# California Behavioral Health Planning Council

## Housing and Homelessness Committee Agenda

*Thursday, April 15, 2021*
8:30am to 10:15am

Zoom Meeting link:
https://us02web.zoom.us/j/86003448919?pwd=cEdyaTRuTUVFbWl1U1EyQU8zYzRkUT09
**Meeting ID:** 860 0344 8919 **Passcode:** CBHPCHHC
**Join by Phone:** 669-900-6833 **Passcode (Phone):** 04621096

| | | |
|---|---|---|
| **8:30am** | **Welcome and Introductions**<br>*Vera Calloway, Chairperson* | |
| **8:35am** | **Approve January and March 2021 Meeting Minutes**<br>*Vera Calloway, Chairperson and All* | **Tab 1** |
| **8:45am** | **Assembly Bill 1766 Implementation Update**<br>*CA Dept of Social Services, Community Care Licensing (invited)* | **Tab 2** |
| **9:10am** | **Review Council's 2018 Report on Adult Residential Facilities and No Place Like Home Requirements**<br>*Jane Adcock, Executive Officer* | **Tab 3** |
| **9:20am** | **Public Comment** | |
| **9:25am** | **Break** | |
| **9:30am** | **2021 Work Plan Discussion and Determination of Priorities**<br>*Vera Calloway, Chairperson* | **Tab 4** |
| **9:55am** | **Public Comment** | |
| **10:00am** | **Discuss Next Meeting Agenda**<br>*Vera Calloway, Chairperson and All* | |
| **10:10am** | **Public Comment** | |
| **10:15am** | **Adjourn** | |

The scheduled times on the agenda are estimates and subject to change.

**Officers:** Vera Calloway, Chairperson Monica Caffey, Chair-Elect

# California Behavioral Health Planning Council

**Committee Members:** Barbara Mitchell, Lorraine Flores, Gerald White, John Black, Arden Tucker, Darlene Prettyman, Deborah Starkey, Steve Leoni, Christine Costa, Sokhear Sous, Iris Mojica de Tatum, Tim Lawless, Angelina Woodberry

**If reasonable accommodations are needed, please contact the CBHPC at (916) 701-8211 no less than 5 working days prior to the meeting date.**

**TAB 1**

# California Behavioral Health Planning Council
# Housing and Homelessness Committee (HHC) Meeting

Thursday, April 15, 2021

## Agenda Item: Approve January 2021 and March 2021 Meeting Minutes

**Enclosures:** Draft Minutes

**Background/Description:**

The Committee members will discuss any necessary edits and vote on the acceptance of the draft minutes.

**1st Motion**: Approve the January 2021 Housing and Homelessness Committee minutes.

**2nd Motion**: Approve the March 2021 Housing and Homelessness Committee minutes.

# California Behavioral Health Planning Council

## Housing and Homelessness Committee Meeting

Thursday, January 21, 2021
8:30 – 10:00 am
Meeting Minutes

**Committee Members Present:**

| | | |
|---|---|---|
| Vera Calloway, Chairperson | Deborah Starkey | Angelina Woodberry |
| Monica Caffey, Chair-Elect | Steve Leoni | Lorraine Flores |
| Barbara Mitchell | Christine Costa | Darlene Prettyman |
| Gerald White | Tim Lawless | |
| John Black | Iris Mojica de Tatum | |

**CBHPC Staff Present:**

Jane Adcock, Jenny Bayardo, Laura Leonelli

**Welcome and Introductions:**

Members were welcomed by Chairperson Vera Calloway and introductions were completed. Ms. Calloway opened the meeting at 8:30 am.

**Approve October 2020 Meeting Minutes**:

No corrections suggested. Minutes were approved by voice vote with Darlene and Lorraine abstaining.

**Update on Project Homekey:** Tim Lawless, CA Department of Housing and Community Development

Tim included background information in the meeting packet materials. He said that the model has a lot of promise. Project Homekey started in July with $800 million to local jurisdictions: cities, counties, and tribes, to purchase real estate and increase available housing. The funds were to be spent by December 2020, and funds were awarded on a rolling basis. Each stage of the process took only a few weeks, and by the end of 2020 there was a total of 94 projects. All projects were occupied within 90 days post escrow. Some properties do need rehabilitation later, in order to become permanent housing. 6000 housing units were created, with a base cost of $150K per unit, much lower than the cost of new construction. Also, it just took months instead of years for occupancy. CEQA and other approvals were waived to save time. The Governor's 2021 budget includes $250M for Project Homekey "2.0" and another $500M is proposed for next fiscal year, to purchase motels as well as manufactured housing.

Member questions:
Question: Barbara Mitchell stated that the real cost is substantially higher, that developers add another $140K per unit, so the actual cost is $1000/square foot. Also, there are no laundry facilities or security at the properties, this is an extra expense. Neighboring businesses are not pleased, they were set up for regular hotel traffic. In Salinas the housing is owned by a private developer and is making a lot of money from this program, how will this continue to be affordable over the long term?

Answer: Tim replied that the per unit cost is not final, it depends on the locality. Some facilities need more or less work. Still, the total cost is a fraction of the cost of new construction (over $500-600K per unit). There are terms in place for long-term housing, some facilities have a 55-year affordability requirement.

Question: Steve Leoni stated that he did some research on number of Homekey awards as of Sept. 14, 2020: 10 projects, 579 units, but most were interim units and only 287 became permanent later. In Sacramento County, when leases for Project Roomkey expired, residents had to move to other locations. The only difference between Homekey and Roomkey is not whether the housing is interim or permanent, but whether the facility is a purchase rather than a lease. and many facilities are doubling up residents.

Answer: Tim responded that there are 3 groups of facilities, over half that continue to be interim. Another group is interim with an option to become permanent. The third group is permanent. Compared to the number of homeless on the streets, it is still a good start.

Question: Steve said that the speaker at the October meeting stated that in Los Angeles they could house 200 people per day but another 227 lost housing due to various causes.

Answer: Tim replied that prevention is important, and the state will receive $2.6 Billion in Federal rental assistance.

**Panel Discussion re: Homelessness and Housing Barriers:** Elijah Deliz, Youth Impact Partnership and Yesenia Rodriguez, ESG Homeless Prevention, Bill Wilson Center, Santa Clara Co

Vera introduced the presenters Elijah and Yesenia. The Bill Wilson Center (BWC) serves over 5000 youth per year, and also does street outreach.
Yesenia is a Case Manager; she works with children and families and meets with them weekly. She offers help with shelter and if they are unemployed, she arranges for them to meet with an Employment Specialist. The priority is housing stability. If the family has a negative credit history the BWC provides a double deposit on rent, furnishings, food and mental health services. She meets with the family after they are housed and checks in monthly. Follow up services last a year, or less if the family becomes stable and stays employed.
Elijah will start a career soon, but as a youth he was homeless at 16. His family kicked him out with no support and it took awhile to find resources. In the meantime, he learned street life, was involved with gangs and drugs and spent 2 years in jail. At that point he realized his need

for help and went to the BWC. He entered their Rapid Rehousing program, and it was effective in meeting his needs for college assistance and in staying off drugs. He couldn't have done it without stable housing. BWH helped him with rent, driver's license, car insurance, therapy, and training to be a fire fighter. He lost his job, couldn't make rent in the pandemic and got back into Rapid Rehousing within one month; they will help pay for whatever is needed. It was a long journey but he found success.

Member Questions:
Question: Vera asked the presenters what was it like working together? How did they establish a relationship?
Answer: Elijah responded that he worked with many departments/programs and providers, with more than one relationship.

Question: Darlene asked if the program uses any funds from MHSA.
Answer: Yes, there are a variety of funding sources including MHSA.
Question: Darlene asked how far was Elijah into his firefighter training?
Answer: He is studying to be an Emergency Response Technician.
Question: What is his relationship to his family?
Answer: He said it was still a struggle, he tries to be forgiving. They do communicate, but Elijah's 'real' family is his support network.

Lorraine commented that she is very impressed with Elijah, she retired from the BWC after 20 years. She congratulated BWC for maintaining housing services for the homeless in the pandemic.

Question: Jane commented that Elijah mentioned it was hard to ask for help, would it make a difference if the Case Manager was a Peer?
Answer: Elijah said yes, having Peer support made him feel more comfortable. Not everyone knows what it's like to sleep on the street.
Jane commented that the Peer Support Specialist bill, SB 803, had finally been signed, confirming the effectiveness of Peer-provided services.

Question: Angelina asked how long is the program? How long do you support youth in the program?
Answer: Elijah responded that youth 16 – 25 years are eligible; services will continue for as long as needed. He thinks that BWC is helping youth even before and after that eligibility period.
Yesenia added that the program does get some low-income units, so they can refer youth to housing that is affordable and sustainable after the program support ends.

Question: Vera asked if Elijah will reach out to youth now that he is an adult?
Answer: Elijah said yes, he currently works with a non-profit and has clients of his own, and he wants to work part-time at the BWC.

Question: Vera asked Yesenia if Case Managers at BWC are Peers with lived experience, or licensed staff?
Answer: Yesenia replied that staff are from all backgrounds: former clients who are trained and educated can work as Case Managers or Program Managers. Staff can do any job that they are qualified for.
Question: What is the funding source for college assistance?
Answer: Staff help clients apply for financial aid, and provide gift cards and other support for supplies.

Question: Darlene asked if the program works with families for reunification?
Answer: Yes, staff interview families and refer them to different departments for help with any kind of support, such as purging criminal records, employment, trauma counseling.

**Public Comment:**

Question: Project Homekey – Steve McNally asked that the state be upfront about the cost per unit; he looks for accurate information and it's not easy or accessible, and it's needed to work with Boards of Supervisors on housing issues in the County. If people know what's missing then they can add more resources. In Orange County, transportation is included in MediCal services, so that's covered.
Answer: Tim said the initial purchase price is good, but yes, it varies by county and any rehab cost. Question in the chat: it's stressful to get interim housing then when that's over to return to the street.
Answer: The County COC needs to coordinate the transition to permanent housing.

Question: Lynda Kaufman asked about Board and Care homes, many 6-12 bed facilities were lost and resulted in an increase in homelessness.
Answer: Tim responded that the state budget includes $250M for the Department of Social Services to acquire and rehabilitate Adult Residential Facilities and Residential Care Facilities for the Elderly.

Question: Barbara Wilson commented that she likes the continuity of care provided by BWC. Going back to the housing issue, she asked if it was possible to divert some homeless funds to licensed Board and Care homes. Licensed homes are the only community resource to care for people with chronic medical or psychiatric issues and residents on medication. 100 beds have been lost just in the last 6 months in her area, due to cash flow problems and the inability to charge enough. Board and Care homes exist for the regional center population and older adults, and they can charge more. Shelters can charge $60/night for just basic services.

Question: Vera asked Tim if the funds for the housing project were from Department of Social Services (CDSS).
Answer: Tim confirmed that DSS is the licensing organization, and yes, $250M has been proposed, some of which can be used by counties to purchase ARFs.

Question: Barbara Wilson asked if that means that counties can purchase Board and Care homes that are closing due to cash flow problems? Licensed facilities have to meet regulatory requirements, and new COVID requirements, but they can only charge $36 per night. That is not a sustainable amount to support all these homes have to do. There is a need for sustained, embedded services for the seriously mentally ill.

Question: Darlene asked if this was part of the Committee's work plan?
Answer: Vera replied that yes, it will be discussed under Goal 1 in the Workplan, Tab 4.
Question: Hector Ramirez, from Los Angeles County, has a psychiatric disability and thanked the presenters for sharing their stories. He says that mental illness is like racism, unless you experience it you don't acknowledge it. Mental illness contributes greatly to the amount of homelessness. Racism contributes to a Not-In-My-Backyard (NIMBY) issue in many communities. He asked if there any education provided to unsheltered clients about disability rights, discrimination against mental illness, preparing clients in shelters to advocate for themselves?
Answer: Tim replied that each jurisdiction was awarded funds in Project Homekey for supportive services and linkages to providers, as well as housing.

**Break:** Chairperson Vera Calloway called a 5-minute break.

**2021 Work Plan Discussion:** Vera Calloway, Chairperson

Goal 1 regards Adult Residential Facilities (ARF) serving people with serious mental illness, to identify regulatory barriers, land use issues, and financial problems. Discussion followed:

- Objective 1 – regulations: Barbara Mitchell stated that regulations are in place to protect residents, but they also prevent facilities from accepting certain residents with medical needs. Lynda Kaufman stated that those with assistive devices, for example a walker, can't be admitted to an ARF and must wait for a skilled nursing facility which costs more. ARF or RCFE facilities don't require education or training in mental health. Local jurisdictions can interpret regulations differently, and some counties cite what other counties allow. Barbara said that CASRA has been trying to advocate for residents, can the Planning Council possibly work with them? Steve Leoni stated that we don't often talk about the financial aspect of regulations; per the above example it is often a waste of money to follow an overly rigid set of rules. Someone needs to review misapplied rules, and work to clarify and streamline them.
  Vera asked what department or organization oversees the regulations? Where can we get this information? Committee members could divide the work to research financial systems, regulations, etc. Barbara stated that the Financial aspect is the biggest barrier. Lynda said that facilities don't want to accept clients with multiple health issues: diabetic, need soft foods, etc. It takes a particular skill set, and some facilities just don't have the capacity. Of 195 clients at her facility, over 120 need medication support (lab work, etc.)
- Vera asked if it would make sense to start by addressing issues separately: financial, land use, regulations, whichever is most urgent. For the next meeting we can focus on

ARFs and invite guests to address issues and questions and then perhaps create a paper to distribute.

- Barbara said there is no need for a white paper, the HHC already has one, and we already talked to a wide variety of guests. The paper lists action items and made specific recommendations for financial aspects. Also, we don't want to focus on the issue as housing, but rather advocate for a system that provides adequate program fees to providers so they can stay in business. Darlene agrees, and that we should just focus on one issue.
- Vera said that actionable and realistic recommendations are needed now. Monica Caffey agrees, and that we have an opportunity to do that.
- Darlene suggested a presentation from someone who can make decisions on financing for the facilities we are talking about.
- Steve suggested to re-circulate the white paper to the committee.
- Barbara: We suggested tiered rates for residential facilities based on the level of need. It is important to increase the State portion of SSI to increase the rate in Residential Care homes for high-need residents. The budget in the white paper might be dated now, but we did estimate a monthly rate of $4000 for people with high needs. How to get other organizations to support this, and a legislator to propose it? We don't know how many adults in the state have mental health and other medical needs. There is a bill in place now that will collect information about how many adults experience severe mental illness. Without this information we don't know how much to ask for.
- Theresa Comstock stated that it is timely to advocate for the proposed $250M in the budget, how to best spend it.
- Vera asked who should we contact? Jane said that the CBHDA talked to the Governor and got funding proposed last year, we should include them to advocate together to both the Legislature and the Governor. Research is needed to get information to support a request. Perhaps that would be a good topic for next meeting, we could bring this information forward to make a request. Lynda said she can share her level system, to give an idea about how to structure a tiered system.
- Lorraine suggested that Regional Centers have a tiered system and get paid well, we could contact them regarding rates.
- Vera stated that was a great suggestion, we can ask Committee Members if they want to consolidate Goal 1 or eliminate all items except the financial issue? She will do some research, but believes the HHC should limit its focus. This can be discussed at an interim committee meeting.
- Steve Leoni said that financial is primary, he wants to hear the Governor's plan from a year ago [pre-COVID budget] and get back on that track.
- Vera said that Objective 4 is to advocate for data and outcomes. Steve asked if there wasn't already a bill to address that?

**Public Comment:**

Barbara Wilson suggested that we don't look at either/or, but either/and. ARFs need bail-out funds to keep from closing and also a tiered system of rates. Board and Care homes need funds

for adults with mentally illness on SSI, at subsidized rates. Last year the Governor's office was in favor; facilities need operating capital.

**Discuss Next Meeting Agenda:** Vera Calloway, Chairperson and All
Steve Leoni made a motion to keep all the objectives under Goal 1 and focus on finances. Darlene seconded the motion. Vera asked if there was any disagreement? None heard, a vote was held and the motion was approved.

**Adjourn**
The meeting was adjourned at 10:25 am.

# Housing and Homelessness (HHC)

Meeting Minutes

March 19, 2020

2:00 pm to 3:30 pm

**Committee Members Present**

Vera Calloway
Lorraine Flores
Angelina Woodberry
Arden Tucker
Monica Caffey

**Staff Present**

Jane Adcock, Laura Leonelli, Gabriella Sedano

**Welcome and Introductions**

Members were welcomed and introductions were completed.

**Review of Recent ARF Funding Initiatives**

Staff presented information on the Governor's proposal for $750 million in one-time General Funds, available over three years, to counties to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources, including the addition of at least 5,000 beds, units, or rooms to expand capacity. The resources will address short-term crisis stabilization, acute needs, peer respite, and other clinically enriched longer-term treatment and rehabilitation opportunities for individuals with behavioral health needs in the least restrictive and least costly setting.
The Governor is also proposing $250 million in one-time General Fund for the acquisition or rehabilitation of Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE).

Vera Calloway asked if the general fund was specific to the senior population. Jane Adcock replied that the proposal specifies funding to both ARFs and RCFEs and does not exclude the $250 million to be used to acquire or rehabilitate facilities that serve adults.

Vera asked what percentage of the $750 million would go to ARFs, and what percentage of ARFs are in need of funding. Jane Adcock replied that counties can apply for 2-3 types of facilities depending on the need of the county.

Lorraine Flores mentioned that it is up to the county to apply for the grant, and questioned what counties may have a greater need. Jane Adcock responded that it depends on how need is defined – a small county with no facilities, or a large county with too few facilities? Jane also stated that funds will often be set aside for small counties because they typically do not have the resources to apply for the grants as quickly as larger counties.

Vera Calloway inquired about the timeline of the grant. Jane Adcock stated the budget proposal will be reviewed again during the May revise and will not be final until the Budget is signed in June. She hopes these two items remain.

**Advocacy Efforts: 2021 Work Plan Discussion**

The Committee discussed existing advocacy efforts and other potential revenue streams. Vera Calloway asked about an advocacy campaign for ARF funding, and Jane Adcock suggested approaching members of both the Assembly and Senate budget committees to show support for the Governor's 2 budget proposals. Staff will provide Vera with the names of the legislatures to send letters and/or videos of support.

Barbara Wilson (public attendee) suggested that Peers be recruited as stakeholder advocates. Vera Calloway asked if there was an Association for ARF's, and Barbara Wilson responded none exist. However, there is a Request for Proposal for a 2-year contract for an organizer for ARFs within Los Angeles County.

Jane Adcock continued her presentation with information about a third financial effort, AB 71, aimed at creating a steady funding source for addressing homelessness. This effort would change the corporate tax rate, and CBHDA communicated that these funds could also be used for counties to acquire and rehabilitate ARFs.

Jane recommended writing a letter of support for AB 71, which could also suggest the bill be amended to include a percentage designated for ARFs. Arden Tucker questioned whether the percentage would actually limit the amount of funding for ARFs. Jane Adcock replied that the Committee could instead mention the need for licensed care facilities, and Vera Calloway agreed with the need to raise awareness.

Angelina Woodberry added that she hopes money will be set aside for smaller counties, as people are often sent to larger counties which makes it hard for family visits.

Vera Calloway expressed that there is a huge homeless coalition statewide, but they may not be supportive for people who are currently housed but could potentially lose housing. Barbara Wilson agreed that the 'homeless industry' is huge and powerful, and they have funding. She also noted that the MHSA should be used to prevent homelessness, such as a subsidy for ARFs.

**Plan April Quarterly Meeting Agenda**

Vera Calloway confirmed with Jane Adcock that the minutes from this meeting will be available for the April 2021 HHC meeting for discussion.

Jane suggested a 20-min presentation by someone from Department of Social Services on implementation of AB 1766 which requires the reporting of number of facilities who serve individuals with serious mental illness, who accept the federal social security rate and facilities who are planning to close.

Staff can also do some research into the requirements of No Place Like Home funds. Then perhaps consult with Tim Lawless on who to invite to a future meeting and if the Housing and Community Development Department is open to a carve-out of No Place Like Home funding for a grant program for ARFs in need of rehabilitation in order to be in compliance with state regulations and to avoid citations or being shut down.

Jane Adcock also suggested that the ARF Report be streamlined to make it more concise and up-to-date.

Vera Calloway would like to prioritize the funding needs for ARFs – e.g. rehab/renovation, or more operating funds. She also asked how smaller counties' needs may be different. Arden Tucker expressed her concern that rural areas have different needs and may not have access to resources as others would in a metropolitan area.

Jane answered that a recent survey of counties showed smaller counties expressed they needed between 5 – 40 beds, while larger counties needed hundreds of beds. Vera asked if most of the funds are going to counties with greater needs. Jane answered that usually there is a formula that allocates funding by county size.

Barbara Wilson stated that San Bernardino County lost over 100 licensed beds since June 2020.

Barbara Wilson said that her County Mental Health department is typically only engaged with the facilities that have contracts, any residents who are not DMH clients are not counted.

Lorraine Flores said that a large percentage of homeless people in her county have SMI and are often refusing housing.

Barbara Wilson mentioned that many people in the homeless population do not like tiny houses and are not given personal restrooms. She added that after investing funds into tiny houses or other buildings there is a tendency to continue using them, creating permanent, substandard housing.

Jane summed up the plan for the April HHC meeting: to invite CDSS to report on implementation of AB 1766, to spend a little time to review the revised ARF Report and staff analysis of No Place Like Home and then use the rest of the meeting to discuss and determine priorities for the ARF project.

**Public Comment**

N/A

**Meeting Adjourned at 3:35 pm.**

**TAB 2**

# California Behavioral Health Planning Council
# Housing and Homelessness Committee (HHC) Meeting

Thursday, April 15, 2021

**Agenda Item: Assembly Bill 1766 Implementation Update**

**Enclosures:** Assembly Bill 1766, Statutes of 2020, Chapter 139

**How This Agenda Item Relates to Council Mission**

*To review, evaluate and advocate for an accessible and effective behavioral health system.*

This agenda item will inform committee members of efforts underway to promote information sharing that will support Council efforts to advocate for licensed residential care facilities serving individual with serious mental illness.

**Background/Description:**

AB 1766 directs the CA Dept of Social Services to collect specific information from licensed adult residential care facilities and report to each county behavioral health department as specified below.

The CA Department of Social Services, Community Care Licensing will provide an overview and update of implementation of AB 1766 per the requirements provided below. Note that the law repeats the requirements for Residential Care Facilities for the Elderly (RCFE).

1507.4. (a) Beginning May 1, 2021, and annually thereafter, the department shall collect information and send a report to each county's department of mental health or behavioral health of all licensed adult residential facilities in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, as defined in Section 5600.3 of the Welfare and Institutions Code, and the number of licensed beds at each facility.

(b) Beginning May 1, 2021, and quarterly thereafter, the department shall send to each county's department of mental health or behavioral health the report of licensed adult residential facilities that closed permanently in the prior quarter, by county, and shall include the number of licensed beds of each facility and the reason for closing. The

report shall include cumulative data and closure trends for each county and be based on facilities identified in subdivision (a).

(c) Upon receiving notice that a licensed adult residential facility intends to close permanently, the department shall notify the county mental or behavioral health department within three business days.

# Assembly Bill No. 1766

## CHAPTER 139

An act to add Sections 1507.4, 1509.6, and 1569.4 to the Health and Safety Code, relating to adult residential facilities.

[Approved by Governor September 29, 2020. Filed with Secretary of State September 29, 2020.]

### LEGISLATIVE COUNSEL'S DIGEST

AB 1766, Bloom. Licensed adult residential facilities and residential care facilities for the elderly: data collection: residents with a serious mental disorder.

The California Community Care Facilities Act provides for the licensure and regulation of community care facilities by the State Department of Social Services, including various adult residential facilities, as described. The act includes legislative findings and declarations that there is an urgent need to establish a coordinated and comprehensive statewide service of quality community care for the mentally ill, the developmentally and physically disabled, and children and adults who require care or services. A person who violates the California Community Care Facilities Act is guilty of a misdemeanor. Existing law, the California Residential Care Facilities for the Elderly Act, provides for the licensure and regulation of residential care facilities for the elderly, as defined, by the department and expresses the intent of the Legislature to require that those facilities be licensed as a separate category within the existing licensing structure of the department.

This bill would require the department to collect information and send a report to each county's department of mental health or behavioral health, beginning May 1, 2021, and annually thereafter, of all licensed adult residential facilities and residential care facilities for the elderly, as described, that accept a specified federal rate and accept residents with a serious mental disorder, as defined, and the number of licensed beds at each facility. The bill would require the department, beginning May 1, 2021, and quarterly thereafter, to send to those county departments a report of licensed adult residential facilities and residential care facilities for the elderly that closed permanently in the prior quarter, as specified. The bill would require the department to notify the county mental or behavioral health department within 3 business days upon receiving notice that a licensed adult residential facility or residential care facility for the elderly intends to close permanently.

The bill would also revise the California Community Care Facilities Act by requiring an applicant or licensee of an adult community care facility to maintain an email address of record with the department and to provide

written notification to the department of the email address and of any change to the email address within 10 business days of the change. Because a person who violates the California Community Care Facilities Act is guilty of a misdemeanor, the bill would create new crimes, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

*The people of the State of California do enact as follows:*

SECTION 1. Section 1507.4 is added to the Health and Safety Code, to read:

1507.4. (a) Beginning May 1, 2021, and annually thereafter, the department shall collect information and send a report to each county's department of mental health or behavioral health of all licensed adult residential facilities in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, as defined in Section 5600.3 of the Welfare and Institutions Code, and the number of licensed beds at each facility.

(b) Beginning May 1, 2021, and quarterly thereafter, the department shall send to each county's department of mental health or behavioral health the report of licensed adult residential facilities that closed permanently in the prior quarter, by county, and shall include the number of licensed beds of each facility and the reason for closing. The report shall include cumulative data and closure trends for each county and be based on facilities identified in subdivision (a).

(c) Upon receiving notice that a licensed adult residential facility intends to close permanently, the department shall notify the county mental or behavioral health department within three business days.

SEC. 2. Section 1509.6 is added to the Health and Safety Code, to read:

1509.6. An applicant or licensee of an adult community care facility shall maintain an email address of record with the department. The applicant or licensee shall provide written notification to the department of the email address and of any change to the email address within 10 business days of the change.

SEC. 3. Section 1569.4 is added to the Health and Safety Code, to read:

1569.4. (a) Beginning May 1, 2021, and annually thereafter, the department shall collect information and send a report to each county's department of mental health or behavioral health of all licensed residential care facilities for the elderly in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, as defined in Section 5600.3 of the Welfare and Institutions Code, and the number of licensed beds at each facility.

(b) Beginning May 1, 2021, and quarterly thereafter, the department shall send to each county's department of mental health or behavioral health the report of licensed residential care facilities for the elderly that closed permanently in the prior quarter, by county, and shall include the number of licensed beds of each facility and the reason for closing. The report shall include cumulative data and closure trends for each county and be based on facilities identified in subdivision (a).

(c) Upon receiving notice that a licensed residential care facility for the elderly intends to close permanently, the department shall notify the county mental or behavioral health department within three business days.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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**TAB 3**

# California Behavioral Health Planning Council
# Housing and Homelessness Committee (HHC) Meeting

Thursday, April 15, 2021

**Agenda Item: Review Council's 2018 Report on Licensed Residential Care Facilities and Review Requirements of No Place Like Home**

**Enclosures:** Updated 2018 Report on Licensed Residential Care Facilities

Overview of No Place Like Home (NPLH)

## How This Agenda Item Relates to Council Mission

*To review, evaluate and advocate for an accessible and effective behavioral health system.*

This agenda item will provide committee members with information that is needed to determine priorities and action steps for Council efforts to advocate for licensed residential care facilities serving individual with serious mental illness.

## Background/Description:

Prior to determining priorities and next steps for the 2021 work plan, the HHC members will review the issues and recommendations provided in the Council's 2018 report on licensed residential care facilities (ARFs). Additionally, since the Governor has 2 budget proposals for 2021-22 targeted to assist with the acquisition and renovation costs of new ARFs. Perhaps the HHC may want to explore the possibility of a carve-out of No Place Like Home (NPLH) funding to be used as grants to existing ARF operators to make repairs necessary to be in compliance with licensing requirements and avoid citations or license revocation. Staff will review pertinent policies, laws and regulations and provide a summary of research into the requirements of NPLH to explore whether such a carve-out is possible.

California Behavioral Health Planning Council

Advocacy • Evaluation • Inclusion

# Adult Residential Facilities (ARFs)

## Highlighting the critical need for adult residential facilities for adults with serious mental illness in California.

Revised March 2021

Original March 2018

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

The original issue paper was the beginning of an ongoing effort to highlight a significant public health issue: **the lack of adult residential facilities as housing options for individuals with serious mental illness in California.**

Welfare and Institutions Code 5772. The California Behavioral Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs;

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

Acknowledgements

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# ADULT RESIDENTIAL FACILITIES

Addressing the critical need for ARFs for adults with serious mental illness in California.

The primary purpose of this issue paper is to discuss the barriers to, and the need for, increasing access to licensed Adult Residential Facilities (ARFs)[1] in California for adults (including seniors) with mental illness. This is an effort to generate dialogue to identify possible solutions to those barriers.

> Adult Residential Facilities (ARFs) are non–medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing and transferring. This level of care and supervision is for people who are unable to live by themselves but who do not need 24 hour nursing care. They are considered non-medical facilities and are not required to have nurses, certified nursing assistants or doctors on staff. Residential Care Facilities for the Elderly (RCFEs) serve persons 60 years of age and older.[2]

In recent decades, California has made great efforts to shift away from institutional care toward community-based care and support. However, there are numerous stories across the state regarding the lack of appropriate adult residential facilities for individuals with serious mental illness who require care and supervision as well as room and board. Per the California Registry (California Registry, 2017), "Residential Care facilities operate under the supervision of Community Care Licensing, a sub agency of the California Department of Social Services. In California in the early 1970's, the residential care system was established to provide non-institutional home-based services to dependent care groups such as the elderly, developmentally disabled, mentally disordered and child care centers under the supervision of the Department of Social Services. At that time, homes for the elderly were known as Board and Care Homes and the name still persists as a common term to describe a licensed residential care home.

Residential care facilities are not allowed to provide skilled nursing services, such as give injections nor maintain catheters nor perform colostomy care (unless there is a credentialed RN or LVN individual working in the home), but they can provide assistance with all daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care."

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[1] Residential Care Facilities (RCFs) —are non–medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing and transferring. Residential Care Facilities for the Elderly (RCFEs) serve persons 60 years of age and older. This level of care and supervision is for people who are unable to live by themselves but who do not need 24 hour nursing care. They are considered non-medical facilities and are not required to have nurses, certified nursing assistants or doctors on staff.

[2] CA Code of Regulations (Westlaw), **§ 58032. Residential Care Facility definition (link)**

Due to a significant number of recent ARF closures and the lack of new facilities and/or adequate supportive housing options available, many individuals with mental illness are not able to obtain community-based housing options, with the appropriate level of care, following stays in acute in-patient treatment programs, hospitals, Short-Term Crisis Residential or Transitional Residential Treatment Programs and/or correctional institutions. This results in a "revolving door scenario" where people are discharged or released from one of the above and then are unable to find appropriate residential care or housing. Thus, another mental health crisis ensues, resulting in a return to high-cost crisis programs, facilities, hospitals, jails/prisons or homelessness.

A robust continuum of community-based housing for adults/seniors with mental illness, is critically needed. ARFs are an essential component of this housing continuum, providing services and supports to meet a complex set of behavioral, medical and physical needs[23]. Many individuals would not live successfully in supportive housing due to their need for more care and supervision with their housing which is what ARFs can provide. Additionally, ARFs are also used for persons exiting institutional care as an interim step before independent living.

The Planning Council is seeking solutions to address the lack of ARFs and RCFEs to serve persons with serious mental illness in California, especially persons who are homeless. Not all would thrive in an independent living situation such as Supportive Housing. A discussion of the critical need, the challenges to ARF financial viability, and ideas for solution follow.

## I. THE CRITICAL NEED

In June 2016, the Planning Council began its effort to explore the actual ARF bed count in the state. After receiving data from Community Care Licensing (CCL) at the California Department of Social Services (CDSS), the Council developed a brief survey to be completed by all 58 county Departments of Behavioral Health. The survey of need for ARFs was disseminated to the counties the Fall of 2016. The following chart provides a summary of needs reported by 22 of the 58 counties in California including small, medium and large counties. While the respondents listed represent only a portion of the state, it is clear there is a high need for this housing option for facilities that provide care and supervision in every county.

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[3] Complex needs include medical (e.g. incontinence, Huntington's, diabetes, etc.), wheelchairs/walkers, criminal justice involvement, dual diagnosis (e.g. intellectual disability, substance use, dementia, etc.), sex offenders, brain injuries and severe behavioral problems.

## ARF Needs By County[4] (Chart 1)

907 beds currently needed, with 783 beds lost in recent years (22 Counties)

| County | Population[5] | Beds Needed | Beds Lost | Out of County[6] |
|---|---|---|---|---|
| Sierra | 3,166 | N/A | N/A | * |
| Colusa | 22,312 | ? | | * |
| Glenn | 29,000 | 0 | No | 22 |
| Amador | 37,302 | 10 | 0 | * |
| Siskiyou | 44,563 | N/A | 0 | Yes, not sure |
| Tuolumne | 54,511 | 4 | 0 | * |
| Nevada | 97,946 | 10 | 0 | ? |
| Napa | 141,625 | 18 | 8 | 22 |
| Shasta | 178,795 | 25 | 12 | 25 |
| Imperial | 184,760 | 10 | 0 | * |
| El Dorado | 182,917 | 25 | ? | 25 |
| Yolo | 212,747 | 40 | 0 | 13 |
| Santa Cruz | 274,594 | 100 | 0 | 20 |
| San Luis Obispo | 276,142 | 50 | 0 | 44 |
| Monterey | 435,658 | 20 | 6 | 45 |
| Tulare | 465,013 | 30-40 | 40 | yes |
| San Joaquin | 728,509 | 140 | 187 | 16 |
| San Mateo | 762,327 | 50 | 34 | * |
| Kern | 884,436 | 100 | 100 | * |
| San Bernardino | 2,127,735 | 40 | 246 | Left blank |
| Riverside | 2,331,040 | 200-300 | 50 | Unknown |
| Orange | 3,165,203 | 35-50 | 100 | Left blank |
| **TOTAL** | | **907** | **783** | |

The information presented above represents only 1/3 of the total counties in California. Additionally, the chart shows a large number of people who could return home if there were appropriate housing options (i.e. ARF in their home county.). *The Out-of-County placement numbers are too small to publish, therefore County responses are replaced with an asterisk, to protect individuals from potential Health Information Portability and Accountability Act (HIPAA) violations.

Implementation of Assembly Bill 1766, Statutes of 2020, Chapter 139, will provide counties with timely information regarding availability of ARFs that serve persons with serious mental illness.

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[4] Twenty-two of the fifty-eight counties responded by November 2016. See Attachment A.

[5] Population estimates in the table above were obtained from the California State Association of Counties website on December 30, 2016. The information can be accessed at: http://www.counties.org/countywebsites-profile-information

[6] This number indicated the individuals who have been placed in an RCF outside of their county of residence due to no beds being available within their home county.

## II. CHALLENGES

The question, 'Why are there so few ARFs available in California for persons with serious mental illness?' must be answered before any solutions can be generated. The Planning Council consulted with a number of experts in this industry as well as stakeholders resulting in the identification of three key challenges.

1. **Financial**: The most apparent and pressing challenge to the viability of ARFs is financial. Due to the income level of individuals with serious mental illness living in ARFs, they are not able to pay much to cover the actual costs for the housing, board and care/supervision. For the most part, these individuals receive Social Security Income/State Supplemental Payment (SSI/SSP) paid to Californian's with disabilities and who are unable to work. The SSI/SSP payment, as sole source of payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF. Therefore, subsidies, often called "patches"[7] are needed.

   ARFs for adults with serious mental illness cannot survive financially on a small scale (under 15 beds) without substantial subsidies. On a larger scale, some residential care homes can be financially viable without additional subsidies, but that is dependent on source of payment for the residents (private pay or SSI/SSP) and the level of care provided to residents. Residents requiring higher levels of care and support will necessitate additional care providers and/or equipment resulting in increased operational costs. Almost never is the SSI/SSP amount sufficient to cover even the most minimum of costs. Even in a facility of 45 beds or more, a subsidy paid by the county in amounts ranging from $64/day to $195/day per resident may be required to maintain fiscal viability.

To illustrate the financial challenges in real life, an actual sample budget is presented below.

**Adult Residential Facility Thirteen–Person Sample Budget**

Assumptions: 13-bed facility licensed by the CDSS, Community Care Licensing.
Average Daily Census of 13 semiprivate rooms.
Facility Lease at $2533 per month. (often would be much more depending on location)
All variable expenses are based on annual cost.
Note this budget utilizes the current SSI/SSP rate of $1026/month/client.

[7] Generally defined, a patch is an extra daily or monthly payment (subsidy), made to a residential care home operator, to cover the cost of extra services to a resident or to accept a resident who may be hard to place. In general, patches would not be Medi-Cal billable typically, related to extra care and supervision. Patches range from a low of $15 to a high of $195/ resident/ day depending on level of service needed for the resident or difficulty of placement.

Additionally, this budget contains the minimum level of staffing of 1.0 FTE onsite 24 hours/day, 7 days a week at a very minimal wage of $15/hour plus benefits. Most facilities are unable to hire properly trained and experienced staff at a $15-hour rate (just $2 above California's current minimum wage). The 1.0 FTE staff is expected to provide administrative management including admissions/all documentation and services such as activities/outings, life-skills training, grocery shopping and all purchasing, and transportation to healthcare appointments. However, since one staff person must be at the facility at all times when a resident is present, a second staff person is necessary in order for the other to do shopping, errands, and resident transport. Thus, the budget of 1.0 FTE is truly insufficient.

Per this budget for a 13-person ARF, in order for the facility to break even, the resident fee would need to increase to $2805/month at 95% occupancy. That would be $1,779 more per person per month than the current rate allowed for SSI/SSP recipients.

## Residential Care Facility Sample Annual Budget (13 Person)

| Title | Amount | Comment |
|---|---|---|
| **Revenue** | | |
| Resident Fees | $160,056 | $1026/month for 13 residents at 95% occupancy |
| **Total Revenue** | **$160,056** | |
| **Personnel Expenses** | | |
| Line Staff | $182,000 | 4.5 Staff at $15/hour covers single coverage 7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors, admissions, grocery shopping, etc. at $20/ hour. |
| Landscaping | $2400 | $200/month |
| Relief Staff | $15,600 | Fill-in for sick/vacation employees at 20 hours/week |
| **Total Wages** | $200,000 | Presumes 9 sick days, 14 vacation days, 8 holidays/employee/year |
| **Salary Related Expenses** | | |
| Health/Dental/Life/Vision Insurance (HSA) | $39,600 | $600 month/employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance. |
| Unemployment Insurance | $1,482 | |
| Worker's Compensation Insurance | $13,836 | |
| FICA/Medicare | $15,116 | |
| **Total Salary Related Expenses** | $70,034 | |
| **Other Personnel Expenses** | | |
| Training | $2000 | |

| | | |
|---|---|---|
| **Total Other Personnel Expenses** | $2000 | |
| **Total Personnel Expenses** | **$272,034** | |
| **Operating Expenses** | | |
| Legal and Other Consultation | $1000 | |
| Household Supplies | $10,000 | Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods |
| Office Supplies | $2,250 | |
| Computer/Office Furnishings | $1000 | |
| Utilities | $20,238 | |
| Maintenance – Building and Equipment | $12,000 | Presumes that this line item includes furniture and appliance replacement |
| Vehicle Maintenance | $6,000 | Presume one vehicle for use at $550/month |
| Food | $40,880 | $8 person/day plus one staff eating |
| Insurance | $8,215 | |
| Telephone/Internet/Cable | $3000 | |
| Printing and Postage | 500 | |
| Licensing and Permits | $1,711 | |
| Property Taxes | $6,000 | Presumes property purchased for $600,000 with $100,000 down payment |
| Advertising | 500 | |
| **Total Operating Expenses** | $113,294 | |
| Rent or Loan Payments | $30,396 | Lease based on $500,000 loan for 30 years at 4.5% |
| **Total Expenses** | **$415,724** | |
| **Total Net Income (Loss)** | **(-$255,668)** | (Revenue $160,056 minus Total Expenses $415,724 = Total Net Income Loss of $255,668) |

2. **Community Resistance/Opposition** – New construction and attempts to obtain a "Use Permit" during property acquisition to establish an ARF (required for ARFs of more than 6 beds) are frequently confronted with "Not In My Backyard" (NIMBY) opposition from communities during the local government meetings. The resistance is most often successful which prevents new operators from obtaining required land use approvals to open ARFs despite support by local elected officials.

3. **Regulatory Barriers** –There are barriers in the regulations for the licensure of ARFs that are uniquely problematic when serving residents with serious mental illness. First example is the hiring of peers which is an evidenced-based practice promoted by SAMHSA. Current regulations prohibit the hiring of individuals with criminal history but oftentimes an individual in recovery, which makes them a peer, usually comes with some criminal history in their background. Another barrier concerns an unwritten "zero

tolerance" policy on resident's leaving the facility and not returning as expected. Known as Absent Without Leave (AWOL), the policy requires unlocked residential facilities to restrict a client's right to leave the facility at any time if they are considered "at risk of AWOL". Most individuals with serious mental illness who reside in an ARF are not under conservatorship and thus have personal rights within the unlocked community setting. Citations and fines can be issued for "unauthorized" absence and is considered, in and of itself, evidence of a lack of supervision. However, the only way to ensure that a resident does not leave the unlocked setting is to restrict their privacy and personal rights or to not accept an individual who the licensing entity considers at risk of elopement due to negative symptoms of mental illness and/or past drug use. We believe that some policies and regulations governing ARFs serving individuals with serious mental illness need to be revised to be based more on clinical understanding and practice than on legal liability avoidance.

## III. IDEAS FOR DISCUSSION AND SOLUTION

1. **Financial Viability**
   There is no doubt that ARFs are an important segment on the continuum of housing for adults and seniors with serious mental illness. It is also indisputable that the when the sole source of income for such an individual is SSI/SSP, that it is grossly insufficient to cover the monthly cost of the housing, board and supervision/care. Further, the diversion of funds designated for behavioral health services to pay for housing is an imprudent use of already limited resources. Other potential solutions are presented below for discussion and consideration.

   **Tiered Level of Care System –** There could be tiered levels of care, with different licensing categories established to allow for higher rates to be paid to accommodate more care and supervision when required, for example, to meet the needs of individuals who are seniors, or incontinent or non-ambulatory. The Department of Developmental Services Community Care Facility Reimbursement Rates[8] for consumers with developmental disabilities offers four Service Level Tiers ranging from $1,026 to $7588 per individual per month.[9] The Planning Council would like to examine the feasibility of implementing a similar structure to meet the ARF needs for adults and for seniors with mental illness who cannot thrive living independently but who do not need inpatient nor institutional care.

   **State Supplemental Payment (SSP) Rate** – Currently, many ARF operators only receive the maximum SSI/SSP rates for individuals in non-medical out-of-home care. The state could consider varying levels of the state supplemental payments that would correlate to the tiered level of care to address the financial hardships

[8] See Dept. of Developmental Services Reimbursement Rates.
[9] This includes the SSI/SSP pass through effective January 1, 2017.

faced by the ARF operators in order to meet the needs of people who require this higher level of housing with care and supervision.

**Medicaid Waiver**

The Planning Council would also like to explore the possibility of drawing down federal funding through a Medicaid Home and Community Based Services (HCBS) 1915 Waiver or State Plan Amendment. Some of these HCBS programs cover some or all of the costs for an individual with serious mental illness to reside in and receive care in the community and who would otherwise be eligible to reside in an institution. It is much more cost effective and beneficial for the individual to receive such support in an ARF or RCFE.

## CONCLUSION

The crisis of limited appropriate housing options for individuals living with serious mental illness has to be addressed. It is imperative to engage in strategic long-term and concurrent short-term planning to solve this crisis. The planning has to include persons with lived experience, vested community partners, and local, county and state government entities from a broad spectrum of interests (e.g. Behavioral Health, Health, Employment, Criminal Justice, Education, Rehabilitation, Aging, etc.).

It is in the best interest of adults with mental illness, and in the best financial interest of the State of California to end the “revolving door scenario.” Adults living with serious mental illness, who are unable to obtain suitable housing in their communities with the appropriate level of care following stays in acute in-patient treatment programs, hospitals, nursing and/or correctional institutions deserve better. The social and financial costs rise when individuals continually return to high-level crisis programs, facilities, hospitals, end up in jails/prisons or become homeless.

It is essential to provide appropriate community-based residential options that include the necessary supports that address mental illness. As part of a robust supportive housing continuum, there is a critical need to have ARFs that are adequately financed and staffed. With the number of older adults growing each year, this type of housing is paramount.

Addressing the financial, community and staffing challenges affecting ARF sustainability could require: 1) Changes to the current licensing structure to accommodate a tiered level of care system; 2) Increasing SSP benefit amounts to correlate to the tiered level of care; 3) Strategic planning regarding siting of affordable and appropriate housing; and 4) Review and revision of licensing regulations to address clinical considerations of the target population.

The following pages contain a more expansive definition of supplemental payments.

## ATTACHMENT A

### Types of "Patches" counties pay to ARFs to provide supplemental services to Adults with Mental Illness, including Serious Mental Illness.

Along with the basic board and care residential facility services that are provided for all ARF clients according to Community Care Licensing (CCL) requirements, counties contract for supplemental services for individuals who have on-going mental health issues, need assistance with daily living and are difficult to place. The RCF provider is expected to provide staffing above the required minimum by CCL to assist clients with medical and psychiatric needs. For these supplemental services, counties pay "patches", ranging from $64/day to $195/day per resident (in addition to the SSI that is paid of approximately $1026/month/resident[10]).

Patches are paid for the following services:

1. Assistance with incontinence
2. Behavioral Management - Provide meaningful day activities and interaction with others – *residents may require one-to-one behavior management and supervision. For example, re-directing the client, educating, and modeling appropriate behavior to maintain the resident in the community.*
3. Monitoring medication compliance
4. Assistance with grooming and hygiene - *residents may require verbal prompts and one-to-one assistance with personal hygiene care activities (e.g. assistance with bathing, hair care, dental care and medical care).*
5. Monitoring and/or assistance with eating difficulties
6. Providing support and assistance for clients with difficult sleeping patterns
7. Monitoring clients smoking behavior
8. Providing transportation to medical and/or psychiatric appointments
9. Hearing loss or deafness – *ARF must be equipped with visual device (such as Video relay machines or other devices for individuals who are hard of hearing or Deaf) necessary for clients to communicate (both to staff and housemates) and get their basic needs met at all times.*
10. Vision loss or legally blind - *Physical layout of the building should be designed to serve this population, exits and restroom should be within close proximity for clients' easy access.*

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[10] In the case where a resident is not SSI eligible, counties additionally pay an "unsponsored patch", covering what SSI would pay (approximately $1026/month). *If SSI is approved retroactively, the county can be reimbursed by the ARF for the daily-unsponsored facility rate, back to the date when the resident was granted SSI eligibility.*

**11.** Monolingual Language (e.g. Spanish, Vietnamese, etc.) - *Providers are expected to have a staff or staff members that speak this language at all times. RCF should be customized to offer culturally specific programming, such as linking clients to cultural activities outside of the home. ARF should serve culturally specific meals as necessary.*

**12.** Medically Frail and/or Insulin Dependent, to include:

a. Diabetic Individuals: *Assistance with all necessary blood work to include reading and interpreting their blood sugar level. Some residents will require finger sticking and basic self-care required to stabilize blood sugar levels. ARF should serve nutritionally appropriate meals to address diabetic and/or other health needs.*

b. High Blood Pressure Medical Issues

c. Medically Frail - significant medical issues that affect mental health conditions such as COPD[11], obesity, renal disease, individuals needing total care (daily assistance with hygiene, grooming and dressing). In addition, residents with specialized equipment may need one-to-one assistance with these devices and require one-to-one supervision of the equipment. (E.g. sleep apnea machines, electric wheelchairs, and colostomy bags, etc.).

[11] Chronic obstructive pulmonary disease (such as chronic bronchitis and emphysema.)

# No Place Like Home

**Background Information**

On July 1, 2016, Governor Brown signed landmark legislation enacting the No Place Like Home program to dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA). In November 2018 voters approved Proposition 2, authorizing the sale of up to $2 billion of revenue bonds and the use of a portion of Proposition 63 taxes for the NPLH program.

Key features of the program include:

- Counties will be eligible applicants (either solely or with a housing development sponsor).
- Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services.
- Counties must commit to provide mental health services and help coordinate access to other community-based supportive services.

Purpose

To acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are experiencing homelessness, chronic homelessness or who are at risk of chronic homelessness, and who are in need of mental health services.

Population to be Served

Adults with serious mental illness, or children with severe emotional disorders and their families and persons who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality or violence and who are homeless, chronically homeless, or at risk of chronic homelessness.

At risk of chronic homelessness includes persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization, and transition age youth experiencing homelessness or with significant barriers to housing stability.

Assistance Type

Loans to counties*, or their housing development sponsors.

Eligible Applicants

Counties*, either solely or with a housing development sponsor.

**Under the NPLH program, the definition of "counties" includes the City of Berkeley and the cities of Pomona, Claremont, and La Verne.*

“Permanent Supportive Housing” has the same meaning as “supportive housing,” as defined in Section 50675.14 of the Health and Safety Code, except that “Permanent Supportive Housing” shall include associated facilities if used to provide services to housing residents. Permanent Supportive Housing does not include “Community care facilities” as set forth in Section 1502 of the Health and Safety Code, “Mental health rehabilitation centers” as defined in Section 5675 of the Welfare and Institutions Code, or other residential treatment programs.

“Supportive Housing” has the same meaning as in Section 50675.14 of the Health and Safety Code, that is, housing with no limit on length of stay, that is occupied by the Target Population, and that is linked to onsite or offsite services that assist the Supportive Housing resident in retaining the housing, improving his or her health status, and maximizing his or her ability to live and, when possible, work in the community. Supportive Housing shall include associated facilities if used to provide services to housing residents. Supportive Housing does not include “health facility” as defined by Section 1250 of the Health and Safety Code or any “alcoholism or drug abuse recovery or treatment facility” as defined by Section 11834.02 of the Health and Safety Code or “Community care facilities” as set forth in Section 1502 of the Health and Safety Code, “Mental health rehabilitation centers” as defined in Section 5675 of the Welfare and Institutions Code, or other residential treatment programs.

**INTRODUCTION**

The No Place Like Home Program (NPLH) provides funding and tools that allow the California Department of Housing and Community Development (Department) to address affordability issues associated with creating housing units that are specifically set aside for persons with serious mental illness who are chronically homeless, homeless, or at-risk of being chronically homeless.

Under the Program, the Department may make loans to reduce the initial cost of acquisition and/or construction or rehabilitation of housing, and may set funds aside to subsidize extremely low rent levels over time.

## Allocation ($190 million)

Distributed by formula allocation to each county based on their 2017 homeless Point-In-Time Count with a minimum allocation per county of $500,000.

## Competitive Allocation (up to $1.8 billion for multiple funding rounds)

Counties will compete for funding with counties of similar size:

- Los Angeles County*
- Large counties (population greater than 750,000)*
- Medium counties (population between 200,000 to 750,000)
- Small counties (population less than 200,000)

*Counties with five percent or more of the state's homeless population may be designated by HCD to receive and administer their own allocations of NPLH funds under their own HCD-approved method of distribution. *(Los Angeles, San Diego and Santa Clara counties qualify for the 5% or more rule.)*

**WELFARE AND INSTITUTIONS CODE - WIC**

**DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5952]**

**PART 3.9. The No Place Like Home Program [10110 - 10198.10]**

*( Part 3.9 added by Stats. 2016, Ch. 43, Sec. 5. )*

**5849.1.**

(a) The Legislature finds and declares that this part is consistent with and furthers the purposes of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election, within the meaning of Section 18 of that measure.

(b) The Legislature further finds and declares all of the following:

(1) Housing is a key factor for stabilization and recovery to occur and results in improved outcomes for individuals living with a mental illness.

(2) Untreated mental illness can increase the risk of homelessness, especially for single adults.

(3) California has the nation’s largest homeless population that is disproportionally comprised of women with children, veterans, and the chronically homeless.

(4) California has the largest number of homeless veterans in the United States at 24 percent of the total population in our nation. Fifty percent of California’s veterans live with serious mental illness and 70 percent have a substance use disorder.

(5) Fifty percent of mothers experiencing homelessness have experienced a major depressive episode since becoming homeless and 36 percent of these mothers live with post-traumatic stress disorder and 41 percent have a substance use disorder.

(6) Ninety-three percent of supportive housing tenants who live with mental illness and substance use disorders voluntarily participated in the services offered.

(7) Adults who receive two years of "whatever-it-takes," or Full Service Partnership services, experience a 68 percent reduction in homelessness.

(8) For every dollar of bond funds invested in permanent supportive housing, the state and local governments can leverage a significant amount of additional dollars through tax credits, Medicaid health services funding, and other housing development funds.

(9) Tenants of permanent supportive housing reduced their visits to the emergency department by 56 percent, and their hospital admissions by 45 percent.

(10) The cost in public services for a chronically homeless Californian ranges from $60,000 to $100,000 annually. When housed, these costs are cut in half and some reports show reductions in cost of more than 70 percent, including potentially less involvement with the health and criminal justice systems.

(11) Californians have identified homelessness as their top tier priority; this measure seeks to address the needs of the most vulnerable people within this population.

(12) Having counties provide mental health programming and services is a benefit to the state.

(13) The Department of Housing and Community Development is the state entity with sufficient expertise to implement and oversee a grant or loan program for permanent supportive housing of the target population.

(14) The California Health Facilities Financing Authority is authorized by law to issue bonds and to consult with the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services concerning the implementation of a grant or loan program for California counties to support the development of programs that increase access to, and capacity for, crisis mental health services. It is therefore appropriate for the authority to issue bonds and contract for services with the Department of Housing and Community Development to provide grants or loans to California counties for permanent supportive housing for the target population.

(15) Use of bond funding will accelerate the availability of funding for the grant or loan program to provide permanent supportive housing for the target population as compared to relying on annual allocations from the Mental Health Services Fund and better allow counties to provide permanent supportive housing for homeless individuals living with mental illness.

(16) The findings and declarations set forth in subdivision (c) of Section 5849.35 are hereby incorporated herein.

*(Amended by Stats. 2017, Ch. 561, Sec. 271. (AB 1516) Effective January 1, 2018.)*

**TAB 4**

# California Behavioral Health Planning Council
# Housing and Homelessness Committee Meeting

Thursday, April 15, 2021

## Agenda Item: Discuss Work Plan Priorities

**Enclosures:** Draft 2021 Work Plan

**How This Agenda Item Relates to Council Mission**

*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The Work Plan is a tool to guide and monitor the Housing and Homelessness Committee activities in its efforts to uphold its duties within the framework of the Planning Council.

**Background/Description:**

The purpose of the Work Plan is to establish the objectives and goals of the HHC, as well as to map out the necessary tasks to accomplish those goals. HHC members will review and update the committee Work Plan in order to fulfill and prioritize activities for the 2021 calendar year.

| Need/Problem | Current Activity Underway | Gap/Proposed Solution |
|---|---|---|
| Information regarding number of beds available for persons with SMI. | Implementation of AB 1766 by CA Department of Social Services. | No gap identified. Await initial reports to identify any additional needed information. |
| Identify regulatory barriers inhibiting Adult Residential Facilities (ARFs) in serving persons with SMI and advocate to get them changed. | Staff began collecting info from operators, consultants and counties on problem regulations. | In process/not completed. |
| Address financial barriers:<br><br>1) Seek stable revenue for subsidy to cover/patch actual monthly cost. | No proposal for ongoing subsidy but Governor Newsom is proposing $750 Million in General Funds for increase of community continuum of Behavioral Health treatment to include Acquisition/Rehabilitation of real estate assets. | Not yet passed. One time funds. Does not address the need for subsidies ongoing. |
| 2) Explore other sources of funding for ongoing revenue such as Medicaid Waiver/State Plan Amendment. | Staff began researching possible waiver opportunities. | In process/not completed. |
| 3) Need funding for existing ARFs to be in compliance and stop closures. | The Governor has proposed $250 Million in General Funds for counties to acquire and rehabilitate Adult Residential Facilities with focus on Residential Care Facilities for the Elderly.<br><br>Explore possibility of No Place Like Home (NPLH) carve-out for grants to existing ARFs for rehabilitation. | Not prudent to seek more money for rehabilitation when the Governor has already proposed $250 Million.<br><br>Current state law is very clear that NPLH funding is for Permanent Supportive Housing only, so would be a very steep hill to change. Also, same as above. |
| Address community resistance for land-use permits/Not in My Back Yard (NIMBY). | Staff began collecting information regarding laws that support the issuance of permits for low-income housing. Staff also collected information on NIMBY trainings. | Not completed. |

# California Behavioral Health Planning Council
# Housing and Homelessness Committee
# 2021 Work Plan
# DRAFT

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## Goal #1

**To improve access to Adult Residential Facilities (ARF) on the housing continuum for persons with Serious Mental Illness (SMI)**

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**Objective 1:** Identify the regulatory barriers inhibiting Adult Residential Facilities from serving individuals with serious mental illness (SMI).

**Activities**

- Identify problematic regulations.
- Research the basis of the identified regulations.
- Develop recommendations for the California Department of Social Services (CDSS).
- Present the recommendations to the CDSS and engage in discussion.

**Objective 2:** Address the financial barriers that inhibit persons with serious mental illness from being served by quality Adult Residential Facilities.

**Activities**

- Research and compile funding opportunities i.e. Medicaid waiver opportunities.
- Explore financial models used by other populations, including the Developmental Disability Community.
- Utilize the information gathered to design long-term viable fiscal solutions for adult residential facilities.
- Propose legislation to support the financial model designed and source of funding identified.
- Collaborate with stakeholders.

**Objective 3:** Address land use requirements and community resistance, which create additional barriers for Adult Residential Facilities.

**Activities**

- Identify the origin of the land use and zoning permit requirements.
- Identify materials and compile a tool kit to address community resistance.
- Disperse tool kits to the Mental Health Boards and Commissions.
- Make recommendations to Board of Supervisors.

# California Behavioral Health Planning Council
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**Objective 4**: Advocate for data and outcomes for individuals with SMI being served by ARFs.

**Activities**

- Review new reporting requirements contained in AB 1766 (Bloom).
- Identify any additional data reporting needs for individuals with SMI being served by ARFs.

**Target Audience:** Counties and state legislature.

**Timeline:** TBD

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## Goal #2 (tabled)

## To advocate for CA to adopt the federal definition of Housing First

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**Objective 1:** Review legislation at the state level that mandates using Housing First policy and make recommendations for changes.

**Target Audience:** Counties, stakeholders, Legislature

**Activities:**

- Research and review legislation
- Collaborate with stakeholders
- Workgroup members compile list of concerns related to Housing First

**Timeline:** TBD