December 4, 2024

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SUBJECT: **REPORT ON CONTINUUM OF CARE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BEDS (ITEM NO. SET MATTER 1, AGENDA OF JUNE 18, 2024)**

As requested at the Board meeting of May 2, 2023, the Directors of Mental Health (DMH), Public Health (DPH), Health Services (DHS), Justice Care and Opportunities Department (JCOD), and the Executive Director of the Homeless Initiative (HI) will report on the Continuum of Care for mental health and substance use disorder (SUD) beds and include in a quarterly written report back to the Board measurable outcomes and challenges and opportunities.

The following provides updates by Departments for the period of July 1, 2024, through September 30, 2024, on these directed topics accompanied by the Los Angeles County (LA County) Bed Status Report Update presentation deck (Attachment A):

Measurable Outcomes

Number and types of beds available, including beds net growth and beds in development.

DMH bed continuum data is comprised of two lead divisions - Health Access and Integration (HAI) and the Housing and Job Development Division (HJDD). HAI includes five bed types: urgent care centers (crisis receiving and stabilization), acute inpatient, subacute, crisis residential treatment program and enriched residential services (crisis residential/extended residential). HJDD includes three bed types: licensed residential care, interim housing (IH) and permanent supportive housing (PSH). In addition to HJDD, contributions to the interim housing bed network also come from the DMH Outpatient Care Services Division, Transition Aged Youth (TAY) Enhanced Emergency Shelter Program (EESP).

DMH has systematically increased bed capacity across the continuum, specifically adding 16 Urgent Care (UCC) chairs, 5 acute inpatient beds, 9 Skilled Nursing Facility-Special Treatment Programs (SNF-STP) subacute beds, 32 Crisis Residential Treatment Program (CRTP) beds, 20 Enriched Residential Services (ERS) beds, 51 Interim Housing beds and 402 PSH beds since the last report. DMH has committed to building a more robust bed continuum, acknowledging it takes time, strategy and countywide planning to ensure that, in the short-term and long-term, the right quantity of bed types is added to increase access.

In addition to the beds added this past quarter, the County has been proactive in developing countywide strategies to leverage several state funding initiatives including but not limited to Behavioral Health Continuum Infrastructure Program (BHCIP), Behavioral Health Bridge Housing (BHBH) and Community Care Expansion (CCE) grants. With the County's implementation of BHBH and CCE, DMH estimates 550 new interim housing beds to be funded with BHBH dollars and 450 new subsidies for licensed residential care beds through the Enriched Residential Care (ERC) program to be funded with CCE dollars. HAI and DPH-Substance Abuse Prevention and Control (SAPC) are engaging with behavioral health providers who were awarded BHCIP grant funds (estimated at $695 million for rounds three through five) to expand behavioral health treatment and increase the number of treatment and residential beds across levels of care. These BHBH, CCE and BHCIP beds will expand LA County's bed network over the next few years as the projects are completed and the beds come online.

As a result of the LA County strategy, over the last two years (2022-24), CRTP capacity was increased by more than 200 beds across County campuses. DMH has addressed priority access points for some of the highest acuity clients by implementing specialized inpatient (acute level of care) and subacute contracts that have added 140 specialized inpatient and 100 subacute beds in order to increase the flow of clients from acute inpatient to subacute care. There has been incremental growth within the ERS level of care and, as a result of DMH forecasting, this will be a focus for additional growth going forward.

DMH also continues to expand PSH resources with capital investments through the No Place Like Home program, the additional allocation of federal housing subsidies and an increase in local rental subsidies through the Flexible Housing Subsidy Pool using Mental Health Services Act (MHSA) dollars.

SAPC contracted SUD treatment network includes four main bed types: Sobering Centers (Crisis Receiving and Stabilization), Inpatient Withdrawal Management (Acute Inpatient/Subacute), Residential Treatment with or without Withdrawal Management (Crisis Residential / Extended Residential), and Recovery Bridge Housing and soon Recovery Housing Beds (Interim Housing) each serving a unique role within the SUD treatment continuum.

Year-over-year trends demonstrate growth across multiple bed categories, reflecting strategic efforts to optimize Medi-Cal revenue and invest in new capacity to better address community needs and timely access to care for those seeking SUD services. Residential SUD treatment beds saw a net increase of 72 beds in the first quarter of Fiscal year (FY) 2024-25 compared to the previous year total, moving from 2,600 to 2,672. Similarly, Interim Housing resources expanded in the first quarter, with an increase of 23 beds from 1,410 in FY 2023-24 to 1,433. Sobering Centers and Inpatient Withdrawal Management remain stable at 15 and 78 beds, with expected growth later this year due to the State's BHCIP awards as well as new efforts at LA General Hospital. Additionally, 83 beds initially categorized as in-development have begun to shift into active capacity as projects reach completion. See Attachment A for additional information.

DHS bed continuum is overseen by healthcare beds operated through our Medical Centers and community beds provided through Housing for Health (HFH) and the Office of Diversion and Re-Entry (ODR). Medical Centers oversee Psychiatric Emergency Services beds and Acute Inpatient Psychiatric beds. HFH oversees IH, ERC, and PSH for people experiencing homelessness who have complex health, mental health, and/or substance use disorder needs. ODR oversees Acute Inpatient Psychiatric beds, Sub-Acute Inpatient beds, IH, ERC, and PSH for people with criminal justice system engagement.

DHS treatment beds include crisis receiving and stabilization beds operated by DHS that provide up to 24 hours of psychiatric emergency services in a licensed facility (excluding sobering centers). Treatment beds also include those located in a licensed hospital setting, including acute inpatient psychiatric beds and subacute beds.

DHS housing beds serve people who are experiencing or previously experienced homelessness by providing social and clinical supports in different housing settings.

DHS ERC is delivered in licensed "board and care" facilities to individuals who require around-the-clock care with activities of daily living support. Both HFH and ODR administer ERC facilities throughout LA County.

DHS IH settings include shelters with supportive services, including Stabilization Housing and Recuperative Care. Stabilization Housing serves unhoused individuals with complex health and/or behavioral health conditions who require more supportive services than are available in most shelter environments. Recuperative Care is short-term housing for individuals recovering from an acute illness or injury who have conditions that would be exacerbated if they are not in stable housing with medical care. Both HFH and ODR administer IH throughout LA County.

DHS PSH pairs a project-based or tenant-based housing subsidy with Intensive Case Management Services delivered by community-based providers for vulnerable people who are experiencing or have experienced homelessness. Both HFH and ODR support clients in PSH with local vouchers through the Flexible Housing Subsidy Pool (FHSP). Additionally, HFH pairs Intensive Case Management Services to people housed through federal project- and tenant-based vouchers throughout LA County.

HFH and ODR continue to expand bed capacity through additional IH and PSH. ODR is also expanding capacity through additional Acute Inpatient Psychiatric (27 beds added) with planned Acute and Sub-Acute beds (25 beds and 171 beds, respectively) funded and in development through December 2025. DHS added 295 Interim Housing beds with 335 beds in development through December 2025. DHS also has 86 ERC beds in development through December 2025. The largest growth was in PSH Intensive Case Management (ICMS) slots. DHS was able to bring on 1,782 new ICMS slots between May and September 2024 through the Flexible Housing Subsidy Pool and strong partnerships with PSH providers and Public Housing Authorities.

JCOD funds Emergency Housing beds, IH beds, and PSH for use by justice-involved individuals with a housing need who are participating in JCOD Programs. As JCOD launched the Justice Connect Support Center in October 2023, based on some of the needs identified by justice-involved individuals calling the Support Center, JCOD immediately saw a need for Emergency Housing that can be accessed by a caller to the Support Center who identified they had no place to sleep that night. The existing housing ecosystem in Los Angeles County has certain parameters that may exclude justice-involved individuals from accessing same-day bed resources. In the instances when a justice-involved individual calls the Support Center and requests same-day housing and the request is made after business hours, the justice-involved individual will be unable to access a bed resource.

Upon identification of this unmet need in our LA County housing continuum, JCOD funded 25 Emergency Housing Beds across four housing provider sites. This results in our ability to connect a justice-involved individual, who calls the Support Center with a bed resource need, to housing on the day the need is expressed.

In addition to the funding of 25 Emergency Housing beds, JCOD increased its interim housing bed portfolio by 30 beds. A subset of JCOD-funded interim housing beds is available for justice-involved women who have children. A percentage of this subset of JCOD-funded

Interim housing beds is also available for justice-involved men and their children. Maintenance of and support for the family unit is critical and JCOD seeks to provide needed support to justice-involved families so their family unit can be maintained and not fractured when these vulnerable families have bed resource needs.

HI funds beds across multiple County departments, cities, Continuum of Care (CoC), Councils of Governments (CoGs), and the LA Homeless Services Authority (LAHSA). In addition, this section includes Department of Public Social Services (DPSS) beds as these beds are not captured in any other section of this report. The number of beds reflected in this report do not include HI funded beds that are administered by DHS and DPH as those beds are included in their department-level data. The bed types reported are IH and Permanent Housing beds funded by Measure H, County Homeless Housing Assistance Prevention (HHAP), and DPSS Housing Support Program (HSP). The Permanent Housing bed types include Time Limited Subsidies (TLS) and Shallow Subsidies. The IH beds include bridge and crisis bridge housing beds that serve the Adult, TAY and family population, enhanced bridge housing beds, motel vouchers, and weather-activated beds and motel vouchers. The report also includes HI developed and funded Homekey beds for permanent and interim housing that are active and will be coming online.

HI funded permanent housing administered through DPSS, LAHSA, CoGs, CoC partners, local cities, and Homekey, has increased systemwide to a total of 5,422 active beds, with an expected 2,001 additional beds to come online this fiscal year. LAHSA beds reflected in this report are TLS for Single Adults, TAY, and Families; Shallow Subsidy; and Pathway Home. The DPSS General Relief (GR) rental subsidy are TLS beds for GR participants who are experiencing homelessness or at risk of becoming homeless and are pursuing Social Security Income or Veterans benefits. Local cities, CoCs, and CoGs have received HI funding that have increased TLS bed capacity, and this funding also supports efforts to assist Permanent Housing placements from Interim Housing. As it is Quarter 1 of a new fiscal year, many Permanent Housing beds are considered "in development" as service providers in the system scale to support them.

For interim housing, HI funds shelter beds, motel vouchers, weather-activated shelter beds and motel vouchers through LAHSA. The IH beds increased from the previous FY 2023-24. There are also HI funded beds through CoGs and CoCs. HI Homekey has Interim Housing sites that provide 1,135 beds countywide. Currently in the pipeline are 102 beds to support Pathway Home operations in Lancaster, 84 beds to support emancipating TAY, and 91 beds in partnership with the City of El Monte for their Homekey site.

Number of individuals served in the prior quarter in each bed type, including, average length of stay, discharge location, requested but unsecured beds, and average wait time per bed type.

The number of DMH clients served includes total episodes (or visits for UCCs and admissions for ERS) as well as the number of unique clients served. Because DMH clients can step up

or down between levels of care, the unique client counts are specific to each level of care. Of note, the State hospital clients (21) represent those placed by HAI Intensive Care Services and not the total number admitted to the State hospitals. Additionally, the most extended average lengths of stay are with the DMH subacute level of care. At an average of 930 days for general subacute and 469 days for those in State hospital, as stated above, addressing capacity and flow for subacute clients is a DMH priority. Mental Health Rehabilitation Facilities (MHRCs) are subacute facilities that are licensed for 18 month stays, with longer stays permitted when authorized. Many DMH clients need longer stays as they move from the hospitals, jails, and streets and are receiving treatment for both specialty mental health and substance use disorders. While throughput is a top priority, DMH is also intent on ensuring that all its clients are at the right level of care at the right time. This journey will look different for each person.

Of the DMH specialized inpatient discharges, 73% stepped down from acute to subacute level of care. For subacute, more than 50% were discharged to ERS level of care. For residential onsite clinical/treatment services (CRTP and ERS), clients were discharged to a more diverse array of programs with Full Service Partnership (FSP) and outpatient as primary placements. Because crisis and extended residential levels of care are voluntary, a notable percentage of clients go absent without leave (AWOL) or leave against medical advice (10% of CRTP clients and 22% of ERS clients go AWOL, while 10% of ERS clients leave against medical advice).

DMH served 867 people in licensed residential facilities through the ERC program between July 1, 2024, and September 30, 2024. The average length of stay for these individuals was 837 days or over two years.

DMH served 1,243 people in interim housing between July 1, 2024, and September 30, 2024, including 1,034 individuals through the Interim Housing Program (IHP) and 209 individuals through the TAY Enhanced Emergency Shelter Program (EESP). The average length of stay in interim housing for IHP clients was 178 days. For the TAY EESP, 82% of clients had stays totaling 60 days or less.

DMH served 5,583 people in PSH between July 1, 2024, and September 30, 2024. The average length of stay for these individuals was 1,589 days or over four years.

During the first quarter of FY 2024-25, the majority of admissions were for SUD Residential Treatment without Withdrawal Management (4,562) with an average length of stay (ALOS) of 32 days. Recovery Bridge Housing requires concurrent enrollment in outpatient SUD treatment and has an ALOS of 49 days; the service was capped at 180 days until October 2024, when it was increased to one year if residents continue to meet housing criteria or secure appropriate housing and remain in outpatient treatment. Total admissions for sobering centers were 596 with an ALOS of one day whereas residential and inpatient withdrawal management was 1,533 admissions with an ALOS of six days. Because of the nature of SUDs and the fact that treatment at every level is voluntary, some patients self-discharge very early

in care while others stay for longer durations, thus impacting the ALOS. See Attachment A for additional information.

DHS served 3,674 unique clients in DHS Psychiatric Emergency Services (PES) beds between July 1, 2024, and September 30, 2024. The ALOS for DHS PES clients was 30 hours.

DHS served 388 unique clients in DHS Acute Inpatient Psychiatric beds between July 1, 2024, and September 30, 2024. The ALOS for Acute Inpatient patients was 51 days.

DHS HFH served 2,698 people in IH, including both Stabilization Housing and Recuperative Care, between July 1, 2024, and September 30, 2024. The ALOS for Stabilization Housing and Recuperative Care clients was 177 days. Based on available data, of the 725 HFH clients who exited interim housing, 85% exited to permanent housing, less than 1% died, 4% exited to a hospital or care facility, 3% exited due to incarceration, 2% exited to a place not meant for habitation such as streets, cars, parks, or abandoned buildings, and 4% exited to other settings not listed above.

DHS HFH served 782 people in ERC, commonly referred to as "Board and Care," between July 1, 2024, and September 30, 2024. The ALOS for ERC clients was 295 days. Based on available data, of the 95 HFH clients who exited an ERC facility, 60% exited to a hospital or other residential setting, 5% exited to non-psychiatric medical residential care facility, 2% exited to jail, prison, or a juvenile detention facility, 2% exited to a place not meant for habitation such as streets, cars, parks, or abandoned buildings, and 31% exited to other settings not listed above.

DHS HFH served 18,435 people in PSH ICMS between July 1, 2024, and September 30, 2024. Ninety-four percent (94%) of ICMS clients remain stably housed after one (1) year in Project-Based Permanent Supportive Housing, and 86% of ICMS clients remain stably housed after two (2) years in the program. Based on available data, of the 364 HFH households who did exit Project-Based PSH ICMS, 37% died, 23% left voluntarily or relinquished housing, 11% exited due to non-payment of rent, an occupancy charge, or eviction, 9% exited due to incarceration, 5% moved to another housing opportunity, and 15% exited due to other reasons not listed above. Eighty-nine percent (89%) of ICMS clients remain stably housed after one (1) year in Tenant-Based Permanent Supportive Housing, and 80% of ICMS clients remain stably after two (2) years in the program. Of the 196 HFH households who did exit Tenant-Based ICMS, 49% died, 10% left voluntarily or relinquished housing, 10% exited due to incarceration, 7% moved to another housing opportunity, 3% moved to another county or state, 2% exited due to non-payment of rent, an occupancy charge, or eviction, and 19% exited due to other reasons not listed above.

DHS ODR served 90 unique clients in Acute Inpatient Psychiatric beds and 41 unique clients in Sub-Acute beds between July 1, 2024, and September 30, 2024. The ALOS for Acute Inpatient Psychiatric beds was 55 days and for Sub-Acute beds was 260 days.

DHS ODR served 2,524 people in IH between July 1, 2024, and September 30, 2024. The ALOS for ODR IH clients was 209 days. Based on available data, of the 661 ODR clients who exited interim housing, 74% exited to permanent housing, 5% exited due to incarceration, 3% exited to a hospital or care facility, 1% exited to a place not meant for habitation such as streets, cars, parks, or abandoned buildings, less than one percent were deceased, and 16% exited to other settings not listed above.

DHS ODR served 322 people in ERC, commonly referred to as "Board and Care," between July 1, 2024, and September 30, 2024. The ALOS for ODR ERC clients is 562 days. Based on available data, of the 88 ODR clients who exited ERC facilities, 43% exited to non-psychiatric medical residential care facilities, 21% exited to a hospital or other residential setting, 7% exited to jail, prison, or a juvenile detention facility, and 29% exited to other settings not listed above.

DHS ODR served 1,000 people in PSH ICMS between July 1, 2024, and September 30, 2024. Eighty-three percent (83%) of ICMS clients remain stably housed in ODR Project-Based PSH after one (1) year, and 63% of ICMS clients remain stably housed after two (2) years in the program. Based on available data, of the 56 ODR households who exited Project-Based PSH ICMS, 32% left voluntarily or relinquished housing, 10% exited due to incarceration, 6% died, 4% exited due to non-payment of rent, an occupancy charge, or eviction, and 48% exited due to other reasons not listed above. Ninety-six percent (96%) of ICMS clients remain stably housed in ODR Tenant-Based PSH after one (1) year in the program, and 69% of ICMS clients remain stably housed after two (2) years in the program. Based on available data, of the 34 ODR households who did exit Tenant-Based PSH ICMS, 17% left voluntarily or relinquished housing, 10% exited due to incarceration, 10% exited due to non-payment of rent, an occupancy charge, or eviction, and 63% exited due to other reasons not listed above.

DHS housing beds do not use waiting lists to manage demand for any of these housing settings, which means that there is no data on average wait times for any of these housing bed types.

During the reporting period of July 1, 2024, and September 30, 2024, JCOD launched its Care Management System where utilization, trends of utilization including but not limited to ALOS will be monitored and ensuing reports generated. As utilization of the Care Management System has just started and end users of the System are becoming acclimated to it, we do not have current data on all the requested data elements associated with the request. We expect to have data available in a future report.

Following is the data that we do have available:

- Emergency Housing:
  - ALOS: 13 days
  - Average wait time for a bed: 1 hour

    - Number of beds requested but unable to secure: 9
- Permanent Housing with supportive services:
    - ALOS:19 months
    - Average wait time for housing: 151 days
    - Number of beds requested but unable to secure: 29

Some of the metrics requested are connected to patient care metrics related to mental health and substance use beds and do not apply to all programs funded by HI. The data reported by HI under this request relate to the beds that our office directly funds through LAHSA, DPSS, cities, CoGs, and CoCs.

Within HI funded Permanent Housing, the total number of active beds available to serve clients is 5,422. These numbers do not reflect the total amount of clients served as these resources can serve household sizes larger than one (1). The ALOS varies among bed administrators. LAHSA manages 76% of the TLS beds funded by HI, and their data reflects an ALOS of 223 days, and over half of the exits are to Permanent Housing. The ALOS within CoGs and CoCs is 533 days, and 63% of clients exited into Permanent Housing. DPSS and cities do not currently track these data elements consistently. The exits to Permanent Housing reflect that clients are able to remain housed within their current TLS housing or have transitioned into another program such as Shallow Subsidy or a higher level of care, such as PSH.

Under HI interim housing funded through LAHSA, the ALOS at an IH site was 156 days. Approximately half of the clients in IH either exited to Permanent Housing or another form of housing, which was similarly reported in FY 2023-24. The number of client exits to "Unknown" destinations are a result of participants being out of the facility for more than two (2) days and not returning, refusal to disclose where they are going, and data quality concerns. We hope to reduce the number of exits to "Unknown Destinations" as we build out functionality within the Homeless Management Information System (HIMS) and implement new reporting requirements to providers. For Quarter 1 FY 2024-25 the average number of days it takes to access an IH bed is not currently available for our city, CoG, or CoC beds, as the method for tracking this data varies significantly and not every jurisdiction compiles this data. However, we are able to provide this data for the HI funded LAHSA IH portfolio, where wait times averaged around 220 days to access an IH bed. This metric is captured by calculating the length of time from a client's referral to IH entry. Clients who enter by walk-in will not be part of the calculation as a consistent start date to calculate length of time from is not available.

NOTE: The number of beds that were requested, but unable to be secured was requested but is not tracked by DMH, DPH-SAPC, DHS, HI, or JCOD. For DMH and DPH-SAPC, the number of beds requested but not secured and the average wait time per bed type cannot be tracked because Medi-Cal prohibits waitlists for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. If the Departments maintained waitlists, this would be in conflict with contractual agreements. The only exception

is the DMH IHP, which tracks waitlist data for interim housing beds. Approximately 69% of IHP referrals received between July 2024 and September 2024 were waitlisted for some period of time in order for the program to accommodate specific client preferences or needs, with the average wait time totaling eight (8) days.

Bed Distribution (Location)

The DMH HAI, HJDD, and TAY EESP bed networks reflect the distribution of beds across Service Planning Areas (SPA) and/or Supervisorial District (SD). For the licensed residential care data, since DMH does not have dedicated beds, the data presented reflects where ERC program clients were living during the July 2024 – September 2024 quarter. For UCC, CRTP and ERS geographic distribution is being considered as capacity is being expanded. Where acute and subacute beds represent the greatest proportion of beds within the HAI bed continuum, the DMH strategy for addressing bed capacity needs focuses on a regional view for this level of care.

SUD residential treatment with or without Withdrawal Management represents the greatest proportion of beds at 64% (2,672) followed by Recovery Bridge Housing at 34% (1,433), Inpatient Withdrawal Management at 2% (78), and Sobering Centers at less than 1% (15). SUD beds are located throughout the County with higher concentration of sites in regions with a higher proportion of Medi-Cal beneficiaries; this reflects that SAPC services are targeted for Medi-Cal beneficiaries. See Attachment A for additional information.

DHS PES and Acute Psychiatric beds are located in SPAs 2, 4, 6, and 8, at Olive View, Los Angeles General, and at Harbor-UCLA Medical Centers. DHS ODR Acute Psychiatric beds are also located in SPA 2 at Olive View Medical Center, as well as SPAs 3 and 4. DHS ODR also has subacute psychiatric beds in SPA 3.

DHS HFH and ODR operate housing beds, including IH, ERC, and PSH Intensive Case Management Services, in all eight SPAs. Although in every SPA, HFH and ODR IH beds are concentrated in SPA 4 and SPA 6.

The 25 Emergency Housing Beds funded by JCOD are located in Supervisorial District (SD) 2 in Service Planning Areas (SPAs) 4 and 6. The 684 Interim Housing Beds funded by JCOD are located in SDs 1, 2, 3, and 4 across SPAs 2, 6, 7, and 8. The 220 Permanent Housing slots with supportive services are available across all SDs and SPAs.

HI funded Permanent Housing beds are located across LA County SPAs and SDs. Programs funded by HI, including TLS and Shallow Subsidies through local cities, CoGs, CoCs, LAHSA, and DPSS are scattered site, which means participants are able to use their housing resource anywhere in LA County. HI further supports these programs by funding countywide Unit Acquisition administered by DHS and LAHSA, with the purpose of engaging property owners in the County to lease to clients enrolled in TLS.

HI either developed and/or provides funding to the following site based Permanent Housing and IH resources as distributed by SD.

The following Homekey chart reflects the number of new HI supported projects online or upcoming projects in each SD. This includes all HI awarded Homekey sites as well as sites where HI was not a Homekey applicant but supported the projects with its funding.

Supervisorial District	Homekey Permanent Supportive Housing	Homekey Interim Housing
1	3	4
2	7	4
3	1	3
4	6	1
5	2	2
Total Number of Sites	**19**	**14**

The following HI funded LAHSA IH chart reflects the current allocation of shelter sites by SD.

Supervisorial District (SD)	HI Funded LAHSA Interim Housing (IH) Sites*
1	24
2	23
3	20
4	17
5	14
Total Number of Sites	**98**

*Note: This count does not include some confidential sites.
*The chart includes HI supported Homekey Interim Housing sites.

Challenges and opportunities

Department of Mental Health

DMH's focus on expanding the bed network is impacted by the following key challenges:

- Within the DMH network there are capacity gaps in levels of care, specifically subacute and residential. While there is urgency regarding access to services for many clients, building this needed capacity takes time. In other words, the demand for services is

clear but there is an inherent lag in supply statewide that has to catch up to the demand.

- To bring these beds online requires a complex matrix of funding sources for capital, operations/services, etc. There are also external pressures such as reduced State funding, insufficient rate structures and unfunded initiatives that significantly impact DMH's ability to bring new beds online.
- And finally, there are factors impacting the provider network such as workforce challenges, difficulty meeting the needs of high acuity DMH clients, rate and contracting issues that affect the pace at which DMH can expand the bed network.

DMH supports the continued focus on collaboration across County departments and building partnerships with the DMH provider network. A few key opportunities include:

- Maintain the cross-departmental approach to CalAIM and other State initiatives (e.g., BHCIP, CCE, BHBH, BHAI, SB 43, etc.) and maximize and leverage these funding sources.
- Focus on bed rates including rate alignment to minimize competition among County departments or rate increases to improve the County's position in the market.

Department of Public Health-SAPC

SAPC's focus on optimizing and leveraging Medi-Cal and other funding sources has enabled expansion of all levels of SUD treatment, including residential SUD beds which are Medi-Cal reimbursable, sobering center beds which may be reimbursable through the public managed care plans, and Recovery Bridge Housing beds which are not Medi-Cal reimbursable. This creates significant opportunity to expand access to care and to continue to increase funding for community-based contractors to add new sites or expand beds/slots at existing sites to better meet community SUD service needs and minimize admission delays. At this time, SAPC has open contracting and can continue to augment contracts for Medi-Cal reimbursable services and add new providers not currently delivering care in its system. While SAPC has continued to grow Recovery Bridge Housing with various County resources (e.g., Opioid Settlement Fund, Care First Community Investment, Measure H) and new State Behavioral Health Bridge Housing (BHBH) grants, divestment or reduced growth could impact availability. Furthermore, while Los Angeles County has several recipients of State BHCIP grants, it takes time to renovate/construct these sites and obtain State licensure which can extend timelines when new beds will become available. Collaborating with these contractors early is one strategy that is being employed to improve timely access.

Department of Health Services

DHS notes the following challenges and opportunities for increasing bed capacity across the continuum.

Challenges: DHS ODR is working in close collaboration with DMH to expand acute and subacute psychiatric bed capacity. DHS ODR is encountering similar challenges to those DMH notes above, including insufficient supply of beds, reduced and insufficient funding, and

workforce challenges. Expansion of subacute (Institution for Mental Diseases-IMD) beds requires DHS ODR to work with operators to secure new facilities, apply for licensure changes, and complete capital improvements. This serves as a barrier to timely launch of subacute beds to meet the high demand.

Interim housing beds are being created faster than permanent housing resources, exacerbating existing challenges to interim housing throughput. HFH is seeing longer lengths of stay in interim housing as more people struggle to access limited permanent housing resources. Interim housing providers' organizational capacity is also stretched due to rapid expansion under encampment resolution efforts in the context of workforce shortages and bed rates that strain operational viability for some providers. Project-based PSH operators are also reporting significant increases in operational costs, particularly insurance costs, that are threatening the operational viability of PSH buildings. A lack of capital funding sources and access to rental subsidies are reducing the number of PSH developments in the pipeline.

Opportunities: Encampment Resolution efforts through the County's Pathway Home are successfully moving people in encampments to interim housing and on to permanent housing. DHS HFH has received strong demand from PSH providers to participate in an open procurement for PSH rental units through the Flexible Housing Subsidy Pool, which has contributed to an increase in the number of rental units provided through the Flexible Housing Subsidy Pool.

DHS is now contracted with Health Plans for the Short-term Post-Hospitalization CalAIM Community Supports program which will provide funding for up to 6-months in Interim Housing following discharge from hospitals or release from carceral settings. DHS will begin claiming for services in the New Year. The state Department of Health Care Services also released a Transitional Rent Concept Paper outlining a model for Transitional Rent to be added as an additional CalAIM Community Support. This new Community Support, if approved by the Center for Medicare and Medicaid Services, would provide a new revenue source to cover six months of interim housing and permanent housing for eligible Medi-Cal participants.

Justice, Care and Opportunities Department

Challenges: Scattered site housing programs like our JCOD Breaking Barriers (i.e., Permanent Housing with supportive services) require partnerships with landlords and property managers who are willing to accept the offered stipend. Our Breaking Barriers scattered site housing program often has to compete with other stipend programs that can afford a higher fair market rate. Furthermore, some property owners/property management entities are resistant to housing justice impacted individuals and in particular justice impacted individuals with certain histories (e.g. arson charges and/or sex offense charges; manufacturing and distributing illegal substances). However, within this challenge is an opportunity to expand the footprint and housing inventory that serves justice impacted individuals as JCOD is receiving inquiries from property managers and building owners who want to provide services specifically for the justice impacted population including individuals with the abovementioned

histories. With appropriate funding, JCOD can facilitate master agreements to expand bed capacity for justice-involved individuals.

Opportunities: JCOD launched its new Care Management System (CMS) on July 15, 2024. The JCOD CMS has been designed to optimize the housing referral processes and allows for practical data entry, including tracking exit reasons and locations/destinations upon exit from JCOD-funded housing. JCOD staff have spent the past quarter (July 2024 - September 2024) training the JCOD-contracted community providers on the CMS platform and its functionalities, along with their specific utilization of the platform that includes but is not limited to utilization of the housing referral process from entry to exit. As with any change initiative that requires change in workflows, knowledge gaps are present and JCOD team members will be addressing them to facilitate JCOD-contracted providers acclimatation to the new platform, its functionalities, and data requirements. As our JCOD-contracted providers gain proficiency in utilization of our JCOD CMS platform we expect increase in our ability to obtain accurate reports regarding various outcome metrics that will inform scaling opportunities, identification of gaps in the overarching housing continuum of care, and opportunities for collaboration with other County Departments and Community-based Organizations. An element of collaboration with other County Departments would include identification of opportunities to enhance pathways for justice-involved individuals to access housing funded by County Departments.

Homeless Initiative

Challenges: The shortage of affordable housing and increased costs to produce new housing are impacting and will continue to impact the system. The 2024 California Housing Partnership report reflects that 494,446 low-income renter households in Los Angeles County do not have access to an affordable home. Construction of new or rehabilitation of affordable, permanent supportive, and interim housing could slow down due to increase costs and inflation.

Opportunities: The passing of Measure A is an opportunity that will allow the County to continue to fund homeless services at its current capacity, while also increasing support for homeless prevention, and the development of affordable housing solutions.

Conclusion

DMH, DPH-SAPC, DHS, HI and JCOD have made progress in expanding the County behavioral health continuum of care. The next Set Matter will provide an update for the period of October 1, 2024, through December 31, 2024.

If you have any questions, you may contact us or your staff may contact Jaclyn Baucum, DMH (JBaucum@dmh.lacounty.gov), Gary Tsai, DPH-SAPC (GTsai@ph.lacounty.gov), Clemens Hong, DHS (CHong@dhs.lacounty.gov), John Franklin Sierra, JCOD (JSierra@jcod.lacounty.gov), Jennifer Lee, HI (JLee@ceo.lacounty.gov) and Courtney Price, HI (CPrice@ceo.lacounty.gov).

LHW:BF: CRG: SA: CT

Attachment A: LA County Bed Status Report Update presentation deck.

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Department of Health Services
Department of Public Health
Justice, Care and Opportunities Department

Los Angeles County Bed Status Report Update

Board Meeting
January 14, 2025

Presenters:
DMH - Lisa Wong, Psy.D.
DPH - Barbara Ferrer, Ph.D., M.P.H., M.Ed.

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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Department of Mental Health

Mental Health Beds Available, Net Growth & In-Development

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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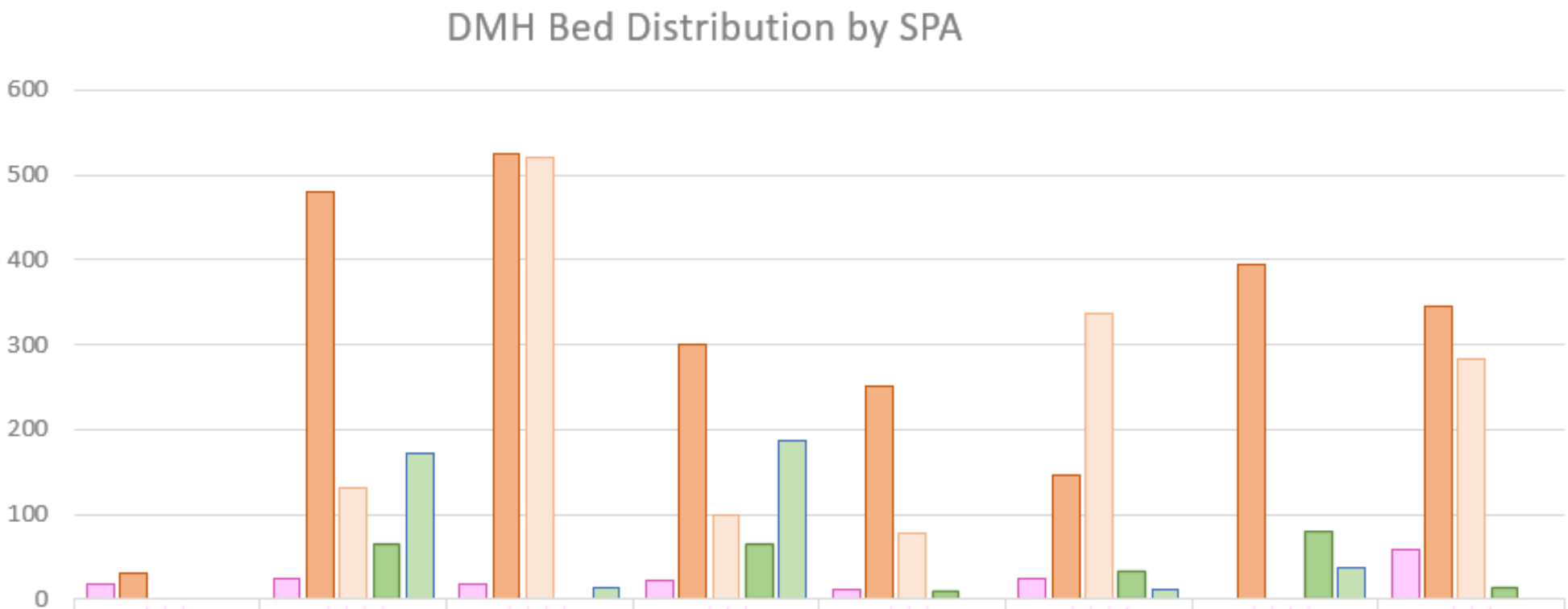
	Accessed Treatment Beds/Slots					Housing Beds/Units		
	Crisis Receiving & Stabilization	**Acute Inpatient/ Subacute**		**Crisis Residential/ Extended Residential**		**Licensed Residential Care**	**Interim Housing**	**Permanent Housing**
	Up to 24 hours (licensed; except sobering center)	*Hospital level care (licensed)*		*Residential with onsite clinical/treatment services (licensed)*		*Residential "board and care" (licensed)*	*Shelter w/ supp. services (unlicensed)*	*Permanent housing with supportive services (unlicensed)*
	Urgent Care Centers	Acute Inpatient Psych	Subacute, State Hospitals	Crisis Residential Treatment	Enriched Residential Services	Enriched Residential Care	Interim Housing	Permanent Supportive Housing
Existing/ Accessed Beds as of Sept 2024	**168** Total Chairs	**1,052** Average monthly census	**1,204** Average monthly census	**287** Total beds	**435** Average monthly census	**1,355**[2] Est number of people served based on allocated funding	**769** IHP Beds **110** TAY EESP Beds	**6,187**[3] Funded units available to be occupied
Beds/Units Added May-Sep 2024	**16** Chairs	**5** Beds	**9** Beds	**32** Beds	**20** Beds	**0** Beds	**51** Beds	**402** Units
# Beds – Funded In Development through Dec 2025[1]	**44** Chairs	**32** Beds	**78** Beds	**48** Beds	**0** Beds	**24** Beds	**550** Beds	**1,068** Units

High ← **Acuity** → Low

1 - Estimates are subject to change and do not represent beds that are not yet funded, that are in the contracting stage or in the longer-term pipeline related to state infrastructure grants.
2 - Includes estimated 450 beds to be funded with Community Care Expansion (CCE) dollars that have not yet come online.
3 - Includes units from developments that are newly opened and still leasing up.

DMH HAI Bed Distribution by Level of Care (July-Sept 2024)



	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
UCC	18	24	18	22	12	24	0	58
Acute Inpatient	30	479	525	300	250	147	395	344
Subacute	0	132	520	99	77	336	0	282
CRTP	0	64	0	64	10	32	80	14
ERS	0	171	13	186	0	12	38	0

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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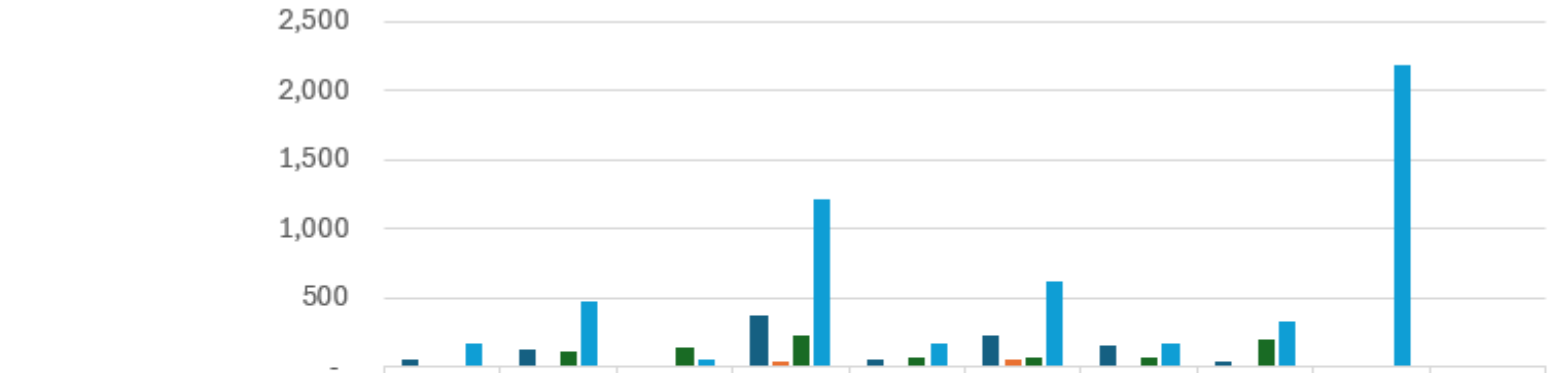
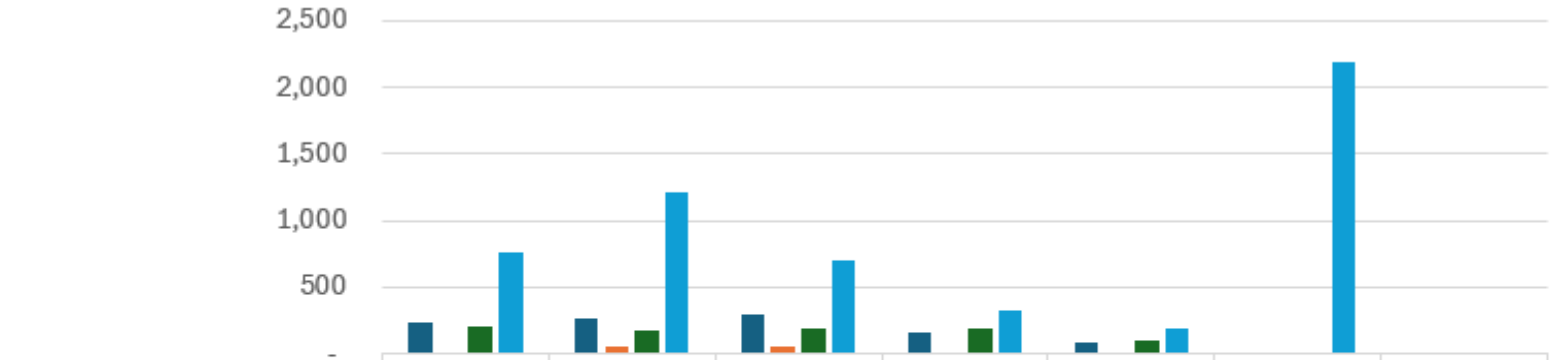
DMH HJDD & TAY EESP SPA & Supervisorial District Bed Distribution by Level of Care (July-Sept 2024)



	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	Scattered Sites	Total
Interim Housing (HJDD)	57	124	5	367	53	228	160	40	-	1,034
Interim Housing (TAY EESP)	-	14	-	38	-	58	-	-		110
ERC	7	110	138	220	63	70	65	194	-	867
PSH	172	471	53	1,213	174	615	171	327	2,190	5,386



	SD1	SD2	SD3	SD4	SD5	Scattered Sites	Total
Interim Housing (HJDD)	233	268	289	160	84	-	1,034
Interim Housing (TAY EESP)	-	58	52				110
ERC	207	174	194	185	107	-	867
PSH	765	1,215	696	325	195	2,190	5,386

*Since ERC does not have dedicated beds, these numbers represent where ERC clients were living during the quarter.

BHCIP DMH Bed Pipeline

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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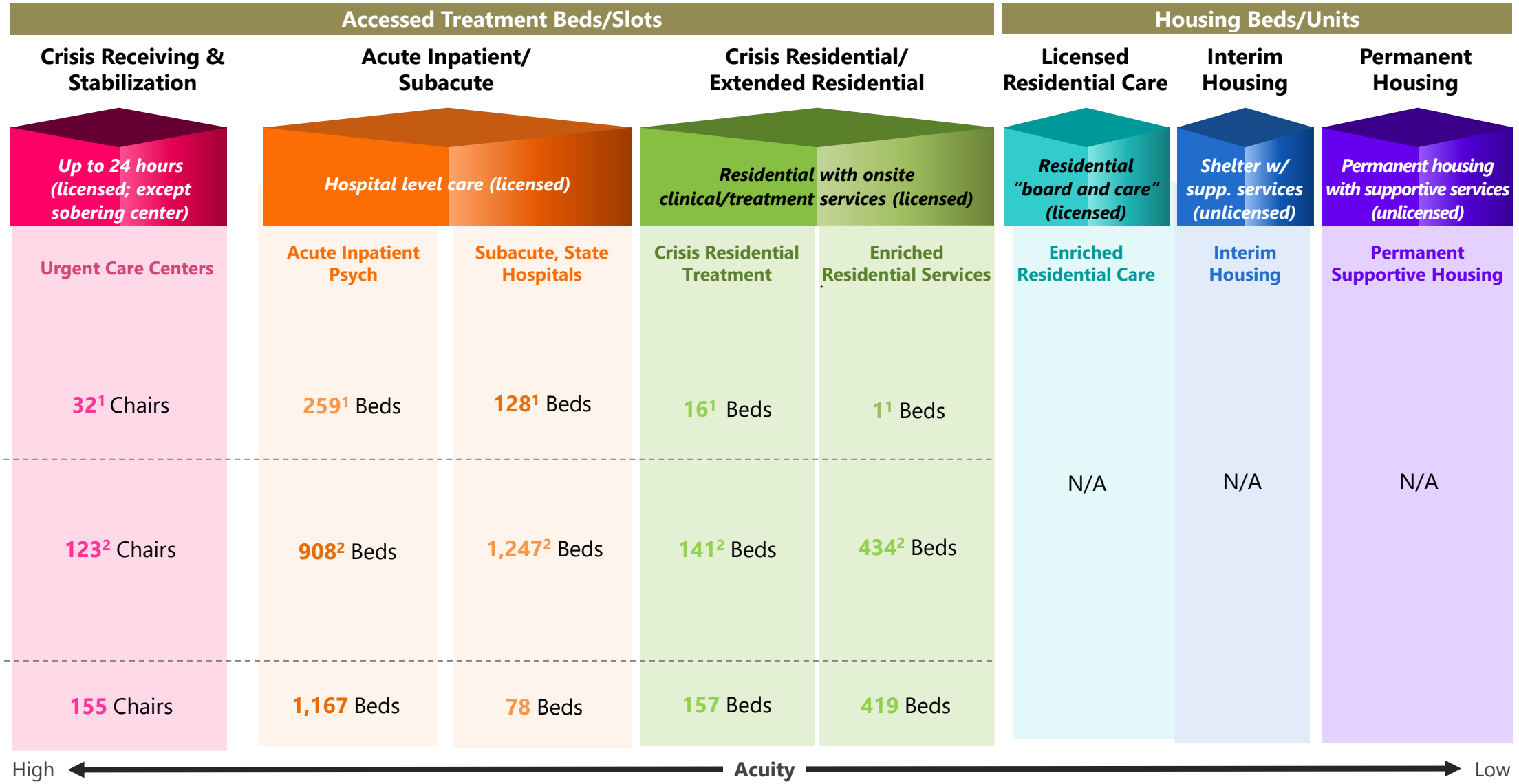

1 – Counts are estimates based on original information provided during RFA letter of support process. DHCS has not published final awarded bed counts. NOTE: providers must also complete the licensing and DMH contracting process before beds can be confirmed to the County network.

2 - Beds/chairs were undifferentiated in Bond BHCIP applications and so it is not possible to know a precise number of indicated bed types. Number of bed requests submitted via Prop 1 Bond applications far exceeded the State allocation for Round 1.

Prop 1 Bond Rd 1 County Project and CBO Breakout

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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	Accessed Treatment Beds/Slots					Housing Beds/Units		
	Crisis Receiving & Stabilization	Acute Inpatient/ Subacute		Crisis Residential/ Extended Residential		Licensed Residential Care	Interim Housing	Permanent Housing
	Up to 24 hours (licensed; except sobering center)	*Hospital level care (licensed)*		*Residential with onsite clinical/treatment services (licensed)*		*Residential "board and care" (licensed)*	*Shelter w/ supp. services (unlicensed)*	*Permanent housing with supportive services (unlicensed)*
	Urgent Care Centers	Acute Inpatient Psych	Subacute, State Hospitals	Crisis Residential Treatment	Enriched Residential Services	Enriched Residential Care	Interim Housing	Permanent Supportive Housing
County Projects	0 Chairs	16[1] Beds	48[1] Beds	0[1] Beds	16[1] Beds			
CBO Letter of Support Requests for DMH LOC						N/A	N/A	N/A
Conditional LOS	26[1] Chairs	545[1] Beds	441[1] Beds	72[1] Beds	402[1] Beds			
Full LOS	97[1] Chairs	347[1] Beds	758[1] Beds	69[1] Beds	16[1] Beds			
Estimated Total	123 Chairs	908 Beds	1,247 Beds	141 Beds	434 Beds			

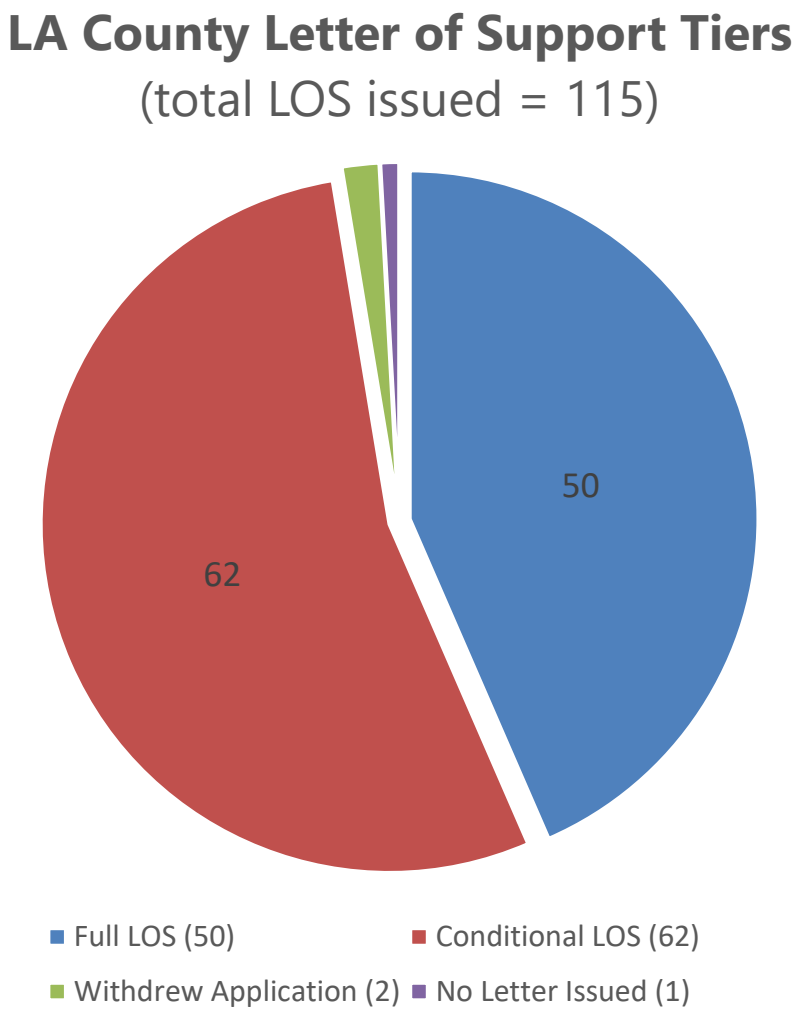
High ← **Acuity** → Low

1 – Counts are estimates based on original information provided during RFA letter of support process. Beds/chairs were undifferentiated in Bond BHCIP applications and so it is not possible to know a precise number of indicated bed types. NOTE: providers must also complete the licensing and DMH contracting process before beds can be confirmed to the County network. Funding requests submitted via Prop 1 Bond applications far exceeded the State allocation for Round 1.

Countywide Letter of Support Response

The County evaluated projects that were submitted to request support letters for Bond BHCIP Round 1: Launch Ready and reviewed each project based on the following criteria to ensure the greatest benefit to the system:

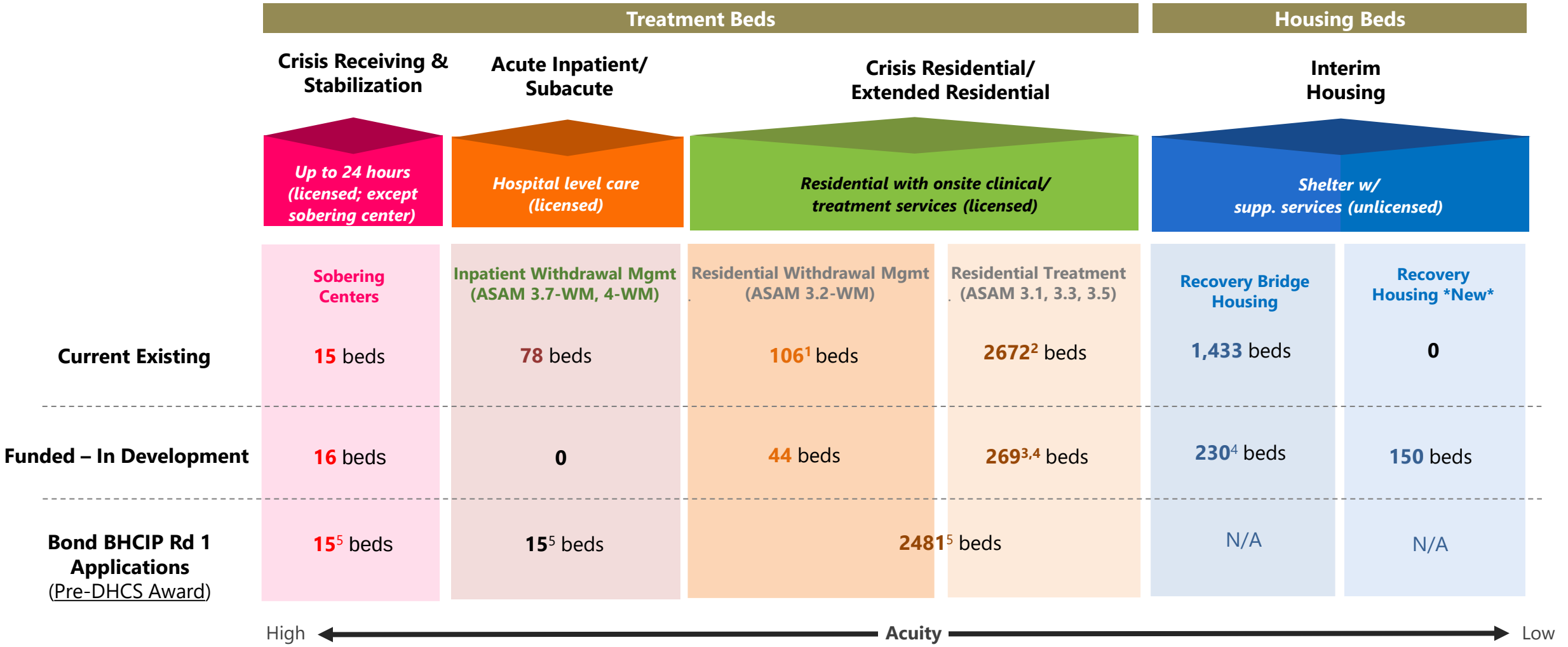
- ✓ Project value to the system by meeting community and County needs.
- ✓ Provider capability including contract standing (as applicable).
- ✓ Support of County priorities such as integrated care and serving safety net populations.



COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

Department of Public Health - SAPC

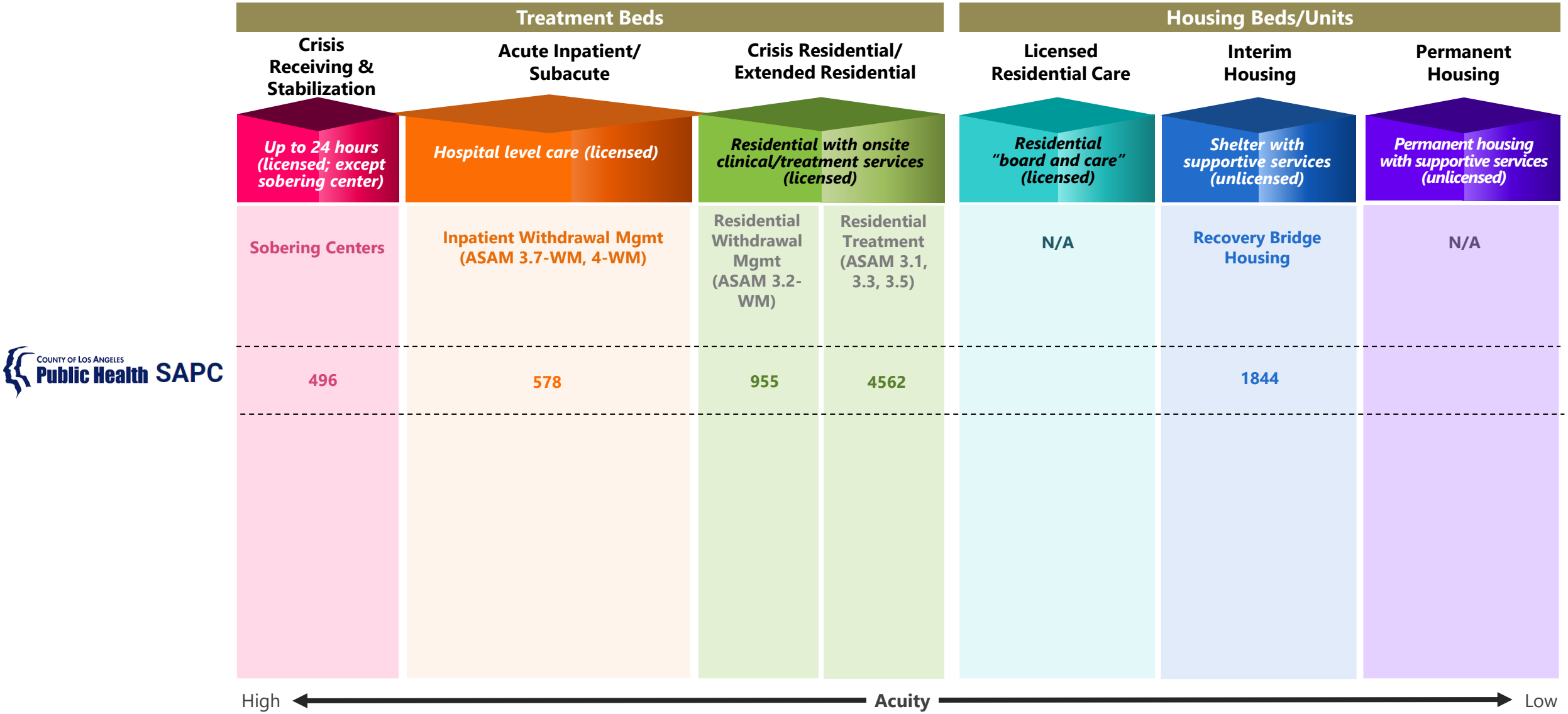
DPH-SAPC Beds Available, Net Growth & In-Development



1 - Beds are estimated as the State does not distinguish between licensure for Residential WM (ASAM 3.2-WM) and Residential (ASAM 3.1, 3.3, 3.5) beds and SAPC's providers utilize these beds flexibly based on need. Historically utilization has been at 4% of residential beds that may be used for WM.
2 - Bed counts are updated to reflect all fully executed contract actions, and the numbers change as beds are added, beds are removed (in addition to facility openings and closures).
3 - Beds include BHCIP recipients currently contracted with SAPC, although additional BHCIP related beds may be funded upon completion of BHCIP projects, DHCS DMC licensure or certification, and meeting SAPC contracting requirements
4.- Amounts have been adjusted to account for variance from Q4, Fiscal Year 2023-24 and Q1, Fiscal Year 2024-25.
5 – Beds were undifferentiated in Bond BHCIP applications and so it is not possible to know a precise number of indicated bed types.

How many people served by DPH-SAPC Level of Care (Sept – Dec 2024)

County of Los Angeles Public Health Substance Abuse Prevention and Control



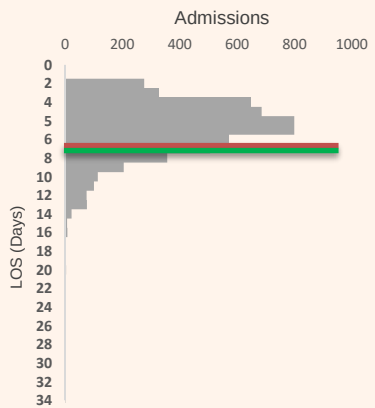
Average (Median) Length of Stay by DPH-SAPC Level of Care

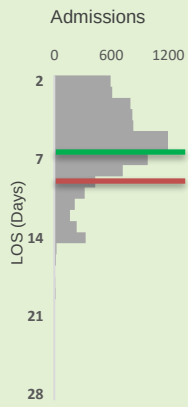
(Sept – Dec 2024)

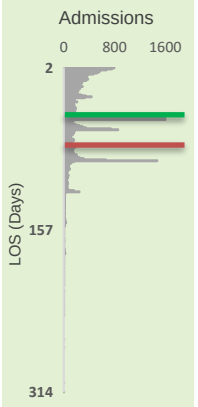
County of Los Angeles Public Health

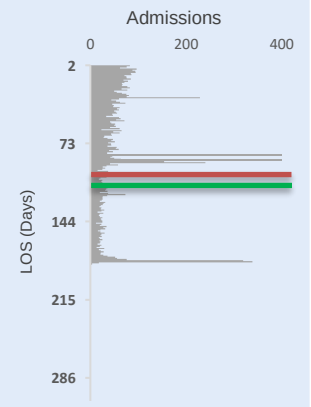
County of Los Angeles Public Health SAPC

Treatment Beds				Housing Beds/Units		
Crisis Receiving & Stabilization	**Acute Inpatient/ Subacute**	**Crisis Residential/ Extended Residential**		**Licensed Residential Care**	**Interim Housing**	**Permanent Housing**
Up to 24 hours (licensed; except sobering center)	*Hospital level care (licensed)*	*Residential with onsite clinical/treatment services (licensed)*		*Residential "board and care" (licensed)*	*Shelter with supportive services (unlicensed)*	*Permanent housing with supportive services (unlicensed)*
Sobering Centers	Inpatient Withdrawal Mgmt (ASAM 3.7-WM, 4-WM)	Residential Withdrawal Mgmt (ASAM 3.2-WM)	Residential Treatment (ASAM 3.1, 3.3, 3.5)	N/A	Recovery Bridge Housing	N/A
Mean: 1 day	Mean: 6 days Median: 6 days	Mean: 7 Median: 7 (days)	Mean: 53 Median: 54 (days)		Mean: 89 days Median: 85 days	









Mean:

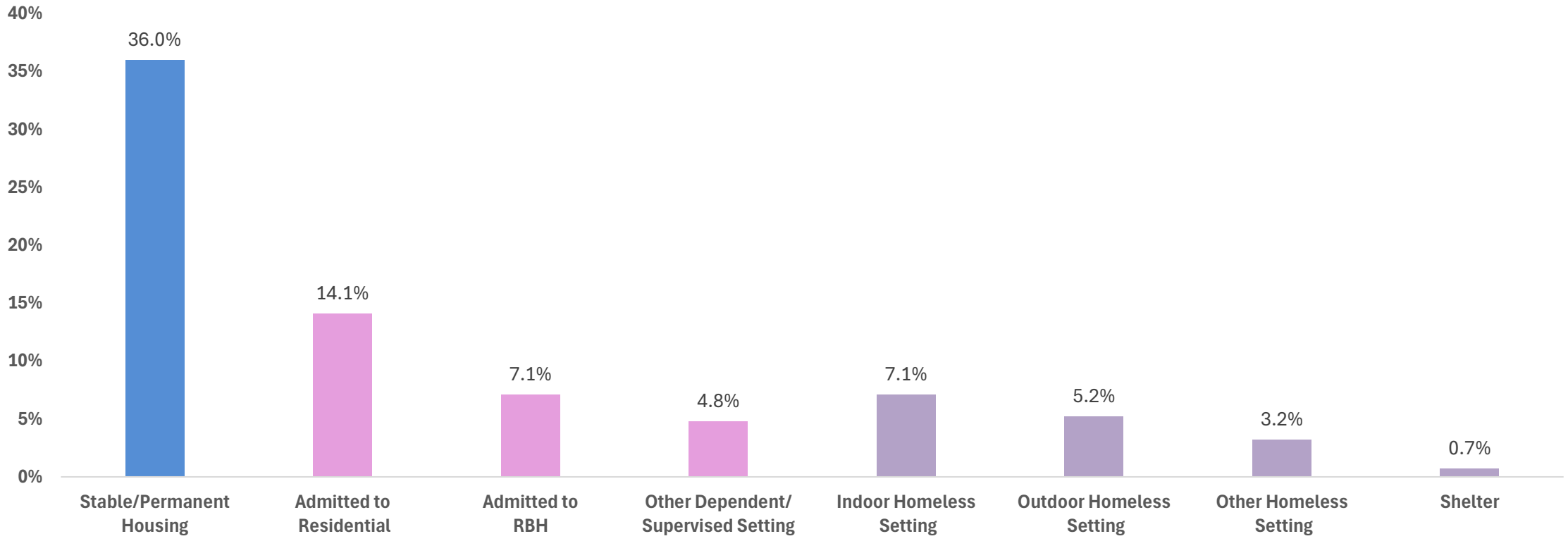
Median:

High ← **Acuity** → Low

*Given that DPH-SAPC operates a continuum with various levels of care, considering the length of stay of any individual level of care is incomplete given that many people access multiple levels of care within a given treatment episode --> **The average length of a treatment episode for clients in DPH-SAPC's system in a fiscal year is 156 days when considering that individuals with SUD access a continuum of services**.

DPH-SAPC: Where Patients Homeless at Admission Went Upon Discharge by Bed Type

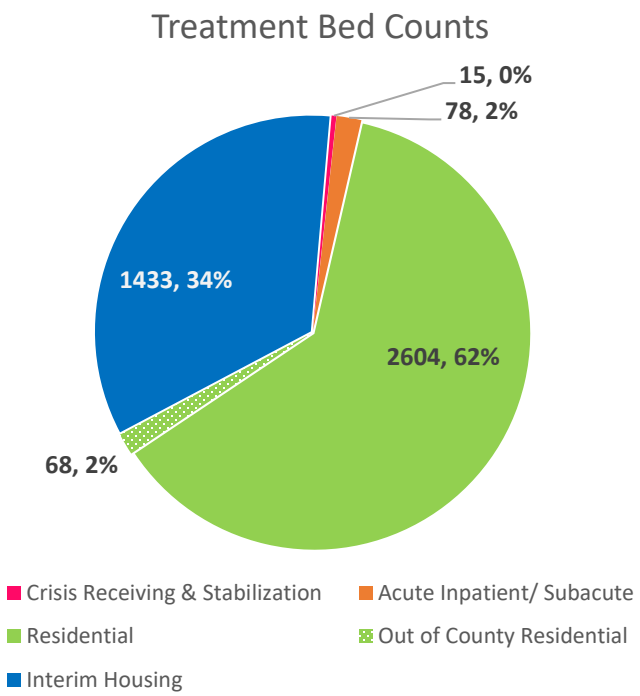
(Residential, Residential Withdrawal Management, and Recovery Bridge Housing)

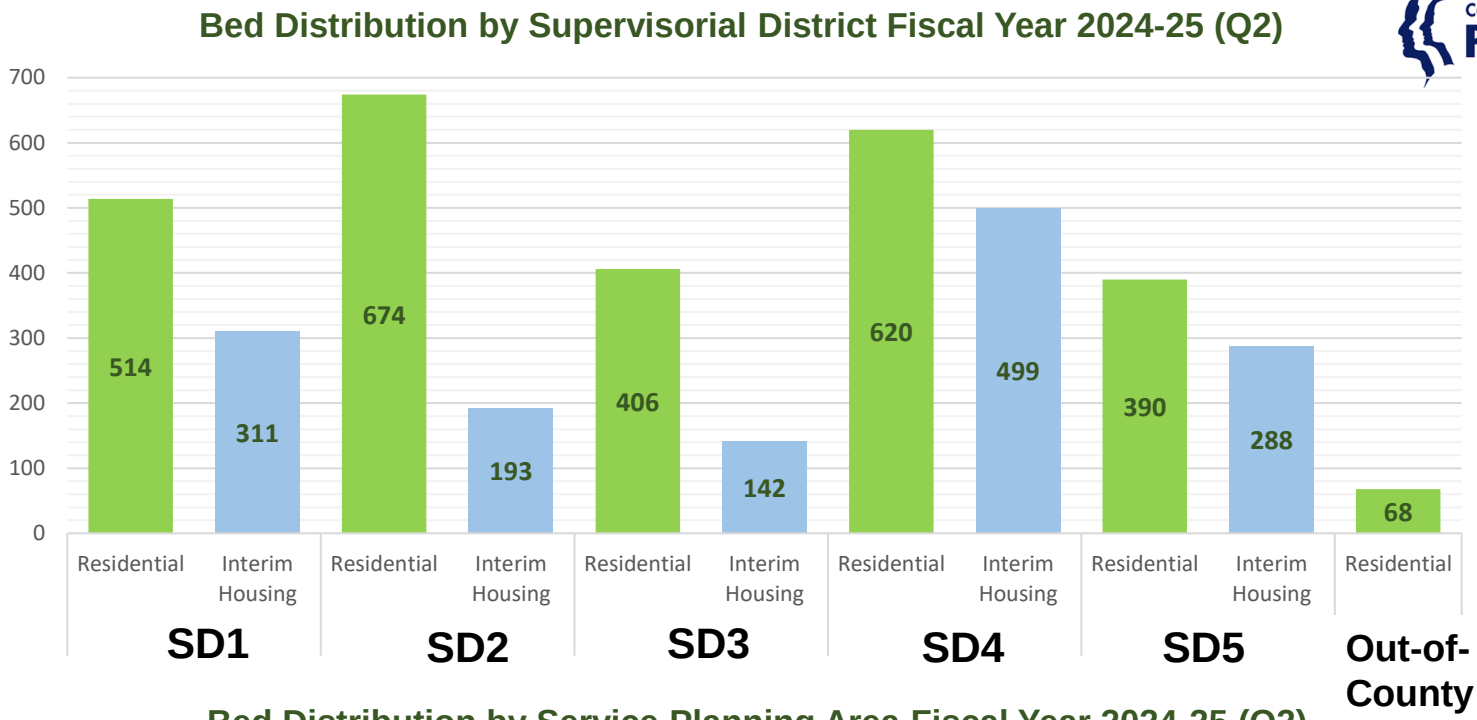


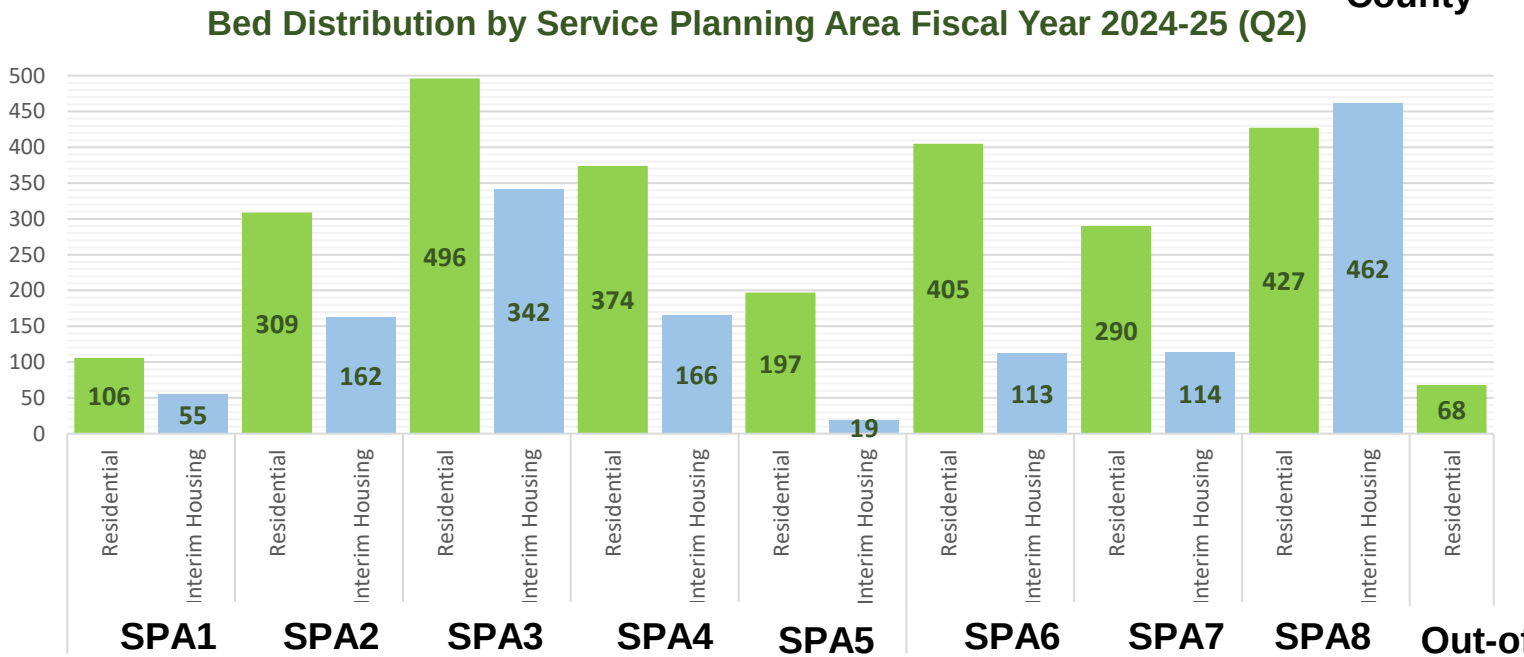
Note:
All percentages are based on the number of PEH admitted to Residential Beds and RBH, who were discharged during the quarter 1, FY2425 (4,441).
Stable/Permanent Housing: based on the self-reported information.
Indoor Homeless Setting: 'Doubling up or living with others temporarily', 'Hotel/motel voucher', 'Motels due to lack of alternative' 'Temporary indoor situation (like abandoned building), etc.
Outdoor Homeless Setting: includes individuals who reported 'Sleeping in car/van' or 'Living outside (sleeping outdoors)'
Other Homeless Setting: indicates individuals reported as homeless upon discharge, with homeless living status not specified.
Other Dependent/Supervised Setting: indicates individuals reported their current living status as dependent/supervised setting, with dependent setting not specified.
22% of the discharges left their treatment program before completing their treatment services with administrative discharges, which does not capture homeless living status.

Data Source: Los Angeles County Participant Reporting System (LACPRS)/California Outcome Measurement System (CalOMS)

DPH-SAPC Bed Distribution







Questions?