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# ***Committee Meeting***

of

## ASSEMBLY REGULATORY OVERSIGHT COMMITTEE

*“Testimony concerning the management and operation of nursing homes and psychiatric community residences, the quality of care residents receive, facility conditions, and the role of the State government in ensuring the well-being of residents”*

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**LOCATION:** Committee Room 8  
State House Annex  
Trenton, New Jersey

**DATE:** September 30, 2002  
10:00 a.m.

### MEMBERS OF COMMITTEE PRESENT:

Assemblyman William D. Payne, Chairman  
Assemblyman Joseph Cryan, Vice-Chairman  
Assemblywoman Nilsa Cruz-Perez  
Assemblywoman Connie Myers



### ALSO PRESENT:

James F. Vari  
Peter J. Kelly  
*Office of Legislative Services*  
*Committee Aides*

Gabby Mosquera  
*Assembly Majority*  
*Committee Aide*

Thea M. Sheridan  
*Assembly Republican*  
*Committee Aide*

***Meeting Recorded and Transcribed by***  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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submitted by

June A. Duggan

President

New Jersey Association of Non-Profit Homes for the Aging

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rs: 1-80

**ASSEMBLYMAN WILLIAM D. PAYNE (Chairman):** Good morning. We, the members of the Assembly Regulatory Oversight Committee, are conducting this hearing today, primarily, to edify ourselves, and, also, to find out just what kinds of services we are providing for our people.

Our society has been set off, in that a society is judged by the manner in which they treat their youth, their seniors, the manner in which they treat their ill, the infirmed. And we have an obligation, as a State, as a government, as a people, to see to it that the citizens of New Jersey are, in fact, provided with a good quality of life. And we, as legislators, have an obligation and responsibility to explore those areas of care that we do provide for our citizens.

The reason for this hearing, of course, is to try to find out, number one, where we are, and where do we stand, as far as our care for our citizens of the State of New Jersey. And we have heard, from time to time, some stories about conditions that exist within some of our facilities. We've heard, sometimes, about the compensation, or the lack of decent compensation, for health-care providers, the people that do work in our society that many people would not want to do.

We're concerned that many of the people that we depend on to care for our loved ones are, simply, not provided with a decent wage, and things of that nature. So we want to hear just what is, actually, going on within our system of health care for our citizens of the State of New Jersey, and then, perhaps, we will be able to come up with some of the solutions. But, also, we will be able to hear of the good things. We're not here to try to find, point fingers, necessarily, but we're here to, also, find out about the positive

things that may be going on within our State and being provided for our citizens.

So the reason for our being here is just that, to edify ourselves, and to try to come up with those kinds of answers to the, sometimes, vexing questions that we have.

We do know that there has been a lot of talk, a lot of testimony, about the size of our waiting list for some of our admissions to our group homes. So there has been an initiative that has been developed by Commissioner Harris, of the Department of Human Services, to try to alleviate, try to minimize, try to mitigate that waiting list. We want to hear just where we stand with that initiative and see whether or not that will be effective.

Last spring, during budget hearings, we heard testimony from people who are home health-care workers, some of whom testified that the compensation they were receiving was inadequate. And we want to hear just what it is that we need to do to try to make sure, number one, that we have properly trained people who care for people, not only in our nursing homes and our boarding homes, and places like that, but also the people that we send out to the homes to care for people within their homes.

So we're hopeful that we will be able to be -- to shed light on a lot of these conditions. I think, one of the things we need to do, also -- and that is, I'm going to have to ask those of you who are testifying, particularly from the Department of Health, and the Department of Human Services, and DCA, for the nomenclature. I think that, often, people mix the names, for instance, group homes, boarding homes, nursing homes. I think there needs to be a very

clear definition of what each one of them is, what they do, so that we will be better educated, and so that we can, also, provide and do the job that we've been elected to do, serve our constituents, serve the State of New Jersey.

So, with that, I'm going to ask our first person who will testify here, today, to begin these hearings. I want to introduce, before I do that, though, Assemblyman Cryan, who is also a member of our Committee, the Vice Chairman. And we will be having Assemblywoman Cruz-Perez -- will be with us today, as well as Assemblywoman Connie Myers.

But we'll start now. I'm going to ask for Mr. William Conroy, New Jersey Department of Health and Senior Services, to testify.

**ASSISTANT COMMISSIONER WILLIAM CONROY:**  
Good morning, Mr. Chairman, Mr. Vice Chairman. Thank you very much for inviting me to speak today before you.

I'm here to talk to you about the Department of Health and Senior Service's role in assuring quality in nursing homes. It's a component of your hearing today. And it's something that I can provide you with some general information on.

I'll try to be concise. I'm cognizant that you have a full list of speakers today. And I'll try to answer any questions you may have after my brief presentation.

MR. VARI (Committee Aide): Red is-- There you go. (referring to PA microphone)

ASSISTANT COMMISSIONER CONROY: Hopefully, you can hear me a little better now.

In terms of providing you with an overview, I want you to know the Division of Long-Term Care Systems, within the Department, evaluates--

ASSEMBLYMAN PAYNE: Let me interrupt you for a second. Do you have copies of your printed testimony?

ASSISTANT COMMISSIONER CONROY: I just have notes today. I can provide you with copies, a cleaned-up copy, later. But I was given relatively short notice.

ASSEMBLYMAN PAYNE: It's okay.

ASSISTANT COMMISSIONER CONROY: I worked off these notes this weekend.

As I said, the Long-Term Care Division is responsible for evaluating nursing homes and the services that nursing home residents receive, to make sure that their compliance with both State licensure and Federal Medicare and Medicaid certification requirements--

All nursing homes in the State participate, with the exception of just a handful, in the Federal program and receive remuneration from Medicare and Medicaid. Our Division operates as the State survey agency, under contract with the Federal government, to make sure that nursing homes are in compliance with the standards of participation.

For the handful, or so, nursing homes that are exclusively private, we apply our State licensing regulations to make sure, again, that they uphold standards and are in compliance.

The survey and certification process encompasses surveys of nursing homes by a multi-disciplinary team of health-care professionals composed of pharmacists, R.N.s, dieticians, and trained life safety code

surveyors. The types of surveys performed are: initial inspections, when providers first come online; reinspections; follow-up visits; complaint investigations; and monitoring visits. The surveys are conducted in accordance with, as I said, the Federal protocols and may result in deficiencies of an enforcement action, which, again, this Division implements.

For each facility, a standard survey is conducted annually, which consists of a health survey and a life safety code inspection. Although all aspects of the facility are evaluated, there are three major focus areas. They are: resident behavior and facility practices, quality of life that residents have while they're residing in these homes, and the quality of care that they received. If any of these three areas are substandard, the facility faces both enforcement actions and the loss of a training program for their certified nurse aides.

Each survey selects a sample of residents, based on the census of the facility. Sampled residents, family members, are interviewed, and they're asked questions about the quality of life and care that are provided for them. The surveyor meets and speaks with the resident council, which is a group of residents living in the home, to get their perspective on the care received. In addition to the interviews, residents are evaluated, observed by surveyors, and medical records are reviewed. Other tasks performed during the survey process are: observation of medication administration, better known as med pass; evaluation of the cleanliness of the facility; and the overall sanitary environment of the dietary department, the kitchen.

The average survey lasts about five days. All surveys are unannounced. And, under our Federal contract, we must average, as I said, an

annual, or 12-month period -- but we are given latitude, so that we can come in unannounced; otherwise, it would be predictable. So we're given a 9- to 15-month window. We must maintain a 12-month average.

In addition to standard surveys, complaint investigations are conducted by registered nurses. The investigations are conducted, again, in accordance with these Federal regulations, which require specific time frames to be met, to come in and respond to the complaint. If the complaint program receives an allegation of immediate and serious threat to resident health and safety, an investigation must be conducted within two working days of receipt of the information. If a complaint is received that alleges actual harm to a resident, an investigation must be conducted within 10 days of receipt-of-notice.

Finally, we monitor facilities under financial hardship or bankruptcy. And the purposes of such monitoring is to ensure that the facility has adequate food supplies -- food and so forth -- that the staff are being paid, and the care is being delivered in accordance with the regulations.

We have 12 survey teams. As I told you, they're comprised of R.N.s, dieticians, and pharmacists. We have three life safety code building inspectors. And each team has a caseload of approximately 33 facilities. We have a complaint unit that's comprised of 21 nurses that go out and hear, follow-up on the complaints that are provided.

That, in a nutshell, is our role. I do have some program statistics and enforcement-related information that I'd be happy to share with you. I do have one clean copy that I can leave for you right now. I got it off the computer this weekend.

I'd be happy to answer any questions you may have.

ASSEMBLYMAN PAYNE: Thank you very much.

Mr. Cryan, do you have any questions, at all?

ASSEMBLYMAN CRYAN: Yes, I do.

Thanks for your testimony, first off, and thanks for coming on short notice. I appreciate the oversight information.

A little bit more -- and some of it's just because I was scrambling to take notes. It's been a while since high school algebra.

Twelve survey teams, 33 facilities each. It's 365, or so, facilities that we manage here.

ASSISTANT COMMISSIONER CONROY: Yes, approximately.

ASSEMBLYMAN CRYAN: All right. And each survey team, again, has a-- Go through them for me, again -- has an R.N.--

ASSISTANT COMMISSIONER CONROY: Dietician, pharmacist, and a life safety code surveyor, building inspector, to make sure that they're in compliance with the life safety code regulations.

ASSEMBLYMAN CRYAN: By the way, when they come in, do weekends count, or is it always Monday to Friday?

ASSISTANT COMMISSIONER CONROY: It's weekends, it's off hours. As a revision to the State Operations Manual that is created by the Federal government, they've asked that all states begin doing off hours and unusual times. And that went into effect, approximately, two years ago.

ASSEMBLYMAN CRYAN: So these teams are employed by your Department, and they're part of the Division of Long-Term Care Systems.

ASSISTANT COMMISSIONER CONROY: That is correct.

ASSEMBLYMAN CRYAN: Okay, so they'll break up in-- I guess I want to understand the actual inspection.

ASSISTANT COMMISSIONER CONROY: The protocol.

ASSEMBLYMAN CRYAN: The protocol and process a little bit better.

ASSISTANT COMMISSIONER CONROY: Sure. I can try to, briefly, describe some of the phases of the protocol. I'm testing my memory, in terms of the specific steps, because I don't have my notes in front of me.

Essentially, every survey starts with the team looking at last year's survey results and any information that's on the file on that provider to make sure that they're going to redress, so to speak, any findings from the prior year.

There's also coordination with the Office of the Ombudsman to see if there are any complaints coming in from the Ombudsman's Office on that provider. There's also a coordination, obviously, with the complaint unit to see if any complaints come in that year. On average, about four complaints are phoned in annually on a 120-bed facility, just roughly. It's about four times a year. So they look at all this information.

Then, when they go out, they ask the facility for a lot of demographic information about the facility at that time. Then they do a random selection of a chart, of charts to look at to make sure that there's proper care delivered, based on the documentation. If patient X was assessed to have this problem, then will the record show that they made a plan to treat it or correct it, whether it's rehabilitation or prevent falls, and so on, and so forth? So they'll look at the records.

Based on the Federal protocol, the survey team should look at unusual cases, and cases where patients have special needs, in the nursing homes. So it's not just a generic selection for the survey. But on average for, again, a 120-bed facility, approximately 30 charts are selected. And they'll look at the charts, but they'll also look at the resident getting the care, and they'll make observations of the care rendered to make sure that the staff are answering the call bells, making sure that the resident is properly nourished, that the resident is getting assistance with feeding, that they're getting their medications, the right medications.

The survey team will, again, meet with family members. They'll select residents who can't express themselves, whether they have dementia or they have expressive aphasia. They'll talk to the families, as their advocate, to see if they're satisfied with the care.

They'll observe the dining room operation. Is everybody getting their food, is it hot, is the food coming up on time, is it matching the menu?

They'll look at the activities calendar. They'll make sure that the activities that are planned are, literally, delivered to residents; that residents aren't just sitting there, bored; that they're actually getting some psychosocial services and rehabilitation.

They'll walk through the building and make sure that it's not hazardous, that fire exits aren't blocked, that the corridors are clear, it's clean, that patients are up and out of bed, that they're moving around, they're not bedfast and being neglected.

They'll look at a whole bunch of record keeping, making sure that the facility had its regular preventative maintenance for important pieces of equipment, whether it's elevators, fire alarms, fire drills, etc.

It's a pretty rigorous protocol. I can tell you, having been a provider for a number of years, I've experienced it from that end, as well. So I'm familiar with how rigorous it is. And it lasts, on average, about five days.

ASSEMBLYMAN CRYAN: Teams break up, and the nurse does a certain portion. I assume everybody has a role.

ASSISTANT COMMISSIONER CONROY: That's correct. All the surveyors must be credentialed by the Federal government, so that they are required to take a training course. They must have, obviously, the higher education and the health-care credentials. We look to make sure that they have some experience in long-term care or in direct care. Then they are -- they take a Federal course. They must pass an exam, and they receive credentialing or certification from the Federal government as a qualified surveyor.

ASSEMBLYMAN CRYAN: Which is what they're employed as, in the State of New Jersey.

ASSISTANT COMMISSIONER CONROY: That's their job.

ASSEMBLYMAN CRYAN: The four, average of four complaints a year-- We talked last time, back in June, and I'm a little sketchy. If I remember right, 75 to 80 percent of the complaints, or so -- not to-- If you were to classify them, they may be considered less important than a percentage that are considered higher.

When they look at the average of four complaints, or however many complaints there are when they go in-- I guess what I want to

understand is the process. They walk in, or they select that they're going to go to the next home next week, they look at the four complaints. Are those-- I assume most complaints are from family members and/or people that are participants in the process.

ASSISTANT COMMISSIONER CONROY: Actually, it's not necessarily that. Often times, it's really a misnomer, to some extent, to just call it a complaint. It's, really, a reportable incident. And many of them are complaints, but on other instances, as part of our Federal and State licensing regulations, providers have to phone in any incident where there is harm to a resident or something catastrophic happened in the building -- there was a fire or something like that. So a lot of the information that comes into the hotline is, actually, a reported incident.

And the other thing is, when I'm saying four times, it's not packaged, it's across the year. So it might be two in four months, and then we go months at a time.

The surveyor will go in and say, "I'm here to investigate a complaint," and then they'll request a chart, they'll take a tour around the facility, they'll look at the staffing schedule to make sure staffing is adequate. And they spend a good part of the day, depending on the complexity of the case, investigating. It's also reviewed by a supervisor. They'll come back and, before they render-- They generally, unless it's so clear cut, they, generally, don't render an immediate finding on site. They need to absorb it and bounce it off their supervisor.

ASSEMBLYMAN CRYAN: Well then-- I have two more areas that I want to ask you about.

ASSISTANT COMMISSIONER CONROY: Okay.

ASSEMBLYMAN CRYAN: That is the follow-up to the process, and then I want to ask you about the-- That covers the ones that are licensed through us, that are part of the Federal program. And there are others that aren't. So I do want you to take me through that process, as well.

ASSISTANT COMMISSIONER CONROY: Okay.

ASSEMBLYMAN CRYAN: But staying on this, for now-- So what happens? We come in-- Let's say, for example, the nurse is unhappy with some of the medical care, which, I assume, would be the nurse's role in the survey process. He or she goes in, and takes a look, and says, "It's not bad, but it's not right. I'm not comfortable." Give me some ideas of how the process and the follow-up work.

ASSISTANT COMMISSIONER CONROY: They'll look at it based on their set of -- their rule book. And the rule book, the regs, also include interpretative guidelines for surveyors. So they'll look at that for guidance. And they'll make sure that the care is delivered timely, that it's delivered respectfully, that it's appropriate, that it meets the standards of practice established by the actual professions, by medicine, by nursing, and so forth. So they'll make sure that care is appropriate.

If somebody required periodic supplementation for their diet, are they getting the Sustacal, or any kind of nutrition, to make sure that they're not having weight loss?

ASSEMBLYMAN CRYAN: But, Bill, what if-- I mean, there's judgement here, I assume. What if they're not-- I mean, it's one thing not to be happy because the kitchen had expired milk. It's another thing to be

unhappy because the floors are dirty. There's quality here. Whether the medicine is brought respectfully is one thing. It's another as to whether it's brought at all. I'm assuming. I'm just making some characterizations here.

How are those judgements made? And what's the follow-up to, not only the severe things-- I mean, we would all agree if we saw somebody in chains, we'd all be there tomorrow morning. But what about the things that most of us wouldn't accept? How does that process work?

ASSISTANT COMMISSIONER CONROY: Well, if they're out of compliance with one of the standards that fall under the grouping that include--

ASSEMBLYMAN CRYAN: There's a grouping of standards?

ASSISTANT COMMISSIONER CONROY: Yes.

ASSEMBLYMAN CRYAN: And how many groups of standards are there?

ASSISTANT COMMISSIONER CONROY: There are, approximately, 200 individual standards, and they're grouped, I think, into, roughly, 16 broad categories. And out of those 16, probably 3 or 4 are directly grouped for direct-care, quality-of-care-related services. Some are more oblique. But they are, inherently, related to direct care, but they're more around the service delivery. I can give you that. I can follow up with the actual regs, if you'd like.

ASSEMBLYMAN CRYAN: I don't. I just want to understand the classifications of it.

ASSISTANT COMMISSIONER CONROY: Sure.

ASSEMBLYMAN CRYAN: Some are more severe, some are less severe.

ASSISTANT COMMISSIONER CONROY: That's correct.

ASSEMBLYMAN CRYAN: And then there's a guideline that says, "Okay, if we don't meet direct care of this, then there's--"

ASSISTANT COMMISSIONER CONROY: Maybe I can help you understand it, looking at it another way. When a surveyor finds a deficiency, under our enforcement scheme, they're to look at it based upon scope and severity. And so, in essence, they're going to score it or grid it as to whether or not the incident, the deficiency -- excuse me -- in the facility is isolated, or if there's a pattern to it, or if it's widespread. So they'll look at it from that perspective. And then they'll look at it based upon whether or not there are degrees, or levels, of harm. The worst being immediate jeopardy, where it's so egregious that people face imminent danger.

The second, and they're almost equal, really, is where there was actual harm. And, again, you have to look at the degree to which someone suffered actual harm. There's a big difference between a scratch, if somebody was scratched, versus somebody died, or somebody fractured a leg. They would look at the actual harm that a resident received in a nursing home. And then it goes all the way down to no actual harm, but the potential for more than something that's minimal harm.

ASSEMBLYMAN CRYAN: And then recommendations are made?

ASSISTANT COMMISSIONER CONROY: They, actually, will document it and file that with the Federal government. And, as I said in my

opening remarks, based on the focus areas, if they're found to be substandard they will be under enforcement, not only to, obviously, correct the deficiency, but there will be, potentially, civil monetary penalties. There could be temporary management -- they could face decertification.

So there's a whole range of enforcement actions that occur, that we recommend to the Federal government, for Federally participating providers.

ASSEMBLYMAN CRYAN: Suppose -- just--

ASSISTANT COMMISSIONER CONROY: Yes.

ASSEMBLYMAN CRYAN: Suppose there's not enough help in the home, and you've come to that conclusion. Folks have taken a look at it, and you've seen it. For argument's sake, scratches have occurred over a number of times, because there's just not enough help in the place, and if we had enough help in care we'd be dealing with the issue properly. A situation comes up, you make a recommendation to the Federal government. How does it get monitored? How do we, actually, get extra help there? It's one scenario of, I'm sure, many. Let me understand that.

ASSISTANT COMMISSIONER CONROY: Sure.

ASSEMBLYMAN CRYAN: I want to understand the corrective action process.

ASSISTANT COMMISSIONER CONROY: Well, the regulatory system is designed to allow providers an opportunity to correct. That's an important underlying, or underpinning, philosophy toward the regulation, if you will, of nursing homes. And it really comes out of the Federal system, which is the primary agent for funding the program for setting the standards.

So that's the underpinning. It's designed to give providers an opportunity to correct.

Providers are expected to correct immediately, if there's an immediate problem, or they face very serious enforcement. We'll be tough with enforcements, steep civil monetary penalties. They can run \$5000 a day. If it was so egregious, we would put in an immediate -- we'd put in a temporary manager. The temporary manager would have the authority to control the operations of the facility. And when you look at staffing, generally, there's always a revenue source coming into nursing homes, because, as I said, the lion share participate in Medicaid and Medicare. So there's no reason why they can't put the money towards assuring that they have the staffing.

And I have to say that, as a standard protocol, we do look at the staffing schedule, and we review it for three weeks. We, obviously, make those observations during the actual survey to make sure that the staff are delivering the care and they're following the care plan.

ASSEMBLYMAN CRYAN: But in the corrective action process, I understand that if the place is egregious, or we have particular serious issues, we can bring in a temporary manager. I understand, and I would venture to say, although I may get an education today, that we probably respond very well to crisis-care type situations, where we walk into it.

What I'm concerned about, and I just want to follow up, through you, Mr. Chairman -- if I'm taking too long, I'm sure you'll tell me -- I want to understand the next level. If we continually provide medicine late, if we continually see repetitive-type issues-- As I understand what you've explained to me -- and I'm not challenging, I'm asking -- we would send this report, since

we're acting as Federal agents, out to the Federal government and say, "Look, we've got repetitive issues here."

What I don't, still, understand is, are there time frames? I understand when the monetary issues are -- are there time frames set that we need to get this fixed by X date? How does that actual process work?

ASSISTANT COMMISSIONER CONROY: There are, within the enforcement rules, or the enforcement manual, dates certain. And if providers cannot come into compliance, then they face decertification. And it's a--

ASSEMBLYMAN CRYAN: Does the Federal government come in after you, or does our survey team go back the second time?

ASSISTANT COMMISSIONER CONROY: Well, to answer your question, technically, it can be both, but, most of the times, it is us. There is a Federal team that conducts look-behind surveys. And they will just check up and make sure that we're following our contract, as the State survey agency. Moreover, they will do comparative surveys, and just come in and, not literally, look behind, but they'll take a different sample.

Providers, fortunately, can, generally, come into compliance, because the stakes are high. I think, on a handful of occasions, we've had to put in temporary management. Again, if we find bad management of the facility our approach is, let's not uproot the residents if the physical plant is safe and the care can be delivered, it's just a question of management. Let's not impose a further hardship by uprooting patients and transferring them out of the facility, if they can stabilize it with better leadership. So that's the approach that we've taken. It seems to have worked.

We have a couple of facilities that are yo-yo facilities. And by and large, most providers, if they have trouble, they come out of it, and, fortunately, they're able to stabilize themselves so that they can stay in compliance with the regulations.

ASSEMBLYMAN CRYAN: Three hundred and sixty-five facilities, right?

ASSISTANT COMMISSIONER CONROY: Yes.

ASSEMBLYMAN CRYAN: In your opinion, today, how many of them are troubled facilities?

ASSISTANT COMMISSIONER CONROY: You know, I'd have to get back to you. I really don't, I wouldn't think it would be fair for me to just make that assessment without going back and looking very closely at it. I would probably say less than two or three, maybe. And in those instances where we, again, need to take enforcement action, we do, accordingly.

ASSEMBLYMAN CRYAN: Mr. Chairman, through you, can I ask a couple more questions? Two more and I will be done, I promise.

ASSEMBLYMAN PAYNE: If you can make it very brief, because, I think, we have about 25 or 35 other witnesses.

ASSEMBLYMAN CRYAN: I'm sorry. This is to understand.

ASSEMBLYMAN PAYNE: Go ahead.

ASSEMBLYMAN CRYAN: The family that complains, or anybody that complains, in those four or five complaints that are given through a year -- process a follow-up so that those folks may know that something happened?

ASSISTANT COMMISSIONER CONROY: If they have an opportunity to tell us that they want to be involved, and they give their name-- Sometimes it's anonymous -- obviously, we can't communicate directly. But if they give us that information, we'll follow up. We'll write them a letter, and we tell them the results of the finding.

ASSEMBLYMAN CRYAN: The last thing, what's different about those facilities that -- the lion's share facilities take Federal money. First off, what's the-- Is it 90 percent, 10 percent?

ASSISTANT COMMISSIONER CONROY: It's close to 90 percent, between Medicare and Medicaid.

ASSEMBLYMAN CRYAN: And on those 10 percent, that are simply licensed through the State, what's different in the process that you just described?

ASSISTANT COMMISSIONER CONROY: Well, by and large, those providers are providing private clientele, so they are able to attract the premium rates, so to speak. They have to follow the State licensing standards. There's N.J.A.C. 839, I believe -- has a set of subchapters that, almost, mirror the Federal regs. In fact, New Jersey had more established and higher standards before the Feds adopted regulations. And we were, sort of, one of the model states, in terms of having quality standards. And those get revised every five years, or amended, if needed, during the interim. So they are reviewed, based upon those standards, and, essentially, the surveyors follow the same protocol.

ASSEMBLYMAN CRYAN: Thanks.

ASSISTANT COMMISSIONER CONROY: You're welcome.

ASSEMBLYMAN PAYNE: Thank you, Mr. Cryan.

I think what you can see Mr. Cryan is getting at, and what I would like to stress, too, is that we want to have prevention, as opposed to correction. In other words, we don't want to have situations that develop because we, the State, has not been monitoring these facilities, as they should.

In the past, there have been situations where, you mentioned something about the financial, you also checked into the financial stability of these facilities. There have been reports made to me, some years ago, that employees of some of these nursing homes have been issued checks, payroll checks, but were told by the owners not to cash the checks, because there's no money to cover them. They have to wait. "We'll let you know when that happens."

Now, I don't know whether that kind of thing continues to exist or not, but what we'd like is for your Department to be vigilant, to make sure that we don't read about some kind of catastrophe later on. That's one of the things we want to make sure of, that that has happened. We have other situations where I, personally, have found out, some years ago, again, that one of the nursing homes -- the air conditioning didn't work, so they moved the patients to another facility they owned and had them sleeping on the floor.

This was something that happened then. I'm sure that, if we're vigilant about it, we can make sure these things don't happen. We don't need to have these things come to our attention after the fact.

Thirdly, the last point I want to make is, somebody does monitor, I suppose-- You mentioned the people who are hired to fill certain kinds of professional roles. We do carefully monitor and check their credentials,

because I do know there's a facility -- at least some of them in the State of New Jersey today -- where people do not have the credentials that they claim that they have had. Their solution to that was, "Well, we'll change the title to fit their credentials."

I want to make sure that we monitor these things, because, as I said before, these are people that are dear to us, and we want to make sure that they're cared for.

You wanted to respond, did you, briefly?

ASSISTANT COMMISSIONER CONROY: Just briefly. Thank you for those comments, Chairman. I wanted to tell you that we are vigilant on looking at providers with the bouncing checks, in those rare circumstances.

But what we've done to try to be more savvy is to look at collective ownership, to make sure that the moneys aren't being moved around. And under our interagency agreement with the Department of Human Services, we will refer any suspected funny activity with the finances to the Office of Program Integrity that looks at the fraud and abuse.

Likewise, the Program Integrity unit, under our State plan, filed with the Federal government, will refer to Criminal Justice, and we have done that on occasion where we found it necessary.

And likewise, with regard to credentials of the staff delivering the care, if we do see deficiencies we will look into the personnel files and make sure that they have-- And we try to verify credentials. And on occasion, we have identified a few that have not been correct, and we've taken action, accordingly, both for administrators, activities directors, R.N.s.

As you, probably, know, we have the criminal background check unit up and running, and we've had that for a number of years now, checking on nurse aides coming into the system, because there are a lot of them in the system. There's, roughly, about 30,000 in New Jersey, employed.

So I did want to recognize your comments, and I share, with you, your concerns.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

I'd like to welcome Assemblywoman Myers, who is with us now.

Mr. Tom Bruno, please, from CWA Local 1040. Mr. Bruno's not here?

**T O M B R U N O:** I'm here.

ASSEMBLYMAN PAYNE: Okay, fine.

We're moving along. I almost put you in the circular file here.

MR. BRUNO: Good morning, Chairman Payne and distinguished members of this Committee.

My name is Tom Bruno. And while I'm here today representing the nearly 10,000 members of CWA Local 1040, it is important that you know that I have worked with the developmentally disabled, and the mentally ill, for over 24 years. I have worked in both the community group home setting, as well as the State institutional setting. As a veteran of the Department of Human Services for over two decades, and as an organizer and negotiator for CWA Local 1040, I find myself in the unique position of being able to see, what I would describe as, the devolution of the industry and what needs to happen in order to correct the situation.

With every new psycho-social breakthrough in the treatment strategies of mentally ill or developmentally disabled, there is a wake of unanticipated consequences from the radical implementation. For example, in the late 1960s and early 1970s, New Jersey jumped on the deinstitutionalization bandwagon and proceeded to empty thousands of beds. The unanticipated consequence of those actions can be seen by looking at the landscape of many of our once-proud shore communities, such as Ocean Grove and Asbury Park.

More recently, Redirection 1 was implemented, which involved the closure of Marlboro Psychiatric Hospital and the creation of 324 community beds to absorb some of the community-bound patients. Not surprisingly, the number of homeless mentally ill climbed during the same period, 1996 through 1998, as did the number of seriously mentally ill being incarcerated. In fact, the number of seriously mentally ill in our State prisons is now documented at well over 3300, or, roughly, 13 percent of the prison population. The cost to inadequately serving these individuals is now over \$20 million a year, not to mention the fact that prison is not the therapeutic milieu of choice for this population, obviously.

Additionally, private providers are already having trouble finding day programs, medical services, and transportation for the people they serve. Many have tried to explain the need to increase the infrastructure before taking additional individuals from institutions into the community, but these pleas for help have fallen on deaf ears for almost a decade.

Nursing homes require direct caregivers to be certified by the Board of Nursing as CNA's, Certified Nursing Assistants. Even direct

caregivers that go to homes require Board of Nursing certification as Home Health Aides. This allows a centralized way to track employees and weed out those that have a history of abuse and get fired from one agency only to be rehired by another.

No such system is in place for group home workers, and one must beg the question, why? Are the mentally ill, and developmentally disabled, any less deserving of protections than elderly in our nursing homes and at home? As a society, do we just abandon these most vulnerable citizens? Should we honestly be entrusting the care of these citizens with workers from an employee resource pool that is shared by McDonald's and Wendy's?

There is a clear need to professionalize the titles of direct care workers with some sort of certification process. This would stimulate increases in pay for more advanced training certifications and, perhaps, stem the massive 75 to 80 percent turnover rate present in most of these group homes. More importantly, this would allow the tracking of less desirable employees who have had a history of abuse somewhere else in the system.

This is not rocket science. There are, at least, three studies, nationally, that have compared the mortality rates of individuals in community settings versus those in institutional settings. The rate for those in community settings is far worse than those in the community, by 75 to over 90 percent, depending on which study you reference.

The three main differences between community and institutional settings are that institutional settings are more structured, and the staff there are trained more, and are paid better, which results in less turnover. In our

institutions in New Jersey, over 80 percent of our workforce has more than five years on the job.

In contrast, staff in community residential settings reach their 80 percent longevity peak at about the six- to nine-month mark. At six months, or even nine months, it is nearly impossible to have any kind of instincts developed, or any kind of fix, on idiosyncratic behaviors regarding the individuals under their care. Most Human Resource people will tell you that it takes about a year for a new employee to get in the groove and up to speed.

Local 1040 represents workers in State institutions, nursing homes, and group homes all over this state. At your June Committee hearing, we brought one of our nursing home workers here to give you some insight into the plight of the workers. That employee is not here today, because she has been the target of her employer's wrath, solely because of her testimony before this body. While Local 1040 is busy handling her case right now, through the Unfair Labor Practice process, unfortunately, I must inform you that her suffering is not unique.

When Local 1040 organized the group home managers at Vineland Training School, a subsidiary of Elwyn Incorporated, in Philadelphia, the company used legal maneuverings to delay and challenge the vote of the managers, and the decision of the National Labor Relations Board, for almost three years. The cost went into the six figures category, and State money that was supposed to be used for the care of the contracted disabled population went to pay that. Pursuit of an anti-union corporate agenda, at the expense of the developmentally disabled and mentally ill, is wrong, and there should be provisions in all State contracts that prohibit the use of State funds for such

endeavors and provide substantial financial penalties for those that violate that provision.

Salary and benefits are, yet, another set of problems, perhaps the biggest. Current salaries range from \$6.50 an hour to \$9.00 an hour, with employee-purchased health benefits on a 90 percent of cost basis for non-union workers. For unionized workers, the range is \$7.50 an hour to \$10.00 an hour, with single health care coverage free, or with a modest co-pay of \$10 a pay, and additional family insurance available for a percentage of the additional cost.

One of the most difficult obstacles to raising salaries for unionized workers has been the health-care costs. For non-union agencies that do not provide health insurance, the motivation behind salary suppression appears to be greed. Departmental policies from the previous administration, with respect to contract ceilings and direct care salary increases, have also hurt workers. For example, last year's \$1.00 an hour increase for direct care staff was never realized by most workers. Instead, the agencies were given the latitude of applying it to health-care costs and other employee benefits.

Additionally, the Department of Human Services decided to back the \$1.00 an hour out of the contract before applying the meager COLA of 1.8 percent. Then they put it back in, after this percentage was added in. And if an agency raises money through fund-raising, that money is deducted from the agencies contract amount, in certain cases. In essence, the agency cannot add more money to its coffers, even if it is to enhance employee salaries or benefits.

Another major problem area is in the placement of high-acuity individuals into a program and the inflexibility of the Department of Human

Services with respect to contract amendments that deal with issues surrounding that.

For example, in one of our agencies that we represent, the Department placed an individual with a severe psychiatric disorder. Group homes generally have two staff on during the day and one at night. Often, one staff is gone during the day with half of the clients, to go food shopping or other activities. Several injuries to staff occurred during these periods where only one staff person is present.

A request to the Department, in February, for a contract modification, to allow for an additional staff person for each of the shifts, has not been acted upon. Even after I contacted the Division Director to explain the seriousness of the problem, I was told that no one could find the request. Meanwhile, clients and staff continue to get hurt and live in a hostile environment, while papers shuffle and shoulders shrug.

There are solutions, but they are not cheap. First, if a provider is being paid by the State for services to the mentally ill, developmentally disabled, or for long-term care in nursing homes, and those employers are required to follow State regulations and Division curriculars, etc., then they should be permitted to join the State Health Benefits Program on a shared-cost basis.

Additionally, if the State is not willing to devise a certification process, like the CNA or Home Health Aid programs, to professionalize the title, then there should, at least, be a parity law, as is found in other states, so that salaries are equal across all agencies and across the public versus private lines. This could easily be accomplished by establishing joint-employer status

with the agencies. That would also alleviate the misuse of State funds for frivolous anti-union litigation and campaigns against worker rights.

A nationally acclaimed expert on mental illness, E. Fuller Torrey, found that 50 percent of mentally ill patients released from a psychiatric hospital into the community stop taking their medications by the end of the first year of release. That fact, alone, explains why more than 40 other states have enacted the, so-called, Kendra's Law. The law permits the involuntary commitment of a mentally ill person for no less than 72 hours if they fail to take their medication or undergo treatment. The commitment is permitted in order to stabilize the individual. Until New Jersey adopts such a law, we should not even be thinking about releasing individuals into an unsuspecting community.

In conclusion, I would offer this Committee any assistance you deem necessary, in order to put us back on track. As a published author of several position papers and a booklet on the plight of New Jersey's mentally ill, I have a plethora of research to share with you, as I did with Tipper Gore, during the White House Summit on Mental Health, in June of 2000.

I thank you for entertaining my comments.

ASSEMBLYMAN PAYNE: Thank you very much.

There are just a couple points that I'd like you to briefly comment on. I'm not going to take too long.

The group home workers, you say, are not required to be certified, as in nursing homes, etc.

MR. BRUNO: That's correct, there's no formal certification process. There is a five-module training set that they're required to undertake

within the first 120 days, but it's your basic first aid, and CPR, and crisis, and those kinds of things. It's, certainly, not a -- like the CNA program, where a person's name is on a registry, where if they're fired for abuse they're not allowed to work in the -- their name is off the registry. They can't get hired anywhere else.

ASSEMBLYMAN PAYNE: How many group homes are there?  
Earlier, I talked about--

MR. BRUNO: Hundreds.

ASSEMBLYMAN PAYNE: Hundreds.

MR. BRUNO: Hundreds.

ASSEMBLYMAN PAYNE: Earlier, we talked about the nomenclature, group homes.

MR. BRUNO: I think there's 2500 group homes, roughly, in this state.

ASSEMBLYMAN PAYNE: Define, briefly define, a group home. Is that run by, like, a community health agency or a mental health association?

MR. BRUNO: Well, yes, a provider--

ASSEMBLYMAN PAYNE: Or private owners.

MR. BRUNO: Most of them are nonprofit. There are some for-profit providers, but they have a group home, they supply the staff, and the patients -- or consumers or clients -- will live inside that group home.

ASSEMBLYMAN PAYNE: DCA monitors them, the Department of Community Affairs? Is that the Department that monitors them?

MR. BRUNO: Well, for licensing, it's done through the Division. I imagine DCA has some input in that as well. But I know the Division, and the Department, has licensing expectations.

ASSEMBLYMAN PAYNE: What about boarding homes? Is that the same?

MR. BRUNO: No, boarding homes are different. In a boarding home there's no supervision. It's, like, essentially, an apartment. I mean, they're, pretty much, on their own in a boarding home. Usually, I think there's one person residing there that's a point person. But, for the most part, they're--

ASSEMBLYMAN PAYNE: But aren't mentally health -- people -- people who are discharged from mental institutions and psychiatric wards also in boarding homes?

MR. BRUNO: Oh, yes. In fact, more often than not, in the mental health arena, you'll find more in that particular setting. At least that's been our experience. Alan Kaufman's here. He could probably expand on that a little bit.

ASSEMBLYMAN PAYNE: Right, sure, he's going to testify next. You said that the person testified back in June -- on June 17, I think -- has been harassed by her--

MR. BRUNO: Oh, yes. We had to file an unfair labor practice against the employer, Carriage House Manor Nursing Home. The employee was Edda Segarra, a 22-year employee, spotless record, excellent performance assessments. Two days after she testified here, and one day after it appeared in the newspaper, the employer began asking all her co-workers about her work

ethics and started trying to dig up something. They couldn't find anything, but, I mean, it was just the whole object. They had her under micro-management. So we filed an unfair labor practice, and, in fact, they're trying to settle that with us, now. We're working out wording.

ASSEMBLYMAN PAYNE: The Assemblywoman is going to make a comment, or would like to say something about this.

What's the name of the employer?

MR. BRUNO: Carriage House Manor.

ASSEMBLYMAN PAYNE: I think that we need to, really, take into consideration some kind of way that we protect, number one, people who do testify before public bodies like this. And, number two, we're going to have to consider some very strong message that goes out to these owners of these facilities that we simply can't tolerate these kinds of things. I think that's something we're going to have to consider.

Assemblywoman Cruz-Perez.

ASSEMBLYWOMAN CRUZ-PEREZ: Good morning, Mr. Speaker.

Thank you, Mr. Bruno, for coming to testify.

I feel not only guilty, but offended that you're telling me that Edda Segarra got in trouble, because, actually, it was me who asked if we had a certified nurse assistant. And the only question we asked her was to tell us what she did on a daily basis, which we have record in here. I was reading through it when you told the Committee that she got in trouble for telling us what her duties were.

I really didn't need Mrs. Segarra to testify, because I was a certified nurse assistant, and I know, exactly, what we do on a daily basis. But I needed to hear from someone who's doing it now to see that didn't change, that we keep doing the same thing we've been doing. We're working with too many patients, and the only thing she said was, "It's humanly impossible to take care of 12 people and do it right."

So I don't know how this Committee can help Mrs. Segarra, because this has to stop. She only told us the truth. She told what she does on a daily basis. And I really want this Committee to do something about it, Mr. Chairman.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

That's noted, and, perhaps, we can have subsequent meetings with you about some of these conditions that do exist. I mean, this, simply, has to stop. We've heard about horror stories, in some instances, where employees are being penalized for speaking out, etc.

Let me ask you just one last question. Compensation for the workers -- compensation and training of these workers. Is it adequate, not adequate? Can the owners afford to pay more money? Just what's the story with that?

MR. BRUNO: I imagine there's some providers that could afford to do more training, but I can-- I know the ones that we're involved with, because we've looked at their records. They can't raise funds for that purpose without having the State chip away from their contract ceiling, as a result of-- So they never get ahead. There's no extra money to provide the training. And,

of course, the staff resource pool -- you have to take them off the job to train them. And so there's not enough staff as it is. In fact, I think there's, probably, more than two dozen group homes, already, that are purchased, ready to go, but they can't operate because there's a lack of staff.

ASSEMBLYMAN PAYNE: There are acutely mentally ill patients that are being released in these homes, and some of the staff -- where the homes are not prepared to deal with them, or what have you-- What's the solution to that. I mean, what do we need there? Do we need more people? Do we need to monitor? For instance, you mentioned that some stopped taking their medicine after a period of time, and they create all kinds of problems.

MR. BRUNO: I think the Kendra Law would -- implementation of a law similar to the Kendra Law in New York -- as a matter of fact, in about 43 other states now -- would go a long way. A lot of the times, it's a refusal for treatment, or a refusal to take their medication that causes the acuity level to rise. They're released okay.

ASSEMBLYMAN PAYNE: Yes.

MR. BRUNO: That's the problem.

ASSEMBLYMAN PAYNE: All right, thank you, Mr. Bruno.

MR. BRUNO: Thank you.

ASSEMBLYMAN PAYNE: Identify yourself please, Mr. Kaufman.

**A L A N G. K A U F M A N:** Good morning, Mr. Chairman.

My name is Alan Kaufman, and I am the Director of the Division of Mental Health Services for the Department of Human Services.

I thank you for the invitation to speak before you this morning, and to provide an overview of procedures followed when a patient returns to his or her community following hospital treatment, and other components of our mental health system.

As you know, though, the Department of Human Services provides services for our most vulnerable citizens, and, in addition to the area of mental health, we also operate institutions and community programs for people with developmental disabilities. Services to these two populations are different in many respects, and my focus this morning will be on persons with mental illness, who may be discharged from our adult psychiatric hospitals or, otherwise, receiving services in the community.

While individual, clinical, and financial circumstances are what determine which placements are appropriate for which patients, most persons who are discharged from State and county hospitals go to one of four different types of residential settings. A substantial number return to the patient's own home, or apartment, or to live with their families. And, in effect, about 60 percent of patients who are discharged from the State hospitals go there.

Where a degree of nursing care is required, some will be discharged to nursing homes or to residential health-care facilities, both licensed by our Department of Health and Senior Services. Some will, also, be discharged to boarding homes or rooming houses, which are licensed by the State's Department of Community Affairs.

Where patients are capable of living in the community, but require continued clinical treatment and supervision, as well as assistance in learning activities of daily living, discharge can be to group homes, supervised

apartments, supportive housing, or family care programs funded and licensed by the Department of Human Services.

While I will provide more detail concerning licensed group homes, apartments, and supportive housing in just a moment, it's important to know that the Department funds a statewide system of community mental health services with which all persons being discharged from a State or county psychiatric hospital are linked. That linkage is effected by a case management system that is unique to New Jersey, both in its scope and in its duration.

Through contracts with community mental health agencies in each of our 21 counties, each patient discharged from any one of the six State or six county psychiatric hospitals is provided with case management services for a minimum of 18 months following discharge. If clinically necessary, this service will be extended beyond the 18-month period for however long it may be appropriate. With an average of only 20 consumers to a case manager, the consumer is connected to other mental health services that may be needed and provided ongoing assistance and support. At the present time, over 6200 persons are receiving these case management services, today, across our state.

In addition to case management services, the Department also contracts with, about, 130 non-profit community agencies to provide a wide range of services for persons with serious mental illness. Serving, approximately, 200,000 persons per year, those services include outpatient counseling, medication monitoring, partial hospitalization and partial care programs, emergency screening and mobile outreach, Programs of Assertive Community Treatment, supported employment, family support, legal advocacy, and other programs.

In response to your request, last week, Mr. Chairman, I have brought copies of the Directory of Mental Health Services for you and the Committee members. These services are listed by county and by types of services, and show the names and contact information of community-based mental health providers with whom the Department contracts.

As I mentioned previously, the Department funds and licenses group homes, supervised apartments, supportive housing, and family care programs for persons with serious mental illness. Group homes typically serve five to eight residents with staff onsite at the facility. Apartments serve, typically, two to four residents, and are, sometimes, grouped in close proximity to another apartment where supervising staff are on duty.

Although the period of time will vary for each individual, consumers will often graduate from group homes and supervised apartments to more independent and permanent living arrangements. One example of a less-supervised setting is our supportive housing program. Here, two or three consumers may live in an apartment where staff visit on a regular, but not as frequent, basis to provide continued support and assistance.

Spread throughout all 21 counties, there are a total of over 3700 consumer spaces now directly funded and licensed by the Division of Mental Health Services. They include 1251 spaces in 203 group homes, 819 spaces in 264 apartments, 1462 supportive housing spaces, and 126 in family care.

These programs are all operated by private, nonprofit, community-based mental health agencies, and all conform to regulations of the Department, which specify standards, life safety provisions, staffing patterns, and staff qualifications. Each separate site is inspected on an annual basis, or

more frequently in the event a complaint is made. We employ a staff of 20 professionals for this purpose and for doing licensing reviews of other mental health programs as well.

Admission to these settings is open to persons being discharged from State or county hospitals, but referrals also come from inpatient units of local hospitals or from the community at large where a consumer is known to require those services, and who can be spared unnecessary hospitalization if it's provided.

Depending upon the needs of individual consumers, staff in these licensed programs provide assistance in activities of daily living, medication monitoring, skill training, counseling, and daily supervision. Typically, residents also attend mental health day programs, vocational training, attend school, perform volunteer work, or otherwise engage in gainful activity.

The programming services in these licensed facilities is, generally, of high quality and complaints from consumers, their families, and neighbors are relatively few. Perhaps the most often-raised concern is with the high demand for too limited available spaces.

As mentioned earlier, where appropriate, patients being discharged from hospitals are referred to nursing homes, residential health-care facilities, or to boarding homes. At the same time, though, hospital discharges account for only a portion of those living in those settings. Community social service agencies, local hospitals, county boards of social services, the Veterans' Administration, the Department of Corrections, and others also refer persons seeking less expensive housing to these facilities.

Because they are licensed and regulated by other State Departments, I am not the right person to provide detailed information during their operation. I can say, however, that the Departments of Human Services, Community Affairs, and Health and Senior Services jointly sit on an inter-departmental coordinating council in an effort to attempt to collaborate on some of the issues concerning boarding homes.

As a result, in a number of, but clearly not all, residential locations, linkages have been made with mental health service providers under contract with the Department of Human Services.

A large number of boarding home residents do attend mental health day programs and/or see clinicians at community mental health agencies. In some cases, mental health clinicians, peer counselors, or case managers also visit boarding homes on a regular basis. And a number of consumer-operated, self-help centers funded by the Department have specific outreach efforts to engage boarding home residents.

In recognition that a significant number of residents have mental health issues, a program is also funded, by the Department, to provide training to boarding home owners concerning psychiatric medications, medication monitoring procedures, access to screening services, day program information, and other matters.

That being said, however, I must also point out that the existing services definitely fall short of those required to meet the needs of all of our adults with serious mental illness, who reside in boarding homes. Clearly, persons with mental illness represent only one portion of those who reside in those facilities, and the need for affordable housing remains a particularly

daunting challenge. But that is even more intensified for those of our residents who also have special needs.

Again, Mr. Chairman, I do thank you for the opportunity to speak with you this morning. I recognize, obviously, that this is a complex matter. I would be happy to try to answer any questions.

ASSEMBLYMAN PAYNE: Thank you, Mr. Kaufman.

My colleagues don't have any questions.

One initiative that I read about in the paper, just the other day, was the initiative on how to relieve the waiting list, I think, of people getting into a boarding home. There is a plan now to, somehow, ameliorate that problem. Could you, briefly, define what that initiative is?

MR. KAUFMAN: First, I have to apologize, Mr. Chairman. That plan, while it's in the Department of Human Services, is being put forward by the Division of Developmental Disabilities, which is a sister division to the Division of Mental Health Services. And I'm told that, under the short notice, they had difficulty finding someone from the Division to come forward. So I apologize, and we, certainly, would make somebody more available to you and to the Committee, as you need it.

We do have copies of the plan itself, that was released last week, for the Committee members. While I can't speak directly to it, I will tell you that the general focus of that plan is to attempt to provide services more about what people require, based upon what families may desire in other areas, rather than simply focusing only on the residential part. Unfortunately, I have to apologize, I'm not able to provide a lot of the detail.

ASSEMBLYMAN PAYNE: Thank you.

Do we have the copies of that?

MR. KAUFMAN: And on your request, Mr. Chairman, I'd be happy to have someone come to give you much more detail on, exactly, what is being proposed and how it's planned to move forward.

ASSEMBLYMAN PAYNE: Thank you.

Let's see, before you leave--

ASSEMBLYMAN CRYAN: I just have two questions.

ASSEMBLYMAN PAYNE: All right, fine.

Assemblyman Cryan has several questions.

ASSEMBLYMAN CRYAN: Just two.

On Page 11 of your testimony, which I don't have real handy -- self-help programs. Elaborate a little bit on that.

MR. KAUFMAN: Yes, Assemblyman. We fund, in each of the 21 counties, programs of self-help, which are basically operated by individual adult consumers of mental health services, who have recovered, and provide help to other consumers. They provide drop-in centers, educational programming, try to link people with services. And a number of these programs have, actually, developed, with our assistance, outreach programs to boarding homes and to other individuals in the community, trying to track people, keep them active in the community services.

ASSEMBLYMAN CRYAN: Page 8, the 20 professionals for the purpose of investigating complaints and licensing reviews of other mental health programs--

MR. KAUFMAN: Yes.

ASSEMBLYMAN CRYAN: The number 6200, kind of, jumped out at me. I think the amount of people receiving the case management-- Is 20 enough to handle complaints and licensing standards?

MR. KAUFMAN: Assemblyman, through the Chair, if you ask my licensing people--

ASSEMBLYMAN PAYNE: Through the Chair, myself, by the way.

MR. KAUFMAN: --they'll definitely tell you it's not enough. But it's always a balance. The Division of Mental Health Services, in the Department, now has the licensing authority, granted by the Legislature, for all mental health programs. And those 20 professionals are, basically, charged with the responsibility of doing licensing across the state, whether individual programs are funded by the State or not.

And, except for residential programs, the reviews of those programs are, basically, done on a three-year basis, unless there's complaint or other frameworks. But the residential programs -- group homes, supervised apartments, family care -- are done on an annual basis because of the nature of those programs and the possibility that there's always more risk in a program that has 24-hour care. I would say that they're challenged, but, I think, the 20 professionals should be adequate to meet the schedulings.

ASSEMBLYMAN CRYAN: Some correlation -- and I'm sorry.

MR. KAUFMAN: It's quite all right.

ASSEMBLYMAN CRYAN: How many programs, on a caseload, are annual versus every three years?

MR. KAUFMAN: All of the group home, apartments, and supervised living are on an annual basis. So all of the 203 group homes, all of the family care settings, all of the whatever -- 700 apartments -- whatever the number of apartments are -- are on an annual basis, all residential programs. The programs that are on a three-year inspection cycle are things like day programs, partial care, hospital-based outpatient programs, other outpatient programs, those kinds of things.

ASSEMBLYMAN CRYAN: Okay, and when something is found to be-- Are there standard -- we heard earlier, from Bill Conroy -- you may have heard that testimony.

MR. KAUFMAN: Yes, I did.

ASSEMBLYMAN CRYAN: Are there standards similar to that -- there are some more offenses that are more egregious than others?

MR. KAUFMAN: Yes, the way our inspection works is, there are regulations for each of these types of programs, that are promulgated, that establish the standards. When a review team does a survey, they will determine whether compliance is either full compliance, meaning every one of those standards are met, or there are certain standards, which we call Type 1 versus Type 2. If a program does not meet a Type 1 type of area -- that may be the credentials of staff, or the number of staff, or medication, or something of a more serious nature -- then licensing could be threatened immediately upon not meeting a Type 1. A Type 2 type of finding would be that it's noted not to meet the standards, but that needs to be corrected prior to either the next survey that goes on, or faster, if necessary.

Now, when a survey is conducted, the staff will send a formal report to the agency, indicating what the problems may be. And the agency is given 40 days to provide a corrective action plan back to the Division. That corrective action plan is then reviewed, and staff either from the licensing area, or other staff, will keep on top to see that those things have been done. If they're corrected, then the evaluation will go forward and move.

There are basically three types of licenses that we issue to residential programs: a full license, which will provide for that organization to operate according to the standards and regulations. It could be a conditional license, which would indicate that it has met, substantially, the compliance areas, but there are some conditions that must be alleviated within a specified period of time, and so it's clear that that license needs to be cleared and made to be a full license down the line. And the third is a provisional license, where an organization may form, or begin to serve -- provide a service. We will review the program standards against their policies, their staffing, but they have not yet begun to provide services. If we approve it, we will, then, give them a provisional license, and then return within six months to, then, evaluate the program while there are consumers in it. And then that provisional license will either be raised to a full license, or a conditional, if that were to be necessary, or the license would be pulled if it wasn't being provided correctly.

ASSEMBLYMAN CRYAN: I'm curious. Do you notify local officials if you have a downgrade in licenses at all?

MR. KAUFMAN: Not typically municipal officials, because this is a treatment and service area problem. If, however, we were to identify in a residential program where there was a life safety issue-- Every one of the group

homes, for example, has to have local certificates of occupancy, and they have to be inspected by local fire marshals. So if our team goes in and identifies that there's a problem from the life safety, then they will notify the local officials immediately.

ASSEMBLYMAN CRYAN: I could probably ask you questions all day. I appreciate it very much. Thank you.

MR. KAUFMAN: I'll come back at any time.

ASSEMBLYMAN PAYNE: Thank you.

Any one else have any questions? (no response)

Thank you very much.

MR. KAUFMAN: Thank you, Mr. Chairman.

ASSEMBLYMAN PAYNE: Mr. Armstrong, please, from the New Jersey Association of Mental Health Agencies. You were here early this morning.

**J. MICHAEL ARMSTRONG:** Good morning.

Thank you for the opportunity to provide input on the issues of quality care and critical staffing shortages in New Jersey's nursing homes and psychiatric community residences. I am Michael Armstrong, a board member of the New Jersey Association of Mental Health Agencies.

Based in the greater Trenton, the New Jersey Association of Mental Health Agencies, NJAMHA, is a statewide trade association representing nonprofit behavioral health providers. Founded in 1951, NJAMHA represents 125 hospital-based and freestanding mental health agencies throughout New Jersey. In aggregate, our members help children and adults with mental health issues more than 1 million times annually, and

employ 25,000 members of New Jersey's workforce. A majority of NJAMHA members provide psychiatric living options.

New Jersey has one of the most acute shortages of affordable housing in the nation for its residents, especially its residents who have a mental illness and are of low income. For example, in New Jersey, one in three households lives in overcrowded, substandard, or housing that is too expensive. A report by the Housing and Community Development Network of New Jersey, released on February 25, 2002, reveals that it now takes an income of \$39,202 a year to afford a typical two-bedroom rental, which rents for about \$970 a month, based on the formula that housing should not cost more than one-third of household income. A person earning minimum wage, the salary earned by the majority of people with mental illness, would need to work 146 hours per week to afford the same two-bedroom apartment.

NJAMHA agencies provide a full continuum of supportive housing, promoting individual independence, while providing a safety net of support services to meet the needs and preferences of all mental health consumers. Mental health consumers need a full range of housing options available to meet their needs and to provide them with choices. These can vary from highly supervised group housing settings, to less supervised group housing, to independent living with or without services in boarding houses, apartments, condominiums, or single-family homes.

As the needs of different consumers vary, and as the same consumers can have different needs at different times, it is critical to support all housing options. Currently, there is a critical shortage of all types of housing for the mentally ill. More housing is needed to ensure the best

possible care for residents and prevent continued overcrowding in existing group homes.

We urge the State Department of Human Services, the State Department of Community Affairs, the State Department of Health and Senior Services, the New Jersey Housing and Mortgage Finance Agency, and the New Jersey Economic Development Authority to collaborate among themselves and with the Corporation for Supportive Housing, nonprofit community mental health providers, nonprofit community housing development groups, and the private sector to maximize the leveraging of capital funding for the development of housing for individuals with serious mental illness.

Quality of care in nursing homes and psychiatric community residences is directly related to the staffing available in each home. In Fiscal Year 1999, the turnover of clinical staff in the community system serving patients averaged around 42 percent, while the length of time required to find a replacement averaged seven months. Staff vacancies result in increased caseloads for the remaining staff, leading to increased staff stress.

As caseload size increases due to staff vacancies, support is stretched thinner and thinner. The result is an environment that has become less stable than it should be for the client population. The problems posed by this situation are significant.

Despite the welcome 2 percent cost of living adjustment in the FY 2003 State budget for service workers' salaries, New Jersey's State budget policy, over the last 12 years, to economize on spending, has created a serious staffing crisis in the community mental health system. As a result, providers

struggle with staffing vacancies in programs serving persons with mental illness. These vacancies expose providers to malpractice claims and threaten the integrity of the State's community mental health system, which has saved taxpayers more than \$1 billion per year over the cost of institution-based treatment.

One would expect that trained mental health staff, willing to serve a vulnerable client population, would be in short supply and able to command a reasonable salary. However, State-funded community-based treatment staff have consistently received less compensation than other State employees, teachers, and other comparable worker categories supported by the State budget, even those who contribute far less to saving tax dollars than those employed by the community mental health system.

Starting salaries for State workers and teachers with comparable credentials average, approximately, \$31,000 compared to the \$25,000 paid on average to community mental health staff. Both State employees and teachers receive annual increases for both merit and to keep pace with inflation. Staff in the community mental health system, however, receive no merit increase and have lost ground to inflation.

For example, assume that two comparably trained individuals were hired in 1992, at a salary of \$25,000, to perform similar duties, one by a State hospital and one by a community provider. By 1999, the State employee would have received a 40 percent increase in merit raises alone, along with annual inflationary increases exceeding the rate of inflation, averaging between 2.5 and 4 percent, or, approximately, another 25 percent. This gives the State

employee a total gain of 65 percent, or a salary of \$41,250, an increase of \$16,250 over eight years.

By contrast, community providers have received less than the inflation rate over the years to cover cost increases in all operational categories, not just payroll. As a result, staff salary increases have ranged between zero and 3 percent. Over the course of the same eight years, the community employee would realize, approximately, a 15 percent increase, for a salary of \$28,700, an increase of only \$3700.

Since community providers match State funding at a ratio of one to two, or one to three, with other funding streams, the State contribution to salary increases is even less, approximately \$2000 over eight years. If one considers the extremely heavy workload of the community treatment staff, the immense challenge of serving vulnerable clients, outreach duties into an often dangerous neighborhood, on-call responsibilities at all hours and weekends, and other unpleasant functions, it is nothing short of miraculous that anyone would be willing to work under such conditions for an increase of only \$2000 over eight years.

Spending a small fraction of the \$1 billion saved per year, because of the community mental health system, provides more than enough resources to correct the staffing problem in nursing homes and psychiatric community residences, and ensure adequate supervision for those who require it. Such action is necessary to halt the crisis in staff turnover and create the more stable treatment environment and quality of care that consumers, staff, and community require.

Thank you for your valuable time.

ASSEMBLYMAN PAYNE: Thank you, Mr. Armstrong.

Just one question on the salary differential. You said that the State workers, teachers, etc., start out at \$31,000.

MR. ARMSTRONG: Right.

ASSEMBLYMAN PAYNE: And over a period of time, they would be at -- maybe receive a 40 percent increase, or \$41,000, as opposed to the community mental health workers, which receive -- by then would have reached \$28,000.

Are the credentials the same, are the requirements the same, for both of those categories or workers, or what?

MR. ARMSTRONG: Right, for a staff worker in a group home, we require a college degree or four years of equivalent experience. So it would be very comparable to what a teacher or other State employees would be required to have.

ASSEMBLYMAN PAYNE: State employees and teachers do require a four-year -- a minimum, I suppose, of a bachelors degree, or something like that, right? That's professionals.

MR. ARMSTRONG: Right.

ASSEMBLYMAN PAYNE: And you said that the community worker would -- it's an equivalent -- it's a college degree, or the equivalent of four years experience.

MR. ARMSTRONG: Exactly, yes, sir.

ASSEMBLYMAN PAYNE: Thank you.

Mr. Phillip Lubitz, please identify yourself.

**PHILLIP LUBITZ:** My name is Phil Lubitz.

ASSEMBLYMAN PAYNE: Organization?

MR. LUBITZ: Mr. Chairman and members of the Regulatory Oversight Committee, I would like to thank you for the opportunity to present comments on the management and operation of nursing homes and psychiatric community residences in New Jersey.

My name is Phillip Lubitz. I am the Coordinator of Family Support and Advocacy Programs for NAMI New Jersey, the National Alliance for the Mentally Ill. NAMI New Jersey is a statewide, grassroots coalition of self-help and support and advocacy groups. We were primarily formed by family members of people with mental illness, but now we consist of family members, consumers of mental health services, friends, and professional people who were affected by mental illness.

People with a mental illness, biological diseases of the brain such as schizophrenia, bi-polar disorder, and major depression, are among the most marginalized individuals in society. Among the most devastating consequences of these debilitating illnesses are the stigma and prejudice that consumers of mental health services and their families must face. The prevalence of this stigma can be seen in the public policies of neglect that have arisen around the housing of people with a mental illness.

The shortage of safe, decent, affordable housing with supportive services for persons with a serious and persistent mental illness has been consistently identified as a major deficiency in New Jersey's system of care for persons with a serious mental illness. A stable living situation has been regularly shown to be the underpinning of a recovery from a mental illness, yet, in New Jersey, a person with a serious mental illness has less than a one in fifty

chance of obtaining New Jersey Division of Mental Health Services funded residential services.

ASSEMBLYMAN PAYNE: Why is that?

MR. LUBITZ: I think Director Kaufman testified that there just is not the resources to meet the need for housing for people with mental illness.

The consequences of our inattention to the residential needs of persons with a mental illness are clearly evident. While each of our State psychiatric hospitals is suffering from acute overcrowding, it is also widely understood that there are now more people with a mental illness in Federal and State prisons and county jails, approximately 16 percent of all inmates, than are in our hospitals. The U.S. Department of Justice statistics reports that persons with a mental illness are two-and-a-half times more likely to have been homeless in the 12 months prior to arrest than the general prison population. This, unfortunately, is a large pool of people from which to pull, as estimates of the percentage of homeless individuals with a mental illness range from 25 to 50 percent of all homeless individuals.

It's not in my testimony, but I just wanted to mention that in a survey we performed at NAMI New Jersey of 1400 individuals, we found that it was either 84 or 86 percent -- it's actually part of your packet -- there's a residential survey, I think, in the back -- had incomes that were too low to qualify for low-income Mount Laurel housing. So people with mental illness, really, are our, probably, poorest citizens.

The passage of the Medicaid-Medicare amendments of the Social Security Act of 1965 provided states, including New Jersey, with the mechanism to shift the financial responsibility for the care and treatment of

persons with a serious mental illness from State-funded psychiatric hospitals to Federally funded placements in the community, a process often referred to as transinstitutionalization. And this is not-- We frequently talk about deinstitutionalization, but, actually, there was a process where people went from large psychiatric hospitals into large boarding homes. We call that, really, moving from an institution in the hospital into an institution in the community.

Thus began a process that was described in the 1979 State Mental Health Plan as the dumping of more than 7000 people into the community with little, if any, planned support services. It is estimated that more than 9000 individuals with a mental illness now reside in board and care homes where as little as 12 minutes of nursing care a week meet the regulatory level of care required, if the care is required at all.

I also have to mention that in the studies that have been done by the Department of Community Affairs and the Department of Human Services there are, really, no statistics at all. And the number of people with a mental illness who end up in illegal rooming houses and boarding homes-- And remember, again, people with mental illness are amongst our most, our poorest citizens. So it stands to reason that large numbers of these individuals will end up in these unlicensed residences.

There is a wide range in the quality of care provided from home to home, but, nevertheless, a NAMI New Jersey survey of more than 1400 consumers of mental health services, family members, and mental health professionals found that only -- and I have to correct my testimony -- it was

actually less than 1 percent of the respondents preferred these homes as long-term housing settings.

A series of reports, dating back to the 1982 Assembly Corrections, Health and Human Services Committee, on the review of boarding home legislation have reported on the failures of the Rooming and Boarding Act of 1979. The 1991 Report on Board and Care Reform by the New Jersey Public Advocate concluded with the admonition, “There comes a time when an issue has been so thoroughly investigated and examined that we have a clear understanding of what the problems are and what needs to be done. After a decade of studies and proposals for reform, now is the time to act.” Again, this report was done by the Public Advocate in 1991. We’re now in 2002. So a second decade has now passed with no discernible change in the lot of persons with a mental illness who are residing in rooming houses, boarding homes, and residential health-care facilities.

By far, the primary care in the community for people with a mental illness is provided by families, who often do so without the resources or supports necessary to perform the task. Approximately 65 percent of all people with a mental illness live with their families. Here in New Jersey, we are facing a pending, if we have not already entered it, crisis. The NAMI New Jersey residential survey found that the average age of a family member caring for a relative with a mental illness is now more than 65 years old. Clearly, we cannot expect these elderly family members to provide care into the indefinite future.

Families of persons with a serious mental illness experience an additional burden. And this part really talks about the turnover in staff that

Mr. Armstrong just testified to. Probably, in no other field, is the relationship that's formed between the patient and the treating professional as important as in the field of mental health, and yet, I think Mike testified that 42 percent, there's a 42 percent turnover rate. So people really aren't able to form that kind of relationship.

In addition, many of these programs, although they're highly thought of, are just terribly understaffed. So either they can't accept the proper number of individuals into their programs, and we've already heard testimony that there's an acute shortage when they are fully available, or people are placed in settings where there aren't enough people to, really, properly care for them.

So we're recommending four things: one, that every person who enters the Division of Mental Health Service -- a funded program, and that's about -- I think Director Kaufman testified this morning -- is about 200,000 people -- that every one of those people have their residential needs evaluated as part of the evaluation when they enter a program. And then, that we develop and fund a program to meet those identified needs.

We also believe that we should prioritize housing with supportive services for persons who are living at home with aging parents.

And fourth, that we increase the salaries of direct care mental health workers to a level that will attract and retain qualified individuals to the public mental health system.

On behalf of NAMI NEW JERSEY, and the families we represent, I would like to thank you for the opportunity to appear before you today. I'd be pleased to answer any questions that you may have.

ASSEMBLYMAN PAYNE: Thank you.

You say that illegal rooming houses-- What is that? I mean, you said there are a lot of people residing in illegal--

MR. LUBITZ: That would be in a place where someone may have a home or an apartment, and have a spare room, and rent that out. And, you know, the quality of these places -- or where a whole house may be rented out without the knowledge of the zoning officials in a municipality.

ASSEMBLYMAN PAYNE: These homes are monitored by the municipalities, aren't they, in addition to the State? For instance, the legal homes--

MR. LUBITZ: The illegal ones would be ones that--

ASSEMBLYMAN PAYNE: Legal.

MR. LUBITZ: Legal ones-- Yes, they're monitored, usually, by the Department of Community Affairs. There's an additional sheet that, I think, is titled *Historical Perspective* that I put in your packets. And that tells a little bit about this process of deinstitutionalization. The second page goes into some detail about rooming houses and boarding homes, as well as a variety of reports that date back to, I guess it was, '82, that talk about the problems in the rooming and boarding home industry in New Jersey.

ASSEMBLYMAN PAYNE: This area has been studied quite a bit, so we know what needs to be done. We just have to do it.

You mentioned the 1979 Rooming and Boarding House Act.

MR. LUBITZ: Yes.

ASSEMBLYMAN PAYNE: It is currently on the books. However, I don't know how far that Act went, at that time, whether or not it meets the

kinds of needs that we have, currently. I don't know whether you're-- I'm not that familiar with that Act, as a matter of fact. What's your assessment of it, and how does it need to be amended or changed? You mentioned the Division of Mental Health -- it was mentioned before, 200,000 people entering into the system and needing help.

MR. LUBITZ: I think we have to apply a historical perspective. In 1979, I think, the Act was a good act for where we were coming from. It's our belief that there are still portions of that Act that are not implemented fully. Part of that Act is, really, case management being provided to every resident of one of these rooming homes and boarding homes, and their mental health needs be identified -- in that those mental health needs be met, for whatever reason, whether there's shortages or neglect. That, clearly, hasn't occurred. So I think that would be an area that we would, really, want to look into and give some strong attention.

ASSEMBLYMAN PAYNE: You used the terms boarding house and rooming interchangeably. Is that--

MR. LUBITZ: Well, again, I'm not an expert. I believe both of those facilities are licensed by the Department of Community Affairs. And we have different levels. Again, I'm not the expert on that.

ASSEMBLYMAN PAYNE: All right, thank you.

ASSEMBLYMAN CRYAN: Can I ask one.

ASSEMBLYMAN PAYNE: Yes, Assemblyman Cryan.

ASSEMBLYMAN CRYAN: I just have one question for you.

MR. LUBITZ: Oh, I'm sorry.

ASSEMBLYMAN CRYAN: You said, in your testimony, on Page 2 -- the top of it -- 1400 consumers of mental health services -- you corrected, less than 1 percent of the respondents prefer these homes.

MR. LUBITZ: Yes.

ASSEMBLYMAN CRYAN: Is that based on the conditions they described in the paragraph before -- as a standard -- that homes, simply, don't work?

MR. LUBITZ: You know, our survey doesn't really go into why as much as why-- They presented people with a variety of living circumstances and asked them to chose which ones they prefer. So this simply tells us that, of the group-- Actually, this came out to be about the same preference as psychiatric hospitals.

ASSEMBLYMAN CRYAN: So homes don't work. And in the recommendations, you talk about, in three, prioritizing housing. Am I missing-- Help me out.

MR. LUBITZ: I think, in our recommendations, we're asking that people who enter programs -- their residential needs be evaluated. Based on those evaluations -- and I would assume, based on our survey, that very few people would be evaluated as these homes being the appropriate setting for them -- that we would look to other kinds of settings, such as the kind of community residences that Director Kaufman testified exist, but do not exist in sufficient number to meet the need.

ASSEMBLYMAN CRYAN: To your knowledge, has there been an increase-- The 200,000 number--

MR. LUBITZ: Yes.

ASSEMBLYMAN CRYAN: Has there been an increase? How does that number stand in the years past?

MR. LUBITZ: I think that's increasing somewhat, just keeping in mind that New Jersey's population increased by nearly 9 percent from 1990 to 2000.

ASSEMBLYMAN CRYAN: So the increase is more of a correlation to population than it is to more active diagnosis of mental health.

MR. LUBITZ: There are a number of factors. I don't know that I would testify that there is a per capita increase in the mental illness in the state.

ASSEMBLYMAN CRYAN: Real help. Thank you.

MR. LUBITZ: Thanks.

ASSEMBLYMAN PAYNE: Thank you very much.

Paul Langevin, from the Health Care Association of New Jersey. Identify your organization, please.

**P A U L R. L A N G E V I N J R.:** Sure, I'd be more than happy to. Thank you for the invitation.

I'm Paul Langevin. I'm the President of the Health Care Association of New Jersey. We're a trade association that represents over 300 members. We represent nursing facilities, residential health care, assisted living, and adult day health care. And I have prepared comments, which are in your packets, but I'd like to digress from those and focus on a few things that I've given to you today, because I think it would be more helpful and informative. You can read my testimony later.

First off, I'd like to call your attention to a glossy publication that, I think, will, hopefully, enlighten the Committee on the statistics about who is in a nursing facility in New Jersey, what kind of folks are delivering the care there, how much money is tied up, and what the turnover rates and recruitment problems are.

I think it's important to know who your customer is. And for our 200 nursing facility members, and other assisted living facilities in the state, it's the people in the facilities that are their customers.

We've talked a lot about regulation and inspection. And the fact of the matter is, I find myself agreeing more and more with the people representing labor and people who work in facilities, because the fact of the matter is, if the facilities don't have the money, they can't turn around and pay and recruit staff, and make the facility a place that people want to stay and work. And we have, depending on the type of facility, very high turnover rates.

One of the things that I call to your attention is the percentage of revenue that comes from different programs, principally, Medicaid and Medicare. And one of the other inserts that I have, in the material for the Committee today, is a study from BDO Seidman. It's an update on a study that I presented to the Committee in June. This came out in July of this year, and it basically shows that New Jersey's leading the nation in underreimbursing nursing facilities. We're now losing \$22.33 per day, per patient, for every Medicaid patient that we serve in a nursing facility. The more you do, the more you lose, with respect to the Medicaid Program.

When we all go to sleep tonight, we're going to be turning off a light, and the Federal government is going to be turning off Medicare funds to

New Jersey, to the tune of \$61 million, that will no longer be coming to New Jersey tomorrow morning when we wake up. Effective with the new Federal budget, there's going to be a reduction in Medicare rates to the State of New Jersey in long-term care. That will be \$61 million not available to nursing facilities to take care of Medicare patients that are residing there.

The other thing I want to point out is that you've heard about the continuum of care in our state, and residential health care is a significant part of that. It has a fairly small nursing component, about two-and-a-half hours a week, 12 minutes a day. But I would point out to the Committee -- and Mr. Chairman, you pointed out that the problems of what were then-termed board and care homes in 1979 has been well-studied.

The fact of the matter is, we haven't had an increase in the State rate paid to residential health care in 20-plus years in New Jersey. Those facilities, which have to provide a place to sleep, three meals a day, and medical monitoring get paid \$20 a day to do that by the State of New Jersey. We've heard about group homes. Group homes are paid well in excess of that, double, triple that.

Long-term care facilities, if they're assisted living and they participate in the Medicaid Program, get \$60 a day, and your average nursing facility rate in the state is now \$125 a day, to give you an idea of the perspective we're dealing with.

Before we beat the residential health-care community into submission, I think we ought to look at the fact that we haven't even provided cost of living for those providers, and that's 7500 beds in the State of New Jersey, in 20 years.

ASSEMBLYMAN PAYNE: You say that-- Which facilities have not received an increase in--

MR. LANGEVIN: Residential health care.

ASSEMBLYMAN PAYNE: And what period of time?

MR. LANGEVIN: Over 20 years. So that's a significant piece.

I think the other thing-- We should focus, certainly, on the residents, but you've heard a lot about workforce. And workforce is, probably, the single biggest problem that's facing long-term care today. It's not the regulations. Finding people who are willing to come to work every day for barely above minimum wage, and take care of a very dependent population, in many instances--

We have over 49,000 people employed in long-term care in New Jersey, and about 21,000 more in related businesses. Nearly \$1.8 billion in wages and salaries are supported by the long-term care community, and another \$900 million in salary and wages paid to related industry employees. And if we don't provide adequate support -- and as I point out, we're losing \$22 a day in Medicaid, and they'll be taking \$61 million out of the Medicare system at the close of business today -- facilities will be unable to pay the people who take care of the residents, mothers, fathers, friends. They'll be unable to pay them any more money in the future.

We are about 50,000 residents in nursing facilities, and another 70,000 who depend on the long-term care community for their livelihood -- that means their salaries, their pensions, their health care. There was just a report in today's paper that the number of uninsured Americans, people

without health insurance, is going up. Well, for 70,000 people in New Jersey, long-term care is the best job they ever have had and, probably, ever will have.

Again, I would urge the Committee to look at the financing, because with 60 percent coming from Medicaid and another 20 to 25 percent coming from Medicare, when you're looking at precipitous declines in those two revenue streams into long-term care services, I think you're preparing yourself to realize that we're on the brink of disaster if we don't do something with that.

We have plenty of regulations. We have more than enough opportunities to go out and take over facilities that can't deliver the goods. But at the end of the day, you can't hire qualified people, you can't train those folks, and you can't make the place where they work attractive if you don't have the financing to do it.

So, in deference to the remaining witnesses that are here today to talk about long-term care, I'd be happy to make myself available for questions and, again, call your attention to the packet. There's an explanation in there about this so-called Medicare cliff that occurs today. And I hope you find the information informative.

Thank you.

ASSEMBLYMAN PAYNE: Thank you, Mr. Langevin.

Any questions? (no response)

Seeing none, I appreciate your testimony.

We'll hear now from the New Jersey Department of Community Affairs, Michael Ticktin and Ray Samatovicz, Bureau of Rooming and Boarding House Standards.

**MICHAEL TICKTIN:** Thank you very much, Mr. Chairman and Committee Members.

To begin with, I'd like to clarify our jurisdiction under the Rooming and Boarding House Act, which we're in charge with enforcing. We license owners and operators of, currently, 1074 rooming houses, with 14,077 spaces; 281 boarding houses, with 8198 spaces; and we, also, under a separate legislation, license 139 homeless shelters with the capacity of 4691--

ASSEMBLYMAN PAYNE: Homeless shelters, you said?

MR. TICKTIN: Yes.

ASSEMBLYMAN CRYAN: Capacity of what?

MR. TICKTIN: I'm sorry, 4691 capacity in 139 homeless shelters.

In the 22 years that this program has been in existence, we have closed 329 boarding houses, rooming houses, which did not meet the standards or were functioning illegally and relocated, approximately, 3500 people.

The definition of a rooming and boarding house, under the Act, is, basically, any place where two or more people, who are independent of each other, are renting living space, and where they don't have their own bathroom and kitchen facilities.

ASSEMBLYMAN PAYNE: That's a boarding?

MR. TICKTIN: That's a rooming or boarding house.

If they provide any sort of personal or financial services, as well, then they have to be licensed as a boarding house. If they don't provide personal or financial services, and all they're providing is the housing, they're a rooming house.

There are several gradations of licensing. There's, what we call, Class A licenses for a rooming house. A Class B license would be for a boarding house that only provides food and laundry. So it doesn't provide any other personal or financial services. The Class C license would be the one where people, with varying degrees of disability or need of assistance, might be found.

It's important to note, also, we are not -- a boarding house -- no medical services are supposed to be provided, or allowed to be provided, above the level of supervision of self-administration of medication. So these are not facilities where people who need nursing home services, or nursing services, should be found. And if they are there, it's the obligation of the licensees, the owner and the operator, to notify the Board of Social Services, so these people can be relocated to appropriate settings where they can get the social services that they require.

Reference was made to illegal rooming and boarding houses. When the Department finds out about them, we go and close them. We can impose significant penalties on anybody who is operating an illegal rooming or boarding house. And this is done with regularity.

ASSEMBLYMAN PAYNE: Excuse me.

MR. TICKTIN: Yes.

ASSEMBLYMAN PAYNE: The rooming or boarding house -- where two or more people reside.

MR. TICKTIN: Right.

ASSEMBLYMAN PAYNE: But there's no individual bathroom.

MR. TICKTIN: They don't have-- They would be, say, renting a room or renting a part of a room.

ASSEMBLYMAN PAYNE: Right.

MR. TICKTIN: They don't have their own bathroom just for themselves.

ASSEMBLYMAN PAYNE: Right, so that's a, what, rooming house?

MR. TICKTIN: Right, an apartment -- you know, in an ordinary apartment, you have your own kitchen and your own bathroom.

ASSEMBLYMAN PAYNE: Right.

MR. TICKTIN: If you're lacking either of those, it's a rooming unit.

ASSEMBLYMAN PAYNE: Rooming house.

MR. TICKTIN: The other thing, of course, being it's nontrangent, because otherwise it would be a hotel. A hotel is rooming units as well. The difference is that if it's, at least, 15 percent nontrangent occupancy, the owner and operator would have to be licensed under the--

ASSEMBLYMAN PAYNE: And a boarding house is what then?

MR. TICKTIN: The boarding house is the same requirement with the addition that various personal or financial services are also provided to the resident, which they have to -- there are standards as to how they are to provide them, and they have to provide them properly, and honestly, and conscientiously. And if they don't, they're subject to penalty. If that's inadequate to get them to change, they're subject to closure.

ASSEMBLYMAN PAYNE: Do you monitor rooming houses?

MR. TICKTIN: Yes, we do. We inspect rooming houses.

ASSEMBLYMAN PAYNE: You do.

MR. TICKTIN: Everything is-- All boarding -- all licensed-- All facilities that we're aware of, obviously, are inspected annually, and the licensees, the owners and operators, have to be licensed annually as well.

ASSEMBLYMAN PAYNE: How many people can reside in a rooming house? Is there any numbering in that?

MR. TICKTIN: Well, as I say, the total that we have is -- we have space -- we have license capacity of 14,077.

ASSEMBLYMAN PAYNE: In an individual facility?

MR. TICKTIN: It could be from two--

ASSEMBLYMAN PAYNE: Two to twenty, thirty, forty? It's like a hotel then, right? Could you go up as far as what?

MR. TICKTIN: Up to 40, perhaps, they might see.

**RAYMOND SAMATOVICZ:** Most of them are a 10- or 12- resident population for rooming houses.

ASSEMBLYMAN PAYNE: And they're monitored by DCA?

MR. TICKTIN: Yes, we would inspect them every year.

ASSEMBLYMAN PAYNE: Okay, so that's a rooming house. So the boarding house is where it's the same thing, except that they provide various kinds of services like food, maybe, and things like that.

MR. TICKTIN: If they provide only food and laundry, which are, basically, things that people without special needs would have, that would be the Class B. There aren't too many of those. There are very few of those, I believe. And most of the boarding houses are, what we call, Class C, where the

people need assistance, perhaps, in things like dressing, having their finances, their money, held, things of that sort.

ASSEMBLYMAN PAYNE: Do you contract with people like that?

MR. TICKTIN: We don't contract with them, we just inspect them to make sure they're doing it properly. We have training programs as part of the licensing procedure. They're required to take training programs. Again, if they don't do it properly, they can risk the loss of their licenses.

ASSEMBLYMAN PAYNE: So they provide services to these folks. Do they monitor their medication or anything like that? Is that one of the things they might do?

MR. TICKTIN: They supervise self-administration. If the person is in need of having somebody else administer it to him, he's not supposed to be in a boarding house. They're supposed to notify the Board of Social Services to get the person moved out and placed in an appropriate place.

ASSEMBLYMAN PAYNE: These people who run the Class C boarding homes contract with the State for people that are discharged from--

MR. TICKTIN: They wouldn't contract with our Department. They probably would contract with Mental Health and Hospitals or Developmental Disabilities. We don't contract the people, we simply inspect them and evaluate their performance.

ASSEMBLYMAN PAYNE: I'm glad there's a, what is it, interdepartmental council, or something like that?

MR. TICKTIN: There's an interdepartmental committee, and there's ongoing coordination.

ASSEMBLYMAN PAYNE: I can't keep straight who does what, where, when, etc. I hope you guys can. I hope that the-- I don't know how often the interdepartmental agency meets. And, sometimes, what it does is allows for, "Well, it's not my job," kind of thing. "We don't do that, we do this." I'm terribly confused about this stuff.

MR. TICKTIN: They have their--

ASSEMBLYMAN PAYNE: How often do they meet, do you know?

MR. TICKTIN: I don't know.

Do you know, Ray?

ASSEMBLYMAN PAYNE: Do they ever meet, do you know?

MR. SAMATOVICZ: Oh, yes. I'm not sure if they meet once a month, or once every other month, but they meet on a regular basis.

ASSEMBLYMAN PAYNE: I'm sure it's clear to other members of the Committee.

Are you finished?

MR. TICKTIN: I might, also, note that the first bureau chief of the Rooming and Boarding House Bureau is your distinguished colleague, Bonnie Watson Coleman. So, perhaps, she could, certainly, fill you in on a lot of the background of the program as well.

ASSEMBLYMAN PAYNE: Thank you.

Do we have any additional testimony?

MR. TICKTIN: No, we can answer any questions that you have.

ASSEMBLYMAN PAYNE: You're there to help him out in case he--

MR. TICKTIN: That's right.

ASSEMBLYMAN PAYNE: What's your name? Give your name anyway.

MR. TICKTIN: My name is Michael Ticktin.

MR. SAMATOVICZ: And I'm Raymond Samatovicz, Acting Bureau Chief of Rooming and Boarding Home Standards.

ASSEMBLYMAN PAYNE: Do we have any complaint -- boarding home-- For instance, there's a council, I think, there's a council of boarding homes that, I believe, I've been appointed as a member of it. Are you aware of this organization of operators of boarding homes?

MR. SAMATOVICZ: At the beginning, they did have a rooming and boarding home association. I think, over the years, it just, sort of, fell through the wayside. They had it for, basically, each county. I'm not really that aware of how active it is, if there is any.

ASSEMBLYMAN PAYNE: There's a statewide organization. There's an organization of New Jersey Boarding Home Advisory Council. Do you know that group?

MR. SAMATOVICZ: Yes, I've heard of it.

ASSEMBLYMAN PAYNE: You've heard of it. They have no affiliation or contact with your Department that you know of?

MR. SAMATOVICZ: No.

ASSEMBLYMAN PAYNE: All right, thank you very much.

MR. TICKTIN: Thank you.

ASSEMBLYMAN PAYNE: Marie Verna, please, from the Mental Health Association of New Jersey. Would you identify yourself for the record, please?

**MARIE D. VERNA:** Good morning. Thank you for the opportunity.

My name is Marie Verna. I'm with the Mental Health Association in New Jersey. I'm the Director of Consumer Advocacy. And we are a statewide organization, a child of the National Mental Health Association, whose goal is to promote mental health and advocate for the rights of the consumers of mental illness.

We appreciate this opportunity. This is a severe crisis in New Jersey, that we've known about for a long time, and realize that what does need to happen is for a lot of education--

In response to New York's difficulty with its system of adult homes, our Executive Director, Carolyn Beauchamp, who is past chairperson of the Boarding Home Advisory Council that you refer to, has gathered information from New Jersey in relation to similar systems of adult homes.

Affordable, appropriate housing and services for those with chronic mental illness is one of the largest problems we face in New Jersey. The absence of the housing has lead us to depend on the board and care industry, including hotels and rooming houses, especially when people are first discharged from State and county hospitals, and their families don't want them anymore.

In New Jersey, there are, approximately, 6000 adults with histories of mental illness in 365 private boarding homes, as defined by other people who have testified. They're in private boarding homes and residential health

care facilities. That number does not include hotels or rooming houses. There are no numbers for the people in those types of facilities.

The latter also provide no services or meals for residents, unlike residential facilities and boarding homes, which do provide an array of services based on their classification and licensure. It is as confusing as it seems.

Since 1990, the number of boarding homes and residential health care facilities has been dropping. Some have closed due to their failure to meet licensure requirements. But the majority of the closings are due, in fact, to lack of adequate SSI rates to meet the cost of care in facilities that accept publicly funded clients.

Currently, the rates paid for public clients are, on a Federal level, approximately \$600 for both boarding homes and residential care facilities. The State rate is \$31 for a boarding home and \$150 for a residential health care facility. Please note that there has been no increase in SSI in the last 20 years.

Currently, in New Jersey, there are about 2000 psychiatric patients in State hospitals at any given time. And in addition, there are about 2000 residents in group treatment homes, which are operated by public mental health agencies. Compare these numbers to the number housed in the board and care industry, which is failing, and you can readily see the problem mounting in New Jersey.

In addition, the Department that controls the board and care industry, which is Community Affairs, is not the Department responsible for the care of people with mental illness, which is Human Services, even though

such a large number of board and care residents have histories of mental illness.

There has been little political will to address the board and care problems, with the result that we know nothing about the rooming house or hotel population, and we are losing existing housing stock due to neglect. Our problems may be different than those of New York, but they are of great concern.

We have a housing shortage of crisis proportions in New Jersey that contributes to the instability and long hospitalizations many consumers have to face. Rather than investing in solutions that will be productive for ex-patients, New Jersey has used the board and care industry as a backup, without providing that system with the financial or service supports it needs to do the adequate job we heard about today.

Chairperson Payne and members of the Committee, I thank you for the opportunity, and I welcome you to contact the Mental Health Association in New Jersey when you try to sort all this out.

ASSEMBLYMAN CRYAN: Thank you for your testimony.

I don't believe the Committee has any questions.

MS. VERNA: Thank you.

ASSEMBLYMAN CRYAN: Nancy Pinkin, please.

**NANCY PINKIN:** Thank you.

I'm Nancy Pinkin for the New Jersey Psychiatric Rehab Association, and I'm testifying in support of the State's efforts to try to help us to look at ways to solve these problems.

I think a lot of people testified today, already, about two of the main problems that we see: one, is the direct care salary problem; and the second is housing, and affordable housing and flexible programs to deal with patients with severely and persistently mental ill problems.

The salary issue we've talked about with the Legislature for a number of years, the past four years. As someone said earlier, we are losing ground with that issue. Even though we had a salary increase this past year, of \$1 an hour, after testifying for about four years on that issue, we're still losing ground. We still have-- Somebody referenced the staffing pool as coming from -- in the same employment pool as McDonald's. I don't know how they feel about that classification, but it's a severe problem. We have people with bachelor's degrees making \$24,000. When they got their \$1 an hour increase, a lot of that ended up going to the health benefits, which they had to pay for. So, in fact, they didn't get that increase.

When we talk about affordable housing, just to switch gears for one second, a lot of our staff cannot afford housing, in addition to the clients not affording housing. When the housing, affordable housing, group said that in order to afford housing in New Jersey you have to make over \$35,000 -- and they said today, actually, the number must have increased to \$39,000 -- and the employees are only making \$24,000.

One of the things we're asking for-- We know there's a tight budget this year, as there had been last year, as well. How can you get those salaries up when we have these budget problems? We're saying, in addition to looking at that salary and having some way to get an increase every year -- but also to look at ways to get benefits. Is there some way, through the Health

Benefit Plan, or something like that -- or coming up with a program where they can use the accruals in their program for salaries, or if they can look at a way to have a buying program -- so these community agencies that are providing these services can work together and get an affordable health-care program, in addition to the salary. So that's a, really, key issue.

Now we're looking at expanding the range of community supports for people with severe and persistent mental illness. And some of those issues include the rehab option to fund needed services.

The rehab option funds the PACT program in the Children System of Care. And a full continuum of community-based services should include expanded in-home crisis intervention services to avert hospitalization; restructuring and expanding partial care program services to offer different levels of care, as well as off-site services; expanding affordable housing opportunities, with an emphasis on developing supported housing; and expanding supported employment and supported education opportunities.

We know that the rehab option is expensive. So what we propose is, to pick one or two of these programs to start and do a pilot program, because we know that it would be cost-effective over time.

And one thing I want to address-- The gentleman from NAMI, which represents the family programs, was talking about the-- You had asked, Assemblyman Cryan, about why is he asking for more housing when he's saying that most of them don't like housing? He was talking about boarding homes and rooming homes. He was not talking about the group homes and supportive housing programs that we have now.

The State has been going into the PACT programs, and other services like that, and they have been working out well. The big problem is they can't get the staff -- one of the big problems is that they cannot get the staff. Somebody else testified that there's a huge number of programs ready to be opened, but they have no staff.

So we appreciate your looking into all of these issues. We'll be happy to work with you on trying to come up with some solutions.

Do you have any questions?

ASSEMBLYMAN PAYNE: As you know, we do have a serious -- and everybody knows that we do have a serious budget crisis in the State of New Jersey, and a lot of these solutions would depend on funding, but a lot would not. I mean, some of it just simply means that we have to make sure that we implement some of the current programs and laws that we have on the books. We do know that there doesn't look, currently, to be any light at the end of the tunnel, as far as additional funds go, for some of these programs that we need.

But we do know, and I think one of the things we've underscored time and time again, is that people who are providing the kind of work that we're talking about, certainly, need to be paid a livable wage. It's ironic that we say that -- affordable housing -- and the people who are working in them every day can't afford it themselves, are making less than what is necessary for an average person to live on. That's something we're going to have to continue.

MS. PINKIN: That's really true.

ASSEMBLYMAN PAYNE: Absolutely. We have to continue to work at it. Many people who work in this industry don't have health care themselves. I mean, they don't have benefits for themselves. It doesn't make sense, it's ironic. And I think we're going to have to try to find some way to resolve that dilemma. I mean, if we do nothing else--

MS. PINKIN: We had met with the Commissioner of Human Services in regard to these issues, in how do we solve this. They're willing to work with looking at more flexible programs. It's always, in health care and human services, which do you do first. How can you get cheaper programs. It's much cheaper and much better for clients to be recovered in the community setting than in the psychiatric facility, in an institution, but, yet, we don't have the services to put them in them. We know it's cost-effective over time. So when you're on a tight budget restraint, it's how to deal with that.

Now, when we did do the last closure of Marlboro, actually, there was a law that said that the money had to follow the patient. When the patient went from the institution into the community -- that they would have community services. That transition went much better than previous closings. We know that as Greystone is being downsized, those same services would be provided. And, again, that's more cost-effective, and it has a better recovery for patients, and they're much happier there. So those are the things we need to continue to work on. But the State has been doing, working, towards those goals. And we do have some really great programs that we're working with now.

ASSEMBLYMAN PAYNE: The PACT, that's a program. It's not in every-- Describe it, if you can. I know you're not from the Department, but, maybe, you can tell what that PACT is. They have a team of people that go to boarding homes or nursing homes -- boarding homes, rather, to evaluate or to provide the care for the people. It's a case-management kind of thing. Do you know?

MS. PINKIN: It's putting the services into the community, both in the group homes and in transitional housing and other types of housing, where they-- Somebody addressed the issue of medication. One great thing for mental health services is the new medications have really changed the lives of many people. It's true that if they don't keep taking them they will regress. So one important way to save money and to provide better services for the patient is to be sure that somebody checks on that patient and makes sure that they take it. That is one of the things that are in the PACT program. And it's going to--

ASSEMBLYMAN PAYNE: All the counties don't have PACT programs yet, though, I understand. They don't exist in every county.

MS. PINKIN: They're phasing them in. And, again, one of the problems with the PACT program is trying -- is the salaries. They can't get people in them. And the turnover is over 40 percent. So even when they get them in there, they leave once they can get another job. Even though we have--

Also, one of the issues was psychiatric rehab certification, which is-- Somebody was talking about certifying staff. They do have those programs. We have programs at UMDNJ that train people in psychiatric

rehab counseling, and they stay in the field for the average -- even once they get a bachelor's or master's degree, after all that training -- four years, because they, basically, cannot afford it. Once they have a family and have those types of obligations, they are forced to leave the field.

ASSEMBLYMAN PAYNE: What does the acronym stand for in PACT?

MS. PINKIN: PACT -- that is a--

ASSEMBLYMAN PAYNE: Patient--

UNIDENTIFIED SPEAKER FROM AUDIENCE: Assertive Community Treatment.

MS. PINKIN: Right. And I do have that. It's outlined, actually, in my background paper.

ASSEMBLYMAN PAYNE: Okay, thank you very much.

MS. PINKIN: Thank you for hearing my testimony.

ASSEMBLYMAN PAYNE: All right, Leslie -- you'll pronounce it for me, Leslie, when you get here -- SEIU 1199 New Jersey.

**LESLIE BEICHT:** Actually, I think I just turned it off. (referring to PA microphone) Is that better?

ASSEMBLYMAN PAYNE: Yes.

MS. BEICHT: It's pronounced Beicht (indicating pronunciation), Leslie Beicht.

I'm with SEIU 1199, which represents 90 nursing homes -- 70, sorry -- I'm on another day -- and 6000 workers. I'm also a former CNA in a nursing home facility. And as I've testified before this council before, short staffing is a crisis in the nursing homes today. I don't believe we are any closer

today, than we were at any time, to resolving the issue of short staffing. I do believe that pay is one of the major issues of why short staffing exists and why we have such a high turnover in the nursing homes.

We have diligently been working as a union trying to make the public, and also, here in New Jersey, our Senate and Assembly aware of the problems we think exist in the reimbursement of Medicaid. We are also, now, on the eve of losing quite a bit of money that is funded into the nursing homes through Medicare. I think the problems are only going to continue to get worse. And I do appreciate it and thank you very much for forming this particular Committee to look into this information.

As always, I'm available for questioning.

ASSEMBLYMAN PAYNE: Any questions? (no response)

Thank you very much.

MS. BEICHT: You're welcome.

ASSEMBLYMAN PAYNE: Well, that's the list. We've exhausted our list of people who are here to testify. I truly hope that we will be able to-- The problems have been delineated for us. There are some dilemmas here that we have to resolve. I mean, it's very obvious that the people, as we say, that are most vulnerable in our society need to get the kind of care that they should have, that we're judged on that.

But, also, we need to find a way to provide the decent, livable wages and benefits for the people who are doing this work. We have come up against this time and time again. You can be sure that we are going to do everything we can, not to just provide lip service for this, but to try to improve the conditions of both the people who are providing the services and those who

operate these facilities that are so vitally needed in our society. We welcome any kind of additional comments you may have, or literature, or anything else, or suggestions, because what we're trying to find is not only exposing the problems or the conditions that exist, but also to try to find some workable solutions. And we really, obviously, need the help of everyone in that community, on both sides here, to try to come up with the solutions that are so vitally needed.

Thank you all for coming. This hearing is adjourned.

**(MEETING CONCLUDED)**