Sustaining a Vital Permanent Housing Resource:

Analysis and Stakeholder Input to Support Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) in Los Angeles County

July 2019

Sadlon & Associates, Inc.

Table of Contents

Executive Summary

An Urgent Call to Action

Adult Residential Facilities (ARFs, for people ages 18 – 59) and Residential Care Facilities for the Elderly (RCFEs, for ages 60+) provide housing and critical support for individuals who are unable to live independently and who require nonmedical care and supervision. In addition to a room and meals, these licensed facilities provide assistance with activities of daily living (bathing, dressing, toileting), assistance with scheduling healthcare appointments, and medication oversight. These ARFs + RCFEs are an essential and often-overlooked resource in preventing and ending homelessness for Los Angeles County's most vulnerable residents.

There are approximately 3,200 of these facilities in Los Angeles County, ranging from under six beds to several hundred. Many that serve low-income individuals are in crisis due to rising real estate costs, increased minimum wage and other operating costs, and low reimbursement rates ($35 a day or $1,058 a month base rate for eligible people with low income). Untenable financials are leading to closures and declining system capacity at a time of increased demand. Recognizing this crisis, the Los Angeles County Board of Supervisors together with the County Health Agency launched a stakeholder process to improve the stability of and coordination among these important facility operators.

Time is of the essence: with another minimum wage increase that began on July 1, 2019 further straining finances, many operators indicate that they have depleted their options and may be forced to close. Their top priority is to receive a sustainable monthly reimbursement rate. In addition, many facilities would benefit from facility improvements to address deferred maintenance and sustain licensure.

The needs of ARF + RCFE operators and residents are well documented. The County has the opportunity to meet the needs of individuals relying on County services who live with mental illness and/or have experienced homelessness, while also expanding the availability of this type of housing for all low-income residents who require care and supervision. Supporting ARFs + RCFEs will improve the quality of life for many Los Angeles County residents, improve operator effectiveness, and expand facilities' capacities to serve. At the same time, advocacy at the state level must push for sustainable funding and supportive regulations.

Board of Supervisors Directive to Convene a Stakeholder Process, Sept 2018

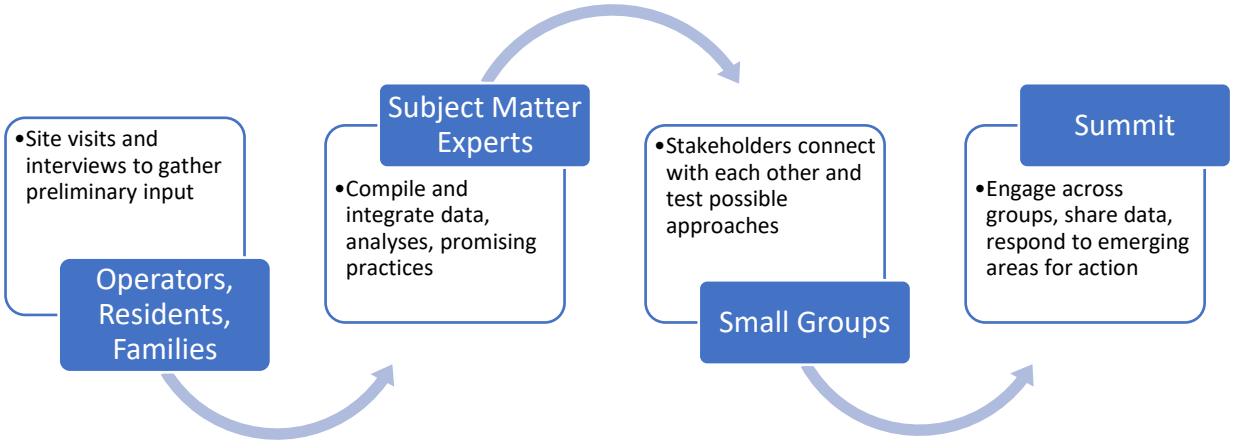
In response to the urgent needs of the system of ARFs + RCFEs, the Los Angeles County Board of Supervisors unanimously approved a motion to stabilize and grow these facilities. The motion called for a stakeholder process to gather input on how to best serve existing Health Agency clients and how to prevent the loss of ARF + RCFE capacity more broadly. This parallels and complements ongoing work at the Health Agency to align processes that provide assessment, and tiered enhanced rates for clients who require this type of housing.

Overview of the ARF + RCFE Stakeholder Process

The goal of the stakeholder process was to identify ways to preserve and expand the stability, sustainability, quality, and capacity of ARFs + RCFEs in Los Angeles County. The process centered on the needs of people living with mental illness and/or experiencing or at risk of homelessness, while recognizing that stabilizing this housing resource benefits many others as well.

> **Purpose:**
>
> To sustain, improve, and expand housing for vulnerable low-income adults and seniors, including those with serious mental illness and those experiencing homelessness, who require non-medical 24/7 care and supervision.

This stakeholder process wove input from a wide variety of experts together with existing data and analysis in an iterative process starting in January 2019 and continuing through June 2019.



Resulting **outreach** gathered direct input from 192 stakeholders:

- 48 ARF + RCFE operators
- 47 government agencies
- 28 service providers
- 17 members of health care associations
- 13 residents, family members, and other advocates
- 39 others

A total of ten **small group stakeholder meetings** convened in diverse corners of Los Angeles County including Antelope Valley, San Fernando Valley, San Gabriel Valley, East Los Angeles, Downtown Los Angeles (three groups), South Los Angeles, Santa Monica, and Long Beach.

A **stakeholder summit** on May 8, 2019 drew 98 participants representing ARF + RCFE operators; consumers, family members, and advocates; a broad variety of government agencies and initiatives; healthcare provider associations; and a range of other service providers and interested parties. The purpose of the summit was to:

- Build connections among stakeholders
- Share information gathered in the ARF + RCFE stakeholder process
- Get further input on draft approaches to strengthen the system.

Summit participants heard the commitment of County Supervisors Janice Hahn and Sheila Kuehl to this effort; updates from the County Department of Health Services (DHS) and Department of Mental Health (DMH); a presentation from Community Care Licensing (CCL); and data collected through the earlier stages of the stakeholder process. In rotating small group discussions, attendees reviewed and provided deeper input to stakeholder ideas for strengthening the ARF + RCFE system.

Subsequent to the summit, two final work group discussions integrated guidance and input from sixteen diverse stakeholders to prepare a thoughtful and compelling set of actions based on the information gathered through the stakeholder process. These leaders, along with many respondents to an operators' survey, are committed to ongoing engagement with the Health Agency in acting on these imperatives.

Operators' Perspective – Survey Results

50 ARF + RCFE operators participated in an online survey. Invitees were identified through DHS and DMH lists of facilities, participants in the stakeholder process, and community outreach by the consultants. Respondents reflect a mix of both ARFs and RCFEs, facility sizes, longevity in the field, and payer, though they skew toward serving SSI residents. Insights are found in yellow text boxes throughout this report.

Summary of Stakeholder Input

To preserve and grow the system of ARFs + RCFEs in Los Angeles County that care for people who have experienced homelessness and/or experience mental illness, stakeholders identify the following six imperatives and related areas for action. See a detailed report of stakeholder input for each of these imperatives beginning on page 21.

1. Operator Financial Sustainability

1.a. Double the number of people to 4,000 benefiting from Housing for Health and Department of Mental Health enhanced rates, using a tiered payment model for high acuity clients

1.b. Expand other sources of operating funding available for facilities serving low-income residents

1.c. Meaningfully improve the sustainability and quality of ARFs + RCFEs serving a threshold percentage of low-income residents with one-time capital improvement funding matched by philanthropy

1.d. Encourage operators to explore new business models and funding streams

2. Resident Quality of Life

2.a. Deliver wraparound on-site professional supportive services for residents

2.b. Foster community and on-site resident enrichment activities with community-based organizations including peer and family support groups

2.c. Partner with existing programs to create a curriculum for peers to transition into professional positions at ARFs + RCFEs

2.d. Assist residents seeking jobs, volunteerism, or other productive uses of time

2.e. Support residents to move to more independent living settings, if appropriate

3. System Capacity

3.a. Preserve existing bed capacity from closures

3.b. Expand total capacity of the system

4. Operator Effectiveness

4.a. Create and sustain an operator member association for facilities serving low-income residents

4.b. Improve utilization and transparency with a real-time bed tracking system

4.c. Increase operator access to and use of technology

4.d. Develop and track metrics of quality care and resident outcomes

5. Integrated County Services

5.a. Complete Housing for Health and Department of Mental Health (HFH + DMH) program integration with consistent eligibility, assessment, and payments

5.b. Create liaisons within the integrated HFH + DMH program to help residents and operators navigate the system and access County and other resources

5.c. Ensure that the integrated HFH + DMH program aligns and engages with other programs and supportive services offered by the Health Agency, including Full Service Partnerships

5.d. Ensure that all County departments that provide relevant training, technical assistance, and other capacity building include ARF + RCFE operators and staff

5.e. Continue to work with Community Care Licensing to strengthen relationships with all operators, support at-risk facilities, and explore changes of ownership and/or management to prevent closures and negative impact on residents

6. State and Federal Policy Advocacy

6.a. Advocate at the State level for increased funding and for regulations that support a strong, sustainable ARF + RCFE system

6.b. Advocate at the Federal level for increased funding and for regulations that support a strong, sustainable ARF + RCFE system

Sustaining a Vital Permanent Housing Resource: A Report on ARFs + RCFEs in Los Angeles County

Definitions and Impact: ARFs + RCFEs

The California Department of Social Services licenses Adult Residential Facilities (ARFs) for adults ages 18-59, and Residential Care Facilities for the Elderly (RCFEs) for people age 60 and over. ARFs are sometimes referred to as "board and cares" and RCFEs are sometimes called "assisted living facilities." There are over 1,700 ARFs and nearly 1,500 RCFEs licensed in Los Angeles County with a total of over 66,000 beds. About half of these facilities accept at least some low-income clients, serving as one solution along the continuum of care, treatment, and recovery for people living with mental illness and/or experiencing homelessness.

Licensed Residential Facilities

Adult Residential Facility (ages 18-59) = **ARF**

Residential Care Facility for the Elderly (age 60+) = **RCFE**

a.k.a. board and care or assisted living facility

ARFs + RCFEs are non-medical, 24-hour staffed residences that provide room and board, three meals a day plus snacks, medication oversight (critical to some people with significant mental illness and/or other medical issues), help with activities of daily living (dressing, bathing grooming), social activities, housekeeping, laundry, protective supervision, and help coordinating access to appointments. The facility may be a private home converted into a six-bed facility, or an apartment building for 200+ people, or anything in-between.

Characteristics of ARFs + RCFEs

- Licensed by the state Community Care Licensing Division (CCL) of the Department of Social Services
- Range from six or fewer beds to 200+ beds
- Non-medical facility; provides housing, meals, medication oversight, transport to medical and other appointments, supervision, housekeeping, laundry

Stakeholders report variation in the quality of ARFs + RCFEs, in part driven by the very low reimbursement rates for providing room, board, and 24/7 care to low-income individuals. Despite this significant revenue limitation, many operators provide pleasant environments and build strong community among residents. Family members often work together as the staff of ARFs + RCFEs. However, stakeholders recognize that some ARFs + RCFEs are unable to provide a quality setting or meet licensing requirements and would benefit from funding for needed improvements and technical assistance.

ARFs + RCFEs Within the Continuum of Stable Permanent Housing

ARFs + RCFEs that accept low-income residents play a critical role in promoting mental well-being and in preventing homelessness, but are often absent from discussions of housing solutions. They are an essential resource for many residents' recovery from physical and/or mental illnesses. They can provide a temporary place to stay until residents gain the strength and skills required to move to a lower level of care or independent living situation, thereby preventing homelessness. Other residents need and benefit from ARF- or RCFE-level of care their whole lives.

Continuum of Stable Permanent Housing

The 2019 Greater Los Angeles Homeless Count[1] showed an increase in both the City and County of Los Angeles of overall homelessness, with a 7% increase among seniors. The increase in street homelessness parallels a period of loss of ARF + RCFE beds. One stakeholder articulated the impact of the loss of ARF + RCFE beds by noting that of the approximately 900 people who died on the streets in Los Angeles County in 2018, many of them formerly lived in ARFs or RCFEs. ARFs + RCFEs can offer the safety and support that adults and seniors need to avoid homelessness and decompensation of physical and mental health.

Per the Los Angeles County Mental Health Commission's ARF workgroup,

> "…it is recommended that policy makers who analyze housing supply and demand in Los Angeles County include Adult Residential Facilities in the continuum of community-based housing available for people with serious mental illness, as well as formerly homeless individuals. Arguably, formerly homeless residents with serious mental illness are more vulnerable than those targeted for permanent supportive housing with services attached. Surprisingly, under federal rules for defining "chronic homelessness," people leaving institutions [e.g., skilled nursing facilities] are often not considered eligible for permanent supportive housing."

ARFs + RCFEs are an appropriate housing alternative for many people being discharged from acute hospitals, state hospitals, and Institutes for Mental Disease (IMDs) who might otherwise become homeless. Homeless service providers, hospital discharge planners, and other care providers struggle to find appropriate placements for their clients who require care and supervision, because relatively few ARFs + RCFEs are willing to accept challenging residents at the current low rate.

[1] https://www.lahsa.org/news?article=557-2019-greater-los-angeles-homeless-count-results&ref=hc

Types of licensed facilities in LA County providing 24-hour care for people with serious mental illness

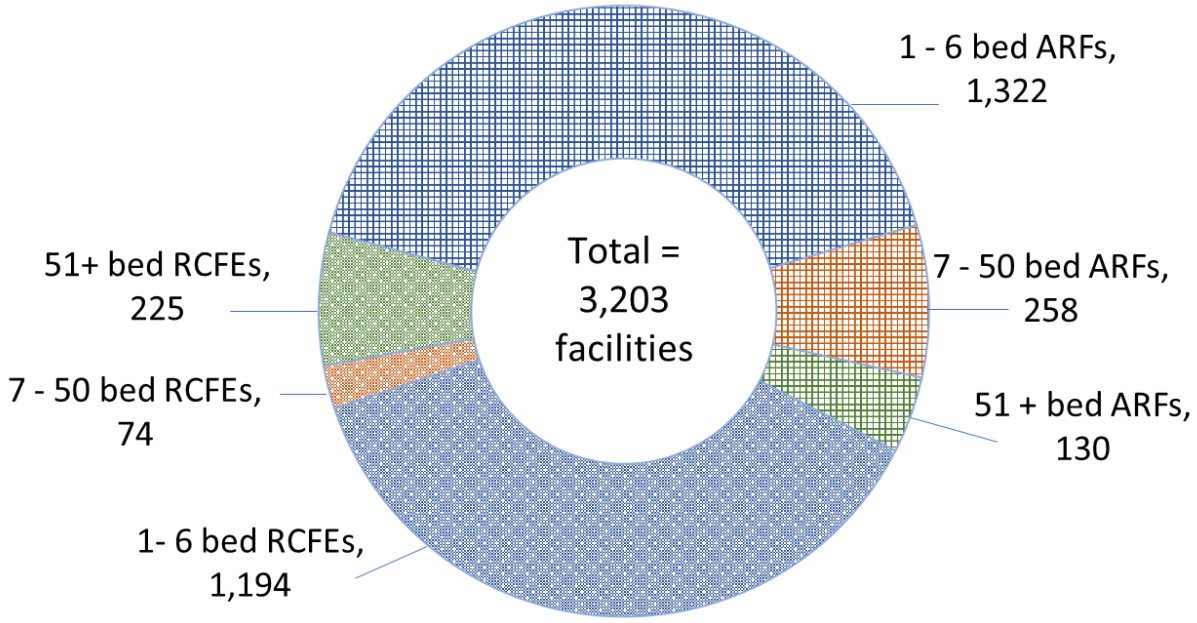
	Adult Residential Facilities (ARF)	Social Rehabilitation Agency	Residential Care Facility for the Elderly (RCFE)	Skilled Nursing Facility (SNF)	Congregate Living Health Facility (CLHF)	Institute for Mental Disease (IMD)
Population	Age 18 – 59 upon entry	People with mental illness	Age 60+ (may include younger)	People requiring skilled medical care	People requiring skilled medical care	People with mental illness
Services	Non-medical services, supervision, assistance	Psychosocial rehabilitation	Non-medical services, protective supervision, personal care	Skilled nursing and supportive care	Medical supervision, skilled nursing, supportive and other care	Diagnosis, treatment, medical care, nursing
Bed size	6 – 200+	6 – 16 (65% = 6)	6 – 200+	10 - 125	Up to 18	16 +
# total LA	1,709 *	19 + 7 pending	1,493 *	390	127	22
# beds LA	24,918 *	229	41,277 *	N/A	N/A	3,388

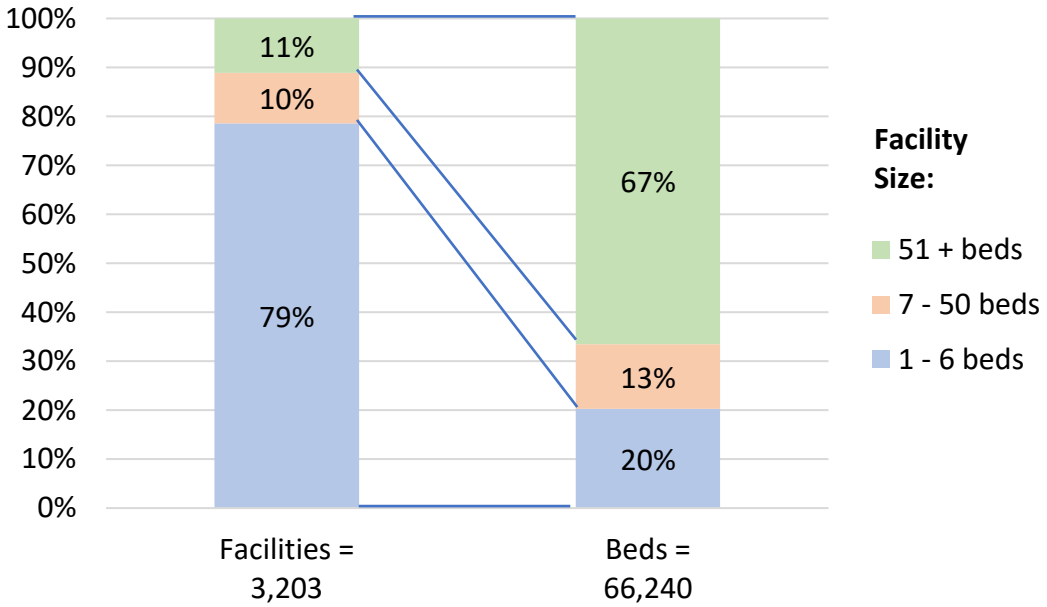
** Most do not serve low-income residents*

Increasing level of care

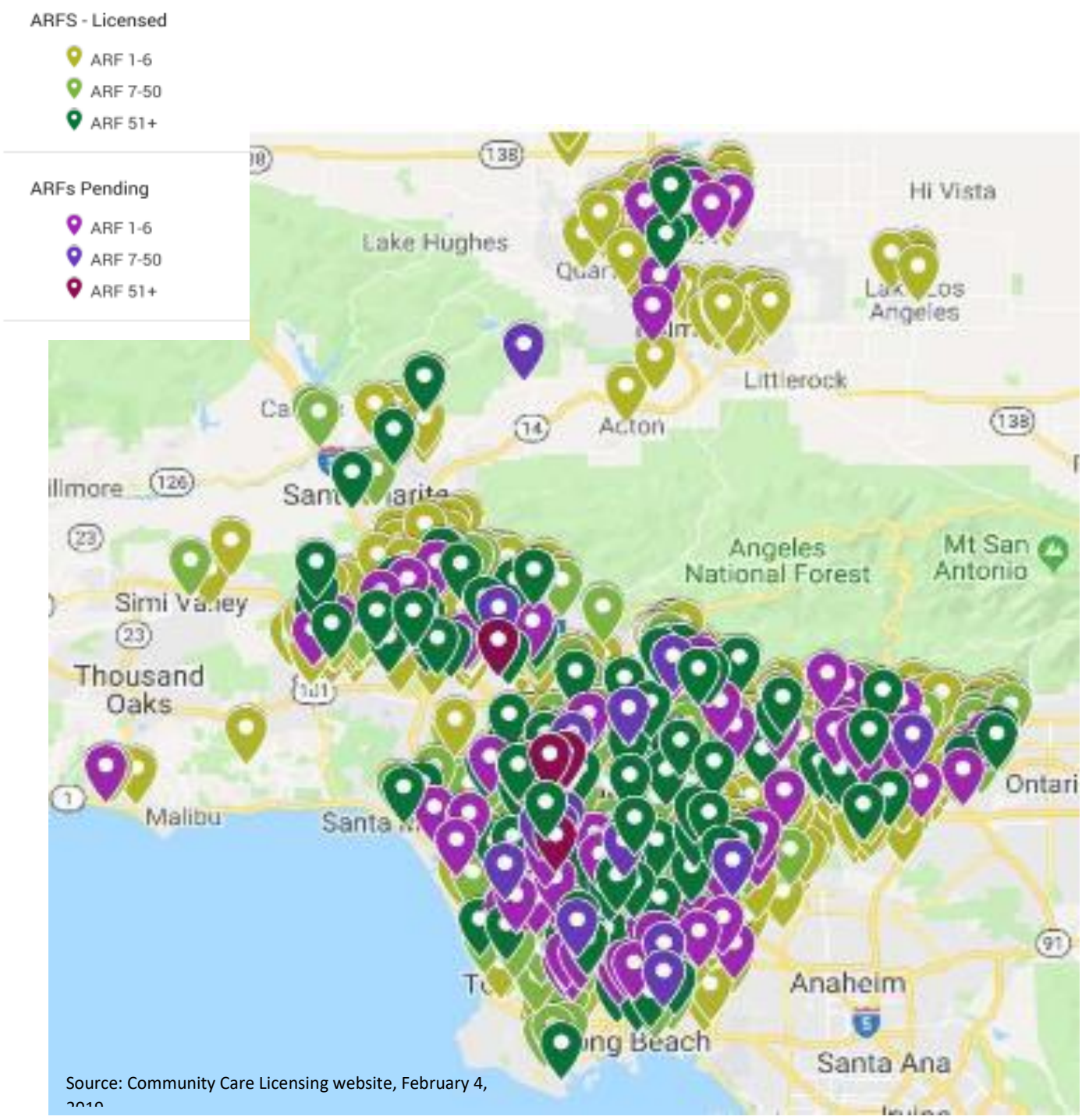
Existing System of ARFs + RCFEs in Los Angeles County

In February, 2019 there were a total of 3,203 ARFs + RCFEs in Los Angeles County, with slightly more ARFs than RCFEs. The largest percentage of facilities have six beds or fewer (80% of the total *facilities*), and are often family operated. The greatest proportion of the total *beds*, though, (67%) is found in larger facilities with 51 or more beds.





ARF + RCFE distribution across Los Angeles County



Source: Community Care Licensing website, February 4, 2019

Urgency of Financial Sustainability

> "The board and care system is precariously resourced and prospects for the continued vitality of this system in the wake of shockingly low daily rental rates per resident ($35) is jeopardized. **The failure of this system could exacerbate the homeless situation** in L.A. County with residents exiting board and cares back into homelessness and/or board and care facilities no longer being available to accept new residents."
>
> – L.A. County Mental Health Commission's "A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County"

SSI rate is $1,058/month per person. People who have low income and are either blind, living with a disability, or age 65 or over may be eligible for a cash grant called Supplemental Security Income (SSI). The California Department of Social Services sets the rate that an SSI beneficiary residing in an ARF or RCFE must pay from their benefits to reside there, referred to as the SSI rate. As of January 2019, the SSI rate is $1,058 per month for an individual[2] or roughly $35/day. This amount is meant to cover a resident's room and board, overall care and supervision, medication oversight, laundry, transportation and activities as well as the facility's insurance, worker's compensation insurance, staff wages, building upkeep, license fees, and all other expenses related to running a safe and supportive residence. Facilities are not permitted to charge individuals receiving SSI above the state-mandated rate.

By contrast, the organization RCFE Reform reports that for private pay residents:

> The median cost of assisted living care in California is $4,275 per month (Genworth Cost of Care Survey: https://www.genworth.com/about-us/industry-expertise/cost-of-care.html). However, the actual cost of care can vary significantly depending upon a resident's specific care needs. For example, dementia care costs are closer to $8,000/month (SeniorHomes.com, 2017).[3]

Thus, facilities receive rates four to eight times higher, on average, for private-pay residents than for low-income residents. One stakeholder characterized the low SSI reimbursement rate as exploitation of ARF + RCFE operators.

---

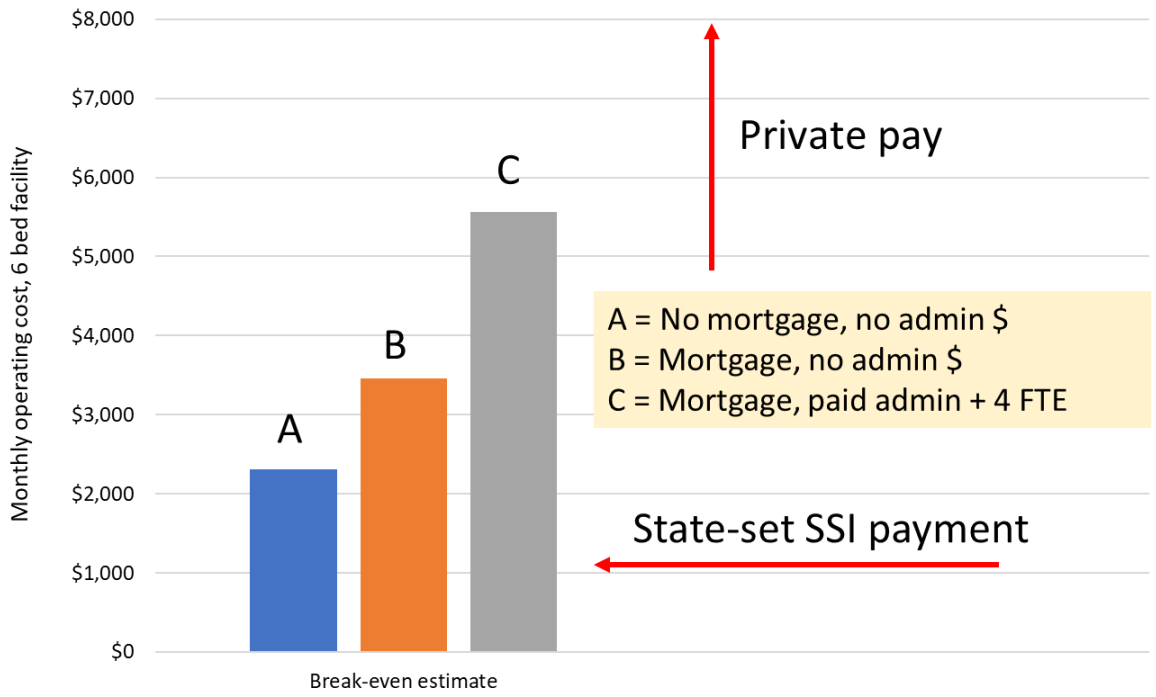
[2] A single person living in an RCFE and eligible for SSI would receive $1,194.37, pay $1,058.37 to the facility for rent, and keep $136 as his/her Personal and Incidental Needs Allowance (P&I). http://www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.ssi.htm

[3] https://rcfereform.org/data-research/californias-assisted-living-waiver-program-alwp-facts-figures

Operators' Perspective – Need for Increased Rates

When indicating what change or resource would be most valuable to sustaining their business, 77% of operators selected "stable increased payment rates."

Expenses are <u>at least</u> twice the SSI rate. Operating expenses for ARFs + RCFEs vary significantly based on many factors including size of the facility, whether there is a mortgage, whether operators pay themselves a salary (shown below as "admin $"), and geographic area. The following chart demonstrates that even the lowest-cost structure for a six-bed facility is double the SSI rate.[4]



"ARFs for adults with serious mental illness cannot survive financially on a small scale (under 15 beds) without substantial subsidies."

"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."

- CA Behavioral Health Planning Council, March 2018

[4] Supporting Affordable Assisted Living in San Francisco, January 2019

Facilities are Closing

Though there are plentiful stories of facility closures and the disruptive resident displacements that result, reliable County-wide data on bed losses is elusive. One stakeholder reported a 12% annual loss rate of ARFs and RCFEs. Another stakeholder documented the loss of at least 800 ARF + RCFE beds between 2017 and 2019 in Los Angeles County. Several operators express interest in converting to an unlicensed private pay model with fewer regulations and restrictions, though there is no existing way to know how prevalent this practice may be.

Community Care Licensing (CCL) indicates that the overall total ARF + RCFE capacity across the state has stayed steady despite many facilities closing. By explanation, the greatest losses are among SSI beds since they represent a large portion of the closures and new larger private facilities do not accept residents on the SSI rate. Oftentimes the smaller facilities are family operated, younger generations do not want to continue in the business, and private developers make enticing offers for the property. CCL reports that "90% of closures are due to finances."

An ARF or RCFE closure means that not only are residents displaced, but in a strong Not In My Back Yard (NIMBY) climate, the beds are lost to the system and extremely hard to replace. Therefore, CCL provides support and technical assistance to facilities that are at risk of losing their license. When operators no longer want to continue in the business, CCL has the authority to place a temporary manager at the facility and may explore change of ownership as an alternative to closing the facility.

Operators' Perspective – Closure Risk

29% of respondents to this question (12 out of 41 operators) report that they're **considering closing**, with half wanting to transfer the ARF + RCFE to another operator. The top changes to help sustain these businesses would be:

1. Stable and increased payment rate
2. Reliable, consistent staff
3. Funds to make needed improvements

Two additional operators indicate that they are **actively moving toward closing**, with one planning to close the ARF, and one intending to sell to a buyer or developer for non-ARF + RCFE use. These two operators indicate that their facilities require multiple improvements that would cost over $200,000 each.

Los Angeles County Health Agency Programs that Support ARFs + RCFEs

Financial sustainability requires an increased payment above the SSI rate to provide basic care and supervision and cover the costs related to residents with higher acuity.

The Health Agency operates four programs through the Department of Health Services (DHS) and Department of Mental Health (DMH) that support formerly homeless or mentally ill persons residing in ARFs + RCFEs. Across these four programs, the Health Agency currently contracts with 182 facilities to serve 2,000 clients. Most of these facilities receive enhanced rates for a subset of their residents, based on programmatic assessments and client needs.

Enriched Residential Care Program	Interim Funding Program	Whole Person Care Program	Enhanced Services Rate Program
• DHS Housing for Health • Since 2016 • 1,000 clients • 130 facilities • Referred from DHS facilities and homeless services providers	• DMH • Since 1990s • 100 clients • 23 facilities • DMH clients ready to transition out of higher level of care (e.g. state hospital/IMD)	• DMH • Since 2018 • 200 clients • 8 facilities • Facility refers WPC-eligible residents	• DMH • Since 2019 • 600 clients • 86 facilities • Existing residents who are high-utilizing DMH clients

182 total facilities

The Health Agency is in the midst of integrating these four programs, including administration, assessment, eligibility, tiered funding rates, invoicing, and payments. Each of the current programs is described below.

Housing for Health (HFH) **Enriched Residential Care Program** (ERCP) was created in 2016 with a focus on creating permanent housing opportunities for homeless DHS patients requiring care and supervision. In addition to people who could live independently or in permanent supportive housing, there was a cohort that needed care and supervision to stay stably housed.

HFH has placed more than 1,000 formerly homeless individuals in ARFs + RCFEs. HFH pays the facility an enhanced services rate for the higher level of service required by these clients. Without this enhanced payment, these individuals would have far fewer (or no) housing options.

Preliminary data from HFH suggest that for a group of 70 clients evaluated, the program produced a 27% reduction in inpatient hospital use and a 6% reduction in emergency department utilization compared to the six months prior to enrollment.[5] These reductions in healthcare utilization are consistent with national research that shows reductions in avoidable healthcare spending when people are housed appropriately, with needed supports.

Profile of individuals served through the Department of Health Services Enriched Residential Care Program:

- Health, mental health and/or substance abuse challenges
- Experiencing homelessness
- Need assistance with Activities of Daily Living or other care and supervision
- May or may not be fully ambulatory
- Require support to manage their physical and/or mental health care

Within the 130 facilities involved in ERCP, HFH master leases four licensed facilities that were previously closed or slated for closure. For those that were not yet closed, the former operators were required to document their plan for transitioning all residents to avoid homelessness. In public-private partnership with trusted property owners, HFH brought in new, experienced operators to re-open the facilities. A per-bed, per-month reimbursement rate was agreed upon that is consistent with rates paid to other ARFs + RCFEs and the needs of HFH clients. HFH and the owner of each facility developed a strategy to cover the costs of essential tenant improvements. The operator guarantees all beds for the HFH program; operators cannot decline high acuity residents. Without County intervention, these facilities would have closed permanently and licensed beds would have been lost.

The Department of Mental Health (DMH) offers three programs that support residents in ARFs + RCFEs. The Homeless and Housing division has managed housing resources for people with serious mental illness since the 1990s. Since that time, DMH has placed clients with little or no income who have typically been living in a higher level of care (such as an Institute for Mental Disease) into ARFs and has subsidized the placement through its **Interim Funding Program**.

In 2018, to reduce the gap between the SSI rate and the actual costs for serving DMH clients in ARFs, DMH began to offer an enhanced rate for eligible clients enrolled in its **Whole Person Care program**. In Fiscal Year 2018-19, DMH increased its investments to support clients residing in ARFs + RCFEs by launching an **Enhanced Services Rate program** to compensate facilities that serve low-income clients with mental illness who have higher service. DMH now serves 900 clients through these three programs.

[5] "Change in 6-month Emergency Room and Hospitalization Rates Pre- and Post-Enrollment for Clients Enrolled January 2017-December 2017." Statisticians caution that the sample size was small, the time frame six months, and the results can't necessarily be generalized to people who did not have Medi-Cal coverage for a full 12 months.

Providers: ARFs + RCFEs in Los Angeles County and contracted with DHS and DMH

		Adult Residential Facilities (ARF)				Residential Care Facilities for the Elderly (RCFE)			
		In Los Angeles County		Contracted with DHS and/or DMH, Unduplicated		In Los Angeles County		Contracted with DHS and/or DMH, Unduplicated	
Facility Status	# of beds	Total Facilities	Total Bed Capacity	Total Facilities	Total Bed Capacity *	Total Facilities	Total Bed Capacity	Total Facilities	Total Bed Capacity *
LICENSED	1-6	1231	5983	12	72	1073	6291	65	387
	7-50	239	6567	33	882	68	1573	8	244
	51+	126	11216	28	2619	211	30705	22	2783
LICENSED Total		1596	23766	73	3573	1352	38569	95	3414
PENDING	1-6	90	416	0	0	114	664	0	0
	7-50	19	440	0	0	5	122	0	0
	51+	4	308	1	58	12	1710	0	0
PENDING Total		113	1164	1	58	131	2496	0	0
ON PROBATION	1-6	1	6	0	0	7	42	1	6
	7-50	0	0	0	0	1	40	0	0
	51+	0	0	0	0	2	130	2	130
ON PROBATION Total		1	6	0	0	10	212	3	136
TRANSFERRING OWNERSHIP	1-6	0	0	0	0			7	42
	7-50	0	0	0	0			0	0
	51+	0	0	2	208			1	70
TRANSFERRING Total				2	208			8	112
Grand Total		**1710**	**24936**	**76**	**3839**	**1493**	**41277**	**106**	**3662**
Percentage of Total		100%		4.3%		100%		6.6%	

Los Angeles County source: CCL website as of February 4, 2019 *(*) not all beds are committed to these projects/ accept SSI*

State-Funded ARF + RCFE Enhanced Rate Programs

In addition to the enhanced rate programs available through HFH and DMH, Los Angeles residents of ARFs + RCFEs may benefit from enhanced rates provided by state programs.

	Populations with need for 24/7 non-medical residential support	SSI base rate	Current enhanced rates
County First Priority Currently for ~ 2,000 people	Low income and living with serious mental illness	Yes	Los Angeles County Health Agency
	Homeless/ formerly homeless	Yes	Los Angeles County Health Agency
Enhanced rates are in place	Low income and living with developmental disabilities	Yes	State-funded Regional Centers
	Low income, meets Assisted Living Waiver criteria, and ALW slot is available	Yes	State Medi-Cal
No enhanced rates in place	Low income, and senior or persons with a disability including traumatic brain injury	Yes	No enhanced rates
	People with means including insurance	No	Private pay

Regional Centers

The Lanterman Act of 1977 was landmark legislation that guaranteed rights and services for Californians with intellectual and developmental disabilities (I/DD) such as Down Syndrome and Autism Spectrum Disorder. The Lanterman Act created and funded the Regional Center system of 21 non-profits throughout the state that coordinate and pay for care and services for people with I/DD.

The Lanterman Act provides funding so Regional Centers can pay for clients to live in ARFs + RCFEs, when appropriate. The payments are tiered based on the acuity and needs of the individual, ranging from $1,058/month (Level 1) to $8,170/month (Level 4).

People with serious mental illness – some of whom, like people with intellectual and developmental disabilities, have brain changes that render them unable to care for themselves – are not entitled to the care and services that are guaranteed to those with I/DD. Stakeholders point out that this glaring lack of parity results in more homelessness, incarceration, institutionalization, and higher healthcare costs for people with mental illness.

Medi-Cal Assisted Living Waiver

Implemented in 2006, the Medi-Cal Assisted Living Waiver (ALW) makes enhanced payments to incentivize ARFs + RCFEs to accept eligible people in lieu of them living in more costly and restrictive settings such as skilled nursing facilities.

ALW currently has 5,700 slots statewide with long wait lists and wait times in every participating county. Another 2,000 slots were added in 2018, still falling significantly short of meeting the need. At the time of this report, Assembly Member Ash Kalra has proposed legislation (AB 50) to expand the Assisted Living Waiver to 18,500 slots statewide.[6]

Other Medi-Cal

Aside from the ALW, Medi-Cal does not pay for services provided in ARFs + RCFEs. However, the California Department of Health Care Services could choose to incentivize Medi-Cal health plans to place members, when appropriate, in ARFs + RCFEs in lieu of more-costly inpatient or institutional care. Stakeholders urge the County to join and actively support advocacy to make this change.

ARF + RCFE Cost Effectiveness

Multiple stakeholders emphasize that ARFs + RCFEs, even with enhanced rates of $50 per day (or $1500 per *month*), are cost effective compared to:

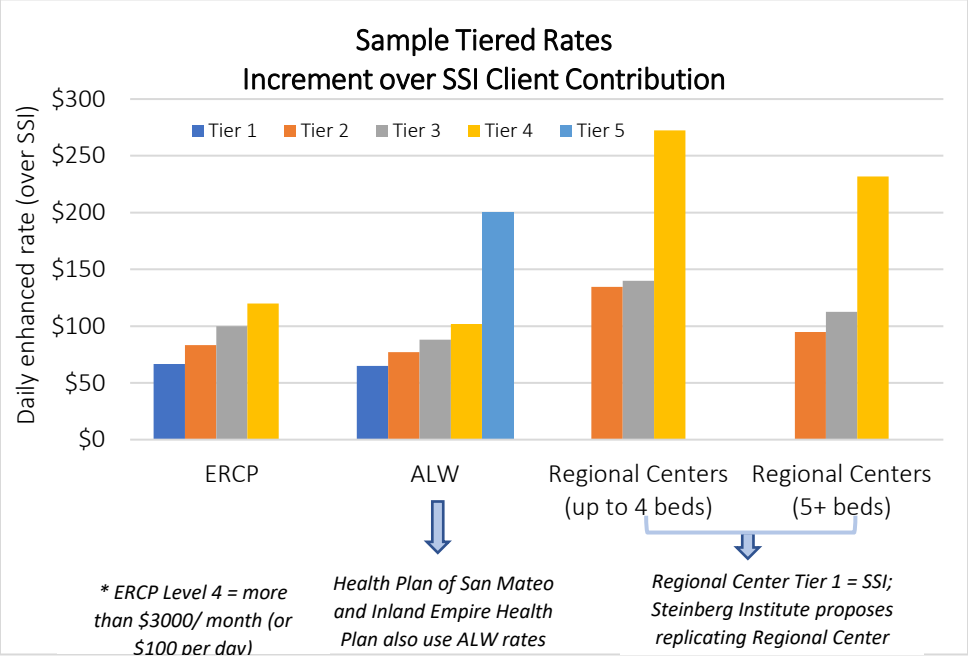
- An "administrative" day in an inpatient acute care hospital, which in L.A. County (both public and private) averages ~ $1,000 per *day* (per Office of Statewide Health Planning and Development).
- An unnecessary day in an Institute for Mental Disease (IMD), which averages in L.A. County around $1,000 per *day* (per Office of Statewide Health Planning and Development).
- An avoidable day in a Skilled Nursing Facility, where the Medi-Cal rate is ~ $225/day.

In addition to these cost comparisons, studies of incarceration and chronic homelessness reinforce the conclusion that ARFs + RCFEs are a very cost effective resource that must be stabilized and maintained.

[6] AB 50: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB50

Tiered Rate Structures Incentivize ARF + RCFE Operators

The Supplemental Security Income (SSI) rate is a flat fee, not based on the resident's acuity or needs, and not based on where the facility is located (higher- vs. lower-cost areas of the state). Enhanced funding sources such as Regional Centers and the Assisted Living Waiver (ALW) use tiered rates based on the acuity and needs of each resident. Los Angeles County's Housing for Health (HFH) also uses tiered rates with its Enriched Residential Care Program (ERCP).



Each program defines their tiers based on the populations served, with increasing acuity and supports required for higher tiers. ERCP and ALW Tier 1 rates are in addition to SSI. Regional Centers Tier 1 is SSI (no enhanced payment).

Because of the variation among these rates, operators have an incentive to seek and accept residents who receive the higher rates of the Regional Centers or ALW, or the higher-reimbursing HFH program over the DMH programs. Current efforts to integrate HFH and DMH's ARF + RCFE programs to use the same assessments and rates will remove this discrepancy within the Health Agency.

Significant Unmet Need for Subsidized ARFs + RCFEs

Analysis of existing data gathered through the stakeholder process leads to best estimates that 25,000 low-income people need the support provided by ARFs + RCFEs across Los Angeles County. Currently a total of 10,400 residents of ARFs + RCFEs pay with SSI (according to data from California Department of Social Services), leaving a significant gap of unmet need.

Though specific numbers are not available, there is significant unmet need among people experiencing homelessness with serious mental illness, those who are ready to move to a less-restrictive setting from a Skilled Nursing Facility (SNF) or Institute for Mental Disease (IMD), and those who are on the Assisted Living Waiver wait list. The total unmet need among these groups is estimated at approximately 12,000 people.

Growing the Number of ARFs + RCFEs that Serve Health Agency Clients

California Department of Social Services reports that 1,560 ARFs + RCFEs received SSI payments in April of 2019 in Los Angeles County, or approximately one-half of the 3,200 facilities. This total includes people with intellectual and developmental disabilities served through Regional Centers. Since facilities are required to accept SSI if a private-pay resident becomes SSI-eligible, it is not possible to know from this information how many facilities take low-income residents upon admission. However, over 40% of facilities in Los Angeles County receive SSI payment for at least 20% of their residents, and 15% (over 400 facilities) have 75% or more residents paying SSI. The capacity represented by these facilities must be sustained with quality services.

There is demonstrated interest among operators to receive enhanced rates through the Health Agency programs. For example, when DMH introduced interim enhanced rates in 2018, they received requests to fund over 2,000 facility residents with serious mental illness but had the funding to accept only 600.

Not all interested operators have experience meeting the complex needs and behaviors of DHS and DMH clients. There are, however, ARFs + RCFEs with experience with these populations who have additional capacity. Among the 182 facilities currently contracted with at least one of the HFH and/or DMH enhanced rate programs, there are an additional 5,000 beds that are not funded through the programs. In addition, there are an undocumented number of facilities across Los Angeles County that have residents who are DHS or DMH clients but are not part of the enhanced rate programs. In addition, some other operators express interest in building the skills and expertise to serve these populations.

Operators' Perspective – Payer Mix

Respondents to the operator survey often take both private pay and SSI-rate residents. (40 operators answered this question)

- 30% of operators have 100% low-income residents (have no private pay)
- A quarter of operators have nearly all low-income residents (<10% private pay)
- Another quarter of operators have a predominantly low-income mix, with 10 – 40% private pay

Twenty percent of survey respondents that accept low-income residents are not yet engaged with HFH and/or DMH enhanced rate programs. These represent the group of operators with experience serving low-income residents who may be interested in accepting HFH or DMH clients.

Report of Stakeholder Input

In order to preserve and expand a robust system of licensed Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), stakeholders identify **six imperatives:**

1. **Operator Financial Sustainability**
2. **Resident Quality of Life**
3. **System Capacity**
4. **Operator Effectiveness**
5. **Integrated County Services**
6. **State and Federal Policy Advocacy**

Detailed input from the stakeholder process and areas of action for each of these imperatives follows.

1. Operator Financial Sustainability

Operator financial sustainability is the highest priority imperative for action. First among actions is to **raise the SSI rate at the State level.** Locally, the first priority is to **expand the Department of Health Services (DHS) and Department of Mental Health (DMH) enhanced rate programs with tiered rates** based on the acuity and functional needs of each individual regarding how much care and supervision is required. This is aligned with the current Housing for Health (HFH) rate structure, how the Medi-Cal Assisted Living Waiver and Regional Centers reimburse facilities, and how enhanced rate programs in other counties operate. HFH and DMH teams are working steadily to integrate these programs, eliminate competition among the departments' efforts, and expand the number of people served.

To sustain the broader group of ARFs + RCFEs, stakeholders encourage collaborative efforts to **expand sources of operating funds** for those facilities that serve residents with low incomes.

One-time funding for capital improvements can help sustain operators who have deferred maintenance that decreases resident quality of life and challenges facilities to meet licensing requirements. Community Care Licensing indicates that facility closures are often tied to noncompliance due to not having the resources to bring the physical plant to required standards.

Operators' Perspective – Deferred Maintenance

Nearly half of survey respondents indicated that "funds to make needed improvements to the facility" would be most valuable to help sustain their business.

Respondents indicated wide variation in the possible costs, with projects most often in the $10,000 - $50,000 range.

Areas of improvement listed in declining order of selection from the operator survey include repairs to structure, such as roof or cracked pavement; bathrooms and showers; paint, carpet, beautification; air conditioning; and efficiency projects, e.g. water, electric.

A forgivable loan fund could provide a capital improvement loan to any operator that commits to maintain a minimum threshold of SSI residents. A portion of the loan would be forgiven for each year that the SSI threshold is maintained. The length of payback could vary based on size of the loan. In return, the County is the first source of referral for any open bed; the facility retains the option to decline a referral but must maintain the agreed proportion of residents paying with SSI. Upon repayment by facilities that no longer sustain the SSI proportion, the funds could be re-invested in additional loans.

Finally, several stakeholders recognize the limitations of public funding sources, and encourage operators to **expand their business models** to generate additional funding streams, for example through Medi-Cal reimbursable Adult Day Health Care programming.

Operator financial sustainability areas for action:

1.e. Double the number of people to 4,000 benefiting from Housing for Health and Department of Mental Health enhanced rates, using a tiered payment model for high acuity clients

1.f. Expand other sources of operating funding available for facilities serving low-income residents

i. Explore short-term operating enhancements to cover the incremental costs of increased minimum wage beginning July 1, 2019

ii. Seek local funds through Measure H, Mental Health Services Act including No Place Like Home and Prevention and Early Intervention funding, Los Angeles County Homeless Initiative

iii. Seek state funds through expanded Medi-Cal Assisted Living Waiver, engaging Medi-Cal health plans, expanded Home and Community Based Services (HCBS) waiver and PACE programs to include ARFs + RCFEs

iv. Build on lessons from demonstration projects by Managed Care Organizations (MCOs) to expand MCO funding for ARFs + RCFEs [7]

v. Establish a "Friends of ARFs/RCFEs" nonprofit to raise funds, adopt a facility, and connect volunteers to volunteer opportunities in facilities

1.g. Meaningfully improve the sustainability and quality of ARFs + RCFEs serving a threshold percentage of low-income residents with one-time capital improvement funding matched by philanthropy

i. Identify funds to seed a facilities improvement fund, possibly using a forgivable loan methodology

ii. Explore philanthropy match: Weingart, Wellbeing Trust, Kaiser, United Way of Greater Los Angeles, Conrad N. Hilton Foundation, Medi-Cal health plan foundations

1.h. Encourage operators to explore new business models and funding streams

[7] https://www.chcs.org/media/HPSM-CCS-Pilot-Profile-032916.pdf

2. Resident Quality of Life

ARF + RCFE operators are encouraged to create environments that provide residents with socialization and activities, and encourage them to engage in self-care. Through a shared community, residents experience improved quality of life.

County programs such as the DMH Full Service Partnerships demonstrate the effectiveness of **on-site professional supportive services** as part of these positive environments. Increased resident engagement with case managers and mental health professionals who are knowledgeable about benefits, programs and other supportive service opportunities improves the quality of life for residents.

Community-based resources including peer groups and family support organizations can also offer **on-site enrichment activities** to improve resident quality of life. Stakeholders suggest a range of classes and activities, noting the importance of asking residents for input. Activities such as arts lessons, field trips, movies, personal care activities e.g. manicures or hair styling, or pet therapy provide residents with a sense of purpose, productivity, and hope. Stakeholders encourage topics for classes such as healthy eating, recovery groups e.g. AA, anger management, and life skills including transportation, budgeting, shopping, and cooking. As residents stabilize, some can be encouraged to seek **paid employment or volunteerism**. On-site support can help recruit prospective employers and volunteer opportunities, as well as provide coaching and job skills training.

Engaging residents with trained and qualified **peers** can have powerful positive impact. Peers serve as examples of how to overcome perceived limitations that are often associated with mental illness, and can offer practical and relatable advice to residents. Peer and family support groups in Los Angeles that can be resources to ARFs + RCFEs include: ACCESS, NAMI, Painted Brain, Project Return, SHARE, and Speak Up (CSH).

Successful facility operators understand the importance of **building shared community** among residents. Enhanced services offer opportunities to connect and strengthen community, as residents share experiences and learn together. Community reinforces residents' stabilization and minimizes destructive isolation. Residents who experience this sense of community report feeling safer and more secure in their lives.

One of the challenges stakeholders report most frequently is the inability of residents to **move to more independent living environments**. As a result, some ARF + RCFE residents may remain in the same facility for longer than is necessary. In addition to the general life skills development, community and peer support described for all residents, stakeholders encourage training for staff to identify and support residents who may be ready to live more independently, guided foremost by residents' own wishes. Volunteers and peers can be role models and form mentoring relationships with residents as they prepare to move, provide support in locating and outfitting new homes, and continue as support following the transition.

Resident quality of life areas for action:

2.f. Deliver wraparound on-site professional supportive services for residents

i. Provide onsite services by case managers, occupational therapists, social workers, substance abuse treatment specialists, and others, e.g. behavioral therapy groups, physical therapy, and occupational therapy

ii. Connect operators with health and mental health providers that offer on-site services, e.g. field-based and/or virtual psychologists, psychiatrists, dentists, podiatrists, and other medical personnel

2.g. Foster community and on-site resident enrichment activities with community-based organizations including peer and family support groups

i. Examples of community and volunteer groups include:

- Civic groups
- Students, e.g. psychology, social work, occupational therapy
- Faith based organizations
- Animal groups and shelters to bring animals for visits with residents

ii. Share activity director, socialization opportunities among facilities

iii. Establish an Assistance Fund to support these activities

2.h. Partner with existing programs to create a curriculum for peers to transition into professional positions at ARFs + RCFEs; organizations with experience:

- Chrysalis
- CSH
- Homeless Health Care Los Angeles

2.i. Assist residents seeking jobs, volunteerism, or other productive uses of time

2.j. Support residents to move to more independent living settings, if appropriate

i. Develop a program to help people in Institutes for Mental Disease prepare for transition to ARF or RCFE, then permanent supportive housing

ii. Prepare residents for transition using Critical Time Intervention

iii. Train DMH, HFH, facility staff, and peer workers to identify residents who could live more independently, and connect them to needed resources

iv. Help residents save money, e.g. with ABLE accounts, people with disabilities can save up to $15,000 over SSI asset limits without penalty

v. Promote the creation of new semi-independent living options, e.g. with private rooms, shared kitchen/living spaces, communal meals, staffing but not 24/7, support for medication self-administration

3. System Capacity

With more operators considering closure, **preserving ARF + RCFE facilities** is essential to strengthen and ultimately expand the capacity and quality of these facilities. Community Care Licensing works with operators who are considering closure to identify alternative approaches that maintain the facility, including transfer of the license to another operator. Experienced and established operators managing facilities can realize economies of scale and improve services to residents.

Stakeholders also encourage opportunities for **creating new ARFs + RCFEs,** including facilities to specialize in housing for persons with specific needs, e.g. substance abuse, trauma, or other challenging populations. Under land use requirements, any facility with more than six beds must receive a permit, which is frequently blocked by Not In My Back Yard (NIMBY) resistance. There are multiple efforts across Los Angeles County to increase community understanding of the causes of and solutions for homelessness, which can include support for ARFs + RCFEs.

Operators' Perspective – Sustaining the Business

Sixty percent of survey respondents indicated an interest in expanding their business, with 45% of the total interested in adding one or more facilities.

When asked what would be most valuable in sustaining existing businesses:

- 77% of respondents chose "stable increased payment rates"
- 62% said "quickly filling vacant beds with suitable residents"
- 49% chose "funds to make needed improvements to the facility," and
- 36% indicated "reliable, consistent staff"

System capacity areas for action:

3.c. Preserve existing bed capacity from closures

i. Partner proactively with Community Care Licensing to identify and address facilities' challenges before they consider closure

ii. Create a focused incubator team to coach operators who are facing challenges

iii. Develop a pool of experienced operators looking to expand to serve low-income residents as an alternative for operators who want to sell and keep the facility as an ARF or RCFE

iv. Develop capital alternatives for new ownership, e.g. nonprofit ownership alternatives that offer tax benefits; Primary Care Development Corporation, which provides financing and capacity building to health clinics

3.d. Expand total capacity of the system

i. Participate in community organizing to increase awareness of solutions to homelessness and to reduce NIMBYism

ii. Expand number of ARFs + RCFEs dedicated to specialized populations, e.g. co-occurring disorders, younger people with schizophrenia

iii. Increase awareness and interest among the general public about opportunities for operating ARFs + RCFEs

4. Operator Effectiveness

The most consistent and far-reaching approach to operator effectiveness is the creation of an **association for operators that serve low-income residents.** ARF + RCFE operators currently gather and connect through meetings led by DMH Service Area Chiefs, Housing for Health operator meetings, and through the organizations Mental Health Hookup and 6Beds, Inc. There is strong interest among stakeholders for broader opportunities to connect with an association through which they can network, learn, and contribute to policy advocacy.

Stakeholders suggest parameters and possible benefits of an ARF + RCFE association:

- Tiered membership rates, including low-cost options
- Staffing to coordinate logistics, members, activities, and follow-up
- Option to attend meetings virtually or with financial coverage for time away
- Creation of the association must come, at least to some extent, from within the group of existing operator champions

Operators' Perspective – Membership Association

When asked about possible benefits from a membership association:

- 77% of respondents indicated that updates on funding, licensing, new regulations, and best practices would be "very valuable" to them
- 74% of respondents indicated that advocacy for more funding and to change regulations would be "very valuable" to them

Among the roughly half of survey respondents who were willing to pay a **membership fee** to an association that provides meaningful benefits, fees of $120 or $300 a year were the most-frequently selected amounts.

Among those who had an opinion of what type of organization would be best suited to **coordinate an association** of operators, the most popular option was a nonprofit organization (26%), followed by a group of volunteer operators (20%), or the county (17%).

Possible models for an operator membership association include the Community Clinic Association of Los Angeles County (CCALAC), Association of Community Health Service Agencies (ACHSA) and the California Association for Adult Day Services (CAADS). 6Beds, Inc. is an organization for RCFEs and ARFs that offers business training, compliance tools, advice, and advocacy for small residential care facilities in return for a membership fee that many facilities accepting the SSI rate find prohibitive. The 6Beds, Inc. board is open to expanding their work beyond small organizations in order to address this need.

Stakeholders were enthusiastic about a **real-time bed-tracking system**. They recognized that no bed-tracking tool can guarantee a placement; meeting clients' needs requires one-on-one

discussions. However, being able to post when a bed is available and under what criteria on a web-based tracking system could be of great value to operators and potential residents. Family members and other stakeholders were also interested in a web resource with transparent, reliable facility information in addition to bed availability. Stakeholders suggest looking at the DPH SAPC (Substance Abuse Prevention and Control) bed-tracking tool as a model. Possible features include:

- App-based with desktop option
- Quickly, easily, and frequently alerts the Health Agency how many slots are available for enhanced rate clients
- Require operators to update frequently, by pushing reminders and alerts
- Companion website where facility uploads pictures, virtual facility tour, rates, licensure, contact person, bed types available, facility activities, neighborhood amenities; include facility star rating; indicate which populations are served

Operators' Perspective – Real Time Bed Tracking

In general, respondents to the operators' survey are not listed in on-line facility websites. Of the 18 who answered a question about what would be necessary for them to be open to listing on a bed-tracking database:

- 56% asked that it help fill their empty beds
- 44% requested ease of use
- 44% want it to be free to operators
- 39% indicated that it be accessible from a smart phone, and
- 33% wanted someone to help them list their facility on the site.

Stakeholders report that operators and staff of ARFs + RCFEs need assistance with understanding and using **technology** to make their operations more efficient and effective. While operators may have an email address and a computer, many have limited technical skills. Many have never participated in a webinar or joined a conference call. Some operators prefer to fax and mail documents, and are not savvy when it comes to internet research or logging into information portals.

Stakeholders mentioned **quality of care** as a chief concern about the current system of ARFs + RCFEs. Stakeholders strongly suggest that enhanced reimbursement be tied to performance, quality, and improved services. In an environment where very little outcomes data exist, stakeholders are interested in measuring and understanding resident outcomes. They suggest looking to similar systems for examples, and partnering with others to tap existing data and to develop systems for gathering more.

Operator effectiveness areas for action:

4.e. **Create and sustain an operator member association for facilities serving low-income residents;** services and benefits of interest include:

i. **Advocacy and public policy**: inform operators of policy and regulatory developments, engage in legislative advocacy for more funding and to change regulations to support operator sustainability and improve quality

ii. **Training and technical assistance**: involve operators in creating curricula and standards; coordinate training through webinars, train-the-trainer, and on-site opportunities; topics include working with people living with mental illness, de-escalating violent situations, appropriate use of emergency services

iii. **Staffing support:** including workforce recruitment; pre-vetted and approved pools of temporary relief workers for administration, drivers with vehicle, maintenance, security, housekeeping, cooks and others for planned and unplanned staffing needs

iv. **Collaborative community of operators**: create regional directories of facilities; host dialogues with Cities and the County; encourage exchange of best practices; make connections to other advocacy groups, such as NAMI; facilitate an operator-to-operator mentorship program; track and analyze trends

v. **Group negotiating and purchasing:** for example, for insurance; furniture and bedding; paper products, cleaning supplies; healthy food

4.f. Improve utilization and transparency with a **real-time bed tracking system**

4.g. **Increase operator access to and use of technology**; suggestions include:

i. Secure funds for operators to purchase computers or tablets, broadband capacity, and training materials

ii. Standardize intake information and processes

iii. Teach operators and staff to use email, participate in conference calls and web-based trainings including those offered by Community Care Licensing

iv. Support operators' ability to collect resident data and track trends

v. Train operators and staff to use online tools that will help them better manage residents' care, including: Medi-Cal health plan member portals, DMH, DHS, and DPH (SAPC) websites, and Medi-Cal transportation request systems

vi. Identify apps to help facilities function more efficiently, e.g., assessment tools or de-escalation checklists

4.h. **Develop and track metrics of quality care and resident outcomes;** suggestions include:

i. Review Skilled Nursing Facility and Interim Housing standards; evaluate if any could be appropriate for ARFs + RCFEs

ii. Partner with Medi-Cal health plans on quality improvement projects with metrics such as avoidable hospital admissions, avoidable emergency department visits, follow up on specialty referrals, access to behavioral health care, and other measures that plans already report per Healthcare Effectiveness Data and Information Set (HEDIS, managed care performance measures)

iii. Consider developing a star rating system similar to the system Medicare uses for Skilled Nursing Facilities

iv. Track outcomes of people who move out, including residents who are transferred as the result of an ARF or RCFE closure

5. Integrated County Services

The stakeholder process tapped the energy of hundreds of people, creating a cohort who are informed about and committed to sustaining a strong ARF + RCFE system. Stakeholders strongly encourage the Health Agency to **maintain this momentum** by dedicating leadership and resources to continue to share information, connect interested parties, and implement the suggestions from this report.

The top priority in this area is to complete the **integration of Housing for Health (HFH) and Department of Mental Health (DMH) enhanced rate programs** including selection of a single assessment tool, eligibility requirements, and rate levels.

The top stakeholder request of the integrated programs is to establish **regional liaisons** to address contract questions, fill vacancies, discuss policies, request training, and identify resources. Ideally, multiple liaisons would be assigned regionally across the County (perhaps by SPA) in order to foster relationships with a manageable number of operators. In addition, ARFs + RCFEs can benefit tremendously from **support, services, training, and technical assistance from across the Health Agency and other County departments**.

Strong, active partnership between the Health Agency and **Community Care Licensing (CCL)** is essential for a strong ARF + RCFE system. Building on discussions begun during the stakeholder process, staff from DHS, DMH, and CCL will identify specific roles and protocols for communication, and will develop agreements for collecting and sharing information including the possibility that CCL's Licensing Program Analysts (who conduct onsite audits at ARFs and RCFEs) could use a new instrument to collect simple point-in-time information at facilities. The shared focus is to support quality, avoid closure of existing facilities, and encourage licensing of new facilities serving low-income individuals.

Consistent with CCL's cultural shift toward support and partnership with operators, the teams will work together to streamline information flow, expand access to capacity building and technical assistance, and partner in efforts to expand funding for ARFs + RCFEs. When a facility is on a path toward closure, all parties will work together to identify alternatives that minimize disruption for residents, maintain the facility's licensure, and as needed engage experienced operators who are interested in expansion.

Integrated county services areas for action:

5.f. **Complete Housing for Health and Department of Mental Health (HFH + DMH) program integration with consistent eligibility, assessment, and payments**

i. Use a clear and transparent system to select who will be funded for enhanced rates; top populations suggested by stakeholders to prioritize:

- Clients coming out of Institutes of Mental Disease (IMDs) to free up critical IMD slots
- Public Guardian conserved clients for whom ARF + RCFE is appropriate level of care
- Clients assigned to DHS for primary care, specialty care, inpatient hospital, and outpatient services for whom ARF + RCFE is appropriate level of care
- Long-term inpatients in County acute care hospitals who do not need acute care and require the support of an ARF + RCFE; if not yet receiving SSI, pay the full amount to the ARF + RCFE until SSI coverage begins

ii. Pre-qualify operators through certification including minimum training and commitment to serve a threshold percentage of residents with SSI

iii. Centralize ARF + RCFE contracting and contract management with a single point of contact

iv. Establish methods for third party referrals so that acute-care hospital and IMD discharge planners, DMH-contracted providers, Coordinated Entry System providers, DPH-contracted SAPC providers, and Medi-Cal health plans can refer clients to the HFH + DMH program

5.g. **Create liaisons within the integrated HFH + DMH program** to help residents and operators navigate the system and access County and other resources

5.h. **Ensure that the integrated HFH + DMH program aligns and engages with other programs and supportive services offered by the Health Agency**, including Full Service Partnerships

5.i. **Ensure that all County departments that provide relevant training, technical assistance, and other capacity building include ARF + RCFE operators and staff**

5.j. **Continue to work with Community Care Licensing to strengthen relationships with all operators, support at-risk facilities, and explore changes of ownership and/or management to prevent closures and negative impact on residents**

6. State and Federal Policy Advocacy

6.c. Advocate at the State level for increased funding and for regulations that support a strong, sustainable ARF + RCFE system

i. Encourage and support advocacy for AB 1766, AB 50, and subsequent relevant legislation by DMH Service Area Advisory Committees (SAACs), MHSA advisory committees, Mental Health Commission, and other Health Agency bodies

ii. Sponsor a bill in the fall 2019 legislative session

iii. Bring the resident, family and operator voices to advocacy efforts, e.g., with Housing CA, CSH, Steinberg Institute, CA Behavioral Health Planning Council

iv. Stakeholders identify the following possible policy and regulatory changes:

- Increase SSI rate
- Incentivize Medi-Cal health plans to place in ARFs + RCFEs in lieu of higher levels of care
- Include people with serious mental illness as priority population for housing initiatives including Section 8, permanent supportive housing
- Support legislation to increase access to funding for ARFs and RCFEs as an important permanent housing option by including them in the definition of permanent housing for people who are homeless or housing insecure
- Make ARFs + RCFEs eligible for No Place Like Home funding
- Improve data tracking and reporting including who is served, real-time bed availability, facility closures
- Expedite the ARF + RCFE license application process
- Allow ARFs + RCFEs to provide different levels of care with higher reimbursement rates at the same facility, e.g. recuperative care
- Require or incentivize every operator over a certain size to include a portion of SSI beds
- Monitor licensed facilities that transition to unlicensed facilities, but continue to serve the same clients; residents are often unaware of their rights in these scenarios
- Increase facility maximum to eight or ten beds in a residential zoned area
- Create a state insurance plan for ARF + RCFE operators

6.d. **Advocate at the Federal level for increased funding and for regulations that support a strong, sustainable ARF + RCFE system**

i. Include ARFs + RCFEs as a permanent housing option that is eligible for funding through other programs to prevent and end homelessness

ii. Address the IMD exclusion, a section of the federal Medicaid rules that limits a residential facility's ability to provide onsite mental health services

First-Person Perspectives: Resident, Family, and Operator Profiles

Note: All names and identifying details have been changed to protect the subjects' privacy

Ava's Story

I asked Ava to check on her brother, to see why he hadn't called us. She found his body, and after that she was never the same. Was that what caused her break? Her mother and I lost two of our children that year. How do you live with that?

The man's voice is raw with agony. Doctors say his daughter's schizophrenia isn't his fault, but the nagging doubt never leaves. Nor does the grief.

Ava is striking, with an odd affect. Her dark brown eyes stare flatly from a carefully composed face. Behind this mask, she feels safe. No one knows the thoughts roiling her mind or that her heart races with fear. At least she hopes no one can read her mind. The voices often warn of threats from mind readers and ill-wishers.

Why can't the voices ever say anything nice? bemoans Ava's social worker.

The only thing that quiets the voices and their ominous admonitions is the medication that nauseates her, makes her sleepy, and dizzy, and fat. How will she ever find someone to love with the side effects running interference? Ava is smart; she reads medication inserts and is reluctant to do long-term damage to her body. She hopes to have children someday. So she refuses the medications, and cruel voices are her constant companions.

Ava's family was always close. Mom homeschooled her bright children until high school, and Ava seemed to live a charmed life. Prodigious musical talent saw her repeatedly win competitions. But it's been ten years since she touched the instrument, ten years since her charmed life abruptly ended. Family contact is sporadic since she relocated across the country. She has no friends.

Ava's troubles started in her late teens. She chose a state university to be near the adored older brother, her anchor. But he had diabetes, and something went wrong. The day she let herself into his apartment and found his lifeless body, according to her family, her beautiful life unraveled.

Soon Ava stopped going to classes, decided it was unsafe to live in her apartment, and started living in her car. The voices moved in with her. They advised her to change locations frequently, to avoid the people they said were after her. The family tried to draw her back into their protective orbit, but the voices cautioned against letting them control her life.

Friends consoled the family for their loss of Ava's brother. They wondered why Ava wasn't around, but her parents evaded the questions. They still conceal her illness from the world outside the family. Eventually people stopped asking. That's the isolating stigma of mental illness.

Following her first hospitalization and diagnosis, Ava decided she couldn't remain in her home state. First, she drove her car to New York, staying with old friends until they could no longer tolerate her unexplained erratic behavior. Then she migrated to Los Angeles, living in her car and occasionally calling home to ask for money. After a while, the car was impounded for unpaid tickets, and Ava found a shelter.

The shelter was a bed, at least, but she quarreled with her neighbors and soon left for the streets. After an involuntary hospital stay, Ava was recruited by an unlicensed residential facility, often called a "room and board" home. There was nothing homey about this place though. It was dirty; the food was inedible; and the gate was always locked. At 9:00 every night the operator went to bed, and any resident still outside spent the night elsewhere, often in a doorway. Ava is a young woman, a gifted musician who enjoys the kind of nightlife found only after 9:00 p.m. She was not happy in that facility.

What are your possibilities when you're young and bright, talented, attractive, and seriously mentally ill? When your family can't help you, or you won't let them? When you can't hold down a job, but you'd like to have a future, where do you turn for help? When your meds make you physically ill and the internal voices keep you isolated and afraid, what are your options?

Ava no longer lives on the street or in a shelter or an exploitative "home". She has spent the past year living in the quiet, comfortable licensed Board and Care home her social worker found. This woman is part residential facilitator, part family mediator, part friend. She is the one person Ava almost trusts.

But Ava's family pays for the social worker. They have not given up on her, unwelcome though their efforts often are. And they can afford someone to help her, to shadow her, befriend her, help her secure a room in one of the vanishingly few licensed facilities that are small enough and well-run enough, and patient and understanding enough to care for challenging residents like Ava. Few people with serious mental health issues are so fortunate. Many are estranged from loved ones. And across the state, Board and Care homes are closing, because shockingly low reimbursement rates make their business model a losing proposition.

What about the thousands of people with serious mental illness on the streets right now? Where will they sleep tonight? How will they eat? Who can they turn to when the voices tell them to threaten, or run, or harm themselves? Can we, please, collectively, imagine the answers?

Adam's Story

Adam is small and round, with gentle eyes that fill with warm light when he smiles, which he does often. His hands have a pronounced tremor from his medications, and his voice has a frequent stutter.

I knew I was off. If I get a cold, I can't really deny it. I know all the clinical symptoms. I have a PhD in psychology. So, I knew how to get myself released from the hospital, even when I wasn't at all stable.

I'm trying to dig into my symptoms, going to seminars and going deep into the experiences. I get flooded with memories of trauma from the past years.

I'm interested in video-based therapy. When you're editing, it teaches you to listen, to sit with anxiety. Making movies is good for PTSD. You can get it out, then relate to the story you tell.

I love sales, could go into the Virtual Reality field and work with trauma and addiction. VR helps for those.

Am I talking in circles? Maybe I'm afraid of the affect that would follow if I connect all the dots.

It doesn't matter how non-functional you are, your basic needs must be met. Everyone should have a case worker, just for legal obligations, filing paperwork. Otherwise we're overloading the jails and hospitals. It's just whack-a-mole.

Where are all these cracks coming from? You can't just sign up for SSI or whatever; you need someone to hold your hand. Why don't we have social worker/case manager connections? My need for support will probably never go away. What happens when I lose my FSP?

I can get overwhelmed by the tiniest thing. I have to start with small goals. Making my bed every day is a good place to start. Someday I'd like to get my license and get back into therapy. I have guest lectured at USC and other places about media psychology.

I'm living in my second board and care now. I like that the environment here is non-judgmental. It's like living in the TV series MASH, being surrounded by the class clowns. When I go to my day program, I'm in group with people from my board and care, so that is very comfortable. It enhances the community feeling.

Adam's Sister's Story

Adam was the world's sweetest baby, my cherished little brother. As a teenager, he turned his passion for filmmaking into a profitable business and was a popular and successful student. In college, though, something happened. He became unstable and was diagnosed with bipolar disorder.

Despite repeated hospitalization, he managed to get his PhD in psychology. We were so proud, and we all kept hoping that the right medication would control his mania, that each round of therapy would help him commit to taking the meds. When he married, we were relieved. Finally, though, his unpleasant and bizarre behavior exhausted his wife, and they divorced.

When he lost his marriage, it was like he lost contact with himself, with us, with the reality of the world. He became one of those wild-eyed word salad people you turn away from on the street, out of fear or embarrassment or futility.

For our family, it was like having the rug pulled out from under us. Dad said he felt like his son had died, or that he was an alien imposter. It hurt, but you couldn't mourn.

I live closest, and I have two kids. I couldn't do anything; couldn't talk to anybody about it. I was isolated from my friends, never knowing when I'd have to drop everything and try to help him. He didn't have a stable place to live, and so nothing else in his life was working. He ran through his money, got evicted from several places, lived in his car.

He would disappear for months at a time, then call to scream at whoever answered, just turning our world upside down. He reported our dad to the professional certification board, claiming dad was a fraud. He shouted vile insults at our mother in a coffee shop, and she became afraid of him. At one point, he dressed up in a weird outfit and assaulted two police officers. That's when he lost his car.

You know, if he were an alcoholic, he could just check himself into a rehab facility, and they would help him. It's not that easy with this brain disease, with mental illness. He has to say he wants to harm himself or someone else if he wants help. And when he is at his sickest and really needs help, he's not aware of that fact.

For a couple of years, I didn't really sleep, even though I tried to block it out. Finally, I joined NAMI and found someone to help us navigate the system. Now he's in a board and care, and there's someone to take care of him, someplace for him to belong. We've all gotten our lives back.

It's important for every mentally ill person to have an advocate that's not their family. Adam's inability to control money was definitely an issue, and it's easy to see how that could lead to family shutting somebody out. Now he has a good place to live, where people make sure he takes his meds. He also has a conservator, and it's much easier for all of us. No more rounds of hospitalization, disappearance, and worry.

We need at least 25% more facilities. Leaving mentally ill people unhoused is destroying families, destroying society. Seriously mentally ill people can't take care of themselves. I used to call around

– so many phone calls – and couldn't find a good place for him to live. We needed help and thank goodness we finally found it.

Our lives have completely changed. He was basically dead or going to be dead. There was this horrifying thing that was supposed to be him. It was like an earthquake every time. You kind of expect it; you just don't know when. And now he says to me, You would not believe what it was like inside my mind. It was terrifying. So sad, so lonely, so scared. He was a prisoner inside his own head, and now he's free.

Why We Do It

These statements come from three interviews of current ARF + RCFE operators who took over existing board and care homes from relatives. The words are their own.

When I was growing up, I worked in the business. At first, I hung out with the clients, playing pool, basketball. It's still the most enjoyment I have - being with the clients.

Sure, I could make more money doing something else. But I can actually help the people here and keep them stable. I would've closed a long time ago if it weren't for the people living here, some of them for twenty years.

I stay in this business because I love the residents. I don't know how I will survive if there's no movement. I'm not the only one; facilities will keep closing.

My daughter isn't interested in taking over the business. I won't force her.

I have a BS in psychology and a good sense of people. My mom is also in the business, but I won't take over her home - it's too small to work. The model of succession doesn't work anymore. You have to pay professionals to do the work.

I'm thankful this is being addressed, finally. The longer you wait, the more facilities will close.

We're not just looking to fill a bed. We're not a motel. I have to be selective to protect the residents. If I take a violent person and they hurt someone, I'm responsible.

Clients are more difficult now than in the 1980s. They used to stay in IMDs for a year, so they were more stable when they came out. Now there is more substance abuse, homelessness, and there's less support, so it's much more challenging, and the money is less.

I really feel for the elderly with mental illness. No one wants them. There's going to be a real challenge there.

We help the consumers stabilize and keep them out of the ER, but it's impossible to show that we reduce ER admissions. How do we do it? A big factor is that we create community. They need to feel safe. We become one large family, and they thrive here.

Three quarters of the residents effectively have no family. This is their home.

It all boils down to community, camaraderie, support.

You have to care. I wouldn't treat my guys any way I wouldn't want for myself.

I insist staff give a certain kind of care – centering on respect. We don't tolerate rudeness.

An association of facilities with 1,500-10,000 residents could be an effective voice. We all feel so defeated. Anything is more than nothing.

Just No Way to Stay Afloat

Each of the three operators quoted here is more knowledgeable about the financial aspects of the business than many board and care operators. Here are their thoughts about the current business model.

I have an accounting background. I took over this business when my husband died. He was a parole officer, so he could handle challenging residents. I only take high-functioning people.

My brother-in-law roped me into this. I was a probation officer before. My staff makes this work. I have an administrator, who makes the money work and is my right hand, and a supervisor who understand the residents.

I was in finance before coming to help my mother-in-law out. I know how money works, and I'm behind on my rent to her now, because there's just no way to stay afloat.

For a larger facility like mine, we need a minimum of $50 per day - $1,500 a month. That's if we have other support, like a psychologist/psychiatrist to keep residents from decompensating and a full-time social worker to help us access services.

For a 100-bed facility we need at least $2,000 a month per person – double the current rate. The developmentally disabled facility minimum rate is two and a half times ours.

I took out a second mortgage on both our properties, trying to keep them going while waiting for higher reimbursement. Now it looks like I may lose both of them.

Licensing used to be a support agency, provide technical assistance. Now it is an enforcement agency, assigning culpability. I run a tight ship, so I have no issues with them. But the model of issuing citations is not as helpful as supporting us.

Yes, we need to paint this place. I will spend weekends doing that myself.

Power bills are up 20-30% in the past year. The minimum wage will be going up July 1, then the next year and the next year. All expenses keep going up.

Food bills keep rising. We penny pinch, but steak once a month, shrimp once in a while would be great. Food is central to the kind of caring environment we provide. I don't know how this industry will survive.

I have to be selective about who lives here. When I meet someone, coming from the street or sober living, I say come back in 3 months. If I take a violent person and they hurt someone, I'm responsible. Right now, 35-40% of my payroll is workers' comp. If someone hurts a staff member, the increase in workers' comp would quickly put me out of business.

When Imperial Manor closed, 20 residents ended up in the hospital. How much do you think that cost?

More support personnel for us would make a big difference. We operate with bare minimum staff. Now we have one longtime resident on SSI who has breast cancer, needs to see a specialist, and can't go by herself. So that's a staff person, a car, a one hour drive each way, $20 to park, gas, insurance, and 4-6 hours of employee time, with maybe some overtime. So, the tangible cost is about $200 per excursion, repeated every week. Did I mention the resident receives only SSI? In the meantime, we're short an employee; so, there's more work for everyone, and some clients get neglected. If the county had a driver available to us, we wouldn't have to go in the hole to provide care for this person. Of course, we could just send her to another facility, where she wouldn't know anyone, and say "Good luck. Hope you get well there, without your community to support you." What kind of person does that to someone?

Sometimes It's Hard to Love You

Many operators lead with their hearts. They love their residents and love helping them. This operator tells the story of meeting and falling in love with his wife, before they bought their board and care business.

My mom is from Guatemala and has a 6th grade education. She was the scholar of the family and encouraged my education. I'm the first in my family to go to college. It took a few times, dropping out, trying to pay off my debt and going back. It took 10 years to get my degree in abnormal psychology. Now I'm working on my master's degree to become a LMT.

While in school, I met the love of my life when we both worked in an ARF. She asked me out several times, but I didn't think she was a serious person. Finally, she gave me candy, and I gave her a kiss. We dated for six years and have been married for sixteen. Now we have three kids, and her daughter from before works with us too. I guess she is serious.

In the beginning I worked for a big Adult Residential Facility, doing FSP. It was a very recovery-oriented company, and I learned how to be professional, to be strict but fair. Then I worked for the County for a while and made connections that helped us get here.

We lease this building. It was an existing facility that was totally disgusting - bed bugs, roaches, mice. Now it might not look the best, but it's clean. And the food is decent. If you and I wouldn't eat it, we're not going to serve it.

We really have a heart for this population. They are our customers. We treat them with respect and establish boundaries. My half-sister has mental illness. That's where my passion comes from.

What do you do; where do you get help? I know those questions, and I'm learning how to answer them.

This is our home. That means all of us. I tell our guys, "I love you. Sometimes it's hard to love you. But this is your family now, and if you can see that, things will change for you." And they do.

There's a shady side to the board and care business. You have to know discharge planners and have relationships to fill the beds. Some of them want to charge you the first month's rent as a fee. Once I made a deal to swap residents with this one operator. But then he kept his resident and mine too.

My wife goes out and makes friends. That's how you find the good operators. One of them helped us a lot in large ways and small, really mentored us. It's hard to make it when you're this small and all alone. It's hard.

Finding good employees is really hard. Then the case managers don't do their job, often just don't show up. There aren't enough hours in the day to do right by our people.

My wife is in the hospital right now, with her glucose out of control. It's stressful, but still we love it. Our dream is to open another facility. More beds would help us make some money.

Sources

County Health Agency leads:
Elizabeth (Libby) Boyce, Department of Health Services
Maria Funk, Department of Mental Health
Jaclyn Drown, Department of Mental Health

Project Management team:
Supervisor Janice Hahn's office
Jaclyn Baucum
Louisa Ollague
Elizabeth Lizardo
Kyla Coates

Supervisor Sheila Kuehl's office
Molly Rysman
Rachael Simon

The County Health Agency
Cheri Todoroff, Department of Health Services

Consultants:
Elizabeth Sadlon
Lisa Kodmur
C Reed

Stakeholders:

How Stakeholders Participated	How Many Participated This Way
Attended small group and/or stakeholder summit	144
Participated in a 1:1 interview	27
Both attended and interviewed	21
TOTAL stakeholders with direct input	192

Participating stakeholders As provided by participants in their registration

Advocates

Name		Organization
Artur	Atoyan	ANO Two
Chanh	To	Asian Coalition
Mike	Chindamo	College Hospital
Vanessa	Rios	CSH
Ellie	Stabeck	Former Advocacy Chair NAMI SGV
James	Morris	JMPM Consultants
Stacy	Dalgeish	L.A. County Mental Health Commission
Lyn	Slotky	LPS Conservation
Justin	Torres	Mental Health Hookup
Linda	Dorbacopoulos	NAMI
Wendy	Kauderer	NAMI
Kerry	Morrison	NAMI
Sharon	Yates	NAMI Los Angeles
Brittney	Weisman	NAMI Los Angeles County Council
Christina	Vera	NAMI Pomana
Paul	Stansburry	NAMI Southbay
Shelley	Hoffman	NAMI Westside Los Angeles
Jean	Harris	NAMI, Antelope Valley
Wayne	Meseberg	San Gabriel NAMI
Alana	Riemerman	Shelter Partnership
C. Cleo	Ray	
Alicia	Rhoden	
Claire	Tolentino	
David	Tolentino	

ARF + RCFE Operators

Name		Organization
Labo	Folayan	Abigail Health Care
Liz	Bijou	Amigo 1 & 2
Serob	Terzyan	Beckford Assisted Living
Galina	Samuel	Bel air guest home
John	Stienfield	Beverly Hills Gardens
Sam	Blake	Blake Home
David	Coloma	Brass Coloma Corp
Martha	Coloma	Brass Coloma Corp
Ted	Bonzon	Fair Oaks Manor
Vladimir	Chertok	Gilmar Manor
Annie	Cardillo	Glen Park Healthy Living
Lita		Golden State Lodge

MaryLou	Bernabe	Golden State Lodge
Judith	Schwartz	Highland Manor
Helen	Terzyan	Horace Assisted Living
Jonathan	Istrin	Libertana
Ana	Kunz	Olivia Isabel Manor
Lynn Kim	Tran	Olivia Isabel Manor
DeWalt	Brown	Pasa Alta Manor
Aharon	Strilks	Pasadena Adult Living
Santos	Dominguez	Pico Rivera Gardens
Julia	Elias	Pico Rivera Gardens
Favish (Moshe)	Weiss	Pico Rivera Gardens
Mark	Samuel	Sepulveda Residential
Edna	Leopoldo	Sharp Ave. Quality Care
Irma	Ramirez	Springfield Manor
Ari	Rosner	Sunland Manor
Dennis	Wilder	The Manor
Greg	Erdosi	Topanga West Guest Home
Michael	Bolong	Trucare Community
Michael	Bolong Sr.	Trucare Community
Ginger	Po	Valley Vista Residential Manor
Chris	Salvador	Valley Vista Residential Manor
Natalie	Neale-Singh	Villa Stanley East
Matthew	Chinichian	Westchester Villa
Bamba	Ramos	Westchester Villa
Alla	Neyman	Westside Manor
Melchor	De Leon	Whitten Heights Assisted Living & memory Care
Vic Jun Helen	Flores Alba	Wilmington Gardens
Lilia	B	
Peace	Chan	
Stephen	H	
Jhay	Maniwang	
Clarel	Martine	
Pascalle	Martine	
Carliss	Monroe	
Emma	P	
Jeffrey	Po	
Michael	Rosb	
Mary Grace	T	
Sim	Ulrich	

Resident, consumer, family member

Name		Organization
Angela	Guida	Golden State
Mark	Gale	NAMI
Tristan	Scremin	Painted Brain
Debbie	Buxar	
Tammy	Castor	
Josh	Cohen	
Sue	Cohen	
Joe	Guida	
Antonio	Ramos	

Government agency, initiative

Name		Organization
Bruce	Saltzer	Assn. of Community Human Service Agencies
Stacy	Barlow	CA Dept Of Social Services Adult & Senior Care Program
Pam	Dickfoss	California Department of Social Services
Monique King	Viehland	CDC/ HACoLA
Shannon	Parker	DHHS
Lidia	Melcher	DHS
Sonya	Smith	DHS
Beatrice	Tan	DHS
Ronnie	Thomas	DHS
Gabriela	Flores	DHS Housing for Health
Jaclyn	Drown	DMH
Maria	Funk	DMH
LaTina	Jackson	DMH
Martin	Jones	DMH
Caroline	Kelly	DMH
Mimi	McKay	DMH
Keris	Myrick	DMH
Manuel	Rosas	DMH
Jonathan	Sherin	DMH
Jacquelyne	Wilcoxen	DMH
Stacy	Williams	DMH
Victor	Bascos	DMH AVMHC
Pamela	Inaba	DMH Housing Workgroup
Valeria	Valadez	DMH-SCVMHC
Patricia	Nwaekeke	Higher Level of Care Services, Housing for Health - Access, Referral and Engagement Unit, Los Angeles County Department of Health Services
Libby	Boyce	Housing for Health, DHS

Cheri	Todoroff	Housing for Health, DHS
Christina	Tuson	Los Angeles City Attorney
Art	Sanchez	Los Angeles County
Liliana	Palacino	LADMH
Marina	Genchev	LAHSA
Luis	Leyva	Los Angeles County Office of the Public Guardian
Patricia	Russell	NAMI
Nicole	Powell	Office Of Supervisor Ridley-Thomas
Connie	Draxler	Office Of The Public Guardian
Fernando	Plazola	Office of the Public Guardian
Gilda P.	Ramos	Office of the Public Guardian Department of Mental Health
James	Coomes	Olive View Community MH Urgent Care Center
Louisa	Ollague	Supervisor Hahn's office
Molly	Rysman	Supervisor Kuehl's office
Rachael	Simon	Supervisor Kuehl's office
Blake	Dewveau	
Steve	Dominguez	
Max	Estrada	
Lucinda	Hayes	
Lynn	Katano	
Matt	Lust	
Ryan	Mulligan	
Alan	P	
Jennifer	Vallejo	

Healthcare provider

Name		**Organization**
Laurie	Ross	Antelope Valley Hospital
Steve	Jennings	Aurora Charter Oak Hospital
Dr. Jennifer	Rousch	BHC Alhambra Hospital
Dino	Leonardi	Cedars-Sinai Medical Center
Stacey	Hill	Citrus Valley Health Partners
Joe	Avelino	College Medical Center
Howard	Mationg	Del Amo Hospital
Velencia	Murphy	Del Amo Hospital
Sandra	Maldonado-Aviles	Harbor-UCLA Medical Center
Jennifer	Murray	Harbor-UCLA Medical Center
Marcia	Penido	Huntington Hospital
Trevor	Asmus	Las Encinas Hospital
Gabriel	Stauros-Caldwell	Las Encinas Hospital
Olga	Felton	Los Angeles Jewish Home
Bob	Trostler	SFV CBAS

LaCheryl	Porter	St. Joseph Center
Inez	Otbo	6Beds
Hector	Rivera	6beds
Roberta	Mendonca	6Beds Foundation, Inc.
Gina	Wasdyke	6Beds, Inc.
Jaime	Garcia	Hospital Association of Southern California
Esther	Aguilera	Housing for Health

Other service provider

Name		**Organization**
Chess	Brodnick	Anne Sippi Clinic
Caitlin	Leeger Langan	Career Smart
Jeff	Fox	DBSA
Sean	Markie	Helping Hands Senior Foundation
Carol	Liess	Homes for Life
Deborah	Gibson	Homes For Life Foundation
Martha	Delgado	Illumination Foundation
Karen	Hess	Jewish Family Service of Los Angeles
Maria	Morris	JMPM Consultants
David	Neptune	Mental Health America of Los Angeles
Barbara	Wilson	Mental Health Hookup
Robert	Perez	Placement Helpers
Joseph	Bantle	Project Return
Guyton	Colantuono	Project Return
Ashley	Flores	Project Return Peer Support Network
Steve	Gilbert	Realtime Sr. Living
Sawako	Nitao	SHARE!
Ricardo	Munoz	Telecare LAOA
Jasmine	Brizuela	Brilliant Corners
Chris	Contreras	Brilliant Corners
Ryan	Macy-Hurley	Shelter Partnership
Elizabeth	Bromley	UCLA

Foundation, funder

Name		**Organization**
Dalma	Diaz	United Way of Greater Los Angeles
Chris	Ko	United Way of Greater Los Angeles
Emily	Bradley	

Other

Name		Organization
Paulette	Grant	Andrews Independent Living
Mike	Austria	Austria.inc
Loida	Barrientos	WFG
Rafael	Diaz	
Michael	Vu	

Possible areas for action drawn from:

- ”White Paper: Preserve and Support Existing Adult Residential Care Facilities for Low-income Adults and Seniors with Mental Illness and Other Disabilities, to Prevent These Individuals from Falling Into, Continuing In, or Returning to Homelessness,” submitted to the California Homeless Coordinating and Financing Council, 2019
- "A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County" L.A. County Mental Health Commission, Jan. 2018.
- "Supporting Affordable Assisted Living in San Francisco," SF City/County Long Term Care Coordinating Council, Jan. 2019.
- "Adult Residential Facilities (ARFs): Highlighting the critical need for adult residential facilities for adults with serious mental illness in California", CA Behavioral Health Planning Council, March 2018.
- “A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness,” Dr. Dennis Culhane et al, 2018
- “The Aging Homeless Population in LA County: Projected Costs, Housing Models and Cost Offsets Results,” Dr. Dennis Culhane et al, 2018
- “Addressing San Francisco’s Vulnerable Post-Acute Care Patients: Analysis and Recommendations of the San Francisco Post-Acute Care Collaborative,” 2018
- “Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot,” Center for Health Care Strategies,” 2016
- Stakeholder interviews
- Small group discussions
- Stakeholder summit