Adult Residential Facilities (ARFs)

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

FINAL
March 2018

The California Behavioral Health Planning Council (CBHPC) is under federal and state mandate to advocate on behalf of adults with serious mental illness and children with severe emotional disturbance and their families. The CBHPC is also statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The CBHPC has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The CBHPC advocates for mental health services that address the issues of access and effective treatment with the attention and intensity they deserve if true recovery and overall wellness are to be attained and retained.

This issue paper is the beginning of an 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.

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This paper was written with the assistance of:
CBHPC Advocacy Committee:
Monica Wilson, Ph.D., Chairperson

Arden Tucker	Barbara Mitchell	Carmen Lee	Darlene Prettyman
Daphne Shaw	Deborah Starkey	Marina Rangel	Melen Vue
Simon Vue	Steve Leoni		

Jane Adcock, Executive Officer, CBHPC
Dorinda Wiseman, LCSW, Deputy Executive Officer, CBHPC

Ad Hoc Members:
Theresa Comstock, President of California Association of Local Behavioral Health Boards/Commissions
Garrett Johnson, Momentum Mental Health
Jennifer Jones, Health Care Program Manager II
Lynda Kaufmann, Director of Government and Public Affairs, Psynergy Programs, Inc.,
Jung Pham, Staff Attorney and Investigator, Disability Rights California
Kathleen Murphy, LMFT, Clinical Director, CVRS, Inc.
Lorraine Zeller, Certified Psychiatric Rehabilitation Specialist, Santa Clara County
Kirsten Barlow, MSW, Executive Director, California Behavioral Health Directors Association
Jeff Payne, Willow Glen Care Center

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 appropriately staffed and maintained 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. In the vernacular of the State, these homes are also known as RCFE's (Residential Care Facilities for the Elderly).

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 ARF closures and lack of new facilities and/or adequate supportive housing options available, many individuals with mental illness are not able to obtain sustainable community housing options within 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-level crisis programs, facilities, hospitals, jails/prisons or homelessness.

A robust continuum of community-based housing, including ARFs for adults 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[3]. Along with this component, many of the alternative supportive housing options require additional resources to successfully provide community-based long-term housing for adults with serious mental illness.

A discussion of the critical need, the challenges to ARF viability, and ideas for discussion follow.

I. THE CRITICAL NEED

In June 2016, the Advocacy Committee 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 committee 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 between September and November 2016. The following chart provides a summary of needs reported by 22 small, medium and large California 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.

ARF Needs By County[4] (Chart 1)

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

[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.

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

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. The number of ARF beds needed is large and must be addressed. 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.

II. CHALLENGES

The question, 'Why are there so few ARFs available in California' must be answered before any solutions can be generated. The Advocacy Committee consulted with a number of experts in this industry and identified three key challenges.

1. **Financial**: The most apparent challenge to the viability of ARFs is financial. Due to the income level of individuals living in ARFs, they are not able to pay much to cover the costs for the housing, board and care/supervision. ARFs for adults with serious mental

[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/county-websites-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.

illness cannot survive financially on a small scale (under 15 beds) without substantial subsidies. For the most part, monthly rates charged by ARFs are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) amounts 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 especially when some amount of the SSI/SSP payment is set aside for personal needs of the individual. Therefore, subsidies, often called "patches" are needed.

On a larger scale, some residential care homes can be financially viable without additional subsidies, but that is dependent on 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. Rarely is the SSI/SSP amount sufficient to cover the costs. Even in a facility of 45 beds or more, a subsidy paid by the county in amounts ranging from $64/day to $125/day per resident may be required to maintain fiscal viability.

To illustrate the financial challenges in real life, real time, three sample budgets are presented for a 6, 11, and 13 bed ARF in a very small northern county and a medium urban county. Jeffrey T. Payne, MBA, provided sample budgets for two facilities. The Willow Glen Care Center entered into contract with Trinity County in June of 2010 to operate an ARF in Weaverville, California to serve Full Service partners. This facility allows individuals, who have been placed out of county, to return home and live near family, friends and support. Trinity County maintains its focus on providing interventions to those individuals who are most in need of support and services. The first two sample budgets provided below represent the realities of small counties in meeting the housing needs of residents who cannot live on their own and who need a little more care and supervision. Note that similar budgets in larger, more urban counties would require augmented facility rental, lease or purchase costs as well as increased salary costs for staff resulting, oftentimes, in insufficient revenue to cover the operating costs.

Example 1
Adult Residential Facility Six-Person Sample Budget
Assumptions in Example 1: 6-bed facility licensed by the Department of Social Services, Community Care Licensing Division. Average Daily Census (ADC) of 6, Semi-private rooms. Facility Lease rate of $3000 per month (would likely be higher in larger urban areas). All variable expenses are based on a per client, annual cost.

ADC:	6
Total Census:	6
Daily Rates	
SSI	35
Mental Health Patch	155
TOTAL INCOME	**416,100**
Expenses	
Activity Supplies	1,182

Contract Services	126,000
Facility Lease	36,000
Food & Supplies	20,564
Housekeeping Supplies	2,190
Insurance	13,800
Insurance - Worker's Comp.	12,484
Licensing & Certification	2,520
Maintenance & Grounds	4,818
Medical Expenses	547
Office Expense	2,190
Other Supplies	2,190
Payroll Taxes	8,496
Personnel Expense	600
Repairs	2,852
Staff Development	2,400
Telephone	10,800
Travel	3,360
Utilities	30,000
Wages	111,061
TOTAL EXPENSES	**$394,054**
NET OPERATING INCOME	**$22,046**

Example 2
Adult Residential Facility Twelve-Person Sample Budget
Assumptions in Example 2: 12-bed facility licensed by the Department of Social Services, Community Care Licensing Division. Average Daily Census of 11 Semi-private rooms. Facility Lease Rate of $3000 per month. All variable expenses are based on a per client, annual cost.

ADC:	11
Total Census	11
Daily Rates	
SSI	35
Mental Health Patch	105
TOTAL INCOME	**$562,100**
Expenses	
Activity Supplies	2,168
Contract Services	126,000
Facility Lease	36,000
Food & Supplies	37,700
Housekeeping Supplies	4,015
Insurance	13,800
Insurance - Worker's Comp.	22,793
Licensing & Certification	2,520
Maintenance & Grounds	8,833
Medical Expenses	1,003

Office Expense	4,015
Other Supplies	4,015
Payroll Taxes	15,513
Personnel Expense	600
Repairs	5,179
Staff Development	2,400
Telephone	10,800
Travel	3,360
Utilities	30,000
Wages	202,790
TOTAL EXPENSES	**$533,504**
NET OPERATING INCOME	**$28,595**

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 (See Attachment B). Patches range from a low of $15 to a high of $125/ resident/ day depending on level of service needed for the resident or difficulty of placement.

Adult Residential Facility Thirteen–Person Sample Budget
Assumptions in Example 3: 13-bed facility licensed by the Department of Social Services, Community Care Licensing Division. Average Daily Census of 13 semi-private rooms. Facility Lease Rate of $2533 per month. All variable expenses are based on a per client, annual cost. Note that unlike the prior two budgets, which also utilized the current SSI/SSP rate of $1026/month/client, this budget shows an annual net deficit of $399,668. Additionally, this budget contains the minimum level of staffing of 1.0 FTE onsite 24 hours/day, 7 days a week (4.5 FTE total) at very minimal wages of $15/hour plus benefits. Many facilities are unable to hire properly trained and experienced staff at $15-hour rate. This budget covers:

- *One FTE staff* to provide 1) Administrative management; 2) Services, such as activities/outings, life-skills training, grocery shopping and all purchasing, and transportation to healthcare appointments. Since one staff person must be at the facility at any time a resident is present, a second staff person is necessary to do shopping, errands, and resident transport, admissions documentation, and meal planning and to serve as the facility administrator.

Items not included:

- *Owner profit*. A modest owner profit is not included and would add approximately $20,000/year at 5%. Adding a 5% profit margin would increase costs by approximately $125/person/month.

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 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	$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 $255,668)

2. Community Resistance/Opposition – New construction or attempts to obtain a use permit for a property to establish an ARF (required for ARFs that provide more than six (6) beds) are frequently confronted with "Not In My Backyard" (NIMBY) opposition from communities. The resistance often is successful which prevents new operators from obtaining required land use approvals to open ARFs larger than six (6) beds.

3. Staffing – Providing and retaining a trained and experienced staff can be a hurdle, requiring proper management, appropriate salaries and on-going training (equates to the "Financial Challenge" listed above.) Additionally, there are barriers in the regulations to hire peers. The policies and regulations governing ARFs need to be revised to include more robust training for staff and owners to better know how to work effectively with this complex and vulnerable population and how to maintain fiscal stability.

4. Cost of facility – The ability to purchase or rent a facility that would accommodate 13 beds at a cost of either $600,000 or a monthly rent of approximately $2500 is highly questionable outside of the Central Valley in California. The largest house for rent listed in Bakersfield, California in June 2017 was five (5) bedrooms at $1900/month. There were no houses listed for sale or rent over five (5) bedrooms. It is likely that a 13 bed or larger facility would need to be newly constructed which ratchets up the overall cost.

IDEAS FOR DISCUSSION

1. **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 incontinent or non-ambulatory. The Department of Developmental Services Community Care Facility Reimbursement Rates[7] for consumers with developmental disabilities, offers four Service Level Tiers ranging from $1,026 to $7588 per consumer per month.[8] The California

[7] See Attachment C or go to Dept. of Developmental Services Reimbursement Rates.
[8] This includes the SSI/SSP pass through effective January 1, 2017.

Behavioral Health Planning Council will examine the feasibility of implementing a similar structure to meet the ARF needs for adults with mental illness.

2. **State Supplemental Payment (SSP) Rate** – Currently, ARF monthly fees are set by the maximum SSI/SSP rates for clients 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 challenges faced by the ARFs in order to meet the needs of people who require this higher level of housing with care and supervision.

3. **Data** – Currently, the California Department of Social Services (CDSS), Community Care Licensing (CCL) Division serves this population “through the administration of an effective and collaborative regulatory enforcement system.”[9] Although the CDSS/CCL collects data on the **types** of facilities, the data is not detailed enough to illustrate how the facilities are utilized and by whom. There is no way to extrapolate the number of behavioral health beds versus those specifically for substance use disorders versus individuals solely receiving Social Security benefits. The Legislature should consider mandating the Department to restructure its data collection to incorporate essential demographic needs. As a State, California should have a working baseline of the type of facilities along with the types of individuals utilizing those facilities. We really need to understand the breadth of the situation we are dealing with.

III. CONCLUSION

The crisis of limited appropriate housing options for individuals living with serious mental illness has to be addressed. It is critical to engage in strategic long-term and concurrent 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, Transitional Residential Treatment Programs 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 long-term residential options that include the necessary supports to address mental illness. As part of a robust supportive housing continuum, there is a critical need to have ARFs that are adequately financed

[9] California Department of Social Services, Community Care Licensing Division website

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; and 3) ongoing dialogue and strategic planning regarding siting of affordable and appropriate housing.

The following pages contain a) data and comments from the 22 counties who reported on their ARF concerns and b) a more expansive definition of supplemental payments.

V. ADDENDUM

The Council held two public stakeholder meetings to obtain additional perspectives on barriers and solutions, not expressed in the original draft, in San Bernardino County (December 5, 2017) and Yolo County (January 26, 2018). Persons with lived experience, family members, non-profit entities, county governments, academic/research institutions and advocates attended each stakeholder meeting. The stakeholder meetings provided a plethora of insight and passion, not incorporated into the previous drafts. Many attendees expressed a general sense of relief that the issue of decreasing Adult Residential Facilities in the state of California is of concern at the state level. Many attendees felt they were alone in their concern for the individuals living in these facilities. They were validated by those in attendance and the effort of the Council to shed light to this aspect of the housing continuum in California for persons with severe mental illness or emotional disturbance.

A. Barriers

1. *Communication*: Many attendees expressed frustration and irritation at the lack of communication. Lack of communication between discharging institutions to care providers/owners, the Court System to/with family members, the state licensing entity to/with provider/owners and family members.

2. *Regulations and Oversight*: There was an overall request to have the regulations updated to meet the needs of the types of individuals served in these facilities. The facility categories do not fit, match or meet the needs of the populations utilizing the services. Two examples – 18-59 (*Adult Residential Facility) and the 60+ (Residential Care Facility for the Elderly) licensing categories do not allow for many Transitional Aged-Youth with children or adults with chronic co-morbid ailments to ‘fit into’ the licensed facility. Many attendees stressed, “This population is living longer with more complex needs.” Current regulations written do not give providers/owners the flexibility to deal with the dynamic and complex needs of this population.

a. Increases in Licensed Facilities electing to become "Unlicensed," yet continue to house the same population. There is not enough oversight and/or advocates aware of all the facilities transitioning. Many individuals residing in these environments are often unaware of their civil or tenant rights.

b. The California Department of Social Services, Community Care Licensing is not required to collect more specific data on the individuals or types of issues these individuals face. Updating the regulations to have the Department to collect more appropriate data will assist in more clearly identifying the numbers of persons with severe mental illness/emotional disturbance, substance use disorders, medical and/or physical limitations.

3. *Programming/Life Skills*: Many advocates advised many individuals in these settings often are not provided on-going programming or life skills/training to assist in personal development and growth. A significant number of individuals want to live beyond the ARF level of care. These individuals do not possess the skills necessary to function more independently, yet have the desire and capacity. They just need to be taught and/or exposed to the skills needed to reside independently or in supportive housing. The current milieu/structure does not enhance an individual's potential. It merely warehouses them.

4. *Antiquated Culture:* Many attendees advised of owner/operators unwilling to learn about the populations they are now serving. They are refusing to participate in trainings, that could potentially increase the quality of care provided in existing facilities.

5. *Political ill will*: Attendees in Southern and Northern California expressed the anguish of working with County Boards of Supervisors and combating the ever-present "Not In My Backyard-isms (NIMBYisms)." There was a collective outcry to educate the greater community at-large that "those people" could one day be each one of us. Typically, the individuals in this population do not have bipartisan support nor an influential political voice. Therefore getting this stigma to shift is often arduous at best.

B. **Solutions**

1. *Increase Technical Assistance*: If the state and/or county is able to provide core Technical Assistance to provider/owners and/or family members on appropriate models of care it could increase the competency and confidence levels of provider/owners. Family members may be more comfortable interacting with provider/owners when advocating for programming or treatment options for their loved ones.

2. *Outside-the-Box Funding Options*: The attendees in both meetings stressed the need to obtain funding beyond current mechanisms. Suggestions ranged from better utilization of Medicaid dollars; more collaborative efforts with the private sector and corporate partnerships; accessing unspent Mental Health Services Act funds; alternative uses of property taxes; redirect Emergency Department and Institutional savings, etc.

3. *Case Management*: Many individuals with Developmental Disabilities have a Case Manager (CM). The CM typically has performed a thorough assessment and provided the Regional Center with a determination of the individual's needs. The individual typically has a reoccurring assessment to determine the appropriateness of the supports in place. Individuals with severe mental illness, serious emotional disturbance and/or substance use disorder, typically do not have such continuity of care, unless involved with a system (e.g. Child Welfare, Juvenile Justice, Criminal Justice or State Hospital).

4. *History*: The use of recent and historical information on how our communities cared for this population in positive ways can and should be investigated and utilized when possible. Hence, do not repeat mistakes, but take the lessons learned to do better.

5. *Promising Practice*: The use of Peer Support Specialists within the Adult Residential Facility industry has far-reaching attributes beyond being "cost-effective." The role of Peer can provide valuable information, continuity of care and services, that speak to many concerns related to greater public safety concerns. Three programs in California are utilizing Peers in rather innovative ways. Santa Clara County has the *Community Living Coalition (CLC)*[10] *,* San Bernardino County has the *Peer-Driven Room & Board Advisory Coalition*[11], and San Diego County has the *Homeless Services and Supportive Housing Council*[12]. Each organization was started from differing perspectives. However, each program seeks to ensure an appropriate, safe and adequate living environment for individuals living with serious mental illness in Adult Residential Facilities and Board and Care Facilities. This ARF white paper is primarily focused on Adult Residential Facilities (licensed) and not Board and Care Facilities (unlicensed) due to the complexity of the regulations. It is our hope that

[10] Community Living Coalition (CLC) – Lorraine Zeller (408.771.4982), Certified Psychiatric Rehabilitation Specialist (CPRP) and Lead Mental Health Peer Support Worker in Santa Clara County.

[11] Peer-Driven Room & Board Advisory Council – Rachel Cierpich, Peer and Family Advocate III, San Bernardino County Department of Behavioral Health, Patients' Rights.

[12] Homeless Services and Supportive Housing Council – Simonne Ruff, Director, Corporation for Supportive Housing-San Diego

through the continued work of this Council, many issues addressed will ultimately affect Adult Residential Facilities and Board and Care Facilities in positive outcomes for current and future residents. The reason these three programs are highlighted is to illustrate the commonality in the development of these programs and their process to collaborate with all entities affected by this housing challenge.

The CBHPC seeks to convene more experts in this field, as well as, hold more public meetings on this topic to further explore the most beneficial amendments to current regulations, as well as, possible legislation.

Are you willing to continue in this journey with us and be part of the solution? If so, check the Council's website often for new information regarding upcoming events, requests for input and next steps. Together our voice is strong!

ATTACHMENT A

2016 RCF SURVEY RESPONSES

Question 1: How many adult residential care beds are available in your county for persons with serious psychiatric disabilities, who can pay the Social Security Income (SSI) rate?

Several counties indicated they had "zero" beds available to accommodate individuals. San Joaquin County reported, "287 Adult beds and 187 older adult beds, totaling 474 beds out of a total of 627 existing (many require additional monies)." The remaining 153 beds are the "RCFE beds for private pay residents only, with a number of the facilities only taking the private pay clientele."

Only few homes take the SSI/SSA rate. This affects the resources available to clients with limited income and serious and persistent mental illness with no ability to pay private pay rates.) The availability of beds typically ranged under 200, within the reported counties.

Question 2: Do you have a Supplemental Payment, or PATCH, for residential care beds? If so, how many beds are provided and what is the PATCH range?

Of the 22 counties responding, nine (9) reported they do not pay any Supplemental Payments for residential care beds. One county responded, "No, we do not have enough beds. We only patch for one Board and Care for those transitioning out of acute or long term locked psychiatric placements. We do not patch for other facilities." Another county responded, "We have attempted to contract with providers for up to $24-day patch since 2005 and have been unable to attract any provider at this rate." Fourteen counties responded they do provide Supplemental Payments for residential beds. Interestingly, of the 14 counties, the supplemental payment range was as low as $12.50 per day to a high of $350.00 per day. Two (2) counties advised their patches were specifically for 'out-of-county' placements.

Question 3: How many additional residential care beds are needed in your county to sufficiently meet your county's needs?

County	Number of Beds Needed
Sierra	N/A
Colusa	Left Blank
Glenn	Zero
Amador	Ten (10)
Siskiyou	N/A
Tuolumne	Four (4)
Nevada	Ten (10)
Napa	18
Shasta	25

County	Number of Beds Needed
Imperial	Ten (10)
El Dorado	25
Yolo	40
Santa Cruz	100
San Luis Obispo	At least 50
Monterey	20
Tulare	40 – 30 additional to meet need
San Joaquin	50 for Adults and 90 for Older Adults
San Mateo	Approximately 50
Kern	100 to meet the need
San Bernardino	Number not provided
Riverside	200-300
Orange	35-50

San Joaquin County responded, “50 for Adults at minimum and 90 beds for Older Adult.” Shasta County stated, “We currently have 25 clients placed in Board and Care homes outside our county.” Tuolumne County’s response to the number of beds needed in their county indicated that there are no board and care beds in the county nor is there supplemental housing. For those in board and care the reasons are specifically matched to their needs – thus no one home would be able to accept all persons currently at B&C, which includes individuals who are elderly, dual diagnosed with intellectual disability and mental illness, and dual substance abuse and mental illness. The responses provided illustrate the lack of resources allowed for individualized care to meet the needs of individuals with substance use disorders, medical conditions and/or other conditions beyond mental health.

<u>Question 4</u>: If your County places individuals out-of-county, how many are placed out-of-county per month?

Of the responses from the 22 counties, the lowest out-of-county placement was one (1) per month, to a high of forty-five (45). The range of explanations for the out-of-county placements included the following in no particular order:

- Not enough of beds, of any kind, are available;
- Not enough placements that will accept clients with serious mental health needs;
- Not enough placements that meet the needs of individuals over the age of 60;
- Not enough placements for individuals with criminal history;
- Not enough placements for individuals that are sex offenders; and

- Not enough placement for individuals with medical needs, such as diabetes, chronic medical needs, incontinence, etc.

Many of the counties responded the needs of individuals who also have medical needs, chronic health conditions, such as diabetes, those with criminal justice involvement and/or substance use disorders are quite difficult to place.

Question 5: Has your county lost any residential care beds within the last two (2) years? If so, please provide the number of lost beds.

County	Number of Lost Beds
Sierra	None
Colusa	None
Glenn	None
Amador	None
Siskiyou	"Have had none to start with."
Tuolumne	None
Nevada	None
Napa	8
Shasta	At least 12
Imperial	None
El Dorado	Number not provided
Yolo	None
Santa Cruz	None
San Luis Obispo	None
Monterey	6
Tulare	40; last 3-10 years over 150
San Joaquin	187
San Mateo	34
Kern	100
San Bernardino	249 within last 6 months; one year ago 105; two years ago 126
Riverside	50
Orange	Number not provided

The top three responses from the Counties, as to why beds have been lost, in order of responses are:

1. Aging out of providers;
2. Poor property conditions; and
3. Not financially viable.

Siskiyou simply responded, “No. Have had none to start with.” Kern County reported losing “100 beds.” Whereas San Joaquin County reported losing “187 both adult and older adult” beds.

Question 6: The counties were asked to provide any anecdotal perspectives. Some of the anecdotal responses are as follows:

- “Referring strictly to locked psychiatric facilities, our county is in need of several more beds (perhaps up to 40 additional beds). Due to recent legislative changes (since 2014), there has been a voluminous increase in referrals for LPS evaluations and more persons placed on LPS conservatorship. We often need our clients to have treatment in State Hospitals or IMDs for a protracted period as we are seeing a more seriously mentally ill profile in addition to a much more violent population. We also are seeing a trend of younger persons in need of this high level of care and some of the IMDs are disinclined to accept said group. Therefore, we need not only more beds, but facilities willing to accept this younger, more violent type of patient.”

- “Land in our county is too expensive to develop. Labor costs are too high. Cannot hire or retain trained and experienced staff. A “Not In My Backyard” mentality of prospective neighbors” hinders increasing the number of board and care facilities in our county.

- One County stated it does not have B&C beds/facilities other than the six bed ARF. Over the last two years, three separate providers have become Room and Boards in a neighboring county, which is one of its larger neighbors. The County further stated it has been difficult to find licensed facilities that are operated by trusted providers in the larger county that can meet the needs of the individuals being served.

- “Lack of in-county board and care availability (specifically, enhanced board and care beds) results in the county having to place large numbers of clients out-of-county. This can cause many challenges related to providing effective case management/treatment and occasionally poses challenges to family members of clients who are placed out of county. There is most definitely a need for more in-county board and care facilities (specifically enhanced board and care beds) to serve the needs of County clients who are often older and facing significant physical health concerns in addition to their intensive mental health related needs.”

- “As older operators age out, the establishment of new facilities is cost prohibitive given the current SSI/SSP rates to provide “basic” care and supervision. Therefore, existing resources are diminishing each year and we are seeing faster turnover (open, then close) of new small facilities. Supplemental Rates are established to reimburse for “augmented” services in order to cover the additional cost for the

operator. It is not designed to cover basic operating cost. The cost of property, related taxes, increased oversight by CCL and enforcement of labor laws (OT, Workman's Comp., Insurance, etc.) either requires the owner/operator of a 6 bed to work 24/7 or not operate (not enough funds to hire help). Reimbursement does not cover facility maintenance costs so a number of existing facilities are in major disrepair. This has resulted in very poor quality housing and increased CCL citations and fines that the owners do not have funds to address. As a result, the only viable fiscal option is to work to establish large homes (40 beds+) to achieve economies of scale and even then, it may not be fiscally viable without some type of augmentation. Larger facilities are generally more institutional in environment and, if new, face the challenge of NIMBY opposition."

ATTACHMENT B

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 $125/day per resident (in addition to the SSI that is paid of approximately $1026/month/resident[13]).

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.*
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.*

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[13] 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 retro SSI eligibility.*

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[14], 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.).

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

ATTACHMENT C

DEPARTMENT OF DEVELOPMENTAL SERVICES
COMMUNITY CARE FACILITY RATES
FIVE OR MORE BEDS PER FACILITY

EFFECTIVE JANUARY 1, 2017

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[15]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[16]
1	$1,014	$1,026.37
2-Owner	$2,357	$2,390
2-Staff	$2,617	$2,650
3-Owner	$2,746	$2,788
3-Staff	$3,083	$3,125
4A	$3,575	$3,619
4B	$3,818	$3,866
4C	$4,059	$4,111
4D	$4,354	$4,410
4E	$4,668	$4,730
4F	$4,990	$5,057

[15] Includes the SSI/SSP pass through effective January 1, 2015.
[16] Includes the SSI/SSP pass through effective January 1, 2017.

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[15]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[16]
4G	$5,364	$5,436
4H	$5,766	$5,845
4I	$6,334	$6,422

The Personal and Incidental (P&I) expenses effective with the January 1, 2017, SSI/SSP payment standard increased from $131.00 to $132.00.

DEPARTMENT OF DEVELOPMENTAL SERVICES

COMMUNITY CARE FACILITY RATES
FOUR OR LESS BEDS PER FACILITY

EFFECTIVE JANUARY 1, 2017

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[17]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[18]
1	$1,014	$1026.37
2-Owner	$3,281	$3,379
2-Staff	$3,642	$3,740
3-Owner	$3,322	$3,422
3-Staff	$3,792	$3,892
4A	$4,423	$4,529
4B	$4,683	$4,797
4C	$4,940	$5,062
4D	$5,272	$5,402
4E	$5,603	$5,743
4F	$5,945	$6,096
4G	$6,361	$6,522

[17] Includes the SSI/SSP pass through effective January 1, 2015.
[18] Includes the SSI/SSP pass through effective January 1, 2017.

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[17]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[18]
4H	$6,788	$6,962
4I	$7,395	$7,588

The Personal and Incidental (P&I) expenses effective with the January 1, 2017, SSI/SSP payment.