Board and Care: How Effective Are Licensing Standards?

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I. Introduction

The District of Columbia Long-Term Care Ombudsman Program investigated a tip that two group homes were being operated as unlicensed board and care homes. The operator said she got many referrals from the community mental health clinic. She also put up an advertisement at local hospitals. The chief of the board and care licensing office agreed to visit these homes with two housing inspectors and a representative from the mental health commission.

During the visits, the inspectors discovered that twelve people lived in one of the homes that had a certificate of occupancy for only four people. One person lived in the attic and three people in the basement (including one person in the boiler room). The houses were cluttered and dirty. They observed boxes of medical supplies and a box of Depends undergarments, indicating that the residents needed some assistance with activities of daily living.

One elderly resident was found lying on a bed with no sheets in a foul-smelling room, swarming with flies. The community mental health clinic had placed her with this operator. She is a diabetic who gives herself shots, yet she does not refrigerate the insulin. She cannot walk because of circulatory problems. She had a portable toilet. Another resident was found in a room piled from floor to ceiling with papers, books, clothes, and boxes. His living space was a six-foot-by-two-foot clearing in the middle of the room. He cannot walk either.

What this case illustrates is the ambiguity in the law concerning what constitutes "board and care," the inappropriate placement of some elderly individuals and individuals with disabilities in the community, and the pressures health care providers, such as mental health and acute care hospitals, experience to discharge patients who have no home to go to. This article discusses the concept of board and care, outlines some of the problems with it, and, finally, offers some recommendations to make it better.
II. What Is Board and Care?

A. Definition

Generally, board and care is defined as "nonmedical community-based living arrangements that provide shelter (room), board (food), 24-hour supervision or protective oversight, and personal care services to residents (not related to the operator)." /1/

Most state definitions focus on the services actually provided, not the needs of the residents. /2/ For example, in the illustration above, there was some question whether the homes were unlicensed board and care homes--not because the residents could live without assistance but because it appeared that the operator did not provide them with any assistance.

The American Bar Association's Model Act on board and care offers a middle position: "'Board and care home' means a publicly or privately operated residence that provides personal assistance, lodging, and meals to two (2) or more adults who are unrelated to the licensee or administrator." /3/

The Model Act then specifically defines such terms as, "provides" and "personal assistance." For example, "provides" includes situations when an operator advertises as being able to make personal assistance available to individuals. /4/ In the illustration above, the operator more than likely held herself out to hospitals and mental health clinics as making personal assistance available. Thus, under the Model Act definition, she operated an unlicensed board and care home. The Model Act defines "personal assistance" in detail, such as helping the resident with the activities of daily living, which in turn are defined specifically (e.g., walking, managing money, obtaining appointments, and self-administration of medication). /5/

B. Demographics

There are over one million elderly individuals and individuals with disabilities living in board and care homes nationwide. /6/ Approximately 32,000 homes with 500,000 beds serve the elderly. /7/ This number does not include all of the "assisted living" facilities and the estimated 28,000 unlicensed board and care homes. /8/ In contrast, according to the 1990 census, under 1.8 million individuals live in nursing homes nationwide. /9/ Thus, in terms of numbers alone, board and care is a significant national issue.

There is some indication that more and more board and care residents are younger because of the increased efforts of states to deinstitutionalize individuals from hospitals for those with mental illnesses and mental disabilities. /10/ The 1987 Nursing Home Reform Law, which screens out individuals with mental disabilities, also increased the use of board and care by younger persons. /11/
III. Financing Board and Care

The manner in which board and care is paid for is largely responsible for the quality-of-care and quality-of-life problems that exist. Approximately one-half of board and care residents pay for their care with private resources. /12/ The single largest public source of payment for board and care is the federal SSI program. An eligible SSI recipient received a payment of up to $434 in 1993. All but ten states supplement the federal payment with an optional state supplement (OSS) that ranges from a few extra dollars a month to over an additional $500 a month. Of the ten states that do not provide an optional state supplement, four use state funds to supplement the SSI payment. /13/

Approximately ten states use Medicaid funds to pay for board and care; other states use block grant and general funds. /14/ Thirty-six states and the District of Columbia allow residents a personal needs allowance (PNA) for such items as newspapers and magazines, snacks, insurance premiums, private telephones, clothing, transportation, personal hygiene products, and entertainment. /15/ Most of these states allow for a minimum $40 monthly PNA.

In many cases, the board and care operator becomes the resident's representative payee for both SSI and Social Security checks. Or operators simply coerce residents to sign over their entire checks to them. There are many documented cases of operators using this money for their own personal benefit--such as buying expensive foreign-model cars and large homes--rather than for the care of their residents, whose meals often consist of cold cereal, hot dogs, and chicken necks. For long periods of time residents go without needed medication and medical care. /16/ In 1989, the Subcommittee on Health and Long-Term Care of the U.S. House Select Committee on Aging in its devastating report on board and care, Board and Care Homes in America: A National Tragedy, documented a history of severe neglect of board and care home residents. /17/ However, unlike with nursing homes, very little has been done to address the problems in board and care. /18/

IV. Regulation of Board and Care

A. Federal Role

The federal government's role is limited. Under the Keys Amendment, states must "establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which . . . a significant number of recipients of supplemental security income benefits is residing or likely to reside." /19/

States must certify annually to the Secretary of HHS (through SSA) that they are in compliance with this section. /20/ If a facility does not meet the state standards, the state supplement portion used to pay for medical or remedial care must be subtracted from the total supplement for each resident of such facility. /21/ Because this penalty tends to injure the resident more than the operator, it has been invoked infrequently. /22/ Moreover, HHS
has indicated that this penalty cannot be implemented because it is virtually impossible to ascertain the portion of the state supplement used for medical or remedial care. Generally board and care homes do not provide medical or remedial care, and state supplement payments are not paid on that basis. /23/

**B. State Role**

1. General Requirements

By design, the regulation of board and care is exclusively a state responsibility. The most comprehensive study of state regulation of board and care was done in 1990 by the Office of Inspector General, HHS. This study found that (1) virtually all states require the provision of minimal personal services, such as assistance with daily living activities and with medications; (2) all states deal with sanitation (e.g., food handling, laundry, and water and sewerage), and almost all deal with physical structure and fire safety; (3) many state laws are not responsive to the changes in a resident's needs; (4) the vast majority of state standards do not require a board and care plan--those that do lack a mechanism for updating the plan; (5) the majority of state standards do not specifically include mandatory case management; (6) only two-thirds of the state standards address staff training, and most do not specify the amount of hours and type of training required; (7) 74 percent of the state standards do not mention unlicensed facilities, so they do not have monitoring and penalty provisions for facilities that are not licensed; (8) barely half the state standards require a complaint procedure; (9) 85 percent deal with residents' rights; (10) board and care is usually defined in terms of the services provided rather than the anticipated care needs of the residents.

2. Enforcement and Monitoring

The effectiveness of state standards is related to the state's enforcement and monitoring system. Recent surveys indicate that states have not been able to implement effective enforcement and monitoring systems.

The HHS study cited three constraints to enforcement: (1) the lack of state resources to enforce current standards actively; (2) the lack of statutory authority in many states to impose both intermediate and severe sanctions; and (3) the lack of alternative placement for board and care residents. /25/ Both the HHS and AARP studies show that states that do have provisions for intermediate sanctions, such as civil fines or bans on admissions, rarely use them. /26/ Furthermore, states are also not likely to use more severe sanctions, such as license revocation or closure of a home, because there are limited homes into which to move displaced residents or because of the time and resources needed to close a home. /27/
Consequently, the most common sanction is a plan of correction. For example, a home can be cited for something as minor as a missing light bulb or something as serious as neglecting a resident's health care needs. The home would then submit a plan, indicating how it would correct the problem. Unfortunately, licensure agencies are more likely to allow the home to document that it made the required correction than to make a follow-up visit itself to ensure correction. /28/

Although most states conduct annual inspections, they are often behind schedule because of staff shortages. /29/ Moreover, most inspectors have nonmedical qualifications. /30/ Because many agencies rely on nonnursing staff to inspect board and care homes, there is a concern that the inspectors may not be making reliable determinations of the quality of care given to residents with special disabilities, especially those involving psychiatric illness or cognitive impairment. /31/

V. Unlicensed "Board and Care" Homes

One reason why the true number of board and care residents cannot be ascertained is that there are so many unidentified unlicensed homes. In 1989, the House Select Committee on Aging estimated the number of unlicensed homes at 28,000--almost half the number of licensed homes. /32/ According to the AARP Study, the estimates range from only 17 unlicensed homes in Mississippi to more than 3,000 in Texas. /33/ Homes may be either legally unlicensed (e.g., they have under the legal limit of residents) or illegally unlicensed.

States have been generally ineffective in dealing with unlicensed homes. Most state licensure agencies make no special efforts to identify unlicensed homes. /34/

VI. Role of Long-Term Care Ombudsman Programs

Since 1981, under the Older Americans Act, long-term care ombudsmen have had the authority to investigate complaints on behalf of board and care residents and to monitor the quality of care in board and care homes. However, because of the lack of funding and human resources, long-term care ombudsman programs have generally been unable to focus on board and care issues. Moreover, many programs lack the authority to enter unlicensed board and care homes. /35/ Some jurisdictions, such as New Jersey and the District of Columbia, have laws that grant ombudsmen authority to enter board and care homes and to enforce board and care laws. /36/

VII. Other Federal Initiatives

In its report on board and care, the Government Accounting Office recommended that HHS conduct a comprehensive assessment of states' oversight activities for their board and care population and then report to Congress on subsequent steps needed to protect
board and care residents. /37/ Instead, HHS said that it would conduct an assessment of the health and safety conditions and quality of care in a sample of licensed and unlicensed homes in a variety of regulatory settings. If there is a documented link between living conditions and specific regulatory requirements, HHS would then recommend specific strategies for ensuring the protection of residents. /38/

As part of the Older Americans Act Amendments of 1992, Congress authorized a study of board and care facility quality similar to the 1986 Institute of Medicine nursing home study that led to the 1987 Nursing Home Reform Law. /39/ The study will examine the existing quality, health, and safety requirements for board and care and the enforcement of these requirements for their adequacy and effectiveness. It will also examine and recommend the appropriate role of federal, state, and local governments in board and care, and recommend to Congress within 20 months the establishment of specific minimum national standards for the quality, health, and safety of board and care residents and the enforcement of these standards. Both residents and their advocates must be represented on the study committee.

VIII. Conclusion

Increasing evidence shows that the most at-risk elderly and disabled individuals in the United States live in board and care homes. While the federal government may be moving toward recommending national standards, at the present time only state and local government entities are monitoring care in board and care--with limited effectiveness. More analysis of board and care regulatory requirements is needed. However, now is the time for action. Board and care in the U.S. is already a national tragedy. Until national standards are developed and implemented, states must act to ensure better enforcement of their licensure laws, to empower residents and their advocates, to increase funding for board and care, and to assist board and care homes with the training and professional development of staff. If the federal government is unable or unwilling to provide direction and leadership on improving board and care, it is essential that local and national advocacy programs fill the leadership void.

footnotes


/2/ HHS, OFFICE OF INSPECTOR GENERAL, BOARD AND CARE 6 (Mar. 1990) [hereinafter HHS REPORT].

/4/ Id. Sec. 2.2.

/5/ Id. 2.3, 2.4.

/6/ HHS REPORT, supra note 2, at 1.

/7/ AARP SURVEY, supra note 1, at 4.

/8/ Id.


/10/ HHS REPORT, supra note 2, at 2.

/11/ Under the new law, states and facilities will not be reimbursed under Medicaid for any mentally disabled individual who either has not been assessed for nursing facility services or has been assessed but does not require nursing facility services. 42 U.S.C. Sec. 1396r(e)(7)(D); 57 Fed. Reg. 56450 (Nov. 30, 1992) (final rules).

/12/ AARP SURVEY, supra note 1, at 54.

/13/ Id. at 58-59. For a comprehensive compilation of all of the state assistance programs for SSI recipients, see SSA, STATE ASSISTANCE PROGRAMS FOR SSI RECIPIENTS (Pub. No. 17-002) (1993).

/14/ AARP SURVEY, supra note 1, at 58.

/15/ Id. at 60.

/16/ See generally Gruber et al., The Care Takers, DET. NEWS & FREE PRESS, May 2-4, 1993.

For example, in 1987, Congress passed perhaps the most comprehensive health care legislation since the enactment of Medicaid and Medicare when it approved the 1987 Nursing Home Reform Law. This law not only mandates stronger provisions on quality of care and quality of life but also strengthens federal and state enforcement of long-term care standards. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330-160 (1987) (codified at 42 U.S.C. Secs. 1395i-3 (Medicare), 1396r (Medicaid)). In contrast, even as late as May 1993, there were still reports of widespread abuse of board and care residents. See, e.g., Gruber et al., supra note 16.

42 U.S.C. Sec. 1382e(e)(1).

Id. Sec. 1382e(e)(3). According to the HHS Board and Care Report, only one staff person is responsible for managing the Keys Amendment and collecting the required information from states.

Id. Sec. 1382e(e)(4).

HHS REPORT, supra note 2, at 15.

Id. at Appendix B; U.S. GOVERNMENT ACCOUNTING OFFICE, BOARD AND CARE: INSUFFICIENT ASSURANCE THAT RESIDENTS' NEEDS ARE IDENTIFIED AND MET 36 (Feb. 1989) [hereinafter GAO REPORT].

A board and care plan describes the resident's ability to function in a board and care home, including the resident's strengths and weaknesses, and it is a mechanism for coordinating the delivery of services to the resident--often referred to as case management. Model Act, supra note 3, at 18-22.

HHS REPORT, supra note 2, at 11.

According to the AARP SURVEY, supra note 1, at 44, only 9 of the 62 state licensure agencies reported using fines, and only 4 of these used fines extensively. According to the HHS REPORT, supra note 2, at 12, slightly more than one-third of the states allow for civil fines, and less than one-third allow for a ban on admissions.

A recent series of newspaper articles demonstrates that, even if a home is closed, licensure agencies do not always ensure that it ceases operating. In 1992, ten residents died in a fire in a Detroit home that had been "closed" a decade earlier. Gruber et al., supra note 16, May 2, 1993, at 10A.

AARP SURVEY, supra note 1, at 40.

Id. at 38.
For example, the AARP SURVEY showed that only 21 agencies used health inspectors, in contrast to 49 agencies that used "other" types of inspectors, such as dietitians, building engineers, and "generalists." Id. at 38-39.

Id. at 39.

BOARD AND CARE HOMES, supra note 17, at ix.

AARP SURVEY, supra note 1, at 53.

In a 12-month period, state agencies identified only 136 unlicensed homes. Id. at 47-53.

GAO REPORT, supra note 23, at 29-32.

Id. at 32; D.C. CODE Secs. 6-3501 et seq. (long-term care ombudsman program act) (1989 replacement vol.), Secs. 32-1401 et seq. (receivership and transfer/discharge law) (1988 replacement vol.).

GAO REPORT, supra note 23, at 41.

Id. at 46-47. This study is being done for HHS by the Research Triangle Institute (RTI), in North Carolina. It has been referred to as the Assistant Secretary for Planning and Evaluation (ASPE) Quality of Care Study. The formal name of the study is Analysis and Comparison of State Board and Care Regulations and Their Effect on the Quality of Care in Board and Care Homes.