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Digest of a Performance Audit of the Office of Licensing

This performance audit of Department of Human Services Office of Licensing was conducted at the request of the Legislative Process Committee. The audit team was asked to determine how effective the Office of Licensing has been in accomplishing its goals and objectives. The audit findings include: 1) there has been a duplication of effort between the Office of Licensing and other regulatory agencies, and 2) the Office of Licensing has been ineffective at obtaining compliance from those who persist in violating licensing standards. These findings are the result of our own observations of licensing inspections; interviews with licensing staff, licensed providers and other state employees; and through a review of provider case files. This report suggests a number of improvements that are based on the practices of other states' licensing programs and on the information obtained from the professional literature.

Although the Department of Human Services has made a number of changes to the Office of Licensing in recent years, additional improvements to this program are needed. In Chapter II we describe the problem with duplication of effort between the Office of Licensing, the other divisions in the Department of Human Services, and with agencies of local county governments. In our view, the primary cause for this duplication is that the state has not clearly defined the scope and authority of the Office of Licensing.

Chapter III describes a second problem---enforcement. The audit team determined that the Office of Licensing has not been effective in dealing with providers who persist in ignoring the licensing standards. As a result, many providers of human services, and particularly those of child care services, have been issued licenses even though they have not complied with the requirements for a license.

Some solutions to these problems are described in Chapter IV. We suggest that the state limit the scope of licensing to those issues specifically aimed at public protection. While the quality of services provided by human services providers is still a concern, other forms of regulation are more appropriate for addressing service quality. Once the Office of Licensing has a clearly defined purpose, the office will be in a better position to do an effective job of enforcing its licensing standards. Enforcement can become more effective by giving licensors more specific policy direction and offering both positive and negative sanctions to providers.

The specific findings of this report include:

Office of Licensing Duplicates Efforts of Other Regulatory Agencies. Significant overlap between the inspections made by the Office of Licensing and those of other regulatory agencies exist. There is also a significant amount of duplication in the day-to-day efforts of licensing staff. For example, on site inspections of provider facilities are made by both the licensing staff and contract monitors of the individual divisions in the Department of Human Services. The licensing staff also inspect buildings for fire and health hazards as do local fire and health officials. Forcing providers to endure virtually identical inspections of the same items is inefficient and places an unnecessary burden on providers. Consequently, we question the necessity of having the Office of Licensing review matters that other agencies have already examined.

Licensing Standards are not Adequately Enforced. The Office of Licensing has been ineffective at requiring some human services providers to comply with its licensing standards. The provider case files that are maintained by the Office of Licensing show that many providers have repeatedly violated the licensing requirements. Contrary to the Office of Licensing rules, these providers are issued standard annual licenses even though licensing staff know that the provider has not fully complied with the state's licensing standards. Typically, a provider will be issued a new license with a letter that first describes the requirements that the provider has not complied with and then requests that corrective action be taken. In the bulk of these cases, no written plans of action were made, and no follow-up visits were made to verify that corrective action had been taken. We found two reasons why enforcement has not been as effective as it should be: 1) licensing staff lack a clear set of procedures to guide their enforcement efforts, and 2) the licensing staff have adopted an attitude of encouraging persistent violators to do a better job of complying with the rules rather than sanctioning them.

Clarify the Purpose of Licensing, Then Strengthen Enforcement. Two things need to be done to avoid duplication with other agencies and improve compliance with licensing standards: First, in order to avoid confusion about the role of licensing and the scope of its authority, the purpose of the licensing program needs to be clearly defined. Clarifying the statute and distinguishing the responsibilities of the divisions from the responsibilities of the Office of Licensing can help resolve the problem. Second, the Office of Licensing needs to strengthen the enforcement of the licensing standards. Enforcement can be improved by:

1. Drafting a set of written procedures so that staff know what their responsibilities are,
2. Using the probationary license for providers who temporarily are out of compliance,
3. Focusing monitoring visits on providers with poor compliance histories,
4. Increasing the use of unannounced visits to providers,
5. Using both positive and negative incentives, and
6. Eliminating or minimizing the process required to renew a license.

Chapter 1
Introduction

In recent years, the Office of Licensing within the Department of Human Services has been the focus of much controversy. For example, those wishing to improve the quality of child care in Utah have encouraged the state to require that care givers be better qualified and that the staff-to-child ratios be increased. Others argue that tougher child care standards will reduce the availability and increase the costs of child care in the state. In addition, some believe the licensing staff are too strict in their enforcement of the licensing rules for those who offer residential and treatment programs to the state. This strictness, they say, has made it difficult for the department to find enough beds for all of its clients. On the other hand, whenever a child is harmed while in the care of a day care provider, a foster parent, or a wilderness youth program, the licensing staff are criticized for not having done more to protect the children that are in the custody of licensed care givers.

In response to the controversy that has surrounded the Office of Licensing, the Office of the Executive Director in the Department of Human Services has conducted a number of studies relating to the licensing process. One report released in June 1996 concluded, among other things, that the Office of Licensing had not adequately defined its mission and poor coordination with the divisions exists. A November 1996 report described the problems with poor external communication and duplication with other agencies in the department. As a result of these reports, the Executive Director has called on the Office of Licensing to make a number of changes. For example, the office conducted a thorough re-examination and revision of its licensing standards. In addition, a committee of licensing staff members was assigned to draft a new mission statement. Finally, the responsibility for child care licensing was transferred from the Office of Licensing to the Department of Health.

Though these efforts will likely improve the licensing function, our report makes recommendations to further streamline and make more effective the licensing process. In our view, two issues are central to the problems facing licensing: First, the purpose of licensing and the responsibilities of other regulatory agencies need to be clearly defined; and Second, the current approach of enforcing the licensing standards needs to be refined.

This report first describes the problems with the licensing program and then suggests a number of ways to resolve the problems. Though the Department of Human Services has determined that there are problems with the licensing program, our review independently confirmed the problems. We conducted limited tests of the provider case files to document the problems within the Office of Licensing and then asked licensing staff to identify some of the causes for these problems. We then reviewed the literature and surveyed other states in an attempt to develop solutions.

The purpose of the Office of Licensing, as stated in the **Utah Code** 62A-2-102, is to "*...permit or authorize a public or private agency to provide defined social services programs. The issuance of a social service license designates that the program has the capacity to provide the service for which it is licensed."*

To this end the Legislature appropriated $2.9 Million in fiscal year 1997 to the Office of

Licensing. During that year, the office had a staff of 61 employees. As of July 1, 1997, the Department of Health assumed responsibility for child care licensing. As a result, the child care unit, consisting of 31 staff was transferred to the Bureau of Health Facility Licensure in the Department of Health. The services that will continue to be licensed by the Office of Licensing, Department of Human Services include: youth corrections, inpatient treatment, residential treatment, residential support adult day care, day treatment, outpatient treatment, comprehensive mental health treatment, substance abuse treatment, domestic violence treatment, and child placing services. For fiscal year 1998 the Office of Licensing has a budget of $1.8 Million and a staff of 36.

Audit Scope and Objectives

This audit was requested by the Legislative Process Committee. Each year, the process committee requests the legislative staff to conduct an in-depth performance audit and budget review of specific state agencies. While the Office of the Legislative Auditor General was asked to focus on the performance of the Office of Licensing, a separate analysis of budgetary matters will be prepared by the Legislative Fiscal Analyst.

Shortly after this audit began in January 1997, the Legislature passed House Bill 113 that transferred the staff responsible for child care licensing to the Department of Health. We might have excluded the child care unit from the scope of our audit; however, one of the reasons legislators requested this audit was their concern with the manner in which child care licensing was being conducted. Further, as we point out in the body of this report, the transfer of responsibility for child care licensing to the Department of Health provides no assurance that the problems associated with this program will be resolved. It is our hope that the Department of Health will benefit from the concerns we have raised about the child care licensing program and that they will be able to use the recommendations in the final chapter of this report to improve that program. For these reasons the child care licensing program as well as all other licensing units of the Office of Licensing were included within the scope of our audit.

The primary objectives of this audit were to:

1. Evaluate the extent of duplication of effort between the Office of Licensing and other agencies.
2. Determine how effectively the Office of Licensing has been enforcing the licensing standards.

Chapter II describes our findings as they relate to the duplication issue. Chapter III describes the problems associated with enforcement of licensing standards. Chapter IV describes a number of strategies for addressing the problems associated with duplication and enforcement.

Chapter II
Office of Licensing Duplicates

Efforts of Other Regulatory Agencies

There is a significant overlap between the inspections made by the Office of Licensing and those of other regulatory agencies. There is also a significant amount of duplication in the day-to-day efforts of licensing staff. For example, on-site inspections of provider facilities are made by both the licensing staff and contract monitors of the divisions in the Department of Human Services. The licensing staff also inspect the buildings for fire and health hazards as do local fire and health officials. Forcing providers to endure virtually identical inspections of the same items is inefficient and unnecessarily burdensome. Consequently, we question the necessity of having the Office of Licensing review matters that other agencies have already examined.

The Department of Human Services has struggled with the complex and challenging issue of regulatory duplication for some time. We do not wish to suggest that there is an easy solution to this question. In our opinion, however, there are two primary causes for the overlapping regulatory oversight: First and foremost, the enabling statute, **Utah Code** 62A-2-102, does not clearly define the purpose of licensing. The lack of a clearly defined purpose has allowed the Office of Licensing to develop rules that go beyond their primary mission---that of protecting health, safety and well-being of the consumers of human services. Second, the apparent failure of correspondent agencies, at different levels of government, to adopt a team approach with regard to physical inspections is contributing to the duplication.

This chapter describes the overlapping efforts of several regulatory agencies in different levels of government. Additionally, we address what the audit team believes to be the cause of the duplication in effort and discuss possible solutions to these problems in Chapter IV.

Duplication Exists Between Office of Licensing and Divisions

Significant overlap occurs between the reviews conducted by the licensing staff and those conducted by other department staff. Just as the licensing staff are responsible for enforcing the licensing standards, each program division (herein referred to as "division") within the Department of Human Services is responsible for monitoring the care that is provided to the special client populations that they serve. The divisions include the Division of Services to People with Disabilities (DSPD), the Division of Youth Corrections (DYC), the Division of Mental Health (DMH), the Division of Child and Family Services (DCFS), and the Division of Substance Abuse (DSA). Most of the services provided to the clients of these agencies are served by private contract providers. It is the responsibility of each division to monitor the quality of the services provided and to verify compliance with the terms of the state contracts.

It is the responsibility of the Office of Licensing to regulate the health, safety and competence of <u>all</u> human services providers whether or not they provide services to clients of the Department of Human Services. There is overlapping regulatory oversight when the licensing staff inspect

licensed providers that also contract with the division. Overlap exist between the licensing standards and division contract requirements in the following categories: administration, governance, direct services management, and personnel administration. While there are slight differences between the licensing standards and the contract requirements, the overlap between the two reviews is inefficient and, according to providers, is unnecessarily burdensome.

Many Categories in the Licensing Standards are Also Regulated by the Divisions

Reviews conducted by the Office of Licensing and the divisions overlap. The divisions within the Department of Human Services consider it their responsibility to monitor the quality of care provided to clients under their jurisdictions. While the divisions use slightly different methods in evaluating the quality of care provided, the contract process used by the divisions requires providers to submit a "request for proposal" or "RFP" which serves as the basis for the contract for services and, once a contract is awarded, for contract monitors to ensure that the providers are meeting the terms of their contracts. The RFP requires providers to affirm, among other things, that they:

1. have adequate accounting systems;
2. will provide services based on the division's mission statement;
3. have adequately trained staff; and,
4. will evaluate the performance of direct service staff.

Once a contract is awarded, contract monitors check compliance with items such as division policies and procedures, record keeping, personnel, training requirements, and individual program plan development. When we compared the licensing process with the contract and monitoring process used by each division, we found that both the divisions and the Office of Licensing reviews significantly duplicated each other in several categories or subject areas. Figure I identifies areas in which this duplication occurs.

Figure I
Areas of Duplication Between Office of Licensing and Divisions

Category of Licensing Standards	Office of Licensing	Divisions*				
		DSPD	DYC	DMH	DCFS	DSA
Administration	X	X	X	X		
Governance	X		X	X		
Record Keeping	X	X	X		X	X
Direct Service Mgmt	X	X	X	X	X	X
Behavior Mgmt	X				X	
Rights of Consumer	X	X			X	X
Personnel Administration	X	X	X		X	X
Infectious Disease	X					
Emergency Plans	X	X				
Safety	X					
Transportation	X					

**** "Divisions" refer to the Division of Services to People with Disabilities (DSPD), Division of Youth Corrections (DYC), Division of Mental Health (DMH), Division of Child and Family Services (DCFS), and Division of Substance Abuse (DSA).***

Figure I shows the areas of duplication in the reviews conducted by the Office of Licensing and the divisions. For example, the Office of Licensing and three divisions (DSPD, DYC and DMH) each require that providers comply with a number of requirements relating to program administration. These include such matters as the establishment of a program philosophy and goals, the development of internal policies and procedures, the use of quality improvement programs, and the management of a provider's finances. Figure I also shows that the categories where there is the greatest overlap with the divisions are those relating to administration, record keeping, direct service management, personnel administration and personnel management. The categories where typically little or no duplication occurs were those having to do with health and safety. The Division of Mental Health is a good example of an agency that conducts a review with many similarities to the one conducted by the Office of Licensing.

Duplication Between Mental Health

and Licensing Standards

The Division of Mental Health has a contract monitor who visits the state's mental health facilities each year to determine whether providers are complying with a wide range of performance standards. Among other things, the division's review covers issues relating to a provider's administration, governance and direct services management. As shown in Figure II, these areas are also covered by the licensing standards.

Figure II
Overlapping Contract and Licensing Requirements
In the Areas of Administration, Governance and Direct Service

Category / Requirement	Office of Licensing Requirement	Division of Mental Health Requirement
Administration		
Quality Assurance	Program has a quality assurance plan that includes methods and standards used for service. Implementation is documented and available to Office.	There is an established policy and procedures for assuring center Continuous Quality Improvement.
Statement of Mission and Program Philosophy	Program has written statement of purpose, including.... 1. program philosophy. 2. description of long and short term goals... 3. description of services provided, 4. The population to be served... .	The center has a formal statement of mission or policy that supports consumer involvement in planning services and choosing residential option. The center has a planning process and plan to indicate the direction of the center and the means of determining the center's direction.
Governance		
Governing Body to Hold Meetings	When the governing body is composed of more than one person, the governing body shall establish by-laws, and shall hold formal meetings at least twice a year, maintaining written minutes....	There are regularly scheduled and conducted meetings of the center's governing board/authority.
Direct Service Management		
Contents of Intake Evaluations	Intake Evaluation: 1. Before admittance an assessment is conducted to evaluate health and family history, medical, social, psychological and, as appropriate, developmental, vocational, and educational factors.	Functional vocational/educational assessment 1. Consumer records contain an individual psychological assessment with evidence of consumer involvement in the assessment. Records are updated quarterly 2. Psycho-social assessments have a specific educational/training or work-related component...
Contents of Treatment Plans	1. Day Treatment activity plans are prepared to meet individual consumer needs. 2. The Plan includes: b) (3) consumer input considered in identifying goals/objectives,	a) Consumers provide input to the center relative to psycho-social program design and implementation. c) Psycho-social planning 1. Plans reflect consumer involvement and state the consumers individual psycho-social goals...

Figure II identifies some of the categories where Division of Mental Health contract

requirements and Office of Licensing standards overlap. For example, both agencies have standards that fall under the category of "Administration". Within that category, both agencies require that providers have a quality assurance plan. The licensing requirement states that *"the program has a quality assurance plan that includes methods and standards used for service. Implementation is documented and available to the Office."* The Division of Mental health requires that *"there is an established policy and procedure for assuring center Continuous Quality Improvement."* While the division's standard is more specific, in that it requires a specific method of quality assurance, both standards review quality assurance.

Even though there are slight differences in the specific requirements developed by the two agencies, we found that on the whole, the two agencies have similar concerns and comparable requirements in the areas of administration, governance and direct service management. The similarity in both concerns and requirements have led us to conclude that, at least in these three categories, a review by one or the other agency would be more efficient.

Activities of Some Licensing Staff Overlap

In addition to the overlap between the divisions and the Office of Licensing, we also found overlap in the day-to-day work of some members of the licensing staff. Licensing responsibilities in the "treatment" programs are divided among the different program areas. Each staff member is assigned to, and specializes in, a specific program area. For example, one staff person is responsible for licensing youth corrections programs and another is responsible for licensing programs that serve clients of the Division of Substance Abuse. Since the workload is divided according to treatment areas, a provider that offers more than one type of service must be licensed by different licensing staff. As a result, it is not uncommon for more than one licensor to visit a provider that offers services in several program areas.

We observed first hand the review process that a provider offering services in two program areas---domestic violence counseling and substance abuse counseling---must undergo. Because two different licenses are required and the responsibility for licensing the two areas lies with two different licensors, a joint visit was made by the two licensing specialists. Both licensing specialists met with the program director and his staff and took turns asking questions from the core rules checklist of licensing standards. Together they inspected the facility and then separately reviewed some of the case files for their respective program areas.

When asked why one staff person couldn't have conducted this review, some staff suggested that specialization by program area is necessary because keeping up-to-date on the special requirements and issues of each program area is too difficult for one person. Staff vigorously assert that they are concerned only with requirements associated with the process of providing services which requires them to be knowledgeable in the specific aspects of each program.

While we recognize that there may be some benefits from having the licensing staff be

knowledgeable in the latest developments in each program area, this approach encourages staff to focus on the qualitative issues associated with the treatment provided by each program. This focus also may be due, in part, to the practice of hiring specialists with experience in the program area for which they will license. For example, the staff person who licenses mental health providers was hired, in part, because of her experience in the mental health field. Similarly, the staff person responsible for licensing substance abuse programs was formerly an employee of the Division of Substance Abuse. Not surprisingly, the licensing staff tend to concern themselves with the quality of care because of their previous experience in the divisions where quality of the treatment provided is the primary concern.

We believe that specialization, as practiced by the Office of Licensing, is unnecessary. As we suggest later in this chapter and in Chapter IV, quality of care should not be a concern of the licensing process. Quality of care is a matter that is better dealt with by the divisions or some other regulatory agency. The Office of Licensing should focus on whether a provider has the "*capacity to provide the service for which it is licensed"* by monitoring compliance with a set of core requirements---those applicable to all social services programs – and with a set of categorical requirements---those applicable to specific program types.

While the categorical requirements differ from program to program, we believe the standards are objective enough that a single licensing staff should be able to judge the level of compliance in several different program areas. Any well-trained licensor should be able to tell if the a provider of adult day care has complied with the requirement that *"Day Care activity plans are prepared to meet individual (group needs) preferences."* Similarly, the same staff person should be able to recognize if an outdoor youth program has met the requirement that "*there is a written general plan for expedition group, as approved by program governing body..."* In addition, we believe that any licensing staff person who is trained in the basics of health and safety should be able to master the different requirements for both a residential treatment program and an outpatient treatment program and conduct inspections for both types of facilities.

Duplication With Local Government Occurs

We also found significant overlap in the efforts of the licensing staff and the local health and fire inspectors. Although it is a licensing requirement that providers have fire and health inspections by the local authorities, the licensing staff also inspect provider facilities for fire, safety and health related hazards. For example, both the licensors and local health officials monitor the kitchen, dining, toilet and bedroom facilities of residential care programs to verify that they are safe, clean and sanitary. Similarly, many county health inspectors make special inspections of child care facilities that cover many of the same items monitored by licensing staff such as diapering, toilets and hand washing, and playground safety. Fire inspections are also conducted each year by local fire safety inspectors. It is our belief that efficiencies could be achieved if the Office of Licensing relied on inspection done by local agencies with certified personnel.

Duplication with Local Fire Inspectors

While the Office of Licensing requires providers to submit local fire/safety inspection reports as part of the licensing process, the licensing staff still inspect facilities for fire/safety hazards during their licensing visits. We observed first hand the manner in which several licensors conducted their licensing reviews. In addition to a review of the core and categorical requirements for a license, the licensors conducted a physical inspection of the facilities. Among other things, licensing staff determine whether:

- a sufficient number of properly charged fire extinguishers exist;
- smoke detectors and fire alarms are in proper working order;
- a sufficient number of exits are free and clear of obstructions;
- proper locks have been installed; and
- evacuation plans are posted.

In fact, one Office of Licensing staff member uses a checklist that is based on the **Uniform Fire Code** – the same set of regulations enforced by local fire inspectors.

Office of Licensing staff justify duplicating elements of local fire inspections on the grounds that they can not trust the quality of all local fire inspections, and that licensing reviews guaranty a certain level of consumer protection. The licensing staff have observed that the uniform fire code is not consistently applied across localities. That is, facilities that will not pass muster in one locality will pass muster in another. Thus, according to staff, duplication gives the user or consumer of a social service an extra level of protection.

The licensing staff's concern with the well-being of consumers is to be commended and we acknowledge the fact that the quality of inspections will vary across localities. Still, we question the need to conduct inspections that, across the board, mimic those conducted by local inspectors. We believe that a substantial number of inspections are conducted in an adequate manner by highly qualified local fire inspectors. The Office of Licensing should be able to identify these localities and accept their inspections so as to avoid duplication during the scheduled licensing visit, and thereby make it possible for the Office of Licensing to shift resources in such a way as to allow an increase in the number of monitoring visits to programs in localities whose fire/safety inspection programs are deemed to be "sub-par".

The Office of Licensing could, as licensing agencies in other states have done, take a proactive approach to addressing the issue of the inconsistent application of the fire code. For example, Minnesota has added fire marshals to the licensing staff in an effort to ensure consistent application of their fire code. Michigan has instituted a system whereby providers are given a list of "approved" inspectors who conduct inspections according to state requirements. What this means is that the licensing agencies in these two states are able to accept the inspections of the local officials rather than conducting those inspections on their own. We do not wish to suggest that implementing similar systems in Utah will be easy. Questions regarding the autonomy of

local jurisdictions may be raised if the state attempts to impose a system designed to ensure the consistent interpretation and administration of the fire code. However, these difficulties should not prevent the department from exploring methods that, in time, will allow for the consistent application of the fire code statewide.

We believe that both the licensing staff and the local fire officials play an important role in protecting of human services clients. Verifying compliance with the licensing can be done more efficiently if licensing staff and the local fire inspectors work together and avoid conducting similar inspections. As we suggest in Chapter IV, we believe the licensing staff should still play an active role in inspecting licensed facilities. However, by relying on the inspections of the local fire inspectors, licensing staff will become more effective because it will free up more of their time for other, more important licensing tasks.

Duplication with County Health Officials

Many of the same licensing requirements checked by DHS in child care centers are also checked by many county health departments throughout the state. Many of the county health officials that we spoke with acknowledged that they conduct special inspections of child care centers that are similar to those conducted by the Office of Licensing. However, these officials expressed support for the duplication in review because it helps to raise the level of protection for the clients of those facilities. In fact, one of the county health inspectors we interviewed described his review of child care centers as a "consulting service" designed to assist DHS Licensors in their compliance efforts.

Figure III shows the similarities between the state and local inspections of child care centers. Specifically, it compares the main requirements considered by state child care licensors with those considered by several counties' agencies.

Figure III
Comparison of Child Care Requirements
Department of Human Services and Selected County Agencies

Requirements	DHS	SLC	Davis	Tooele	Bear River	Central Utah
Staff Ratios	X	X	X			X
Staff Qualifications	X			X		
Daily Program/Activity Plan	X					
Attendance Records	X			X		
Menu Posted	X					
Food Service/Kitchen Sanitation	X		X	X	X	X
Building Safety	X	X	X	X	X	X
Playground and Equipment	X	X	X	X	X	X
Transportation	X					
Criminal Background Checks	X					
Toxic Substances	X	X	X		X	X
Toilet and Hand Washing Facilities	X	X	X	X		X
Diapering	X	X	X	X	X	
Health Assessment/Immunizations	X	X	X	X		X
Bedding and Sleep	X	X	X	X		
Animals	X	X				X
Laundry	X	X	X			
Medication Administration	X	X	X	X		
Care of Sick/Injured Children	X	X		X		X
Solid Waste Disposal	X	X	X		X	X
Pest Control	X	X	X		X	X
Utah Indoor Clean Air Act	X	X				

The above compares inspections make by the Office of Licensing (DHS), Salt Lake County (SLC), Davis County (Davis), Tooele County (Tooele), Bear River Health Department (Bear River), and the Central Utah Public Health Department (Central Utah).

The data show a significant overlap between the inspections by the state and local health inspectors. The data also show, however, inconsistency in the inspections by the various inspectors. This inconsistency is based on the unique differences between the requirements of the various government entities.

When we asked the state licensing staff and the county health inspectors to explain why they felt they both needed to inspect the child care centers, we received several different answers. Several of the local health inspectors told us that the main reason they need to perform inspections of child care centers is that the state licensing staff do not possess the proper educational background or training to adequately inspect child care centers. Health inspectors at the county level must sit for an exam administered by the Department of Professional Licensing (DOPL) to obtain an *Environmental Health Scientist License* in order to inspect child care centers. In addition to passing DOPL's exam, all county health inspectors must have a college degree in one of the "hard sciences" (i.e. botany, biology, or physics). Because the DHS licensors are not required to have these qualifications, county inspectors believe it is necessary that they, not the licensing staff, review facilities for these issues.

Duplication between state and local inspectors is also defended on the grounds that it gives the consumer an extra level of protection and that it makes compliance more likely because providers take the rules more seriously if several agencies tell them that they need to improve. A typical explanation by the licensing staff was that *"If we tell a provider that they need to fix a problem and then the local health inspector tells them the same thing, they realize that it is not just our opinion but that it really is important that they comply."* However, we question whether these multiple inspections have been effective at raising the level of compliance among providers. In Chapter III, we report that the current approach to regulation has not achieved a high level of compliance among some providers.

While we recognize that state licensing staff must play a significant role in protecting the health and fire safety of licensed facilities, we suggest in Chapter IV that they can reduce the duplication between their inspections and those of local health and fire inspectors. For example, if the local fire and health inspectors were relied upon to conduct the annual inspections necessary for licensure, this might free up time for the licensing staff to focus on those providers that have a history of non-compliance or on other areas of concern.

Overlap With Other Agencies is Inefficient and Unnecessarily Burdens Providers

We are concerned that having different agencies look at the same issues is both an inefficient use of public resources and an unnecessarily burden to providers. Reviews require a significant amount of time from both the licensors and the providers, and they require providers to supply the same information at different times to different government regulators.

Duplicating the regulatory efforts of another agency is inefficient because a significant amount of licensing staff time is used on tasks that have already been completed by others. During their licensing visits, Office of Licensing staff typically conduct a verbal interview with program directors and discuss verbatim every core and applicable categorical standard. They also conduct a physical inspection of the program facilities. We found that over half of the core licensing standards are related to issues that are not directly related to public protection. These include rules relating to program and personnel administration, governance, statutory authority and direct service management. If the Department of Human Services were to ask the divisions to take full responsibility for these issues, both the scope of the licensing process and the time spent reviewing the checklist items could be reduced significantly. Moreover, our observations indicate that a good portion of the time spent inspecting program facilities is devoted to the initial review for fire and health-related hazards which local inspectors already review.

Several providers expressed concern about the duplication between the different agencies and the impact it has on their programs. While most of those that we interviewed said that they feel licensing is a necessary function, they observed a significant amount of duplication between the different agencies. This, they said, places an unnecessary burden on their programs. For example, an administrator of an organization that provides residential services to the handicapped said that her program is subjected to what she feels is an excessive number of inspections each year. She said that the Office of Licensing and the Division of People with Disabilities both inspected her facility at least once each year and that the county fire and health inspectors made visits twice a year. She observed that licensing was mainly concerned with health and safety of the physical facility and that DSPD was mainly concerned with program quality, but she felt that licensing did get involved in a lot of "program issues" that were already handled by DSPD. She suggested that the process could be improved if licensing were limited to the issues pertaining to the physical environment and if DSPD were limited to program issues. Licensing staff, she felt, should not be looking at program issues.

The overlap between the Office of Licensing and other agencies has also been well documented by DHS. In fact, one of the reasons the Office of Licensing was created in 1987 was to eliminate the duplication in effort that resulted from each division having its own licensing unit. However, as affirmed in a 1996 internal report, duplication remained a problem. According to the report:

> *"The checklists used by the Office of Licensing, Division of Youth Corrections, Division of Child and Family Services, and the Revenue Management Unit contain many of the same type questions and require review of the same client and program records... These duplicate questions involve both administrative issues (personnel records, staff training) and client issues. These are not "value added" activities. In other words, asking the same questions more than once does not add anything substantially to the licensing, contracting, or monitoring process."*

While the Department of Human Services has made an effort to reduce the amount of duplication

between its divisions and the Office of Licensing, they have found that there are no easy solutions to this problem. As the department itself has recognized, the underlying problem seems to be that those sections of the statute that apply to DHS do not clearly define the scope of the Office of Licensing's authority. As the following section describes, this has allowed the Office of Licensing to adopt standards that go beyond the scope traditionally given to the licensing function, that is the protection of health and safety.

Responsibility of Licensing and the Divisions are not Clear

The primary cause for the duplication between the Office of Licensing and other agencies is that the purpose and scope of the licensing process has not been clearly defined. As a result, confusion exists as to whether the purpose of licensing should be limited to public protection or whether the licensing process should be used to regulate other "quality of care" issues that have traditionally been the responsibility of the divisions. We recognize that it is important for the Department of Human Services to make sure that human services clients receive high quality care. However, as we report in Chapter IV, high quality care can be achieved through other forms of regulation, mainly through the divisions. The purpose of licensing is to make sure that a minimum level of protection is provided, not the ideal level of care. Confusion regarding the different roles of the Office of Licensing and the divisions is the main cause for the duplication in the state's oversight of human services providers.

Statute Does not Clearly Define Scope of Office of Licensing's Authority

The section of the **Utah Code** that describes the purpose of licensing does not provide clear guidelines regarding the issues that should be included in the licensing standards. **Utah Code** 62A-2-102 states that *"The purpose of licensing... is to permit or authorize a public or private agency to provide a defined social services program. The issuance of a social service license designates that the program has the capacity to provide the service for which it is licensed."* In addition, **Utah Code** 62A-2-105(1)(c) appears to limit the issues that can be addressed by rules to those that are necessary for *"the protection of the basic health and safety of participants in human services program."* However, according to department staff, the phrase *"capacity to provide the service"* in section 62A-2-102 has opened the door to the adoption of many standards that go beyond the protection of the basic health and safety of the public.

Some legislators told us that they believe licensing should be limited to matters of health and safety issues. In fact, some legislators thought they passed legislation that limited the Office of Licensing to this. Nevertheless, there still seems to be a debate among DHS staff regarding how broadly the statute's reference to *"capacity to provide services"* can be interpreted. The ambiguity of the wording seems to have allowed the Office of Licensing to accept greater responsibility for issues that go well beyond their core mission of public protection. The following describes the

extent to which licensing has become involved in quality of care issues.

Licensing is Overly Concerned About Quality Issues

Some of the staff and many of the Office of Licensing's core and categorical rules appear to be concerned about ensuring the provision of care that is of a higher quality than the minimum or baseline care that licensing standards generally require. The audit team received a variety of answers when we asked department staff for their opinion regarding the proper scope of licensing rules. While some felt that licensing requirements should be limited to "life safety" issues, many felt their job was to help providers improve the "quality of care" and to make sure the care being provided is the "best for children." It also appears that many rules have been designed to encourage high quality care rather than a minimum or baseline level of protection. For example, most of the rules that fall in the categories of program and personnel administration, governance, and direct service management have little to do with public protection. We also found child care rules that appeared to regulate the quality of child care center curricula. Those responsible for licensing foster parents have also been required to make qualitative judgements about the parenting skills of those they license.

Most of the rules contained in categories of program and personnel administration, governance and direct service management appear to be aimed at ensuring high quality care rather than providing basic protections. For example, the licensing standards require that providers have *"a written statement or purpose to include: 1) program philosophy, 2) description of long and short term goals..."*, and, 3) *"the program shall have an organization chart..."* Rules specify the contents of the provider's admission policy, their intake procedures, and the treatment plans. A treatment plan must have *"measurable goals or objectives that are long and short term, with performance time frames and limitation."* In our opinion, these requirements should be the concern of someone who is interested in ensuring that the consumer is getting what was paid for. We question, however, whether these are appropriate questions to ask when deciding whether or not a provider should be licensed. While we recognize that it is good for providers to have a written statement of philosophy or long range goals, in our opinion the only relevant question when deciding whether or not to license a provider is whether the minimum requirements for public protection have been met.

Some child care standards also seem designed to encourage high quality care. For example, child care center rules require that *"Each child will have the opportunity to use at least four of the following activity areas each day: Creative/Art; Book language; Dramatic/role; Large Muscle Activities (climbing, running jumping); Manipulative/Small Muscle Activities; Science/Discovery; Music/Listening; Blocks; and Outdoor play."*

We recognize that a curriculum is very important in the development of children. Studies have shown that a mentally stimulating environment is required for the mental development of infants, and children are better behaved and less likely to injure themselves or others in a stimulating environment. While it might be appropriate to require providers to offer some type of curriculum,

we question the appropriateness of requiring that the curriculum contain this specific a set of activities. In our view, requirements such as these go beyond what is necessary for the protection of children. During our audit, the responsibility for child care licensing was transferred to the Department of Health and the above cited rule no longer applies. However, that department will be responsible for justifying, on the basis of protecting health and safety, the extent to which the state might regulate the daily program operations of child care centers, if at all.

Finally, staff who license foster parents are also asked to consider issues relating to the quality of foster parenting rather than limiting the review to consumer protection issues. This review, for example, requires that staff make subjective judgements about an applicant's parenting skills. As an example, licensing staff typically ask applicants *"How do you and your spouse resolve marital conflicts?"* The licensing standards also require staff to use their "professional judgement" to decide whether an applicant has the *"emotional health, degree of maturity, ability to discern and meet emotional, social, cognitive, and physical needs of the child or adult who will be placed in care; characteristics such as good judgement, flexibility, ability to cooperate and communicate with the worker."* While it is important that foster parents have the parenting skills, maturity and emotional health to be effective parents, we question whether it is appropriate for a licensor to make qualitative decisions about a possible foster family. According to the National Association of Regulatory Administrators, licensing standards need to be objective so they can be applied consistently to all providers. The inclusion of subjective standards makes it difficult to evaluate applicants in a fair and consistent manner. In our view, the parenting skills of a foster parent should be judged solely by those responsible for regulating the quality of care, such as the Division of Child and Family Services. The licensing process, on the other hand, should be limited to health, safety and other measurable requirements.

The duplication described in this chapter is significant and can affect the efficiency and effectiveness of the licensing program. The primary cause of duplication is that licensing monitors program quality issues rather than limiting itself to health and safety issues. We believe that reducing duplication would help free staff time to more effectively enforce regulations, a problem described in the next chapter.

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Chapter III
Licensing Standards are not Adequately Enforced

The Office of Licensing has been ineffective at requiring some human services providers to comply with its licensing standards. Our tests of the provider case files maintained by the Office of Licensing show that many providers have repeatedly been found violating licensing requirements. The results of our case file review are also supported by dozens of interviews with licensing staff, providers and outside observers of the licensing process. Finally, the lack of enforcement was also documented through our observations of licensing inspections.

Contrary to the Office of Licensing rules, providers are issued standard annual licenses even though licensing staff know they have not fully complied with the state's licensing standards. Typically, a provider will be issued a new license with a letter that first describes the requirements that the provider has not complied with and then requests that corrective action be taken. In the bulk of these cases, no written plans of action were made and no follow-up visits were made to verify that corrective action has been taken. The reasons for the lack of enforcement are: 1) the licensing staff lack a clear set of procedures to guide their enforcement efforts, and 2) the licensing staff have adopted an attitude of encouraging persistent violators to do a better job of complying with the rules rather than sanctioning them.

There are enforcement problems in each of the human services categories licensed. However, we were unable to document the extent to which non-compliance is a problem because licensing staff do not always document a provider's violations in the case files. Licensing staff told us of several providers that were in violation of the licensing regulations. In addition, we observed several licensing visits when licensing staff observed violations with the licensing rules. However, often these problems were never reported or otherwise documented in the provider case files. As a result, we are not confident that our review of the case files uncovered the extent to which providers are complying with the licensing standards. Even so, our case file review did show that at least 33 percent of child care centers failed to correct important health and safety violations despite repeated requests to take corrective action. We also determined that noncompliance is a problem among providers who offer treatment and residential services, as well as home-based day care services.

Administrative Rule R501-1-3(A)(1) requires the Office of Licensing to *"issue an annual license after determination has been made that the applicant is in compliance with rules and standards."* If a provider is not in full compliance, the licensors can issue a conditional license that gives the provider up to 90 days within which to make the necessary corrections to reach full compliance. Our tests showed that the licensors generally do not place providers under a conditional status. Instead, they generally take no other action than to encourage the provider to comply with the rules. Occasionally, a deadline for coming into compliance is suggested by the

licensing staff, but rarely do the staff actually verify that the corrective action has been taken. This strategy of "cajoling" providers into compliance has been ineffective in dealing with providers who persistently violate the standards.

Enforcement actions should receive a high priority for several reasons. First, enforcement supports licensing's mission of public protection. If the state allows providers to avoid coming into full compliance with the licensing standards, it increases the risk of harm to clients, and, according to the state's risk manager, this risk increases the state's exposure to liability. Second, the lack of enforcement gives the public a false impression that providers are complying with the rules when they really are not. Finally, the lack of enforcement encourages noncompliance because there is no incentive to take the required corrective action.

The Office of Licensing has not been effective at enforcing its licensing standards for several reasons. First, licensors lack a set of procedural guidelines to follow when providers fail to comply with licensing standards. While the Office of Licensing has issued rules that provide general guidelines, the staff need additional procedural guidance so they know how to proceed when they encounter violations. Second, licensors have adopted a service oriented approach to enforcement. That is, the staff view themselves as advisors or consultants whose primary role is to assist providers to come into compliance with the standards. The attitude that it is better to encourage than to sanction providers is reinforced by the perception that meager support for tough enforcement exists within management. Additionally, the lack of human services providers and the wide-spread impact that revoking a license has on clients, parents, guardians, and the divisions makes strict enforcement difficult.

This chapter describes our findings as they relate to the enforcement of licensing standards and some of the reasons why it is particularly difficult to obtain compliance from Human Services providers. We designed a number of tests to determine how effective staff are at identifying violations and getting providers to correct the problems. Our tests included a review of provider case files, on-site inspections of provider facilities and interviews with licensors. While this chapter discusses the challenge of enforcing licensing standards, Chapter IV describes some possible solutions to these problems. It should be noted that the child care licensing staff was moved to the Department of Health while this audit was being conducted. However, moving the licensing function to the Department of Health, does not necessarily assure that problems identified in this chapter will be resolved. The Department of Health needs to pay particular attention to the problems identified in this chapter and the possible solutions suggested in Chapter IV in order to improve their management of the program.

Compliance is a Problem

A standard annual license does not guarantee that the holder is in compliance with licensing standards. Our case file reviews, in addition to first hand observations of monitoring visits and licensor interviews, indicate that noncompliance occurs at several levels. First, a significant number

of providers continue to operate despite their failure to correct violations after they were notified of the need to take corrective action. Second, licenses are regularly issued to providers who are not in full compliance with the standards. While these circumstances exist in both child care centers and treatment programs, they appear less widespread among the treatment programs. We are particularly concerned, however, about the level of compliance among child care providers. About one-third of the child care centers in our test were repeatedly found to be out of compliance with important health and safety standards.

Many Providers are not Adhering to the Regulations

Our review of provider case files suggests that a significant number of providers are not adhering to the licensing rules. The case file review of randomly selected child care centers showed that many centers are not in compliance with child care center licensing requirements. We drew similar conclusions from our case file review of the treatment programs. We found, however, that unlike the child care centers, most treatment programs exhibited a willingness to correct the violations that were brought to their attention by the licensors.

Many child care centers failed to correct violations despite repeated requests to take corrective action. The case file review of child care centers indicated that from 1992-1997, approximately 33 percent of the centers failed to correct *Category One* violations---those that posed a threat to the immediate health and safety of children in their care. Additionally, many child care centers failed to correct violations that, while not posing an immediate threat to the health and safety of children, had the potential of placing children at risk if not corrected over time.

To determine the extent to which licensing requirements are being enforced among child care centers, we reviewed the case files of 30 randomly selected child care centers dating back to 1992. Our intent was to determine whether each provider demonstrated a willingness to take corrective action when requested or whether the provider had a history of persistently violating the licensing standards even when licensors had repeatedly documented a lack of compliance. In order for a provider to be considered a "persistent" violator of the licensing standards, a specific violation had to appear two or more times during the period being studied.

Among state licensing authorities, it is a common practice to distinguish between those requirements that are serious in nature from those that are more preventative. For this reason, and at the recommendation of the child care licensing staff, we made a distinction between *Category One* violations---those that pose a threat to the immediate health and safety of children, and *Category Two* violations---those requirements that are preventative in nature and not immediately life-threatening or hazardous. We also relied on the child care licensing staff and Officials from the Department of Health to help us identify which requirements should fall into each category.

As previously stated, we found that approximately 33 percent of the child care centers in our sample failed to correct *Category One* violations. While not exhaustive, the following examples illustrate the potential danger to children when *Category One* violations exist. For example, many of the centers in our survey repeatedly failed to comply with staff-to-child ratios, especially the ratios for infants and toddlers. In fact, one center had 35 toddlers (ages 2-3 years) to one care giver. Staff-to-child ratios affect the health and safety of children in several ways. First, studies indicate that ratios affect the emotional and social development of children. Second, ratios help to protect children. We were told that the number of children that an adult can safely guide in case of an emergency, depending on the childrens' age, plays an important role in calculating the appropriate staff-to-child ratio. Other examples of *Category One* requirements include: 1) that playground area be fenced when adjacent to a busy street; 2) that staff and children have their immunizations; 3) that there be no unsanitary conditions in the center; and, 4) that cleaning supplies and other unsafe materials be properly stored.

Our child care center case file review also revealed that many child care centers have a problem complying with *Category Two* violations. *Category Two* violations include requirements to: practice and document monthly fire drills, provide DHS licensors with an emergency plan, and to provide adequate cushioning for playground structures. While violations in this category did not pose an immediate threat to the health and safety of the children, it is our opinion that chronic non-compliance has the potential of placing the health and safety of children at risk.

We shared the results of our case file review with the child care center licensors and asked them to comment on our findings as a check on the accuracy of our review. After explaining the methodology, criteria, and subsequent results of our case file reviews, the licensors not only confirmed that we had correctly categorized the violations that we found, but they also concurred with our overall conclusions. During our discussions, the licensors not only confirmed that serious violations were going uncorrected, but they also voiced their concern about the unwillingness of many providers to conform with the rules and their own inability to bring chronically non-compliant centers into compliance.

Compliance Among Division Providers is Also a Problem. We also determined that compliance with the standards was also a problem for providers that had entered into contracts with the divisions. However, we believe that the compliance problems in the treatment programs is less extensive than the problem found in child care centers. Most treatment programs, unlike the child care centers, exhibited a willingness to correct the violations that were brought to their attention by the licensors.

A number of divisions within DHS enter into contracts with providers to render treatment services to clients. For instance, the Division of Youth Corrections contracts with group homes to provide services for delinquent youth. The Office of Licensing is responsible for ensuring that the providers, in this case the group homes, comply with all applicable licensing standards.

To determine how well these providers are complying with the standards we reviewed case files,

accompanied licensors on their monitoring visits and interviewed providers.

Our review of a random selection of child placement and treatment programs revealed that many had yet to fully comply with licensing standards when they were given a standard annual license. However, unlike child care centers, most of the programs we reviewed exhibited a willingness to take the corrective action required by the licensors, and fewer programs were continually out of compliance with standards. While 79 percent of the 29 programs sampled were not in compliance when they received their licenses, only 4 (or 14 percent) of the programs were classified as unwilling to correct the violations found by the licensors. While most of the treatment programs eventually come into compliance, our case file review and interviews with staff point to two items that programs had problems providing prior to the grant of a license: fire/safety inspections and criminal background checks.

According to our case file review, 7 or 24 percent of the 29 programs reviewed had not completed the required criminal background checks for all of their employees in a timely manner. Licensors also identified background checks as a problem area. Criminal background checks (commonly referred to as BCI or CBS/USSDS checks) are reviews of state criminal records that identify reported instances of an abuse or neglect or criminal behavior in the past. Background checks are designed to protect children and vulnerable adults from individuals "*who have been convicted of a serious crime*," or "*whose conduct or pattern of conduct is contrary to the safety and well-being of children*" as well as those who "*may have committed acts of abuse, neglect, or exploitation of a child, disabled and functionally impaired adult*."

To complete a background check, an employee must complete a request for a background search either to the Office of Licensing or to the provider, who sends information on the employee to the Office of Licensing. The office then reviews the Department of Human Services data processing system (USSDS) to see if there is a record of abuse or neglect on the employee. The name is also submitted to the Department of Public Safety for review of criminal records (BCI) and to another state if the employee comes from outside Utah.

We found instances where, several months after the issuance of a license or the hiring of an employee, the criminal background checks still had not been completed. Discussions with the licensors indicated that the problem is caused either by employees failing to provide authorization for the checks to be conducted, or providers not submitting information on a timely basis to the Office of Licensing, and by states outside of Utah not returning the information in a timely manner. This suggests that there are inherent weaknesses in the process. The most worrisome being the employees' and providers' ability to delay the process merely by withholding rather than submitting the information in a timely manner.

Completing these checks is important because they protect vulnerable clients from known abusers and criminals. The Office of Licensing should do all it can to conduct the check as quickly as possible. However, as with child care center enforcement, the licensors do not sanction

those providers who are tardy in submitting the paperwork to the Office of Licensing.

Our survey of treatment programs also showed that 7 or 24 percent of the 29 randomly selected programs had difficulties obtaining fire/safety clearances, yet these programs were allowed to continue operations. For example, a program that had not met fire and building code requirements was allowed to operate for almost one year before the necessary corrections were completed. Another program was allowed to continue operating despite licensor concerns that a safety hazard existed at the facility.

When we asked the licensors if problems with fire safety inspections existed, they told us that many providers had difficulty meeting the requirement of a fire inspection. However, the feeling among licensing staff was that the lack of a fire safety inspection alone was not sufficient grounds to withhold a license.

Licenses are Issued to Providers who do not Comply with Standards

Our review of provider records indicates that it is the general practice of the Office of Licensing to issue standard licenses even though the provider has yet to meet all licensing requirements. During their licensing and monitoring visits, licensors often find deficiencies that must be corrected in order for a program to be in compliance with standards. However, contrary to **Administrative Rule** R501-1-3(A)(1), which requires that an annual license be issued only *"after a determination has been made that the applicant is in compliance with rules and standards,"* providers are issued a new license with a letter that first describes the requirements not complied with and then requests corrective action be taken at some point in the future. The situation is further aggravated because the Office of Licensing is not following its own rules that require providers to prepare a written plan of corrective action. **Administrative Rule** R501-1-4(B) requires that *"if the provide is out of compliance with rules or standards, the provider and Office of Licensing staff shall develop a plan of action with a reasonable period of time to achieve compliance."* We found that the licensing staff rarely require providers to prepare a plan of corrective action. In addition, the administrative rules also allow licensing staff to issue a conditional license so that providers can continue operating while they correct problems that do not pose an immediate threat to the health and safety of their clients. We found that the licensing staff have not used the conditional status as frequently or as effectively as they should.

Our review of provider files showed that 87 percent of child care centers were issued licenses even though the provider was not in full compliance with the licensing standards. Typically, the annual license would be issued with a letter identifying the violations that needed to be corrected. Similarly, 79 percent of the treatment programs and child placement agencies we surveyed were issued licenses with a letter requesting that a number of violations be corrected. Unfortunately, our review found that in many instances the deficiencies were not corrected.

The problem of issuing licenses without full compliance with the rules seems particularly

significant in child care. While the vast majority of the child care centers were not in compliance with child care center rules, we found that almost all centers were given a standard annual license even though DHS's child care center licensors had reviewed the facilities and found deficiencies. In our view, this practice gives providers very little incentive to come into compliance with the licensing standards. As long as the Office of Licensing is willing to issue licenses before providers have come into compliance with DHS rules, they will lose any leverage they may have with providers who are unwilling to make the necessary improvements to their programs. Moreover, this practice gives the public the false message that certain providers are in compliance with state standards when, in fact, they are not.

DHS rules indicate that if "*the provider is out of compliance with rules or standards, the provider and the office staff shall develop a plan of action with a reasonable period of time to achieve compliance.*" (R501-1-4(B)). Our review failed to identify even one written plan of action in any of the provider's files. While we do not believe that a written plan of action would solve all of DHS's problems in gaining compliance, the absence of accountability on behalf of the providers could be exacerbating DHS's problem.

Our review of child care center files showed that most of the License Approval Letters sent to providers included a list of "conditions" that described the center's deficiencies. Please see Appendix A for examples of License Approval Letters with conditions. Nevertheless, providers that failed to correct the conditions listed in the License Approval Letters were still granted standard annual licenses. For instance, a center whose License Approval Letter specifically stated that "*the playground must be fenced in. This remains an outstanding condition from last year,*" as a condition, was granted another annual license. Ironically, the center's License Approval Letter from the previous year identified the same problem. The Approval Letter specifically stated that the center needed to "*complete fencing around playground this summer*."

Issuing conditional licenses without requiring corrective action also occurred in the treatment programs as the following cases illustrate. A residential treatment program associated with the Division of Youth Corrections was granted a license on the condition that it correct several fire and building code violations. The program was given several 90-day license extensions and was allowed to operate for almost a full year without correcting the condition before the Office of Licensing forwarded a Notice of Revocation to them. At one point during the period, the licensor sent a letter to the provider stating:

> *"It has been almost a year now since you were originally licensed and the fire inspection has not been completed... The possibility of a fire related disaster weighs heavily on my mind and needs to be addressed with a finished fire inspection.*"

While the provider corrected the fire and building code violations immediately after the Notice of Revocation was sent, the fact remains that the program was placing clients at risk during the period it took to correct the violations. A child placement agency's application was also expedited and a license issued on the understanding that the provider would comply with conditions to be forwarded

in a separate letter. At present, concerns about the agency's governance structure remain' and the required BCI checks have yet to be completed.

Lack of Guidelines and a Service Orientation Hinder Enforcement

Several factors contribute to the weakening of licensing's enforcement function. While administrative rules provide some guidance on enforcement, licensors do not have the benefit of procedural guidelines to direct them on the appropriate actions to take when providers violate the standards. Licensors also claim administrative support for aggressive enforcement is lacking. Although they view themselves as a regulatory agency, the licensing staff tell us the message they receive from management, the divisions, providers and even some consumers is the need to be a "customer friendly" organization and learn to "work with" providers who persistently violate licensing standards. As a result, the staff see themselves as advisors or consultants whose primary role is to assist providers to come into compliance with the standards. The belief that licensing staff's primary role is to provide assistance is a reaction, in part, to the realities of the human services market. The lack of providers makes the denial or revocation of a license particularly difficult because "closing" a facility affects not only the provider, but it also affects the clients who have to be placed in other facilities and the parents, guardians or the division staff who have to find suitable alternatives for them.

Guidelines for Evaluating Noncompliance are Lacking

The lack of procedural guidelines to be followed when providers fail to comply with standards contributes to the Office of Licensing's enforcement problems. While the administrative rules provide some guidance on enforcement, licensors need formal guidelines that give directions on when to sanction and the appropriate sanction to be imposed for a specific violation because violations differ in severity, duration and causation.

Guidelines are needed to help implement the Office of Licensing's rules. Currently, the Office of Licensing has formal rules that merely outline the steps to follow when a provider violates the standards. R501-1-4(B) states that if a provider is out of compliance with standards, a plan of corrective action must be developed. Also, R501-1-5(B) describes the sanctions that may be imposed on a provider, and R501-1-6 describes the hearing process. While these rules provide general enforcement guidelines, licensors do not have the benefit of procedural guidelines that define the parameters under which licensors are to sanction providers and the conditions under which different sanctions can be applied. One licensing staff person told us that when he was hired he felt he had little guidance as to exactly how to perform his responsibilities. When he asked three of his colleagues how to handle a specific situation, he said that he got three different answers.

One reason that having specific procedural guidelines is important is that enforcement can become too subjective without them. Violations differ in severity and extent, as well as in the

degree of risk that a consumer is exposed to. The differing natures of the violations, as well as the frequency of the violations, suggest that it would be inappropriate to apply the same sanction to each offense. In the area of treatment programs, for example, we found that providers were being asked to correct violations that had a wide range of severity from the failure to replace linoleum to the failure to comply with both building and fire codes. The broad range of conditions suggests that guidelines for distinguishing between substantial and non-substantial violations, as well as unintentional and "willful" violations are necessary for the equitable enforcement of rules. The range of conditions also points to the need to develop a method by which non-compliance could be evaluated so that the sanctions imposed are appropriate.

Perceived Lack of Management Support Contributes to Weak Enforcement

Many of the licensing staff believe they lack management support for strict enforcement of standards. Consequently, licensing staff view themselves as advisors or consultants whose primary role is to be "customer friendly" and help providers come into compliance with the licensing standards.

Many of the licensing staff we interviewed told us that they felt they did not have management support when they tried to take action against providers who were persistent in violating the licensing standards. We were told, for example, that many years ago the Office of Licensing took swift action when providers were found to be violating the state's licensing standards. However, in recent years licensors have been given the message that they should "quit hassling" the providers. These actions have given staff the impression that, as one staff member put it, *"there is no one to back you up"* when attempting to enforce the rules. As a result, the licensing staff have become what one licensor describes as a "cajoling force" rather than an enforcement minded agency. This same licensor informed us that she and her colleagues have received the message that they have "*...overstepped [their] boundaries, and that [they] were out of line, and that [they] should quit harassing the owners and providers*." Several staff told us that only in the case of the most egregious violations are the licensing staff able to sanction a provider.

A 1996 Management Review described the Office of Licensing as "*a service organization who's* (sic) *product is certifying that agencies can provide a service based on minimum standards,*"and went on to state that "*Based on our review, it appears that a service philosophy has not always driven decision making at the Office of Licensing."* The review has reenforced the perception among staff that the office is a "service organization" and they should focus on their roles as consultants and technical assistants. They have been encouraged to be sensitive to the needs of the divisions. According to licensors, the divisions are primarily concerned about having a sufficient number of "beds" or slots in which to place individuals who are in their custody. One staff person told us that licensors are made to understand, in no uncertain terms, that facilities should not be shut down. Others told us that the divisions put pressure on them to issue licenses to providers who do not meet standards. Licensing staff also told us that some division staff discourage the licensors from taking action against providers because the divisions are reluctant to go through the difficult

process of relocating clients.

Support for the proposition that the Office of Licensing prefers to encourage providers to come into compliance rather than aggressively impose sanctions can be found in the statistics that the Office of Licensing compiled on licensing actions for the period June 1996-July 1997. The summary given to us indicated that the Office of Licensing rarely revokes, suspends or denies the renewal of licenses for failure to comply with licensing standards. No licenses were revoked during the period. Additionally, when we reviewed the case files of the programs that were categorized as "closed/denied," we found most of the programs in the treatment area that were in that category did not close as a result of action taken by the Office of Licensing. Rather, these programs either let their licenses expire, decided not to use the facility, or failed to obtain authorized contracts with the divisions.

It should be noted, however, that current management, when told of our findings regarding the lack of enforcement and the perceptions of the staff, immediately requested a list of providers that may be placing individuals in their charge at risk, and communicated their support for strict enforcement of the licensing standards. We believe it is appropriate to be "service oriented" and to be "customer friendly" towards providers who do not willfully violate the state's licensing standards. Current management, however, should use whatever means necessary to reverse the perception among the staff that support for enforcement activities is meager. The state can ill afford to issue licenses to providers who persistently violate the state's health and safety requirements due to confusion about management's position regarding enforcement.

A Limited Number of Providers Also Discourages Strict Enforcement of Licensing Standards

Besides a lack of procedures and direction by management, market conditions also influence the licensors' actions. The Office of Licensing is limited in the sanctions that it can impose to those that are enumerated in **Administrative Rule** R501-1-5(B). In cases involving persistent and willful violations, however, it appears that the only sanctions that can be applied under R501-1-5(B) are license suspension and revocation. The practical effects of revoking or suspending a license make licensors uncomfortable with strict enforcement. Revoking or suspending a license places licensors in an awkward position because these actions, in practical effect, will result in the closings.

According to the licensors, the limited number of providers means that the Office of Licensing cannot fully discount the importance of capacity. Closing a facility reduces the number of providers in a market where, because of the unique needs of the clientele, the supply of appropriate space is already limited. Closing a facility that may be the only provider of human services in a rural community, for example, makes it impossible to provide the necessary services to the clients. Even in areas where other providers exist, the staff also worry about the all too real possibility that displaced individuals will be placed in a facility that is not appropriate for them. According to the licensors, *"the client has to be placed in a facility where they fit."* Finally, the need to find facilities that fit displaced individuals, is a contributing factor to the tremendous resistance that the

divisions have to closures. Caseworkers, already feeling overloaded, are reluctant to shut down a provider because they have to place the clients in new facilities, and it is difficult for caseworkers to reassign the clients to appropriate facilities.

We believe that a change in the way the Office of Licensing enforces the rules is needed. In addition to providing technical assistance to providers, the office also needs to sanction providers that are persistently or willfully out of compliance. While we do not question the validity of techniques designed to encourage compliance without the use of sanctions, we, nevertheless, question the strategy of "cajoling" providers who demonstrate willful or persistent non-compliance. While technical assistance allows well-meaning providers to achieve compliance, enforcement helps ensure that all licensed facilities, especially persistent and willful violators, stay in compliance with established standards. In the next chapter we discuss how the enforcement process can be strengthened.

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Chapter IV
Clarify the Purpose of Licensing, Then Strengthen Enforcement

Two things need to be done to avoid duplication with other agencies and improve compliance with licensing standards: First, to avoid confusion about the role of licensing and the scope of its authority, the purpose of the licensing program needs to be clearly defined. Clarifying the statute and distinguishing responsibilities of the divisions from those of the Office of Licensing can address this issue. Second, the Office of Licensing needs to strengthen the enforcement of the licensing standards. This can be accomplished by drafting a set of written procedures so that staff know what their responsibilities are, using the probationary license for providers who temporarily are out of compliance, focusing monitoring visits on providers with poor compliance histories, increasing the use of unannounced visits to providers, using both positive and negative incentives, and eliminating or minimizing the process required to renew a license.

Accomplishing these goals will be difficult. Clearly defining the purpose of the licensing program will require the state to decide whether licensing standards should be limited to health and safety issues or whether quality of care issues should also be incorporated into the licensing standards. Strengthening the enforcement function will require a fundamental change in the way the Office of Licensing approaches the licensing process. Better enforcement requires the office to shift its focus from providing technical assistance to aggressively applying sanctions to programs that are out of compliance. It is our opinion, however, that these issues must be addressed if the licensing process is to be improved.

Clarify the Purpose of Licensing

Both the Department of Human Services and the Legislature must address several tough policy issues if the scope of the Office of Licensing's authority is to be clearly defined. Confusion regarding the purpose of the Office of Licensing and the proper scope of its authority has resulted in duplication between the Office of Licensing and other agencies. In order to clarify the purpose of licensing, two steps need to be taken: 1) clarify the statute's description of the purpose of licensing; and 2) distinguish the responsibilities of the Office of Licensing from those of the divisions.

Clarify the Statute

As mentioned in Chapter II, confusion exists regarding the purpose and authority of the Office of Licensing. **Utah Code** 62A-2-102 states that the purpose of a license is to permit an agency to *"provide defined social services programs,"* and its issuance *"designates that the program has the capacity to provide the service for which it is licensed."* However, there is confusion throughout

the Department of Human Services as to the what "capacity" entails. In our view, either the Department of Human Services or the Legislature needs to clarify what the purpose of licensing is if the effectiveness and efficiency of the licensing program is to be improved. While some would like the licensing standards to represent an ideal or high quality of care, the professional literature suggests a fairly limited purpose for licensing.

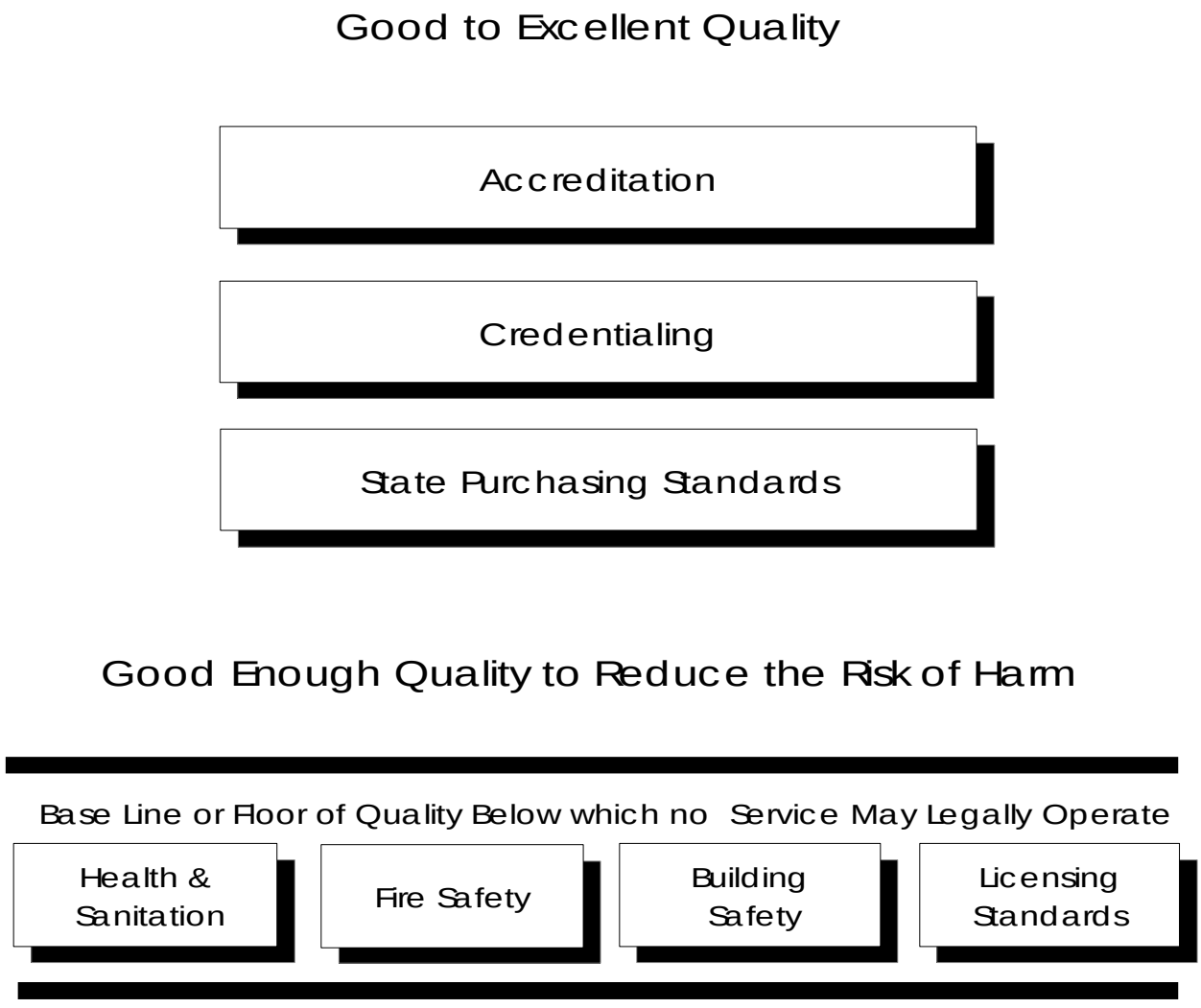
Licensing Standards Should Provide a Baseline or Minimum Level of Protection. There is general agreement among experts in the field of licensing that licensing standards are designed to provide nothing more than a minimum level of protection for consumers and users of social services. As part of a system of regulation, licensing standards occupy the lowest position in the hierarchy of types of regulations used to govern human services providers. They establish the baseline or floor of quality below which no program may legally operate. Consequently, they should not be used to ensure the provision of an optimal level of care. According to the experts, other methods of regulation, such as purchasing requirements and accreditation programs, are better suited to achieving higher levels of quality care since they apply higher standards.

According to a publication by the National Association of Regulatory Administrators (NARA), the basic purpose of a licensing program is to *"protect the health, safety, and well-being of children and vulnerable adults."* Protecting the health, safety and well-being of clients is accomplished by imposing *"licensing rules [that] are basic minimum requirements that must be met in order to operate in a specific state. Licensing rules assure a basic level of quality and not an optimal level of quality."* Similarly, Howard Gazan, an "at large" board member of NARA and a researcher in the field of human services licensing told us that *"Government's role is to establish a floor or minimum standard below which no provider should be allowed to go."* Furthermore, Professor Gwen Morgan of Wheelock College, perhaps the most widely cited expert in our search of the literature, stated that *"all mandatory standards at the licensing level are justified only on the basis of reducing risk of predictable harm."*

Figure IV serves to illustrate the position that licensing occupies within the system of regulations that govern human services. The model, developed by Dr. Morgan, shows licensing is just one means of assuring a minimum level of protection and suggests that other methods of regulation, such as; purchasing standards, certification and accreditation are better suited to achieve higher levels of program quality.

Figure IV
Levels of Regulation

In describing her model, Dr. Morgan said:



> "*The bottom layer of standards is a line drawn by the state as essential for the protection of the public. The state's legislative bodies have made the strongest possible intervention into the market, to say that a program will not be permitted to exist (i.e. granted a license) unless it meets necessary standards. In ascending order there are higher levels of standards, but the base line is licensing. These higher levels of standards do not rest on the licensing powers, but rely on other means for achieving higher quality.*"

In other words, the primary purpose of licensing is to assure that all of those who participate as providers in an industry meet a set of minimum standards. Generally, these standards are limited to matters having to do with consumer protection. Those wishing to promote higher standards of

quality in an industry are invited to pursue other forms of regulation such as the state's own purchasing requirements, credentialing or accreditation.

Dr. Morgan's model also suggests that those who are interested in protecting the basic health and safety of children in child care should look to the licensing process as a means of providing that protection. However, the model also indicates that those who are dissatisfied with the overall quality of child care in the state should consider strategies other than raising the licensing standards. Achieving quality care through another form of regulation is in fact the goal of the Utah Private Child Care Association. That organization is currently in the process of establishing an accreditation program for its members. Developing an accreditation program, they tell us, is being done with the intent of achieving a higher level of program quality than the baseline level of protection currently offered through the state's licensing process.

Montana offers a "minimum level of protection." Montana uses an approach to licensing based on the concept that licensing should represent a baseline level of protection. Montana does this by strictly limiting the scope of its licensing standards to matters of safety. For example, the following statement from a legislative audit report from Montana, describes how that state views its licensing standards as a "minimum level of protection":

> "*Current laws, rules and policies provide only a minimum level of protection to ensure the safety and well-being of children in child care. Most requirements of the Act relate to safety. Quality of child care is not defined in statute nor is quality measured by personnel. For example, administrative rules for family homes include fire safety requirements, but do not include requirements for daily activities.*"

This statement is consistent with the purpose of licensing suggested by Gwen Morgan, the NARA and other professional literature cited above. The objective, according to the Montana audit report, is that *"regulatory activities conducted by the department provide a minimum level of protection for children in child care, but activities do not supplant parental care. It is up to the parents of children in care to determine whether a child care facility will provide all needs of their children, including proper nurturing and development.*" The report also suggests that providing a minimum level of protection is consistent with the intent of the Montana Child Care Act to *"promote the availability and diversity of quality child care services."* Montana believes that requiring a higher set of standards could limit the availability of care and the choices available to the consumer.

To summarize, many of the leading experts in the field of professional licensing indicate that the purpose for a program of licensing human services providers is to provide a base line level of protection. Further, they argue that in order to obtain services that exceed the base line level of

quality, individual consumers or the divisions must rely on other means such as division purchasing requirements or accreditation.

Responsibilities of Office of Licensing Must be Distinguished From Those of Divisions

The department will need to define the responsibilities that the Office of Licensing and the divisions will have in monitoring the quality of care being provided. Theoretically, the Office of Licensing and the divisions should be concerned with different levels of quality. Licensing standards represent a minimum standard of quality below which no provider will be allowed to operate. As a result, the Office of Licensing is charged with the responsibility of determining that all human services programs at least meet the basic licensing requirements. On the other hand, the divisions are responsible for ensuring that the human services providers, with whom they have contracted, are delivering the quality of care specified in the contracts.

The grant of a license is determined on the basis of a comparison between the program and the core standards that apply to all social services programs, as well as the categorical standards which only apply to specific program types. However, as discussed in Chapter II, both the Office of Licensing and the divisions have developed standards that, while not identical, deal with the same subject areas. Consequently, duplication in the regulatory efforts of the Office of Licensing and the divisions occurs. Clearly distinguishing between the areas of responsibility for the Office of Licensing and the divisions would help to eliminate the areas of regulatory overlap.

The department must identify the subject areas that are best regulated by either the Office of Licensing or the divisions. The challenge that faces the Department of Human Services is to determine which of the licensing categories or subject areas are better regulated by the Office of Licensing and which are better regulated by the divisions. Efforts to determine regulation must be guided by two principles: First, that licensing standards are justified on consumer protection grounds. They are designed to safeguard the health, safety and well-being of consumers and users of a service by reducing the risk of exposure to predictable harm. Therefore, it follows that a standard that cannot be justified on the ground that it reduces the risk of harm is inappropriate for licensing. Second, that licensing standards should not be used to achieve quality or ideal care. Licensing standards merely serve to establish the base floor of protection and a minimum level of service quality. These principles suggest that the scope of the Office of Licensing's responsibilities should be confined to monitoring compliance with limited number of standards directly linked to health and safety concerns.

Consumer protection is achieved through risk reduction. According to NARA, licensing standards that are designed to reduce risks in human services programs focus on:

1. The character and competency of the licensee and staff;
2. The adequacy and appropriateness of activities, materials, and equipment used to provide the regulated service; and
3. The safety and appropriateness of the building and grounds.

Provisions in the Office of Licensing standards cover these particular issues. However, many other provisions in the standards go beyond the items suggested by NARA. The task that the department must come to grips with involves deciding on whether the Office of Licensing should monitor provider compliance with standards, many of which are not directly linked to health and safety, that go beyond these particular areas.

We reviewed the licensing standards and found that they covered the spectrum in terms of the degree to which they were linked to basic consumer health and safety. After reviewing the standards, we developed Figure V to show the spectrum between those issues related to public protection and those issues related quality care. Items in the left-hand column are provisions in the Office of Licensing standards that we identified as dealing directly with health and safety issues, such as fire and transportation safety and sanitation. The middle column contain provisions that, in our opinion, occupy the middle ground between health and safety and program quality. These "middle ground" items appear to be directed at providing quality care but, also, have a health and safety component to them. Finally, items in the right-hand column are provisions that appear to be directed at ensuring quality or ideal care only. Examples of these provisions are those dealing with program philosophy and direct service management.

Figure V
Issues That can be Regulated by Divisions or the Office of Licensing

Consumer Protection	Middle Ground	Quality Care
Fire Safety	Education, Experience and Other Qualifications of Personnel	Administration
Food Safety	Management of Client Behavior	Governance
Sanitation	Ratios of Staff to Clients	Organizational Philosophy
Infectious Disease	Direct Service Management	
Transportation Safety	Adequacy of the Equipment and Physical Facility	
Emergency Preparedness	Adequacy of Provider's Internal Procedures for Providing Care	Financial Mgmt. Practices
Criminal Background of Personnel	Record Keeping	Program Philosophy
Safety of the Physical Facility	Confidentiality of Client Records	Curriculum
	Billing Practices	Outcome of Services Provided
	Quality of the Service Records	
	Financial Health of Provider	
	Consumer Rights	
	Staff Training Requirements	

The process of assigning specific areas of responsibility will be difficult. Once the purpose of licensing is clarified, we believe that the divisions and Office of Licensing need to determine which issues fall within the scope of authority of the Office of Licensing and which are matters of quality and, therefore, the responsibility of the divisions. Determining which issues are within the scope of Licensing's authority will be difficult because many standards, the "middle ground issues" in Figure V that appear to be directed at providing quality care, also have a health and safety component. For example, on page 16 of Chapter II we suggest that the department may have gone too far in its regulation of the curriculum at child care centers. On the surface, program curriculum appears to be a quality of care issue that is best regulated by consumers. Studies indicate, however, that it is

essential for the mental development of children that they be engaged in some kind of activity. As a result, there may be justification for requiring a set of minimum standards in the area of curriculum even though it is generally considered a program quality issue.

The same can be said about staff ratio standards. To the public, staff to client ratios speak to the quality or richness of the experience that a program client will have. However, concerns about the number of users that can be safely shepherded by a staff member during an emergency enters into setting the ratios.

We understand the complexity of the task that faces the department. In fact, some of the provisions that we classified as "middle ground" items are considered by NARA to be essential to risk reduction. Still, the process of defining the purpose of licensing and distinguishing the respective areas of responsibility must begin if the licensing process is to become efficient. During the process of determining the purpose and responsibilities of licensing, the Department of Human Service and the Legislature should bear in mind the following: licensing standards are not intended to provide optimal care and other methods of regulation are better suited for ensuring levels of care beyond the minimum established by licensing standards.

While the licensing staff seem to recognize that they need to eliminate any areas of overlap with the divisions, we are concerned that they may be overly concerned about the quality of care offered by providers that do not contract with the divisions. Licensors are concerned that limiting the scope of the licensing standards would result in inadequate oversight of private placement programs. Private consumers, staff believe, are not in the position to judge the quality of care offered by providers who are not regulated by the divisions. For this reason, some licensing staff have proposed that they will need to assume an expanded regulatory role when licensing providers, such as child placing agencies and some outdoor youth programs, that do not have contractual relationship with the divisions.

However, as stated above, mandatory licensing standards define the baseline of quality below which no program may legally operate. Licensing standards are not meant to provide absolute protection from harm, and licensing offices are not responsible for ensuring a high level of program quality. Once the scope of licensing has been decided, it is the responsibility of those who would place children and vulnerable adults in private placement programs, not the Office of Licensing, to ensure that the program meets their expectations. Additionally, the Office of Licensing cannot afford to apply a different standard to private placement programs merely on the basis that the divisions are not involved in monitoring these programs. It is bound to fairly and equitably apply the standards to all social services providers and a program that meets the basic requirements must be allowed to engage in business just like a program that exceeds those standards.

It is our opinion that the principles discussed above will assist the department in its efforts to define the proper scope of licensing responsibilities, either by limiting the number of categories or the number of items within categories, that must be monitored by the Office of Licensing in its

efforts to protect the health, safety and well-being of consumers or users of human services.

Strengthen the Enforcement of the Licensing Standards

Once the Office of Licensing has limited its rules to the requirements that are essential to public protection, they then need to develop the tools necessary to enforce those standards. As mentioned in Chapter III, the Office of Licensing currently places too much emphasis on providing technical assistance and encouraging providers to comply with the licensing standards. Although NARA affirms that providing technical assistance is a valid tool, NARA also emphasizes that "*technical assistance is not the answer to all compliance problems by any means. Assuring bottom-line protection for the consumer is a greater duty than giving the licensee extraordinary opportunities to meet his compliance obligations*."

In the following section we offer a few suggestions on how the Office of Licensing can strengthen its enforcement of licensing standards. First we suggest that they provide staff with a set of written procedures and protocols that explain exactly how staff should perform their responsibilities. Second, we describe the tools or techniques that comprise an effective enforcement program. Finally, we describe several ways the Office of Licensing can streamline its process so staff will be able to devote more time to enforcement activities.

Establish a Written Set of Enforcement Procedures

The Office of Licensing staff do not have a set of written procedures or protocols to guide their enforcement activities like other states and the Utah Department of Health have. In our view, the licensing staff need better guidance on how to enforce the state's licensing standards which will help them consistently handle violations. Providers will also have a better understanding of how the state will respond if they violate the rules. Furthermore, the enforcement actions will be handled in such a way that if providers decide to challenge licensing's enforcement actions, the Office of Licensing will be able to withstand the scrutiny of an administrative law judge.

After observing the DHS licensing staff in the field, we discovered that staff do not use a consistent approach when responding to violations of the licensing standards. In fact, staff told us that they do not have methods or protocols to help them evaluate whether or not providers are out of compliance. In contrast, other states contacted have established guidelines to help licensors identify and evaluate whether providers are in compliance with specific rules. For example, Arizona's Department of Economic Security, Division of Developmental Disabilities has developed a reference manual that explains the intent of a rule, the items that must be

verified in order to declare that a program is in compliance with standards, as well as examples of deficiencies that must exist in order to characterize a program as noncompliant.

We also found that the licensing staff at the Utah Department of Health follow written procedures covering nearly every facet of the inspection process. If a *class two* violation is found, for example, department staff are required to notify the provider of the rules violated within 10 days of the inspection. The provider is required to submit a written plan of action to the department within 14 days of the notice. Protocols then require department staff to verify that deficiencies have been corrected, either through a physical inspection or other documented evidence of compliance.

In our view, a set of written procedures and protocols describing how to conduct inspections and how to respond when violations are observed can significantly improve the enforcement of the licensing standards. Staff will have a better understanding of what is expected of them. Additionally, in cases when staff members are required to take strong action against a provider, they will know what the appropriate response is and will not have doubts as to whether they are overstepping their authority. Formal procedures and protocols should also help providers have more confidence in the licensing process because they will know that they are being treated the same as every other provider.

Conduct More Effective Monitoring Visits

The Office of Licensing may be better able to ensure continued compliance with standards by making several changes to its monitoring policy. Under the current practice, the Office of Licensing's capacity to conduct on-site monitoring appears to have eroded. Our discussions with licensors revealed that they are able to inspect programs only once a year. The Office of Licensing may be able to make monitoring visits more effective by prioritizing inspections so that resources are concentrated on providers with a poor compliance history and by conducting random, unannounced visits.

Being more discriminating in the choice of providers to be inspected, the Office of Licensing will be able to provide better oversight, monitoring programs that need it most---those that have a poor compliance history. Monitoring visits are widely recognized as an effective way of determining whether providers are in compliance with licensing standards. A 1992 report issued by the United States General Accounting Office on state efforts to ensure quality child care through enforcement of licensing standards states: *"For all types of care, licensing directors ranked on-site monitoring as the most effective regulatory activity for assuring provider compliance with state child care standards."* Monitoring visits allow regulators to oversee and determine provider compliance first hand.

The Office of Licensing should make random, unannounced visits to maximize compliance with licensing standards. According to Montana's Audit Department, unannounced, on-site monitoring visits are a deterrent to non-compliance because they allow licensors to "*see care provided as it functions from day-to-day, without the preparation which accompanies an announced inspection."*

In other words, licensors will get a better picture of a particular program's condition than they would otherwise get if the visit was announced. There appears to be broad support for the use of unannounced on-site monitoring visits as a deterrent for non-compliance. According to the GAO, many states conduct a combination of announced and unannounced visits to providers. Minimum standards developed by the National Association for the Education of Young Children (NAEYC) require states to conduct at least one unannounced visit to child care centers every year. Similarly, Dr. Morgan supports the use of unannounced monitoring visits to determine continuing compliance with standards. In fact, DHS licensors voiced support for the use of unannounced monitoring visits because they not only allow inspectors to see how well the provider is complying with the rules and standards in a *"real world"* situation, but visits also allow them to focus their efforts on centers having difficulty with compliance.

Use Positive and Negative Incentives to Achieve Compliance

The use of positive and negative incentives gives the Office of Licensing the distinct advantage of responding to violations without revoking a provider's license. Additionally, incentives offer flexibility because they can be tailored to the severity of the violation. According to NARA, incentives *"do not result in an adverse action, but instead are designed to encourage or facilitate compliance with licensing requirements."* Similarly, NARA claims that negative incentives are used *"not to 'punish' the violator, but to compel compliance."*

Using Positive Incentives. Our discussions with the representatives of licensing agencies in other states revealed others have implemented positive incentives designed to encourage providers to comply with licensing standards. The Office of Licensing may want to try some of the incentives that have been implemented in other states:

For example, some states extend the licensing period for providers with good compliance histories. Minnesota has a program where providers are given two-year licenses for demonstrated good performance. According to their representative, the two-year program is working well. Minnesota has not seen a rise in the number of complaints against centers as a result of the new program. Additionally, approximately 80 percent of their providers presently have two-year licenses.

Another positive incentive that the Office of Licensing may wish to consider is to offer training to the staff of providers who have difficulty complying with certain standards. Florida, for example, has established training programs and seminars designed to educate providers about their rules and standards. This training program takes place at different locations throughout the state in an effort to give providers a strong education base as well as a forum to discuss their concerns about their particular industry. Arizona identifies providers that have difficulty complying with standards and requires them to attend a training program. Although some DHS licensors believe they are already offering technical assistance when they inspect facilities, the training that providers receive in Florida and Arizona appears to be different in nature. Both the

Florida and Arizona programs offer the advantage of enhancing and standardizing their efforts to assist providers improve the safety of their facilities.

A final way the Office of Licensing could provide a positive incentive would be to find ways to give public recognition to those demonstrating good performance. The results of licensing reviews, for example, could be published or otherwise made public. This is the approach taken by the Department of Health which issues annual "report cards" on provider compliance to state standards. The publication of licensing reviews would, however, require that the office use a consistent approach in rating provider compliance. The establishment and adherence to proper protocols could be a strong factor in developing a public recognition program.

Using Negative Incentives. As with positive sanctions, we found that other states have implemented negative incentives whose purpose is, in keeping with the principles suggested by NARA, "*not to 'punish' the violator, but to compel compliance."* The negative incentives adopted by other states range from public reprimands to the imposition of fines. The Office of Licensing may want to consider using some of these negative incentives in the following:

NARA suggests that states consider the use of a "probationary" status in cases where a provider is out of compliance with certain rules. A probationary license generally means that the licensing agency will increase the level of monitoring to ensure progress toward compliance is being made. Based on what we have learned in the professional literature from NARA and from other states, we have determined that the following steps are generally taken when placing a provider on a probationary status:

1. Issue a report citing the specific standard violated.
2. Require the provider to draft a written plan of corrective action.
3. Establish a 30, 60 or 90-day deadline by which time the corrective action must be taken.
4. Verify, at the end of the probationary period, that the provider has taken the required corrective action.

Licensing staff and providers need to recognize that the probationary period is temporary and cannot be extended. If, at the end of the probationary period the provider has not taken the required action, the probationary status should cease. The license is revoked, and the provider must cease operation until it can subsequently demonstrate compliance with the licensing standards.

One approach used by other states and by Utah's Department of Health (DOH) in cases where a licensee is having difficulties complying with the standards is to reduce the number of clients a facility can serve. Thus, the approved capacity for a facility may be changed from 20 clients to 15 clients if there are repeated infractions. The status could be made permanent or until the violations are corrected. For example, DOH has the ability to restrict or limit the ability of providers to conduct business if repeated infractions occur. In fact, we attended one inspection where DOH's licensee was barred from admitting more clients to their center until the violations were corrected. The provider seemed eager to rectify the situation so that his business prospects would not be

limited.

A few states have statutory authority to impose fines against those found to be violating their licensing standards. Georgia's Office of Regulatory Services has the ability to impose fines on providers that are out of compliance with the state's standards. Monies collected, however, are funneled back into the child care center or treatment program to redress the problem. The director of the Georgia licensing agency reports that the issuance of fines has been a significant motivator in assuring consistent compliance in Georgia. Oregon has likewise reported an increase in compliance as a result of the imposition of fines.

The Office of Licensing could also consider the feasibility of using a public reprimand when providers violate the licensing standards. For instance, DOH publishes the names of violators in a monthly newsletter. DOH has found the use of public reprimands to be a very effective tool in curbing non-compliant providers because the providers know they will be brought into the spotlight if they are not complying with the department's licensing standards.

Resources Must be Freed up to Increase the Number of Unannounced Visits

Changing the focus of the Office of Licensing from technical assistance to aggressive enforcement constitutes a shift in an operational mind set. In order to implement this change the Office of Licensing will need to streamline many elements of the licensing process. Our observations of the staff during the licensing process suggest several areas where a more efficient system could result in substantial time savings. Time saved on the process could be used for enforcement activities, especially against providers with poor compliance histories. First, the Office of Licensing should streamline the process of renewing existing licenses. Second, a team approach between regulatory agencies should be created. Third, the licensing staff can save time by functioning as generalists rather than specialists only assigned to specific program areas. Fourth, licensing may be able to reduce the types of programs they license or reduce their visits to programs that are heavily regulated by other agencies.

Streamline the Renewal Process. Much can be done to streamline the renewal process and thereby allow more time for staff to increase the number of on-site monitoring visits they conduct. Currently, Office of Licensing staff are involved in a time consuming inspection of providers. Not only do they conduct a physical inspection of program facilities, they also conduct a verbatim review of the core and categorical checklists with the providers as well as request and collect reports prepared by correspondent agencies. According to NARA, a lengthy renewal process "*drains off energy that might be used to achieve better care generally*." To combat this problem NARA suggests: 1) expanding the licensing period to two or more years and 2) reissuing licenses as a matter of routine "*unless there are known instances of failure to conform to standards...*" While the second approach is "generally preferable", NARA also suggests that routinely reissuing licenses would require an increase in the number of informal monitoring visits. Alternatively, the renewal process could also be expedited simply by requiring providers to submit the necessary

documents through the mail. Providers could submit their criminal background requests, a report of their annual training, annual inspection reports completed by the local fire marshal and health inspectors, and fill out and sign a checklist that enables them to self-certify compliance with the core standards.

Create a Team Approach. Relying on the reviews and inspections of correspondent agencies would not only be an effective way to free up time for increased oversight but it also can help licensing staff avoid the problems of duplication mentioned in Chapter II. While the team approach delineates areas of responsibility, it also requires all agencies involved to give full credit to the work done by others and, thus, to support one another. If local officials or division staff discover that a provider is violating the conditions of a license, they should report the problem to the licensing staff who would then make a follow up inspection. If, on the other hand, licensing staff find problems relating to the division's contract requirements, they should notify the divisions. Team work has been used effectively in other states; for example, Michigan gives certain providers a list of approved fire inspectors who conduct inspections according to state requirements and submit copies of the inspection to the licensing office. Minnesota has also placed fire marshals in the Office of Licensing to ensure consistent application of the fire codes.

Lessen Staff Specialization. Licensing staff could also find more time for enforcement activities if they were to become generalists rather than specialists. Reducing staff specialization would allow the Office of Licensing to save time by reducing both staff travel time and, as previously pointed out, the time spent in duplicated licensing reviews. We observed that a great deal of staff time is spent traveling throughout the state because they specialize by program area. The licensing specialist for youth corrections programs, for example, travels to Richfield, and Logan and Price when youth corrections programs need to be licensed in those cities. Similarly, the licensing specialist for substance abuse programs must also travel to those same cities when providers of substance abuse counseling need to be licensed. If providers offer services in multiple categories, they will receive visits from different licensing specialists. Generally the two staff will try to make visits simultaneously, but we question whether this is an effective use of staff time.

We did not observe sufficient difference between the licensing requirements for the different program areas to justify having separate licensing staff assigned to each area. As an alternative, we believe the Office of Licensing should determine whether a single licensing generalist could be responsible for several different programs areas. Generalists might reduce time spent traveling and, thus, increase the time staff have to devote to enforcement activities.

Reduce Oversight of Programs Monitored by Other Agencies and Reduce the Types of Programs Licensed. Finally, licensing may be able to increase time available for enforcement activities if the number of visits to programs regulated by other agencies is reduced. Programs heavily regulated by other agencies may not require as much attention from the licensing staff as programs not monitored by correspondent agencies. Licensing staff should shift more time and attention to those programs where the greatest risk exists. The level of scrutiny that programs regulated by other agencies receive suggests that they are less likely to violate standards. Consequently, they should receive less attention from the Office of Licensing. For example, mental

health centers are highly regulated because they contract with many different state and local agencies. On the other hand, licensing staff may find other programs, such as outdoor youth programs, are more likely to violate the licensing standards and thereby place clients at a greater risk.

Recommendations:

1. We recommend that the DHS propose and that the Legislature consider changes to the statute that clarify and limit the purpose of the Office of Licensing.

2. We recommend that DHS require providers to comply with its rules and standards regarding both standard and conditional licenses.

3. We recommend that DHS require non-compliant providers to write a "*plan of action*" for each violation found.

4. We recommend that the Office of Licensing develop rules that identify the specific protocols and procedures that licensing staff should follow when conducting inspections and enforcing the licensing standards.

5. We recommend that the Office of Licensing use positive and/or negative incentives to promote greater level of compliance among providers.

6. We recommend that the Office of Licensing increase the number of unannounced visits to providers, focusing on non-compliant providers in particular.

7. We recommend that the Office of Licensing consider the following strategies for increasing the amount of time staff can devote to unannounced visits and other enforcement activities:
   - streamline the renewal process
   - increase reliance on county fire and health inspections
   - reduce staff specialization
   - reduce the number and type of programs licensed.

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Appendix A

Annual License Approval Letters and Licenses Issued with “Conditions”

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Agency Response