Commission's study was the third it has conducted on the use of plural bodies in California state government. The first concerned boards and commissions in the Resources Agency (April 1965) and the second considered those in the predecessor to the Department of Consumer Affairs, the Department of Professional and Vocational Standards (September 1967). In its latest review, the Commission focused on overall state problems with boards and commissions, rather than evaluating the need and/or performance of any single entity.

Findings and Recommendations

The Little Hoover Commission letter report on boards and commissions contained three findings and five recommendations.

FINDING #1: Statutory boards, commissions, authorities, associations, committees and councils are created without any systematic evaluation of the most effective approach to solving the perceived problem. The state, for the most part, has no guidelines or criteria to be used in the creation of boards and commissions.

Recommendation: The Governor and the Legislature should enact specific "sunrise" criteria to determine when autonomous bodies can be created and what form of body is most appropriate for different types of activities. The criteria should encompass the creation of regulatory, administrative and advisory types of functions.

FINDING #2: Few organizations are subject to periodic review subsequent to their creation. Since most organizations are created to achieve specific goals, a mechanism should be in place to evaluate results and accomplishments.

Recommendation: The Governor and the Legislature should enact a statute that requires "sunset" clauses to be used whenever autonomous bodies are created and to be amended into the statutes authorizing existing entities. This "sunset" provision should set a date for the termination of an organization, require a review of operations by an independent organization and require the Legislature to take positive action to continue an entity's existence beyond the sunset date.

Recommendation: The Legislature should assign the Legislative Analyst responsibility for developing and performing sunset review procedures.

FINDING #3: Some boards, commissions, authorities, associations, committees and councils have overlapping functions. Numerous organizations have been created that have similar functions. Sometimes the overlap is a product of the passage of time and changing conditions; in other instances, the overlapping functions may exist from the beginning. The overlap becomes particularly troublesome when both bodies are regulatory in nature. It is difficult to discern these overlapping functions in advance since no centralized database of autonomous bodies is kept.

Recommendation: The Governor and the Legislature should direct the Department of General Services to create and maintain a database of all statutory boards, commissions, authorities, associations, committees and councils. In addition, the Department would require each of these autonomous organizations to follow the state's standard administrative, budgetary, accounting and recordkeeping policies.

Recommendation: The Governor and the Legislature should direct the Auditor General to report on the benefits of combining any or all of the functions of regulatory entities into a single unit.

Legislation

The Little Hoover Commission will be involved with two bills during 1990 that come from the recommendations in the boards and commissions letter report.

Bill	Little Hoover Role	Outcome
AB 1272 (Eastin) Requires Auditor General to conduct a consolidation study of professional regulatory agencies; the study will cover both the function and the areas of jurisdiction.	Sponsor	Converted to formal study request
AB 2572 (Eastin) Requires Joint Budget Committee to develop and operate "sunrise/sunset" reviews for all proposed boards, commissions and committees.	Sponsor	In Committee

Conclusion

The Little Hoover Commission's boards and commissions report has stirred considerable interest in the Legislature, where the Assembly Governmental Efficiency and Consumer Protection Committee has conducted a special hearing on the report's findings. In addition, the Senate Office of Research is using the Commission's database from the study to conduct inquiries of its own. While it is too early to assess the impact of the report, these areas of concern will continue to be pressed in the future.

The Trashing of California

Is California in a garbage crisis? That was the main question addressed by a Little Hoover Commission study in 1989 on solid waste management. The Commission's report, issued in July 1989, noted that with the entire state slated to run out of landfill capacity by the year 2000, there is a drastic need for state leadership, a move away from landfills and the aggressive pursuit of alternative disposal technologies.

The report found that, despite a state law that outlines an effective policy of solid waste management, California continues to rely on landfills to get rid of its garbage. This is because, in part, California's lead agency responsible for solid waste management policies has emphasized landfilling in past years and there has been little pressure to develop disposal alternatives, including recycling. With landfills rapidly filling, the state has allowed a situation to develop that threatens the health of citizens and the environment, as well as depletes natural resources and engenders escalating costs.

Findings and Recommendations

The Commission's solid waste management report detailed three findings and five corresponding recommendations.

FINDING #1: California lacks an integrated system for managing its solid waste. Experts have agreed that managing solid waste rationally involves a multifaceted approach that includes source reduction, recycling, incineration and landfilling. Without such an approach, the state runs the danger of ruining the environment, affecting the health of those who live here and wasting natural resources unnecessarily.

Recommendation: The Governor and the Legislature should enact legislation that explicitly establishes a statewide program that is based on a hierarchy in which source reduction is the first priority, recycling and composting the second, environmentally safe incineration the third and environmentally safe landfill disposal the lowest priority.

Recommendation: To educate the public to the real costs of landfills, the Governor and the Legislature should require counties to establish solid waste programs that institute per-can or per-bag fees and to bill separately for garbage hauling. Further, the state should embark on an aggressive public education program to teach the value of conservation and efficient use of resources.

FINDING #2: The state lacks a comprehensive statewide recycling program. Because the state lacks such a program, landfill space decreases faster than necessary and valuable natural resources are depleted.

Recommendation: The Governor and the Legislature should enact legislation that requires local governments to prepare, adopt and implement plans to divert 25 percent of the waste that now goes to landfills. To underwrite the costs, local governments would be allowed to impose fees on generators of the waste.

Recommendation: A study should be conducted to determine the costs avoided by increasing recycling. If consistent with the results of the study, the Governor and the

Legislature should enact a program of tax credits and mandatory government purchase of recycled materials to encourage recycling and save the costs found in the study.

FINDING #3: The California Waste Management Board has been ineffective. The board has failed to meet its responsibilities to encourage integrated waste management, as already required by state law, and has failed to discourage the use of landfills. The board's effectiveness is hampered by the public's attitude to solid waste and the common perception that the board is not independent of certain interests in the waste industry.

Recommendation: The Governor and the Legislature should change the structure of the California Waste Management Board to an independent five-member board appointed by the Governor, Senate Rules Committee and the Assembly Speaker, with a diversity of membership and expertise. In addition, requirements concerning conflicts of interest should be tightened for the board.

Legislation

The Little Hoover Commission actively supported three pieces of legislation in 1989 that would overhaul the solid waste management efforts in California.

Bill	Little Hoover Role	Outcome
AB 80 (Killea) Omnibus Recycling Act of 1989. Makes changes in local and state planning requirements for solid waste disposal.	Support	Amended into AB 939
AB 939 (Sher) Omnibus Solid Waste Management, Source Reduction, Recycling, Composting and Marketing Development Act of 1989. Establishes new statutes to encourage source reduction, recycling and composting of solid waste, as well as restructures the Solid Waste Management Board.	Support	Chapter 1095, 1989 Statutes
AJR 13 (Farr) Resolution to Congress. Encourages the creation of a national recycling policy.	Support	Chapter R107, 1989 Statutes

Conclusion

The Little Hoover Commission's report on solid waste management was issued at a time when there was widespread unhappiness with the state's handling of solid waste. The report served to document the severity of the crisis and focus attention on the need for immediate solutions. With the passage of a major overhaul of the state's solid waste management structure now in law, this area will be ripe for a review in the future to determine if all recommendations have been implemented effectively.

Homeless Help: It Takes More Than A Roof

California's homeless are not a hidden problem. Not only are they highly visible all around the state, but also they are the focus of more than \$780 million worth of programs and services annually--a clear sign of commitment to and concern for the homeless on the part of Californians. Yet still the state's streets, parking lots, greenbelts, alleys and stairwells are hosts to thousands nightly. The Little Hoover Commission explored this problem in a report entitled "Meeting the Needs of California's Homeless: It Takes More Than A Roof" in June 1989.

In its report, the Commission concluded that despite the intense interest in meeting the needs of the homeless and despite the allocation of considerable resources to do so, the state has failed to provide an effective safety net that ensures people will be adequately housed.

Findings and Recommendations

The report contained three findings and 13 recommendations flowing from those findings.

FINDING #1: Because of diffused state leadership, services provided for the homeless are fragmented. As a result, some segments of the homeless population are not served or are served inadequately. Programs around the state are as diverse as the homeless themselves. But the effectiveness of this diversity is hampered by a lack of firm leadership and policy direction from above. Because no one agency or individual is in charge of setting priorities for spending, some categories of homeless are left with few or no programs and there is little control over efficient use of dollars.

Recommendation: The diverse state programs dealing with the homeless should be unified under the state Health and Welfare Agency.

Recommendation: The Department of Housing and Community Development should set up a unit to qualitatively evaluate local homelessness efforts based on state-promulgated priorities and policies, and aggressively recommend model programs and alternatives to local regions.

Recommendation: The Department of Housing and Community Development should serve as a clearing house for information on programs for the homeless.

Recommendation: The Governor and the Legislature should expand the duties of the Attorney General's Charitable Trust Division so that it can operate more effectively on the public's behalf.

FINDING #2: Availability of the three main types of homeless programs (emergency, transitional and permanent) is uneven, and there is no efficient, coordinated method of moving the homeless through the different programs. Simply placing a roof over someone's head for one night rarely solves the causes for that person's homeless state. A more coordinated and integrated approach needs to be taken if a person is trapped in a cycle of homelessness by mental illness, substance abuse problems, poor money management skills, illiteracy and/or poor work habits. This particularly needs to be accomplished for the mentally ill, substance abusers, homeless families and runaway youths, all segments of the homeless that now fall through gaps in existing programs.

Recommendation: The Governor and Legislature should fund the creation of Homeless Coordinated Intake Centers, funneling one-time grants to counties through the Department of Housing and Community Development.

Recommendation: The Governor and the Legislature should require the Health and Welfare Agency to create a training program for homeless case management workers and provide such training to county personnel.

Recommendation: The Governor and the Legislature should amend the Lanterman-Petris-Short Act to further define "gravely disabled" to allow a wider scope for treatment of the homeless mentally disabled.

Recommendation: The Governor and the Legislature should create a "provisional leave" program for mentally ill persons for continued monitoring after involuntary care is completed.

Recommendation: As funding is provided for emergency shelters, such as from state bond money, it should be focused on facilities for homeless families, runaway youths and dual-diagnosed individuals (mentally ill substance abusers).

Recommendation: The Governor and the Legislature should investigate the use of state-owned vacant, surplus property for development of transitional housing, particularly for the mentally disabled.

Recommendation: The Governor and the Legislature should expand the use of innovative tools to place people in permanent housing.

FINDING #3: Because there is no cohesive approach to a statewide housing policy, many actions at various levels of government drive up the cost of housing and/or discourage the availability of adequate, affordable housing. A complicated array of laws and regulations that changes from city to city and county to county drives up the cost of both rentals and homes. The need to address the affordability of permanent housing is as pressing as the short-term need for temporary shelters. The state should have a larger, long-range role of creating an environment where affordable housing units, rather than the numbers of homeless, will flourish.

Recommendation: The Governor and the Legislature should study the interplay and effect of land use factors including, but not limited to, slow-growth initiatives, locally imposed building fees, general plan housing elements, rent control and restrictive zoning practices.

Recommendation: The Governor and the Legislature should authorize a complete review of the Building Standards Code.

Legislation

During 1989, the Little Hoover Commission sponsored three measures and supported nine others that were in line with the homeless report recommendations. Unfortunately, only one measure met with success, three were vetoed and another five died early in 1990. Three bills remain alive.

Bill	Little Hoover Role	Outcome
SB 502 (Lockyer) Requires charitable fund-raisers to register with the Attorney General to ensure better monitoring of private efforts to raise money.	Support	Chapter 307, 1989 Statutes
AB 597 (Hauser) Makes the Department of Housing and Community Development a clearinghouse for all state homeless programs.	Support	Vetoed
AB 1691 (Bronzan) Establishes a commission to lease state hospital lands and develop transitional homeless housing.	Support	Vetoed
SB 691 (Alquist) Requires the Business, Transportation and Housing Agency to determine what single agency will be responsible for all state building standards.	Support	Vetoed
AB 1393 (Wyman) Changes definition of "gravely disabled" for purposes of involuntary treatment to include homeless persons who are "likely to deteriorate" rather than the current standard of "clear and present danger to themselves or others."	Sponsor	Died
AB 1714 (Hayden) Creates a "provisional leave" program to continue monitoring those who leave involuntary care, but who have been committed to institutional care three times in the past five years.	Support	Died
SB 820 (Alquist) Creates a pool of money for homeless services by increasing the documentary transfer charge on real property.	Sponsor	Died
ACR 46 (Hauser) Creates a special legislative committee to explore incentives to keep federal Section 8 housing in the community as rental property for low-income dwellers.	Support	Died

Bill	Little Hoover Role	Outcome
SB 1205 (Alquist) Uses general fund money to create additional funding for homeless programs, especially for families and youths.	Support	Died
AB 795 (Moore) Gives one-time grants to counties to set up Coordinated Intake Centers for homeless to integrate services and case management.	Sponsor	In Senate Appropriations
SB 1286 (Seymour) Creates tax incentives to encourage owners of Section 8 property to sell units to low-income residents.	Support	In Assembly Revenue & Taxation
SB 1288 (Seymour) Allows developers density bonuses when they contribute to a fund set up for building low-income housing.	Support	In Assembly Local Government

Conclusion

Although major shifts in the state's approach to homeless programs were not immediately adopted, the Little Hoover Commission's efforts to increase the efficiency and effectiveness of state programs will continue in future years. The Commission sees a clear linkage between this initial homeless report and a planned, but unfunded, study required by Chapter 1423, Statutes of 1988, that will explore the effect of growth management and other policies on affordable housing. It is anticipated that the growth study, if the Commission is able to go forward with it, will provide insights into the long-term aspects of homelessness.

Nursing Homes: Inadequate Care, Inadequate Oversight

When someone is frail, elderly and friendless, the State should be particularly vigilant in shielding that person from harm. Yet many of the 115,000 persons in California's nursing homes face their final days alone and neglected. The Little Hoover Commission in 1989 issued its third report on conditions in nursing homes. Entitled "The Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight," the report focused on the medical care that is provided to nursing home residents.

The current report follows in the footsteps of its predecessor reports in that substantial recommendations are made for improving the quality of life of those in nursing homes. A review of the earlier reports shows that progress has been made: "The Bureaucracy of Care," issued in 1983, resulted in the enactment of the Nursing Home Patients' Protection Act and further changes in law came out of recommendations in "New and Continuing Impediments to Improving the Quality of Life and Quality of Care in California's Nursing Homes," issued in 1987. Those two reports can be briefly summarized as follows:

The Bureaucracy of Care

Specific recommendation areas included eliminating Medi-Cal patient "dumping;" overhauling the enforcement/fining system; better defining the oversight role of the Department of Health Services; increased criminal penalties for willful and repeated violators; greater statutory rights for complainants; and creating better information systems and public access to that information. Among the changes achieved were a new class of penalties ranging from \$5,000 to \$25,000 when the facility is responsible for the death of a resident.

Legislation

Bill	Little Hoover Role	Outcome
AB 180 (Isenberg) Redefines and strengthens penalty system and increased fines for violation of patient rights and endangering patient health and safety (A and B citations).	Sponsor	Chapter 10, 1985 Statutes
AB 3580 (Duffy) Revises membership of committee on nursing homes that advises the director of the Department of Health Services.	Support	Chapter 1351, 1986 Statutes
AB 3644 (Stirling) Gives priority status to criminal cases where the elderly are victims or material witnesses.	Sponsor	Chapter 588, 1986 Statutes
SB 3923 (McClintock) Makes falsification of skilled nursing facility records a Class "A" or "B" citation (as defined).	Support	Chapter 1126, 1986 Statutes

Bill	Little Hoover Role	Outcome
SB 53 (Mello) Requires acceptance of Medi-Cal patients in licensed skilled nursing facilities.	Sponsor	Chapter 11, 1985 Statutes
SB 26 (Mello) Increases penalties for repeat facility offenders from \$1,000 to \$2,500.	Support	Chapter 856, 1986 Statutes
SB 274 (Watson) Requires the Department of Health Services to develop programs for facilities to contract with or employ geriatric nurse practitioners.	Sponsor	Chapter 119, 1986 Statutes
AB 1834 (Connelly) Requires Department of Health Services to report enforcement actions to the Board of Examiners for Nursing Home Administrators for disciplinary action.	Sponsor	Chapter 816, 1987 Statutes
AB 2047 (Katz) Requires facilities to reimburse for or replace articles lost or stolen if facility did not have reasonable safeguards.	Sponsor	Chapter 1235, 1987 Statutes
SB 73 (Lockyer) Mandates expeditious resolution of contested "B" citations and permits families to meet privately with residents.	Sponsor	Chapter 1125, 1987 Statutes
SB 526 (Mello) Designates Attorney General's Office responsible for investigation and prosecution of cases of abuse in nursing homes.	Support	Chapter 637, 1987 Statutes
SB 1220 (Mello) Allows State to place insolvent homes in receivership so as to continue caring for the patients.	Support	Chapter 666, 1987 Statutes
SB 1330 (McCorquodale) Specifies contents, terms and conditions for admissions agreements.	Support	Chapter 625, 1987 Statutes

New and Continuing Impediments To Improving the Quality of Life and the Quality of Care In California's Nursing Homes

Significant recommendation areas included increasing enforcement and penalty collection efforts by the State, allowing state receivership for certain skilled nursing facilities as an intermediate sanction, ensuring that voluntary Medi-Cal decertification would not penalize current residents, and increasing consumer information services.

Legislation

Bill	Little Hoover Role	Outcome
AB 258 (Wyman) Requires the Department of Health Services to develop theft and loss protection and recovery policies for facilities.	Sponsor	Chapter 1226, 1987 Statutes
AB 688 (Isenberg) Requires facilities that voluntarily decertify from Medi-Cal to continue to care for all patients in the facility at the time of decertification.	Sponsor	Chapter 1141, 1987 Statutes
SB 860 (Campbell) Expedites the hearing process on AA, A and B citations.	Sponsor	Chapter 84, 1987 Statutes

Unlike the two reports detailed above, the 1989 report focused solely on medical care provided to nursing home residents. In essence the report determined that high quality medical care was not the top priority of any state agency or any industry group involved with nursing homes.

Findings and Recommendations

The 1989 report included 18 findings and 18 corresponding recommendations.

FINDING #1: There is no regular formal procedure or process to regularly and systematically review and evaluate the quality of medical care provided to nursing home patients. Although the process of peer review is standard in acute care facilities, there is no similar procedure in place for chronic care settings.

Recommendation: A formal system of physician peer review should be established as a requirement for licensure and operation of all nursing homes in California.

FINDING #2: There has been little attempt made to develop guidelines for standards of medical practice in nursing homes. While there are multiple state and federal regulations regarding the nursing home and its employees, there is a comparative dearth of guidance concerning the acceptable standards of medical care.

Recommendation: An ad hoc committee should be convened to develop guidelines and standards of practice for medical care in nursing homes.

FINDING #3: For a number of people in nursing homes, effective contact with their physician is extremely difficult to either establish or maintain. Typically, physicians do not follow their patients from outpatient or hospitalized status to nursing homes. This means the nursing home resident must not only adjust to new surroundings, but also to a new physician. Often the treating physician in the nursing home may have never seen the resident prior to his or her arrival in the facility.

Recommendation: Patient neglect, or de facto patient abandonment and mistreatment, should be clearly defined in law and substantial penalties for such conduct should be prescribed.

FINDING #4: Despite the fact that the Board of Medical Quality Assurance has the legal authority to issue citations and fines, this has not been done. While nursing homes are subject to fines and citations, doctors are not. These means that the professional directly responsible for the quality of care is not subject to any mechanism for sanctions if they are needed.

Recommendation: The Board of Medical Quality Assurance should establish regulations for the issuance of citations and fines for poor medical care of nursing home residents.

FINDING #5: To a certain extent, the Board of Medical Quality Assurance has been hampered in its oversight activities by restrictive guidelines and enabling legislation and regulations. The board is not able to obtain a waiver of confidentiality of medical records when it is investigating cases. And the board cannot conduct a "blind" (names deleted) review of patient records to see if there is a pattern of poor care by a physician.

Recommendation: Investigators from the Board of Medical Quality Assurance should be granted a waiver of confidentiality for medical records for investigatory purposes.

FINDING #6: There is a lack of coordination between the Licensing and Certification Division and the Board of Medical Quality Assurance. While finger-pointing goes in both directions, the fact is that neither the Division nor the Board handles medical care complaints in a timely and professional manner.

Recommendation: The Licensing and Certification Division should immediately coordinate and centralize all reports from its regional offices concerning medical care cases that are to be referred to the Board of Medical Quality Assurance.

FINDING #7: The Licensing and Certification Division does not have a centralized referral process for complaints about medical care in nursing homes. Without this monitoring mechanism, the Division cannot track cases and be aware of time delays in resolution.

Recommendation: Both the Licensing and Certification Division and the Board of Medical Quality Assurance should rapidly improve their management information and tracking systems.

FINDING #8: It is difficult for the ordinary citizen to determine where or how to complain about conditions or treatment in long-term care facilities. Several people who testified at Little Hoover Commission hearings spoke of their frustration in trying to reach the proper authorities to lodge complaints.

Recommendation: An attachment to the current Admissions Agreement for every long-term care facility in the state should be developed by the Board of Medical Quality Assurance and the Licensing and Certification Division describing how to access and follow up with requests for information and complaint-filing procedures.

FINDING #9: There are an inadequate number of "eyes and ears" observing the care needs of the residents of long-term care facilities. The state-federal Ombudsman Program may be the sole link for some nursing home residents to the outside world.

Recommendation: The Ombudsman Program should mandate that as part of its training for all professional and volunteer staff, a portion of the curriculum shall be devoted to describing in detail the procedures for filing requests for information or complaints with the Board of Medical Quality Assurance and with the Licensing and Certification Division.

FINDING #10: There is an insufficient number of physicians who work effectively in long-term care settings. There is a lack of physicians trained in geriatric medicine and there is little educational emphasis on geriatrics for practicing professionals.

Recommendation: The Board of Medical Quality Assurance in cooperation with the University of California, the California Association of Medical Directors and the California Medical Association should develop additional training and continuing education in geriatric medicine.

FINDING #11: Although there may be a substantial oversupply of physicians in the United States, it is unlikely that this will, of itself, guide physicians to work in geriatric medicine in long-term care settings. Present training programs to right this situation are usually small and have little impact.

Recommendation: Every effort should be made to increase the number of physicians with skills in gerontology and geriatrics. The Governor and the Legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools.

FINDING #12: Given the shortages in available physicians to work in long-term care settings, the use of physician extenders has not been adequately explored.

Recommendation: Programs that enhance the role of physician extenders (physician assistants and geriatric nurse practitioners) need to be further developed. Medi-Cal requirements should be modified to permit direct payment for services provided by licensed physician assistants, geriatric nurse practitioners and other qualified nurse practitioners.

FINDING #13: The position of Medical Director of a long-term care facility is a critically important one. These medical personnel should be the model of accessible and high-quality medical care for the residents.

Recommendation: Medical Directors contracted by any California long-term care facility after September 1, 1989, should be required to have completed a specified number of Continuing Medical Education hours in gerontology and geriatric medicine as a contractual condition of initial and continued employment.

FINDING #14: The role of the Medical Director needs to be expanded in terms of the training and experience that he or she must have in order to provide medical leadership for the facility.

Recommendation: Title 22 of the California Code of Administrative Regulations should be amended in order to significantly broaden the responsibilities of the Medical Director of any long-term care facility.

FINDING #15: The number of patients and nursing homes that a Medical Director can be responsible for is unlimited.

Recommendation: No Medical Director should be responsible for more than four separate facilities or a total of 400 beds.

FINDING #16: California long-term care facilities are the home for a large number of persons who present some of the major bioethical discussion, decisions and dilemmas of our time. Decisions concerning the best interest of a patient--including such major issues as withholding treatment, the discontinuance of feeding and hydration and resuscitation--frequently take place in the long-term care setting.

Recommendation: Long-term care facilities should establish either regional or institutional Ethics Committees.

FINDING #17: Many residents of nursing homes are receiving too many psychoactive drugs. Too many residents either suffer from reactions to the interplay of various drugs or are over-drugged to make them more manageable.

Recommendation: Policy standards regarding the maintenance of mental health and the treatment of mental illness in nursing home patients need to be developed.

FINDING #18: The severe and ongoing nursing shortage has resulted in nursing homes having to depend on nursing registries to secure the services of part-time nurses. These nurses may be unfamiliar with the needs of long-term care patients.

Recommendation: Standards for the operation of nursing registries that provide part-time nurses to long-term care facilities should be quickly and cooperatively developed.

Legislation

Although the Little Hoover Commission sponsored and/or supported legislation on skilled nursing facilities in 1989, most of the bills were held over for consideration in 1990.

Bill	Little Hoover Role	Outcome
AB 1370 (Connelly) Requires the Department of Health Services to check the criminal records for all applicants for jobs in skilled nursing facilities.	Support	In Senate Committee
AB 1945 (Eastin) Allows for license suspension or revocation of skilled nursing facility licenses for failure to pay unappealed or finalized court fines or penalties.	Support	Died
SB 660 (Watson) Requires all skilled nursing facilities to establish peer review and quality assurance panels.	Sponsor	In Assembly Committee
SB 778 (Hart) Makes changes in the use of psychotropic medication for nursing home patients. Requires informed consent by patients or their representatives and limits the use of psychotropic medications under specified circumstances.	Support	In Assembly Committee
SB 1381 (Watson) Establishes definition of patient abuse, neglect or abandonment by physicians or other health professionals, and establishes criminal penalties for the same.	Sponsor	Died

Conclusion

Since it first began investigating skilled nursing facilities in 1984, the Little Hoover Commission has repeatedly expressed grave concerns about the treatment of California's elderly citizens who cannot spend their final days in their own homes. With a trilogy of reports, the Commission has tackled nursing home problems from a wide range of perspectives: administrative, medical and simple humanity. Over the years, the Commission's sponsorship and support have resulted in the passage of 13 new laws to increase the effective monitoring of facilities, to safeguard the rights of patients and their families and to improve the quality of care. It is anticipated that the Commission will monitor progress in this type of facility in the future and continue to pursue the implementation of the recommendations that it has forged in the past six years.

Board and Care: Homes for the Forgotten

The nation watched in shock in December 1988 as Sacramento police unearthed the bodies of seven elderly people from the backyard of an unlicensed board and care facility. But the Little Hoover Commission, which sharing the universal dismay, could hardly be shocked. It had investigated such residential facilities in reports issued in December 1983 and February 1985, and was on the verge of issuing yet another followup in early 1989. The conclusion of all of these reports was that the state has not committed adequate resources--either in manpower, legal sanctions or computer systems--to ensure that board and care homes are safe havens for the elderly.

The earlier reports can be summarized as follows:

Community Residential Care in California: Community Care as a Long-Term Care Service

The major areas for findings in this December 1983 report included the need for case management services for the elderly, the need for training and certification for caregivers, the fact that the State's data base and information management systems were not adequate, the need for more "eyes and ears" to inspect facilities and the failure of the state to root out unlicensed facilities.

Legislation

Bill	Little Hoover Role	Outcome
AB 3474 (Wyman) Establishes automated license information system to maintain records for facilities.	Sponsor	Chapter 1524, 1984 Statutes
AB 3589 (Mojonnier) Permits residents of community care facilities to organize resident councils.	Sponsor	Chapter 1272, 1984 Statutes
AB 3662 (Filante) Creates 24-hour hotline from community care facilities to State Ombudsman.	Sponsor	Chapter 1623, 1984 Statutes
AB 3839 (Rogers) Authorizes State Ombudsman to form a foundation eligible for tax deductible donations.	Sponsor	Chapter 1206, 1984 Statutes
AB 3906 (Allen) Requires publication of a consumer brochure for licensed community care facilities.	Sponsor	Chapter 552, 1984 Statutes
AB 133 (Allen) Develops yellow pages listing for community care facilities according to major group served.	Sponsor	Chapter 89, 1984 Statutes

Followup Report on Conditions in Community Residential Care Facilities in California

This February 1985 letter report focused on the failure of the Department of Social Services to respond to and resolve complaints, to coordinate its monitoring efforts with other governmental units and to manage its resources more effectively. In addition, the letter report urged adoption of all the recommendations from the previous report that had not yet been implemented.

Legislation

Bill	Little Hoover Role	Outcome
AB 17 (Wright) Requires placement agencies to place persons only in licensed facilities.	Sponsor	Chapter 1096, 1985 Statutes
AB 83 (Herger) Requires community care facilities to adhere to the rules for all "long-term care facilities."	Sponsor	Chapter 503, 1985 Statutes
AB 384 (Filante) Prohibits operation of unlicensed community care facilities in the State.	Sponsor	Chapter 728, 1985 Statutes
AB 1539 (Seastrand) Encourages regular family involvement with residents of care facilities.	Sponsor	Chapter 954, 1985 Statutes
AB 1674 (Wyman) Requires timely processing of license revocations.	Sponsor	Chapter 1536, 1985 Statutes
AB 1676 (Wyman) Allows the Department of Social Services to take stronger enforcement action against deficient care facilities.	Sponsor	Chapter 1372, 1985 Statutes
AB 1940 (Bates) Establishes additional enforcement mechanisms for Department of Social Services against unlicensed facilities.	Sponsor	Chapter 1415, 1985 Statutes
SB 185 (Mello) "Residential Facilities for the Elderly Act" establishes separate licensing procedure for elderly care facilities.	Sponsor	Chapter 1127, 1985 Statutes

The Commission's January 1989 report, entitled "Report on Community Residential Care for the Elderly," continued to focus on the state's role as a watchdog over board and care facilities.

The report notes that one in every six residential care facilities is unlicensed and found that a backlogged, time-consuming licensing process actually encourages operators to begin their businesses with no licenses. An increased fine structure recommended in earlier Little Hoover Commission reports is either not used at all by the state or is enforced so haphazardly that its deterrent effect is little. Overworked ombudsmen can only reach about 40 percent of the facilities each year, and they estimate at least 550 cases of abuse a year in the small numbers of places they visit.

All in all, the 1989 report found little positive about the state's oversight of board and care facilities.

Findings and Recommendations

The January 1989 report included 11 findings and 10 areas of recommendations. (Since recommendations may spring from more than one finding, the recommendations are presented separately below. The original report lists multiple, specific actions to be taken under each general recommendation.)

FINDING #1: Abuse and neglect of residents are ongoing problems. Surprise inspections by Commissioners yielded horror stories of residents lying in filth in cold rooms, unable to clear flies away. Statistics were no more comforting: During a 12-month period ending June 30, 1987, ombudsmen received 12,214 complaints of various types of abuse from board and care residents.

FINDING #2: Performance by the Community Care Licensing Division often is characterized as arbitrary and slow. Applications for licensure were severely backlogged and the division's computer system was not adequate to allow the division to operate effectively and efficiently. During the first three months of 1988, almost 500 licensure requests were pending action each month as applications poured in faster than the division could handle them.

FINDING #3: The Department of Social Service's enforcement program suffers from underutilization of penalties, fines and relationships with local law enforcement agencies. Fines for licensing violations in residential care facilities are much less than for similar violations in skilled nursing facilities. Of the fines that are assessed, only half are collected. And coordination between the department and local law enforcement agencies, which could result in prosecutions, is almost completely lacking.

FINDING #4: Unlicensed facilities are undeterred by current enforcement efforts. Not only does the Department of Social Services do little to track down and impose sanctions on unlicensed facilities, but the department also fails to publish updated lists of licensed facilities so that the elderly can be referred to them.

FINDING #5: Case management services are not systematically available to older Californians. Because many of the residents of board and care facilities have lost touch with outsiders (either family or friends), they have special need of coordinated services.

FINDING #6: State fire regulations do not recognize residential facilities as a special case. Residential care facilities may be faced with slow inspection and enforcement practices, as well as rigid interpretations of requirements that may not be applicable to the board and care facility's situation.

FINDING #7: Small facilities lack the special oversight they need to function in the residential care network. Burnout among caregivers and isolation from others providing the same types of services may hinder the performance of board and care facilities.

FINDING #8: Quality is a low priority in California's residential care regulatory program. Licensing alone cannot prescribe and monitor the quality of care.

FINDING #9: Emergency relocation procedures are not standardized and are underfunded. When facilities are closed or go out of business, residents may be caught in a vacuum of responsibility between the state and local agencies.

FINDING #10: The costs of providing residential care are not documented by the state. Those who provide residential care argue that state support through programs such as SSI/SSP is not set at a high enough level to reimburse board and care homes for quality care. But the state neither measures costs nor assesses financial need of residential care operators.

FINDING #11: Private funding mechanisms are too new and untried to relieve the public sector's financial burden. While some insurance companies are beginning to offer coverage, most policies are expensive and restrict coverage to skilled nursing facilities.

Recommendation #1: Certify residential care facility administrators to increase their level of training and responsibility.

Recommendation #2: Authorize and fund counties, at their option, to license small residential care facilities and provide placement counseling and assistance.

Recommendation #3: Identify new revenue sources from which to increase funding for residential care for the elderly.

Recommendation #4: Improve effectiveness of monitoring and law enforcement.

Recommendation #5: Launch a well-coordinated campaign to detect and eliminate unlicensed facilities.

Recommendation #6: Strengthen current law and regulations pertaining to resident protections.

Recommendation #7: Develop protocols for emergency services coordination.

Recommendation #8: Develop a waiver application procedure for requesting permission to operate a locked facility.

Recommendation #9: Upgrade the Department of Social Services' information management capabilities.

Recommendation #10: Develop fire safety regulations specific to residential care facilities.

Legislation

The Little Hoover Commission sponsored or supported 21 residential care bills in the 1989 legislative year. Fourteen were signed into law, one was amended into a bill that was signed, one was vetoed and five were pending as the new legislative year began in 1990.

Bill	Little Hoover Role	Outcome
AB 314 (Leslie) Requires the Department of Social Services to determine if applicant for residential care facility licensure has been arrested for specified crimes.	Support	Chapter 825, 1989 Statutes
AB 1043 (Hansen) Establishes an amnesty program for unlicensed residential care facilities for the elderly.	Sponsor	Died
AB 1112 (Bentley) Requires the Department of Social Services to establish regulations and criteria for locked facilities for the elderly.	Sponsor	Amended into SB 481
AB 1451 (Speier) Requires third-party notification by the facility of substantiated complaints or citations. Also requires posting in facility of substantiated complaints or citations.	Support	Chapter 565, 1989 Statutes
AB 1455 (Pringle) Allows counties to license residential care facilities for the elderly having six beds or less.	Sponsor	Chapter 488, 1989 Statutes
AB 1484 (Bentley) Requires State Fire Marshal to develop new fire code classification for residential care facilities.	Sponsor	Chapter 1261, 1989 Statutes
AB 1554 (Wyman) Allows both district attorneys and city attorneys to prosecute violations regarding board and care facilities.	Sponsor	Chapter 675, 1989 Statutes
AB 1556 (Wyman) Requires Department of Social Services to establish in-service training for operators and designated employees of residential care facilities.	Sponsor	In Senate Committee

Bill	Little Hoover Role	Outcome
AB 1815 (Connelly) Establishes emergency protocols for transfers of residents of residential care facilities. Requires Department of Social Services to establish regulations regarding procedures to use to close facilities.	Sponsor	Died
AB 1989 (Hannigan) Redefines residential care facilities fire regulations to allow quad canes and walkers in selected facilities.	Sponsor	In Senate Committee
AB 2323 (Hannigan) Requires Department of Social Services and others to complete a study to establish criteria for certification of administrators for residential care facilities. Also requires DSS to survey training and education requirements for other hands-on employees.	Sponsor	Chapter 434, 1989 Statutes
AB 2348 (Harvey) Establishes doubled fines for unlicensed facilities that, when detected, refuse to apply for licensure, or cannot become licensed. Also allows criminal prosecution of such facilities.	Sponsor	In Senate Committee
AB 2414 (Waters, N.) Requires residential care facilities and child day care facilities to post and use license number in all public advertisements and documents.	Support	Chapter 458, 1989 Statutes
ACR 41 (Pringle) Requires Health and Welfare Agency to identify new funding sources, outside of new taxes, for residential care facilities.	Sponsor	Chapter R116, 1989 Statutes
SB 481 (Mello) Allows licensure of residential care facilities that provide care to residents with irreversible dementia; establishes pilot programs.	Support	Chapter 1372, 1989 Statutes

Bill	Little Hoover Role	Outcome
SB 944 (Rosenthal) Provides for criminal penalties for state employees who divulge specified information regarding residential care facilities to any member of the public.	Support	Chapter 694, 1989 Statutes
SB 1076 (Bergeson) Requires written notice of public access to Department of Social Service facility licensing reports.	Sponsor	Chapter 911, 1989 Statutes
SB 1077 (Bergeson) Requires inclusion of facility license number in all advertising and correspondence.	Sponsor	Chapter 465, 1989 Statutes
SB 1102 (Roberti) Allows family councils in residential care facilities.	Support	Chapter 466, 1989 Statutes
SB 1166 (Mello) Omnibus residential care facilities reform bill. Deals with licensure, enforcement, minimum requirements for housing and funding.	Support	Chapter 1115, 1989 Statutes
SB 1502 (Ayala) Establishes amnesty program for unlicensed residential care facilities and requires the State Fire Marshal to establish specific classifications for residential care facilities.	Sponsor	Vetoed

Conclusion

The Little Hoover Commission, through its reports, recommendations and significant legislative success, has been able to have substantial impact in the past year on the issue of residential care facilities. Progress has been made on ensuring that the public is well-informed when it chooses a facility, on educating and training those who work in the facilities and on prodding the state into a more effective oversight mode. The long-term effect of these measures, however, will have to be assessed in the future.

Crime and Violence in California's Schools

When schools do not educate children, it is a tragedy. But when schools fail at the very minimum to keep children safe, it is nothing short of a scandal. Yet each day in California, parents send their offspring to school to be exposed to assaults, drugs and violent crimes. The Little Hoover Commission examined the situation in its December 1988 report entitled "Report on Crime and Violence in California's Public School System."

The report found that despite a constitutional right to safe school campuses, students and school staff are exposed to violent crimes, alcohol and drug abuse and property crimes. For the fiscal year 1986-87, schools reported more than 70,000 violent crimes and more than 71,000 property crimes.

Findings and Recommendations

The Commission's report contained two findings and 12 recommendations.

FINDING #1: Crime and violence in California's public schools are serious threats to students and staff. Crime and violence on school campuses exist for many reasons, including a continuation of the crime and violence in the surrounding community, ineffective administration at some of the schools, and a lack of leadership and direction by the State to ensure the safety of children.

Recommendation: The Governor and the Legislature should create incentives to encourage parent and business community involvement in schools.

Recommendation: The Governor and the Legislature should support the School Safety Partnership program with legislation that would expand its resources and responsibilities.

Recommendation: The Department of Education should adopt model curriculum standards for alcohol and drug abuse education.

Recommendation: The Governor and the Legislature should require each school to have an annual school safety plan.

Recommendation: The Department of Education should require teachers and administrators to have training in issues of safety, alcohol and drug abuse prevention, methods of handling disruptive activity on campus, youth gangs and legal responsibilities.

Recommendations: The Governor and the Legislature should establish a nongovernmental institute for school safety to conduct research, provide a clearinghouse for information and develop training materials.

Recommendation: The Governor should designate a portion of funds available through the Office of Criminal Justice Planning to assist schools with safety programs.

Recommendation: The Superintendent of Public Instruction should assume an aggressive leadership role by placing a high priority on school safety.

FINDING #2: School crime reports do not accurately describe the extent of crime and violence in schools. The reports are inaccurate because of the districts' inconsistent interpretation of Department of Education instructions, differences in data collection techniques and the State's inability to enforce reporting requirements.

Recommendation: The Department of Education should be allowed to mandate that all school districts attend training workshops on crime reporting.

Recommendation: The Department of Education should develop and implement a system for monitoring school crime reports for accuracy.

Recommendation: The Department of Education should refine its instructions for completing the school crime report.

Recommendation: The Governor and the Legislature should enact legislation that provides for criminal sanctions against school officials who intentionally misreport crime figures.

Legislation

The Little Hoover Commission in 1989 sponsored or supported four pieces of legislation stemming from the school safety report.

Bill	Little Hoover Role	Outcome
AB 450 (La Follette) Encourages and makes grants available for schools to develop specified school safety plans.	Support	Chapter 1253, 1989 Statutes
AB 1113 (Bader) Expands the duties of the Department of Education and the Attorney General's School Safety Partnership program.	Sponsor	In Senate Committee
AB 1114 (Bader) Establishes a California School Safety Institute to do research and act as a clearinghouse for information on school crime.	Sponsor	Dropped
AB 1395 (Wyman) Mandates attendance by school district employees at Department of Education sponsored workshops on school crime reporting.	Sponsor	Died

Conclusion

As the Commission issued its report on school safety, the state was rocked by the actions of a man who entered a Stockton primary school yard and indiscriminately sprayed children with automatic gunfire, killing four and wounding others. This tragic incident was an extreme case of the kinds of crime that students face every day in California, but served to highlight the problem dramatically. The Little Hoover Commission will continue to pursue reform in this area so that children will have a safe environment for learning.

California's State Public Defender

The Little Hoover Commission turned its spotlight on the Office of the State Public Defender in 1988 because of concern about the increasing cost of its operation and the potential for serious delay in the justice system.

In a report issued in October 1988, the Commission found that the cost of indigent appellate defense has risen dramatically--\$9.7 million in 1981-82 compared to \$32 million in 1988-89, an increase of 230 percent in seven years. While some of this added cost was due to an increase in the number of capital cases, much of it was due to an inefficient operation that failed to handle cases in an expedient manner. Because of this inefficiency, the state's indigent appellant defense budget is now divided between the State Public Defender and the court-appointed private counsel system, resulting in duplicative administrative and overview costs.

Findings and Recommendations

The Commission's State Public Defender report included seven findings and eight recommendations. (Since recommendations embrace the impact of more than one finding, they are listed separately below.)

FINDING #1: Indigent appellate defense in California could be provided in a more effective and less costly manner. Because California's case load is divided between two systems, one lodged in the judicial branch and one in the executive branch, there are inefficiencies and duplications. There is competition between the two systems for certain types of cases, shortages of attorneys for other types of cases, duplicative administrative and oversight costs and less effective handling of cases.

FINDING #2: The professional work performed by the Office of the State Public Defender is currently more complex than the work performed by private court-appointed counsel and is at least comparable in quality. This disparity in comparable cases, as well as a lack of cost information, makes it difficult to make valid cost comparisons.

FINDING #3: The Office of the State Public Defender has recently focused its efforts on capital and complex non-capital cases, but has had trouble achieving its own workload productivity goals. This failure is attributable to several factors including faulty caseload projection methodologies, an inability to control type and case numbers assigned to the office and unanticipated, excessive staff turnover.

FINDING #4: The Office of the State Public Defender needs to develop workload standards to measure staff performance. Although the office tried to set caseload standards in 1978, and again in 1986, it has been unsuccessful in applying or enforcing such standards.

FINDING #5: The Office of the State Public Defender has not implemented an effective management information system to track cases and monitor and control the work of its staff.

FINDING #6: The lack of a consistent case selection process has hampered the workload management efforts of the Office of the State Public Defender. In most of the appellate districts, the State Public Defender has very little say in what cases it is assigned or how many cases it must carry. This makes it difficult to manage case workloads.

FINDING #7: California is experiencing an increase in the amount of work associated with death penalty appeals due to an increase in the number and complexity of appeals. Adding particular strain to the system is the number of appeals that may result in federal review. From 1978 through the end of 1986, five death penalty cases were affirmed by the state Supreme Court; but from 1987 through August 1988, 37 capital cases were affirmed.

Recommendation #1: The Office of the State Public Defender as a distinct executive branch agency should be abolished and the functions of the current office, the Appellate Projects and private court-appointed counsel should be merged into a single autonomous agency within the judicial branch of government.

Recommendation #2: The director of the new Appellate Defense Agency should be a member of the State Bar and should be appointed by Judicial Council.

Recommendation #3: Until the above are implemented, the Office of State Public Defender should continue its efforts to develop, implement and enforce workload production standards.

Recommendation #4: The office should assign a high priority to implementing a comprehensive timekeeping and docketing system.

Recommendation #5: The office should increase the current law clerk program in order to expose more law students to criminal appellate work and to identify potential staff candidates.

Recommendation #6: The Judicial Council should periodically retain an independent consultant to perform a detailed cost analysis of the public defender system and its functions.

Recommendation #7: The public defender system should collect, maintain and annually report to the Judicial Council information relating to the cost of the indigent criminal appellate work.

Recommendation #8: The public defender system should limit itself solely to legal representation in court of indigent individuals convicted of felonies. It should not engage in legislative advocacy or educational efforts of incarcerated individuals.

Legislation

Because of a change in leadership at the Office of the State Public Defender, most entities involved with the public defender system preferred to adopt a "wait and see" attitude with regard to the Little Hoover Commission's recommendations. Therefore, no legislation was pursued in 1989 or was anticipated in 1990.

Conclusion

Although no specific action has taken place on the Little Hoover Commission's primary goal of restructuring the public defense system, progress has been made on other goals recommended in the report. A status report from the Office of the State Public Defender one year after the Commission's report indicated that steps had been taken to implement a workload production standard program, comprehensive time-keeping and docketing systems and an expanded law clerk's program. The Little Hoover Commission anticipates reviewing progress of the Office of the State Public Defender in the future before pursuing the report's primary recommendation.

California's Fragmented Approach to Drug Programs

The Little Hoover Commission in June 1988 issued a letter report on the state's system of handling state and federal drug use prevention funds. While finding that existing law addressed the need for coordination, the Commission discovered that in practice the anti-drug programs were split among three departments: Department of Alcohol and Drug Programs, the Department of Education and the Office of Criminal Justice Planning. As a result, there was a lack of coordination and control over the use of funding and resources for drug programs.

Findings and Recommendations

The Commission's letter report contained three findings and 10 recommendations. (Since recommendations address the interplay of all three findings, they are listed separately below.)

FINDING #1: Existing requirements and mechanisms for coordinating drug programs are frequently ignored or underutilized. Financial and administrative responsibility for drug programs is fragmented. Among other things, this contributes to an inability to collect uniform data on the success of such programs.

FINDING #2: The intense competition for drug program funding adversely affects the coordination of drug programs. Funds are not funneled through one source.

FINDING #3: Considerable barriers exist which hinder the coordination of drug program funding. Federal, state and local groups each bring their own perspectives and procedures into play.

Recommendation #1: The Governor and the Legislature should establish a master plan for addressing drug abuse in California that would encourage cooperation and coordination.

Recommendation #2: The Governor's Policy Council on Drug and Alcohol Abuse should be involved in the development of the goals and priorities established in the State's master plan.

Recommendation #3: The Governor and the Legislature should adopt a flat-rate incentive payment of up to \$50,000 to those counties choosing to assign responsibility of coordination of drug program funding from all sources to the county drug program administrator.

Recommendation #4: The Governor's Policy Council for Drug and Alcohol Abuse should form standardized definitions of drug abuse prevention, treatment and enforcement programs and services to be adopted by all State agencies.

Recommendation #5: The Department of Alcohol and Drug Programs should prepare standardized data collection forms for use by all programs in receipt of state funds.

Recommendation #6: The Governor's Policy Council on Drug and Alcohol Abuse should prepare an annual report of aggregated data from all programs.

Recommendation #7: The Governor and the Legislature should study the feasibility of establishing a computerized management information system dedicated to providing up-to-date information to agencies providing drug program services.

Recommendation #8: The Governor and the Legislature should require the California State Library Foundation to publish a drug program supplement to the "Catalog of California State Grants Assistance."

Recommendation #9: The Departments of Alcohol and Drug Programs, Education and Justice and the Office of Criminal Justice Planning should cosponsor annual conferences for the purpose of facilitating presentation of recent findings on drug abuse prevention.

Recommendation #10: The Attorney General's Office should continue its sponsorship of the community action seminars, which bring together prevention teams in each county.

Legislation

No legislation was carried based on this report.

Conclusion

Although no specific legislation was enacted out of the Commission's report, a number of compatible measures impacting the drug program have been incorporated into law. The Little Hoover Commission anticipates returning to this area for review once the Office of Criminal Justice Planning has had time to implement recent legislation giving it a leadership role in drug program coordination in the schools.

The Road to Nowhere: California's Highway System

In March 1988, the Little Hoover Commission pointed out that California was on the verge of a transportation crisis that would affect the economic prosperity of the state. Even though the Governor and the Legislature have committed \$2.7 billion per year to developing and maintaining the transportation system, the Commission found that California's ability to meet its transportation needs were being eroded by inflation, project delivery delays and project cost increases.

The Commission's report, entitled "The Planning, Operation and Funding of California's Highway System," laid out both short- and long-term solutions to the problems the Commission found.

Findings and Recommendations

The Little Hoover Commission's report contained eight findings and 16 recommendations, four of them short-term and 12 of them long-term solutions.

FINDING #1: The State is not aggressively pursuing immediate options to reduce traffic congestion. Because of pressing needs now and in the future, the state will not be able to build itself out of congestion but instead should consider low-cost operational improvements and transportation systems management techniques.

FINDING #2: Caltrans has an inadequate long-term planning process. The bulk of Caltrans resources are focused on short-range programs and year-to-year plans. The lack of planning may lead to additional transportation problems in the future because resources may not be expended prudently.

FINDING #3: Highway project development and approvals are unnecessarily delayed due to procedural problems in the planning process. The state has a five-year plan that is updated annually for the highway system, mass transportation and aeronautics projects. But because cost estimates are understated, this plan over-commits the funding and establishes unrealistic project schedules that cause additional delays and cost increases.

FINDING #4: Caltrans has insufficient staffing available to deliver the transportation program in a timely manner. Twenty-five percent of state funded highway projects and 60 percent of locally funded highway projects have been delayed, including proposed highway projects that are being funded by local governments and private developers.

FINDING #5: The environmental process is cumbersome and results in project delays and increased project delivery costs. Both the state and federal governments have environmental impact laws and one document is produced to satisfy both entities. But the review of this document is performed consecutively rather than concurrently, resulting in four- to six-month delays.

FINDING #6: State funding available for transportation is inadequate. Over the last 20 years, the funding available for transportation has not kept up with inflation. At the same time, California's existing roads are growing older and need maintenance, and Californians are traveling more miles per year than ever before.

FINDING #7: Current funding allocation requirements hinder the effective allocation of State

Highway Funds. Because of formulas to split money between the north and the south part of the state, as well as to provide a minimum allocation for each county, funds are not always expended on the highest priority projects.

FINDING #8: The state has not developed a position for long-term federal funding after the completion of the interstate program. The federal government is considering three different approaches to providing funding once its interstate program ends in 1992. Unless California takes an aggressive stance on which approach it favors, it may end up with less than its fair share of funds.

Short-Term Recommendations:

Recommendation #1: The Governor and the Legislature should aggressively pursue options to reduce congestion in urban areas.

Recommendation #2: Programs such as the SMART Street program and low-cost operational improvement should be given high priority.

Recommendation #3: The Governor and the Legislature should permit the Department of Transportation to contract out for project development activities.

Recommendation #4: Caltrans should continue to encourage cities and counties to contract out project development activities to qualified private engineering firms whenever necessary.

Long-Term Recommendations:

Recommendation #5: The Governor and the Legislature should establish a Blue Ribbon Ad Hoc Commission on transportation to examine the long-term needs of the state through the year 2010.

Recommendation #6: The Governor and the Legislature should restructure the county minimum formula.

Recommendation #7: The Governor and the Legislature should modify the county minimum allocation for all counties to exclude expenditures necessary for safety and support costs.

Recommendation #8: The Governor and the Legislature should expand the criteria for projects eligible for statutory exemption from the environmental clearance process.

Recommendation #9: The Governor and the Legislature should exempt highway projects that expand the capacity of existing highways from the environmental clearance process.

Recommendation #10: The Governor and the Legislature should seek a federal demonstration project that would delegate authority for review and approval of the National Environmental Policy Act documents to the State.

Recommendation #11: The Governor and the Legislature should direct Caltrans to undertake a study to further streamline the environmental clearance process, both internally and externally.

Recommendation #12: The Department of Transportation should develop and implement a long-range planning process that will allow the State in cooperation with local and regional agencies to project future transportation needs.

Recommendation #13: The Governor and the Legislature should modify the State Transportation Improvement Program process to allow for better coordination with the budget process.

Recommendation #14: The Governor and the Legislature should address the long-term state funding shortfall.

Recommendation #15: The Governor and the Legislature should empower the Commission on State Finance with the authority to review and approve the inflation rates for development of the State Transportation Improvement Plan.

Recommendation #16: The Legislature should adopt a Joint Resolution stating California's preferred federal program after completion of the interstate program in 1992.

Legislation

The Little Hoover Commission sponsored or supported four bills on transportation in 1988. All were successful.

Bill	Little Hoover Role	Outcome
AB 1573 (Eastin) Accelerates the process by which locally funded State highway projects can be planned and constructed.	Support	Chapter 886, 1988 Statutes
AB 1575 (Eastin) Requires the Department of Transportation to prepare a study and present recommendations to the Legislature on ways to improve the efficiency of the environmental review process for State highway projects.	Sponsor	Chapter 152, 1988 Statutes
AB 3705 (Eastin) Requires transportation planning agencies, for urban areas with more than 50,000 in population, to include a separate transportation system management element in the regional transportation plan.	Support	Chapter 752, 1988 Statutes

Bill	Little Hoover Role	Outcome
AJR 63 (Katz)	Sponsor	Approved
<p>This resolution calls on Congress to reduce or eliminate the federal gas tax and the federal role in funding highway construction programs after 1993, in order to allow resources to be focused on state and local transportation priorities.</p>		

Conclusion

The Little Hoover Commission report on transportation came at a critical time for California's transportation needs. As the report pointed out, the state fell short of funding the projects envisioned by the five-year construction plan and by 1989, the year after the report was issued, the State was suspending work on projects until more funds were available.

The Commission's report focused on many of the same elements that in 1989 were included by a bipartisan, many-factioned coalition in a plan that would substantially revamp the State's approach to transportation, as well as substantially increase funding. That plan, embodied in Proposition 111 on the June 1990 ballot, will achieve many of the goals outlined by the Commission, including intensive use of regional planning and transportation system management techniques.

California's Workers' Compensation System

California's Workers' Compensation System, the largest in the United States, has seen a rapid rise in premium payments and operating costs while at the same time paying among the lowest benefits to workers in the country. With these concerns in mind, the Little Hoover Commission in March 1988 issued its report entitled, "A Review of the Current Problems in California's Workers' Compensation System."

The Commission found that the system suffered from delays that slowed benefits to workers and raised administrative costs, a lack of persistence in pursuing suspected fraud and an increasing perception of the program as a negative for California's business climate.

Findings and Recommendations

The report contained eight findings and 13 recommendations. (Since recommendations may embrace more than one finding, they are listed separately below.)

FINDING #1: The cost of operating California's Workers' Compensation System is among the highest in the United States. Premium rates for coverage are among the highest in the country, and the number of claims filed and litigated have been increasing.

FINDING #2: Neither private insurers nor the Department of Insurance are actively encouraging the investigation and prosecution of fraud and abuse in the Workers' Compensation System. Private insurers referred only 160 cases of suspected fraud to the Fraud Bureau of the Department of Insurance in the past eight years. Only 17 cases were opened for investigation by the Department and only one of those cases was prosecuted.

FINDING #3: Delays in the Workers' Compensation System have slowed payments to injured workers and increased administrative costs. The average injured employee during the first half of 1987 had to wait 32.5 days for the first benefit payment, more than twice as long as the 14 day standard established in regulations. In 1986, it cost 52 cents in direct overhead to deliver \$1 in benefits to the injured worker compared to 32 cents 10 years earlier.

FINDING #4: Employers who do not report accurate wages to insurance carriers effectively raise premium rates for other employers. While the extent of such inaccurate reporting is not known, no central organization is focusing significant attention on locating and penalizing employers who follow this practice.

FINDING #5: The escalating use of employer liability insurance has significantly raised the costs of employers and carriers. Since 1979 there has been a dramatic increase in the number of civil suits brought against employers, raising the costs for employers and carriers.

FINDING #6: The increase in subjective claims for psychological disability has had a negative impact on the workers' compensation system. From 1980 to 1986, claims for mental stress injuries increased 531 percent and added to litigation figures. This in turn drove up administrative costs, increased administrative hearing backlogs and caused delays of benefits to workers.

FINDING #7: The effectiveness of the use of vocational rehabilitation training in California has not been evaluated. Vocational rehabilitation costs have grown from a total of two percent of the

system in 1976 to 15 percent of benefit costs in 1986. The effectiveness of this training, as administered by the California system, has never been evaluated.

FINDING #8: Opportunities exist to better control the cost of vocational rehabilitation programs. One of the major factors that increases the cost of vocational rehabilitation is the delay and disruption in commencing and completing such plans by qualified workers. Other states have taken measures to track and control vocational rehabilitation costs and results.

Recommendation #1: The Department of Insurance Fraud Bureau should establish written criteria for opening and closing fraud and abuse cases.

Recommendation #2: The Governor's Multi-Agency Task Force on the Underground Economy should specifically establish a method to identify employers who intentionally fail to report wages or who misclassify employees in order to reduce workers' compensation premiums.

Recommendation #3: The Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau should establish a policy and method to identify employers who change business or corporate identities in order to avoid being properly rated based upon prior claims experience.

Recommendation #4: The current allowable vocational rehabilitation service should be modified based upon the evaluation of studies of long-term effectiveness and costs of such programs.

Recommendation #5: The Governor and the Legislature should provide the Division of Industrial Accidents with the authority to identify insurance companies based on poor performance, including untimely payment of benefits.

Recommendation #6: The Department of Insurance should require the Workers' Compensation Insurance Rating Bureau to collect information on the carrier's employer liability policy sections and to recommend a standardization of policies.

Recommendation #7: The Department of Industrial Relations should consider the use of professional court administrators to assess and manage the ongoing administrative systems and calendars of the Workers' Compensation Appeals Board Offices.

Recommendation #8: The Department of Industrial Relations should consider assigning Motions and Settlements Judges to review only Compromise and Release agreements as a method of expediting the adjudication process.

Recommendation #9: The Governor and the Legislature should enact legislation to require a single and final "agreed upon third party" medical report when the results of two previous reports do not agree.

Recommendation #10: The Governor and the Legislature should enact legislation to repeal the "power press" exception to general workers' compensation coverage.

Recommendation #11: The Department of Industrial Relations should examine the impact of recently implemented regulatory examination protocols on the evaluation of claims for psychological and stress-related injuries.

Recommendation #12: The Governor and the Legislature should consider adopting legislation to clarify and strengthen the Insurance Commissioner's and Director of Industrial Relations powers to assess penalties on carriers and self-insured employers for delaying payment to injured workers.

Recommendation #13: The Governor and the Legislature should consider requiring employers to provide employees with a thorough description of the full spectrum of benefits available through the workers' compensation program when an employee is hired.

Legislation

The Little Hoover Commission supported or sponsored seven pieces of legislation in 1988 and 1989, eventually culminating in one omnibus bill passed late in 1989.

Bill	Little Hoover Role	Outcome
AB 4222 (W. Brown) Establishes pilot projects in designated Workers' Compensation Appeals Board Offices based upon civil court procedures, to speed adjudication and claims settlement processes.	Support	Died (1988)
SB 1775 (B. Green) Provides the Division of Industrial Accidents with the legal authority to identify insurance carriers for audit, based upon poor performance as defined, and to specify necessary audit and reporting procedures to the Department of Insurance.	Sponsor	Amended into SB 323 (1988)
SB 1786 (B. Green) Gives the Director of Industrial Relations specific authority to assess penalties upon insurance carriers and self-insured employers for unwarranted delays in settlement or payment to injured workers.	Sponsor	Amended into SB 323 (1988)
SB 323 (Lockyer) Omnibus Workers' Compensation Reform Bill of 1988. Raises benefit levels, institutes review of rate setting, tightens provisions for vocational rehabilitation, develops processes and criteria for speeding hearings and claims settlement, provides penalties for delayed claims payments, revises medical basis for claims of mental stress, and revises requirements for medical evidence for claims.	Support	Held in committee; basis for AB 276 (1989)

Bill	Little Hoover Role	Outcome
AB 993 (Bader) Requires the Department of Insurance Bureau of Fraud to establish criteria for investigation and referral of potential fraud cases.	Sponsor	Amended into AB 276 (1989)
AB 2032 (Margolin) Omnibus Workers' Compensation Reform Act of 1989. Deals with eligibility requirements, benefit levels, claims processing and other related matters.	Support	Amended into AB 276 (1989)
AB 276 (Margolin) Workers' Compensation Reform Act of 1989. Raises benefit levels, institutes review of rate setting, tightens provisions for vocational rehabilitation, develops processes and criteria for speeding hearings and claims settlement, provides penalties for delayed claims payments, revises medical basis for claims of mental stress, and revises requirements for medical evidence for claims.	Support	Chapter 892, 1989 Statutes

Conclusion

The Little Hoover Commission's two-year fight to win reform of the Workers' Compensation process was successful. How the many changes in law are actually implemented, however, will bear review in the future. The Commission will want to ensure that the reforms achieve the goals of making the system more effective and efficient for workers, employers and program administrators.

Appendix A

The following were members of the Little Hoover Commission during 1988 and 1989 (alphabetically):

Senator Al Alquist	George Paras
Mary Anne Chalker	Nathan Shapell, Chairman
Albert Gersten Jr.	Abraham Spiegel
Richard Gulbranson *	Barbara Stone
Haig G. Mardikian, Vice Chairman	Richard R. Terzian
Senator Milton Marks	Assemblyman Phillip Wyman
Assemblywoman Gwen Moore	

Commission staff include the following:

Jeannine L. English, Executive Director
Michael R. Tritz, Deputy Executive Director
Michael S. Cannon, Legislative Coordinator
Kathleen Johnson, Project Editor
Lillian E. DeYoung, Executive Assistant

* Mr. Gulbranson served on the Commission from September 15, 1988 until he resigned on June 30, 1989. He replaced M. Lester Oshea, who resigned on June 24, 1988. The seat has remained vacant since Mr. Gulbranson resigned.

Appendix B

Reports issued by the Little Hoover Commission in 1988 and 1989:

1. A Review of the Current Problems in California's Worker's Compensation System--March 1988
2. A Report on the Planning, Operation and Funding of California's Highway System--March 1988
3. A Report on the Coordination of Funding for Drug Programs in the State of California (Letter)--June 1988
4. A Review of the Operation and Performance of the Office of the State Public Defender--October 1988
5. A Report on Crime and Violence in California's Public School System--December 1988
6. A Report on Community Residential Care for the Elderly--January 1989
7. The Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight--February 1989
8. A Review of the Organization Operation and Performance of the California State Lottery--May 1989
9. Meeting the Needs of California's Homeless: It Takes More Than a Roof--May 1989
10. Report on Solid Waste Management: The Trashing of California--July 1989
11. Boards and Commissions: California's Hidden Government (Letter)--July 1989
12. Follow-up Review of the Organization, Operation and Performance of the California State Lottery (Letter)--December 1989

LITTLE HOOVER COMMISSION FACT SHEET

The Little Hoover Commission, formally known as the Commission on California State Government Organization and Economy, is an independent state watchdog agency that was created in 1962. The Commission's mission is to investigate state government operations and through reports and recommendations promote efficiency, economy and improved service.

By statute, the Commission is a balanced bipartisan board composed of five citizen members appointed by the Governor, four citizen members appointed by the Legislature, two Senators and two Assembly members.

The Commission holds hearings once a month on topics that come to its attention from citizens, legislators and other sources. But the hearings are only a small part of a long and thorough process:

- * Two or three months of preliminary investigations and preparations come before a hearing is conducted.
- * Hearings are constructed in such a way to explore identified issues and raise new areas for investigation.
- * Two to six months of intensive fieldwork is undertaken before a report, including findings and recommendations, is written, adopted and released.
- * Legislation to implement recommendations is sponsored and lobbied through the legislative system.
- * New hearings are held and progress reports issued in the years following the initial report until the Commission's recommendations have been assimilated.

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