

## Response to the California Homeless Coordinating and Financing Council's Request for White Papers

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With the support of:  
California Behavioral Health Planning Council  
Mental Health Hookup  
NAMI Los Angeles County Council  
The Steinberg Institute  
United Way of Greater Los Angeles

...and please see **Appendix 9** for a resolution passed by the Los Angeles County Democratic Party regarding Adult Residential Facilities that Serve Adults with Serious Mental Illness

This proposal focuses on one achievable, attainable solution: **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.** These existing settings are under dire threat of closure and elimination; if the state and counties do not intervene, we will lose an available resource that is currently supporting thousands of formerly homeless individuals, and could serve thousands more.

“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” (Appendix 4)

**There has been no focused funding to support these facilities from any state entity, aside from the base reimbursement rate that is less than half of what facilities need to operate effectively.**

## RECOMMENDATIONS TO THE HCFC.

In order to preserve and grow the system of ARFs +RCFEs that care for formerly homeless individuals, we recommend the following, which will be explained throughout this document:

- 1) **Immediately raise the NMOHC rate to \$2,586 per month – the equivalent of the lowest Level 2 Regional Center facility rate<sup>1</sup> - for one year**, which will keep existing facilities operational while the legislature and its partners figure out a longer-term fix.
- 2) **Increase the number of Assisted Living Waiver slots** statewide (via the passage of AB 50)
- 3) **Remove regulatory barriers\*** that inhibit licensed residential facilities from serving homeless individuals with serious mental illness
- 4) **Address land use requirements and community resistance\*** which create additional barriers for licensed residential facilities that serve homeless individuals
- 5) **Encourage the CA Department of Health Care Services** to incentivize Medi-Cal health plans to place members, when appropriate, in licensed residential facilities in lieu of more-costly, higher levels of care
- 6) **Encourage Counties to create and innovate** with local dollars (including MHSA funds) to support this critical safety net for people experiencing homelessness
- 7) **Include people with mental illness as a priority population** in state-funded and state-supported housing initiatives

**GOALS AND STRATEGY.** In the HCFC’s Request for White Papers, Question #1 asks “What are the top strategies the State of California should employ to make the largest difference in each of the goals listed below, and why?” and then lists six goals. The strategy in this proposal addresses all six goals in regards to individuals (not families) experiencing homelessness. Bolstering the system of care described in this paper will prevent chronic and non-chronic homelessness; reduce unsheltered homelessness; prevent youth, adults and seniors from falling into homelessness; and will increase the overall supply of important housing options for vulnerable individuals experiencing homelessness.

As for Question #2, we believe the state should prioritize its resources by focusing on saving this existing housing inventory for some of the most vulnerable individuals.

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<sup>1</sup> Rates for Regional Center facilities are available in Appendix 5 and here: [https://www.dds.ca.gov/Rates/docs/CCF\\_rate\\_January2019.pdf](https://www.dds.ca.gov/Rates/docs/CCF_rate_January2019.pdf)

\* This is a stated policy objective of the California Behavioral Health Planning Council’s ARF Workgroup, an agency under the auspices of the Department of Health Care Services

**WHAT THESE FACILITIES ARE AND DO.** Licensed residential care facilities are licensed by the state Department of Social Services as either Adult Residential Facilities (ARFs) for adults ages 18-59, or 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.” There are thousands of ARFs and RCFEs licensed in California but only a small fraction accept low-income clients, for compelling financial reasons we will explain. **These facilities are one solution along the continuum of care, treatment, and recovery that some of our fellow Californians experiencing homelessness need.**

Licensed residential facilities are non-medical, 24-hour staffed residences that provide a room and a bed, 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 medical appointments. The facility may be a private home that’s converted to a six-bed facility, or an apartment building for 200+ people, or something in-between. Most facilities are six beds or fewer.

A small subset of these facilities serves and cares for low-income Californians with significant mental illness as well as other disabilities. The subset is small because the reimbursement these facilities receive is extremely low, while the need and acuity of the residents can be extremely high.

**ARFs and RCFEs that accept low-income residents play a critical role in preventing homelessness.** They serve people with mental illness who might otherwise be homeless. They are a step along the road to recovery from physical or mental illnesses, and they help people gain strength and skills before moving to a lower level of care, thereby preventing people from falling into homelessness. They accept people being discharged from acute hospitals, State Hospitals (for people with mental illness) and Institutes for Mental Disease (IMDs) who might otherwise be homeless. They are part of the safety net.

In the City and County of San Francisco’s Long Term Care Coordinating Council released a report in January 2019 called “**Supporting Affordable Assisted Living in San Francisco,**” 94% of ARF operators surveyed indicated they accepted clients who were formerly homeless, demonstrating that ARFs are already playing a key role in supporting formerly homeless individuals. This report is attached as **Appendix 1.**

**THE RATE PROBLEM.** Many people experiencing homelessness are beneficiaries of Supplemental Security Income, or SSI<sup>2</sup>, because they are unable to obtain

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<sup>2</sup> The SSI Program is a federally funded program which provides income support to eligible individuals who are aged 65 or older, blind or disabled. SSI benefits are also available to qualified

meaningful work due to a disability (e.g., mental illness). SSI is intended to cover an individual's "room and board" (a roof and meals, essentially). The state sets the rate that a low income SSI beneficiary residing in a licensed residential facility must pay to reside there. This rate is called the "**Non Medical Out of Home Care (NMOHC) rate**". As of 1/1/19, the NMOHC rate is **\$1,058 per month for an individual**.<sup>3</sup> Divided by 30 days, that's around \$35/day. This amount is supposed to cover all the services listed previously, as well as the facility's insurance, worker's comp insurance, staff wages, building upkeep, license fees, and all other expenses related to running a safe and supportive residence. The facility is not permitted to charge the individual anything above this state-mandated rate. This rate is woefully inadequate. Facilities are closing due to this low rate. Facilities are also refusing to accept low-income clients because they can't make ends meet for \$1,058/month, especially in more-expensive counties like San Francisco, San Mateo and Los Angeles. Please see **Appendix 2** for a breakdown of the current NMOHC Payment Standards effective 1/1/19.

By contrast, the organization RCFE Reform reports that for individuals paying market, non-NMOHC rates to ARFs+RCFEs:

"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)."<sup>4</sup>

Therefore, facilities accepting private-pay clients are paid rates **four to eight times higher**, on average, than a facility accepting low-income residents.

**ONE SIZE DOES NOT FIT ALL.** The Non-Medical Out of Home Care rate is not based on the acuity or needs of the individual; it is a flat fee, regardless of the person's needs. Likewise, the rate does not differ county to county. When examining this rate problem, policymakers should consider using a tiered rate structure (such as Regional Centers and the Assisted Living Waiver use) and also adjust for variations in operating costs, such as property tax and minimum wage, in different geographic regions.

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programs is determined by SSA using federal criteria. If an eligible individual qualifies for SSI, they qualify for SSP. The benefits are in the form of cash assistance.

<sup>3</sup> A single person living in an RCFE and eligible for SSI would receive the \$1,194.37 NMOHC benefit ,

<sup>4</sup> <https://rcfereform.org/data-research/californias-assisted-living-waiver-program-alwp-facts-figures>

**FACILITIES ARE CLOSING.** Reports from Counties all over the state indicate that we are losing these facilities for low-income people at an alarming rate. The writers of this report have requested five years of closure data from the state Department of Social Services Community Care Licensing Division – the entity that licenses and monitors ARFs and RCFEs – but the data were not available prior to the HCFC deadline. We will supply those stats as soon as they are available.

**BACKLOGS AND BOTTLENECKS.** Homeless service providers are struggling to find appropriate placements for their clients who could thrive at the ARF or RCFE level of care, because very few ARFs+RCFEs are willing to accept residents who can only pay the Non Medical Out of Home Care (NMOHC) rate. As a result, hospital discharge planners often cannot find appropriate placements for people in their hospitals who could be discharged to a lower level of care. For example, the San Francisco Long Term Care Coordinating Council’s report on this crisis states that:

“Hospitalized individuals who are unable to privately pay for assisted living or ineligible for [an assisted living] subsidy may end up stuck at the hospital without a clear discharge solution. As part of the Post-Acute Care Collaborative, a point-in-time 2017 survey of hospitals found that 50% of 117 hospitalized individuals awaiting discharge needed custodial care and 24% could be accommodated at a lower level in the community. Many of these patients had behavioral health characteristics, including substance use, severe mental illness, and/or dementia, that can make it difficult to find an affordable placement. “

In addition, Institutes for Mental Disease (IMDs, inpatient treatment centers for people with mental illness who are usually on conservatorship) have difficulty discharging low-income homeless patients who need the type of support provided in an ARF or RCFE, because few ARFs and RCFEs are willing to accept people at the low NMOHC rate. This creates a backlog in the IMDs, which then creates a backlog in inpatient hospitals that can’t discharge people to IMDs. This not only takes a human toll on the people who are kept in inpatient settings longer than is necessary, it takes a financial toll on the counties and Medi-Cal which are paying for these excess inpatient days. The lack of ARF and RCFE options also incentivizes the healthcare system to place homeless individuals in skilled nursing facilities even when that is not the level of care that people need, because that might be the only placement available, however inappropriate and expensive it may be.

The California Behavioral Health Planning Council released a report in 2018 called **“Adult Residential Facilities (ARFs): Highlighting the critical need for adult residential facilities for adults with serious mental illness in California.”**<sup>5</sup> This

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<sup>5</sup> <https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/2018-ARF-Final.pdf>

report is attached as **Appendix 3**. The report addresses this cycle of backlog and discharge from higher levels of care:

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

**HOMELESSNESS AND MENTAL ILLNESS.** The direct line between homelessness and mental illness is well-researched and well-documented. The L.A. County Mental Health Commission’s Ad-Hoc Committee on the Board and Care System released a report in 2018 called “**A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County.**” This report is attached as **Appendix 4**. This report states that:

“In Los Angeles County, where [the most recent point-in-time homeless count](#) identified 57,794 homeless people, the number of people living with mental illness far exceeds the housing options available. The 2017 demographic survey conducted by the Los Angeles Homeless Authority (LAHSA) identified that 30 percent of the homeless population in Los Angeles County suffers from a serious mental illness. That would amount to approximately 15,728 people.”

**THERE IS NO PARITY: THE RELATIVELY ROBUST SYSTEM OF CARE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD).** The Lanterman Act of 1977 was a landmark piece of legislation that guaranteed certain rights and services for Californians with intellectual and developmental disabilities. By passing the Lanterman Act, we collectively agreed that we value people with Down syndrome, Autism Spectrum Disorder, and other intellectual disabilities. The Lanterman Act created and funded the Regional Center system – 21 non-profits throughout the state that coordinate care and services for people with I/DD, and pay for those services. But, it was not always so; we as a nation have a shameful record of how we once treated our fellow citizens with intellectual and developmental disabilities.

The Lanterman Act sought to right some of those historical wrongs. For example: The Lanterman Act provides funding so Regional Centers can pay for clients to live in licensed residential facilities, when appropriate. The payments are tiered based on the acuity and needs of the individual, ranging from \$1,058/month (Level 1) to

\$6,953/month (Level 4). The current Regional Center Community Care Facility Rates are attached as **Appendix 5**.

Advocates for people experiencing homelessness and people with mental illness are painfully aware that they have no Lanterman Act. People with serious mental illness – some of whom, like some 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 people with I/DD. So we have a system where parity is not in place. Rather there's a glaring disparity in how policymakers have chosen to finance licensed residential facilities for different populations. This disparity results in more homelessness, incarceration, institutionalization, and higher healthcare spending for people with mental illness.

**REGULATORY BARRIERS.** Existing rules and regulations inhibit threaten the survival of ARFs and RCFEs serving low-income people, and discourage new operators from entering the field.

One group of stakeholders identified several ways<sup>6</sup> that regulations could be amended to support this system of care, including:

- Require the state Licensing division to report more robustly on who is served by licensed facilities, e.g. people with mental illness, substance use disorders, or formerly homeless individuals
- Require the state Licensing division to report regularly on facilities that close permanently, and why
- Amend licensing categories that do not currently allow for many Transitional Aged-Youth with children or adults with chronic co-morbid ailments to 'fit into' the licensed facility
- 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

The City and County of San Francisco recommends the following strategies to address regulatory barriers<sup>7</sup>:

- Explore opportunities to reduce costs through local business and property tax policies.
- Explore compliance cost of labor laws and opportunities to streamline, minimize, and/or alleviate costs while still fully complying with requirements (e.g., minimum wage, unemployment)
- Provide support with state licensing and/or local permitting process, which can be particularly complex for new applicants. A primary burden is the lengthy state approval timeline.

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<sup>6</sup> "Adult Residential Facilities (ARFs) : Highlighting the critical need for adult residential facilities for adults with serious mental illness in California." CABHPC, 2018

<sup>7</sup> "Supporting Affordable Assisted Living in San Francisco," San Francisco Long Term Care Coordinating Council, 2019

- Support facility operators with initial application (e.g., accuracy, business acumen). The CA Department of Social Services-Community Care Licensing Division (CDSS-CCL) has expedited applications in the past for specialty ARFs+RCFEs, such as dementia and non-ambulatory beds.
- Advocate for CDSS-CCL resources to improve processing time.
- Develop and publicize a “how to” guide for new operators seeking licensing
- Publicize opportunities and support transfer of existing licenses

Please see **Appendix 6** for a list of additional regulatory barriers identified by the CA Behavioral Health Planning Council.

**LAND USE AND COMMUNITY RESISTANCE.** According to the CA Behavioral Health Planning Council’s ARF report:

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

“[Stakeholders] expressed the anguish of working with County Boards of Supervisors and combating the ever-present ‘Not In My Backyard-isms (NIMBYisms).’ There was a collective outcry to educate the greater community at-large that ‘those people’ could one day be each one of us. Typically, the individuals in this population do not have bipartisan support or an influential political voice. Therefore getting this stigma to shift is often arduous at best.”

The ARF Workgroup of the CA Behavioral Health Planning Council has identified land use requirements and community resistance as two of its key policy objectives, recognizing that these are barriers to the development of new ARFs.

San Francisco’s report on the ARF+RCFE crisis urges its city and county leadership to consider making “city-owned land available for businesses to build and operate new [ARFs+RCFEs].”

**THE AGING HOMELESS POPULATION.** All demographers agree: we must prepare for the largest-ever cohort of seniors experiencing homelessness. While L.A County’s 2018 Homeless Count showed a slight drop in homelessness overall from the previous year, it showed a 22% increase in homelessness among people aged 62

and older.<sup>8</sup> ARFs+RCFEs can offer the support that older adults need to avoid homelessness.

Dr. Dennis Culhane of the University of Pennsylvania describes this demographic shift in a 2018 report called “A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness.” Dr. Culhane also created a sub-report entitled “The Aging Homeless Population in LA County: Projected Costs, Housing Models and Cost Offsets Results.” Dr. Culhane *et al* present compelling evidence that using healthcare systems to invest in supportive housing settings for seniors offers a substantial return on investment. These reports are attached as **Appendix 7**.

To quote from the report:

“The key finding of this study is that **reductions in the use of shelter and healthcare services costs stand to substantially, if not completely, offset the cost of providing housing and related services for shelter- using, elderly homeless adults (i.e., adults age 55 and older)** [emphasis added]. Study results show that the elderly homeless incur greater costs in conjunction with their use of health care services (mostly inpatient services and nursing home use) as they age, and when shelter costs supplement these healthcare costs in the systems available for this study then these combined costs can potentially offset the costs related to providing housing and related services costs.”

In other words, providing a homeless older adult with an appropriate living situation costs less than providing avoidable healthcare services.

**MEDI-CAL’S ROLE.** Implemented in 2006, the Medi-Cal Assisted Living Waiver (ALW) makes enhanced payments to licensed residential facilities to incentivize the facilities to accept Medi-Cal beneficiaries, in lieu of those beneficiaries residing in a more costly and restrictive setting such as a skilled nursing facility. The state Department of Health Care Services piloted the Assisted Living Waiver to test whether placing Medi-Cal beneficiaries in licensed residential facilities could improve quality of life and quality of care, and reduce costs. Beneficiaries still pay the NMOHC rate themselves; the Medi-Cal ALW pays enhanced rates above and beyond the NMOHC. The rates are tiered based on the acuity and needs of the individual. The enhanced rates that Medi-Cal pays for people enrolled in the Assisted Living Waiver range from \$55/day (approximately \$1,500/month) to \$200/day (approx \$6,000/month) for the highest-need individuals. In addition, the ALW pays \$320/month to agencies that provide ongoing case management and care coordination, recognizing that high-need individuals need additional care and

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<sup>8</sup> <https://www.lahsa.org/documents?id=2059-2018-greater-los-angeles-homeless-count-presentation.pdf>

support. Please see **Appendix 8** for the current Assisted Living Waiver rate structure.

The Assisted Living Waiver (ALW) currently only has 3,700 slots statewide and there are long wait lists in every county that participates in the Waiver. Another 2,000 slots are about to be added. But those slots will still fall significantly short of meeting the need, or clearing the wait lists. Assembly Member Ash Kalra has proposed legislation to expand the Assisted Living Waiver to 18,500 slots statewide.<sup>9</sup>

Aside from the ALW, Medi-Cal does not pay for services provided in an ARF or RCFE since neither is a Medi-Cal benefit. However, Medi-Cal has the *option* of paying for care delivered in these settings, especially if it is done so in lieu of more-costly inpatient or institutional care. We strongly recommend the Council consult with its colleagues at the Department of Health Care Services to explore opportunities for partnering on a plan to bolster the ARFs+RCFEs serving formerly homeless individuals by using Medi-Cal dollars to increase the NMOHC rate to a level that will allow for a financially sustainable system.

**THE CONTINUUM OF HOUSING OPTIONS.** Per the L.A 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 and RCFEs are one important option for people experiencing homelessness, but they are usually left out of discussions concerning “permanent supportive housing” because they don’t meet the definitions of PSH<sup>10</sup>. Yet they are providing important health and housing services for individuals that need the supports of care and supervision. In addition, for some homeless individuals ARFs and RCFEs may be a stop along a continuum; for some people, a much-needed shorter-term stay in a licensed residential facility can help prepare them for a more independent, community-based, integrated living situation. And without a short-term AFF+RCFE stay, some people would not succeed in living more independently. While some people may need ARF- or RCFE-level of care their whole lives, for many people it’s a crucial step along the road to recovery.

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<sup>9</sup> AB 50: [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201920200AB50](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB50)

<sup>10</sup> U.S. Interagency Council on Homelessness: “Supportive Housing”  
<https://www.usich.gov/solutions/housing/supportive-housing/>

## **BEST PRACTICES: LOS ANGELES COUNTY**

L.A. County's Departments of Health Services and Mental Health operate four programs that support formerly homeless or mentally ill persons residing in licensed residential facilities.

Los Angeles County Department of Health Services' (DHS) **Housing for Health Division** has placed **more than 1,000 formerly homeless people in licensed residential facilities**. The County pays the facility a supplemental rate to incentivize the operator to accept low-income, formerly homeless individuals who require this level of care and services. Without this supplemental payment, these individuals would have far fewer (or no) reasonable housing options. The Housing for Health program overall has housed more than 10,000 people since its inception (most in non-licensed settings). However, the County has limited resources to continue and grow this program, and the need far exceeds the program's capacity.

The Housing for Health (HFH) Division<sup>11</sup> at DHS was created in 2013 with a focus on creating permanent supportive housing opportunities for homeless patients of the DHS system of care. DHS is reinvesting in communities by providing supportive and clinical services to its most vulnerable populations.

Access to community based housing options is an important element of the evolving county healthcare system, particularly in response to the homeless crisis.

By housing homeless persons who have been high utilizers of DHS services with complex medical and behavioral health conditions, Housing for Health made its mark in the homeless services area by meeting the following objectives:

- Improve the health and well-being of a vulnerable population that typically experiences long episodes of homelessness, high rates of disability, multiple untreated health conditions, and early mortality.
- Reduce costs to the public health system incurred by a relatively small, but costly cohort of individuals, who due to their lack of housing, remained hospitalized for greater lengths of time and/or have repeated and unnecessary contact with the public health system.
- Demonstrate DHS' commitment to improve living conditions for homeless people within Los Angeles County.

Preliminary data from the Housing for Health epidemiologists 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**

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<sup>11</sup> <http://dhs.lacounty.gov/wps/portal/dhs/housingforhealth>

**utilization compared to the six months prior to enrollment.**<sup>12</sup> 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.

In addition, L.A. County took over the operations of three licensed facilities that were slated for closure. Without County intervention, those facilities would have closed permanently and those licensed beds would have been lost.

The Los Angeles County Department of Mental Health has had a Homeless and Housing division since the 1990s that has managed housing resources for clients of the Department – people with severe mental illness. Since the 1990s, the Department of Mental Health (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 the DMH Interim Funding Program. In 2018, to reduce the gap between actual costs for serving DMH clients in ARFs and the NMOHC rate, DMH began to offer an enhanced rate for eligible clients enrolled in its Whole Person Care program. This fiscal year, DMH increased its investments to support clients residing in ARFs and RCFEs by launching an enhanced rate program to incentivize facilities to serve low-income clients with mental illness who have higher service needs. DMH now serves 900 clients through these three programs that make enhanced rate payments to licensed residential facilities.

These County programs do not meet all the needs of a County as large as Los Angeles, but they signify progress towards ensuring appropriate placements for people at high risk of homelessness.

**NEXT STEPS:**

**We welcome questions from the Council on this proposal and would be happy to collaborate on implementing the recommendations within.**

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<sup>12</sup> “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.

## **Appendix 1**

City and County of San Francisco

**Long-Term Care Coordinating Council**

**Assisted Living Workgroup**

# **SUPPORTING AFFORDABLE ASSISTED LIVING IN SAN FRANCISCO**

**January 2019**

# CONTENTS

- Executive Summary..... i
- Assisted Living Workgroup Membership ..... iii
- Introduction and Background ..... 1
- Supply and Demand: Key Findings ..... 3
  - Small facilities are disappearing at a fast rate and are unlikely to return ..... 4
  - Cost is – and will remain – a key barrier ..... 8
  - The City is a key funder of assisted living ..... 9
  - There is unmet need for affordable assisted living ..... 13
- Recommended Strategies ..... 14
  - Sustain existing small businesses..... 15
  - Increase access to existing ALF beds..... 17
  - Develop new models for meeting needs ..... 19
  - Enhance state waiver program ..... 21
- Conclusion..... 23
- Appendix A. ALF Operator Survey..... 24
- Appendix B. Cost Estimates. .... 31
- Appendix C. DAAS-Subsidized ALF Placements..... 34
- Appendix D. DPH-Subsidized ALF Placements. .... 35
- Appendix E. Additional Strategies..... 37

# EXECUTIVE SUMMARY

Assisted living is a vital resource for many seniors and people with disabilities who are no longer able to live independently and safely. **These facilities are a key piece of the City's service system**, both supporting individuals living in the community to transition up to a more protective level of care when needed and also providing a more independent and community-like setting for consumers able to transition down from a more restrictive institutional setting. **Maintaining an adequate supply of assisted living in San Francisco supports the movement of individuals through medical and mental health systems**, ensuring that the right level of care is available and accessible when it is needed.

Over the last several years, **the City's supply of assisted living – particularly affordable assisted living – has been declining**. At the request of Mayor London Breed and Supervisor Norman Yee, the Long-Term Care Coordinating Council convened a workgroup to study this issue.

This report is the culmination of the **Assisted Living Workgroup**, which met between August 2018 and December 2018. Focusing primarily on the **availability of assisted living for low-income persons**, the scope of this work included facilities licensed as **Residential Care Facilities for the Elderly (RCFEs)** that support seniors age 60 and older and **Adult Residential Facilities (ARFs)** serving adults between ages 18 and 59. In this report, both types are collectively referred to as **Assisted Living Facilities (ALFs)**.

The Assisted Living Workgroup examined factors that impact the supply of assisted living, as well as sources of consumer demand and unmet need, before delving into strategies to support access to affordable assisted living in San Francisco. This included study of assisted living subsidy programs managed by the San Francisco Department of Public Health (DPH) and Department of Aging and Adult Services (DAAS). Key findings and recommendations are summarized below.

## FINDINGS RELATED TO SUPPLY AND DEMAND

- **Small facilities are disappearing at a fast rate and are unlikely to return.** The decline in ALF capacity has primarily occurred through the closure of the small facilities that have been more affordable and accessible for low-income persons. In particular, this has resulted in a significant bed loss for adults under age 60. Due to increased costs and shifting family interest, this trend will be difficult to reverse; while efforts should be taken to support the viability of these existing small businesses, this small home-based model may prove to be unsustainable in the long-term.
- **Cost is – and will continue to be – a significant barrier.** Estimates suggest the monthly break-even rate per board and care home bed is, at minimum, well over two times higher than the \$1,058 state-set rate for Supplemental Security Income (SSI) recipients residing in assisted living. Moreover, larger facilities tend to charge closer to \$3,500 to \$5,000, and this cost increases greatly for specialized care needs. Given business costs, it is unlikely that new ALFs will cater to a lower-income population without outside funding or support. To secure ALF placement, SSI recipients will require a meaningful subsidy.

- **The City is a key funder of ALF placement.** Through DPH and DAAS programs, the City supports 586 placements at an overall cost of about \$11.2 million per year. Approximately 15% of ALF beds in San Francisco are supported with a City-funded subsidy. This is particularly pronounced among ARF beds: the City subsidizes approximately 42% of ARF beds. It is in the best interests of both the City and ALF operators to work together towards sustainability to ensure this critical resource remains available and clients are able to flow through systems of care.
- **There is unmet need for low-income ALF placement in San Francisco.** Available waitlist data suggests at least 103 individuals have expressed a need for subsidized ALF placement through the DPH placement program, the DAAS-funded Community Living Fund program, and the state’s Assisted Living Waiver program.

## RECOMMENDATIONS

Based on these findings, the Assisted Living Workgroup identified four major strategies to support the availability of affordable assisted living in San Francisco. Each strategy has two specific and actionable recommendations. While these require further conversation and planning to implement, these recommendations were identified by the Assisted Living Workgroup to have greatest likelihood of meaningfully supporting and/or expanding the City’s supply of assisted living. These are:

### Sustain existing small businesses by:

- **Supporting business acumen skills** to empower and support the viability of small ALFs
- **Develop a workforce pipeline** to provide trained caregiver staff with time-limited wage stipend

### Increase access to existing ALF beds by:

- **Increasing the rate for City-funded subsidies** to ensure the City is able to secure ALF placement for low-income individuals
- **Increasing the number of City-funded subsidies** to increase availability of affordable ALF placement for low-income individuals

### Develop new models by:

- **Piloting the co-location of enhanced services and affordable housing** to develop alternate resources for people on the verge of needing assisted living but able to live in the community with more intensive and coordinated supportive services
- **Making space available for ALF operators at low cost** to reduce a major operating expense and allow the City to more directly impact the resident population (e.g., support low-income ALFs)

### Enhance the state Assisted Living Waiver program by:

- **Increase use of existing ALW slots** by individuals and facilities
- **Advocating for expansion of the program** to increase the number of Assisted Living Waiver slots

# ASSISTED LIVING WORKGROUP MEMBERSHIP

The following individuals participated as members of the Assisted Living Workgroup and/or its subgroups on supply, demand, and strategies:

Alicia Neumann, UC San Francisco, Optimizing Aging Collaborative  
Allegra Fortunati, Felton Institute, LTC Ombudsman Program  
Anna Chodos, UC San Francisco, Optimizing Aging Collaborative  
Benson Nadell, Felton Institute, LTC Ombudsman Program  
Bernadette Navarro-Simeon, Progress Foundation  
Catherine Omalev, Controller's Office  
Cindy Kauffman, SF Department of Aging & Adult Services  
Dan Kaplan, SF Human Services Agency  
Dorie Paniza, 6Beds, Inc.  
Gina Wasdyke, 6Beds, Inc.  
Jarlene Choy, SF Board of Supervisors, Norman Yee  
Juliana Terheyden, Homebridge  
Kelly Hiramoto, SF Department of Public Health  
Laura Liesem, Institute on Aging  
Manish Goyal, SF Office of Economic and Workforce Development  
Mark Burns, Homebridge  
Max Gara, SF Department of Public Health  
Melissa McGee, SF Department of Aging & Adult Services  
Mike Wylie, Controller's Office  
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Roberta Mendonca, 6Beds, Inc.  
Rose Johns, SF Human Services Agency  
Ruth Zaltsmann, Dignity Health  
Shireen McSpadden, SF Department of Aging & Adult Services  
Valerie Coleman, SF Department of Aging & Adult Services  
Wendy Lee, Controller's Office

# INTRODUCTION AND BACKGROUND

In San Francisco, the decreasing availability and increasing cost of assisted living present real and significant barriers for individual consumers, as well as the service systems tasked with supporting older and disabled residents to live safely in the community. At the request of Mayor London Breed and Supervisor Norman Yee, the Long-Term Care Coordinating Council (LTCCC) convened a workgroup to study the need for assisted living, identify challenges that impact the ability of small facilities to stay open, and develop actionable recommendations to support the supply of assisted living beds in San Francisco. This report presents the key findings from the Assisted Living Workgroup and its recommendations to support the availability of affordable assisted living in San Francisco.

## ASSISTED LIVING

**Assisted living facilities** offer supportive residential living for individuals who are no longer able to live safely independently. These facilities offer assistance with basic daily living tasks, provide around-the-clock supervision, and support medication adherence. While most people with disabilities can live safely in the community, many persons with a higher level of functional impairment require this higher level of care, including those with dementia, intellectual disabilities, and other behavioral health needs. Unlike skilled nursing facilities or other medical care paid for by Medi-Cal or Medicare, assisted living care is predominantly a private-pay service, and the cost of assisted living is often prohibitively expensive: the average rate for the least expensive facilities in San Francisco is approximately \$4,300 per month.

**Currently in San Francisco, there are 101 facilities and 2,518 total assisted living beds.**<sup>1</sup> More specifically, this includes facilities licensed as Residential Care Facilities for the Elderly (RCFEs) that support seniors age 60 and older and Adult Residential Facilities (ARFs) serving adults between ages 18 and 59. Both types of facilities are collectively referred to as Assisted Living Facilities (ALFs) in this report. As shown below, the majority of facilities and beds are licensed as RCFEs.

**Assisted Living Facilities and Beds by Type in San Francisco, 2018**

Type	Facilities	Beds
Residential Care Facilities for the Elderly (RCFEs)	59	2,040
Adult Residential Facilities (ARFs)	42	478
<b>Total</b>	<b>101</b>	<b>2,518</b>

Source: CA Department of Social Services, August 2018

<sup>1</sup> This analysis does not include Continuing Care Retirement Communities (CCRCs), which provide a continuum of aging care needs – from independent living to assisted living to skilled nursing care – to support residents as their needs increase. CCRCs are targeted to higher-income individuals; in addition to high monthly rates, CCRCs require an initial entry charge or “buy in” fee. Because of the significant differences in the CCRC model and relative inaccessibility of its ALF beds to the general public, these four facilities (which contain 984 ALF-licensed beds) are excluded here.

These facilities range from large-scale facilities with over 100 beds to small homes that house six or fewer clients (often called “board and care homes”). As the name describes, these are typically residential homes that have been opened up for boarders who require assistance around the home; residents typically share a bedroom with another resident and historically have lived under the same roof as the ALF administrator. All of these facilities are licensed by the California Department of Social Services’ Community Care Licensing division.

## **ASSISTED LIVING WORKGROUP**

The **Assisted Living Workgroup** met monthly between August and December 2018. During this time, smaller research groups met more frequently to **investigate demand** for assisted living, **identify factors impacting the supply** of assisted living in San Francisco, and **develop potential strategies** to support assisted living capacity in San Francisco.

In particular, the **Assisted Living Workgroup focused on the availability of assisted living for low-income persons unable to pay privately for this service**. Through the San Francisco Department of Public Health (DPH) and Department of Aging and Adult Services (DAAS), the City provides subsidies for low-income individuals meeting certain eligibility criteria. However, this information had not been synthesized or studied in the context of broader trends affecting the industry, including overall system capacity, supply of affordable assisted living, and sources of consumer demand.

As part of this work, a **survey of small facility operators** was conducted to develop key information not available through existing reports and materials and to provide an additional opportunity for those directly impacted by these trends to have a voice in this work. The input ALF operators provided through this survey have directly informed the direction of this report and its recommendations; please see Appendix A for a detailed summary of findings.

Participants in the workgroup and smaller research teams included: representatives from community-based organizations that serve older adults and people with disabilities; ALF operators and advocacy organizations (including 6 Beds, Inc.); medical and healthcare professionals, including the UC San Francisco Optimizing Aging Collaborative; the local Long-Term Care Ombudsman; and staff from key City agencies, including DAAS, DPH, the Human Services Agency, Office of the City Controller, and Office of Workforce and Economic Development. Research and analytical support was provided by staff from DAAS, HSA, and the Controller’s Office.

# SUPPLY AND DEMAND: KEY FINDINGS

Building upon the Assisted Living Workgroup's first report, *Assisted Living: Supply and Demand*, this section presents key findings and trends impacting the supply and demand of assisted living in San Francisco.

## KEY FINDINGS

- **Small facilities are disappearing at a fast rate and are unlikely to return.** Assisted living has declined across both RCFEs and ARFs but primarily has occurred through the closure of small facilities, particularly the “board and care homes” with six or fewer beds. This is concerning, because these facilities have typically been more affordable and accessible for low-income persons. Notably, because ARFs tend to be smaller facilities, this has resulted in a larger loss in capacity for adults under age 60. Due to increased housing, staffing, and business costs and shifting family interest, this trend will be difficult to reverse. While efforts should be taken to support the viability of these existing small businesses, this small home-based model may prove to be unsustainable in the long-term.
- **Cost is – and will continue to be – a significant barrier.** Cost estimates suggest the monthly break-even rate per bed is, at minimum, over \$2,000 for small facilities. This is over two times more than the state-set rate for Supplemental Security Income (SSI) recipients residing in assisted living. Full rates for private pay clients in larger facilities are estimated to be closer to \$3,500 to \$5,000 but can increase greatly for specialized care needs. Given business costs, it is unlikely that new ALFs will cater to a lower-income population without outside funding or support. It is evident that SSI recipients will require a meaningful subsidy to secure ALF placement.
- **The City is a key funder of ALF placement.** Through DPH and DAAS programs, the City supports 586 placements at an overall cost of about \$11.2 million per year. Approximately 15% of ALF beds in San Francisco are supported with a City-funded subsidy. This is particularly pronounced among ARF beds: DPH's 199 ARF placements in San Francisco account for 42% of ARF beds. It is in the interests of both the City and ALF operators to work together towards sustainability to ensure this critical resource remains available and clients are able to flow through systems of care.
- **There is unmet need for low-income ALF placement in San Francisco.** At the time of this report, available waitlist data suggests at least 103 individuals have expressed a need for subsidized ALF placement through the DPH placement program, DAAS-funded Community Living Fund program, and the state's Assisted Living Waiver program.

## SMALL FACILITIES ARE DISAPPEARING AT A FAST RATE AND ARE UNLIKELY TO RETURN

**Assisted living supply has declined across both RCFEs and ARFs.** In total, San Francisco has 43 fewer ALFs in operation today than in 2012. This has resulted in a decrease of 243 ALF beds (a nine percent decline). The scale of this loss varies by licensure:

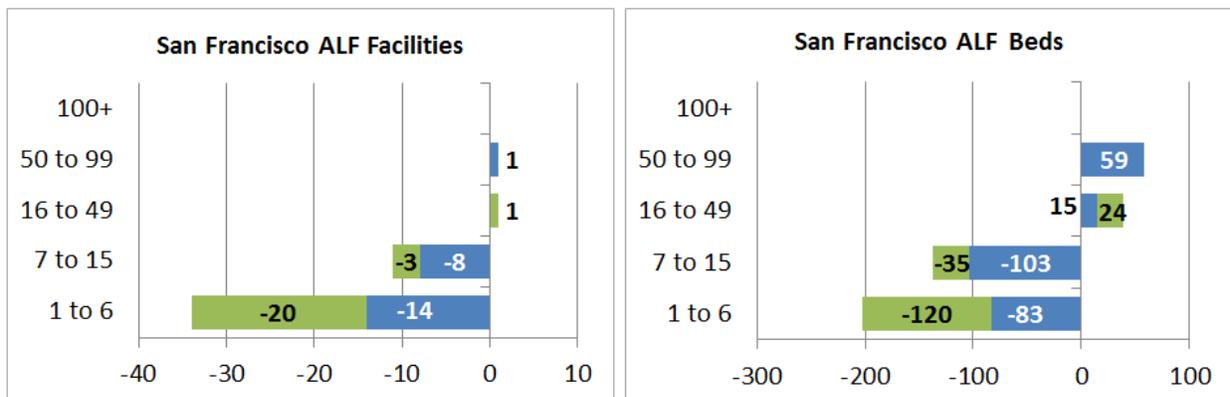
- **RCFE:** Today, San Francisco has 21 fewer RCFE facilities than 2012 – a 26% decline. However, because most of these closures were small facilities, the overall change in number of RCFE beds is small across this time period: a five percent decrease (112 beds).
- **ARF:** Both the supply of ARF facilities and beds has declined precipitously in recent years. Since 2012, there has been a 34% decline in the number of ARF facilities and 22% decline in the number of ARF beds in San Francisco. In total, San Francisco has 131 fewer ARF beds than in 2012.

### San Francisco ALF Supply by Licensure: 2012 to 2018

Measure	Total				RCFE				ARF			
	2012	2018	#	%	2012	2018	#	%	2012	2018	#	%
# of Licensed Facilities	144	101	-43	-30%	80	59	-21	-26%	64	42	-22	-34%
# of Beds	2,761	2,518	-243	-9%	2,152	2,040	-112	-5%	609	478	-131	-22%

In both licensure categories, the **decline has been in smaller facilities – the ALFs that have traditionally been more accessible to lower-income residents** (including those supported with City subsidies). The scale of this small-facility loss has been somewhat obscured by growth in larger facilities, particularly on the RCFE side. Since 2012, the City has seen a net loss of 34 homes in the smallest facility category – ALFs with six or fewer beds (often called “board and care homes”). In total, there are 203 fewer beds available in board and care home settings.

### Net Change in San Francisco ALF Supply by Facility Size 2012 to 2018



Source: CA Department of Social Services, August 2018

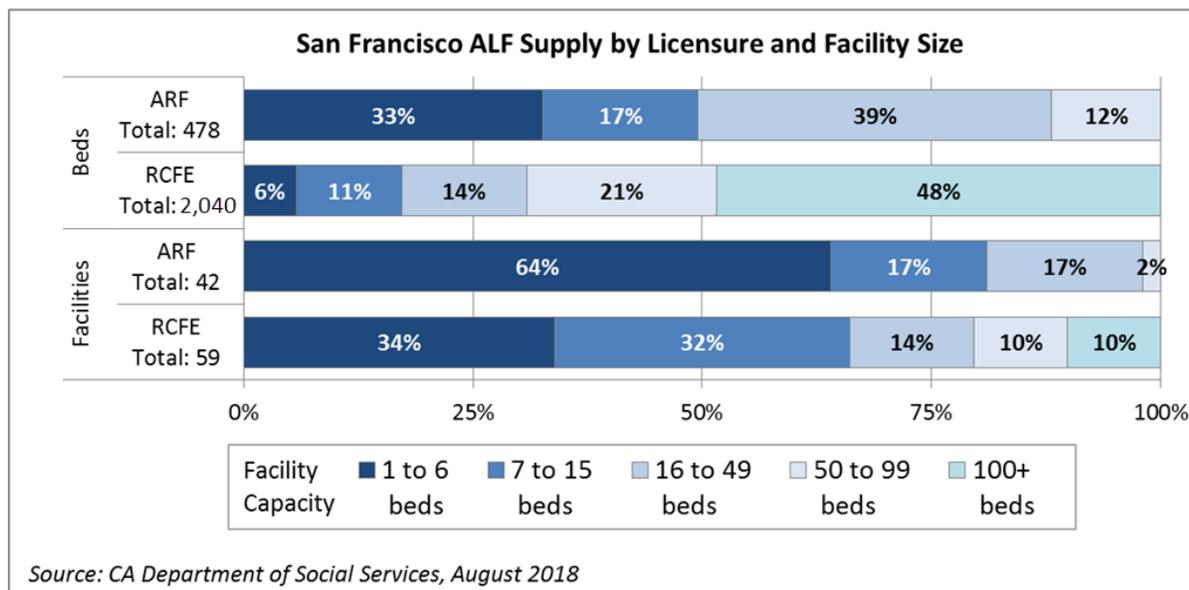
■ RCFE ■ ARF

The **loss of small ALF facilities puts the City’s supply of assisted living for adults under age 60 particularly at risk**. While RCFEs come in a variety of sizes, ARFs are much more likely to be small facilities. Half of the City’s ARF beds are located in facilities with 15 or fewer residents. Conversely, large-scale RCFEs with 100 or more beds account for almost half of ALF beds for seniors age 60 and older. As shown below, about a third of ARF beds (and almost two-thirds of ARF facilities) fall into the smallest facility category, called “board and care homes,” with six or fewer beds. **If the rapid loss of small ALF facilities continues, the City’s ARF supply will be decimated.**

**Assisted Living Facilities and Beds by Type in San Francisco, 2018**

Facility Size (Total Beds)	Total		RCFE		ARF	
	Facilities	Beds	Facilities	Beds	Facilities	Beds
1 to 6 beds	47	276	20	118	27	158
7 to 15 beds	26	313	19	233	7	80
16 to 49 beds	15	464	8	279	7	185
50 to 99 beds	7	478	6	423	1	55
100+ beds	6	987	6	987	0	0
<b>Total</b>	<b>101</b>	<b>2,518</b>	<b>59</b>	<b>2,040</b>	<b>42</b>	<b>478</b>

Source: CA Department of Social Services, August 2018



Source: CA Department of Social Services, August 2018

**This loss in board and care homes results from several factors, particularly increased costs and declining family interest.** This is described in greater detail below, beginning with a cost analysis.

As private businesses, ALF costs and rates are typically considered confidential proprietary information, and this information is not made publicly available, making it difficult to identify the true cost of operating a board and care facility. Based on available research literature and reports on assisted living,

the ALF operator survey, and one-on-one consultation with current ALF operators, the ALF Workgroup has attempted to approximate costs and estimate a “break-even” monthly rate for a six-bed ALF.

More specifically, the Assisted Living Workgroup developed three cost estimates to represent a range of ALF ownership and cost scenarios. The first two scenarios below reflect the typical origin of a board and care home, in which a homeowner has opened their private residence up to boarders in order to provide a little extra income or help with mortgage costs. The third model attempts to simulate the cost for a new entity to operate.

- **Scenario A:** Family-owned and operated ALF with property owned outright (i.e., no mortgage). Owner serves as administrator and does not draw a salary. Facility is staffed by 2.0 FTE direct care workers; the administrator pitches in to help out as needed during the day and, since this is her home, lives onsite and addresses any needs that arise overnight. Other family members may also pitch in to help as needed without pay.
- **Scenario B:** Family-owned and operated ALF with property under mortgage. Owner serves as administrator and does not draw a salary. Facility is staffed by 2.0 FTE direct care workers; the administrator pitches in to help out as needed during the day and, since this is her home, lives onsite and addresses any needs that arise overnight. Other family members may also pitch in to help as needed without pay.
- **Scenario C:** Newer ALF with property under mortgage and providing a higher level of staffing: 1 paid administrator and 4.0 FTE direct care workers. This staffing level provides 1.0 FTE active at all times; that is, this model relies on paid staff available 24/7 and does not include free labor.

**ALF Annual Cost Estimate and Monthly Break-Even Rate for Six Bed Facility<sup>2</sup>**

<b>ANNUAL EXPENSES</b>	<b>A</b>	<b>B</b>	<b>C</b>
Administrative Costs (e.g., licensing, supplies)	\$30,490	\$30,490	\$30,490
Property Costs (e.g., property tax, mortgage)	\$22,346	\$105,182	\$111,614
Labor Costs (e.g., wages, healthcare)	\$77,330	\$77,330	\$216,711
Staff Development (e.g., training, recruitment)	\$3,685	\$3,685	\$3,770
Resident Supports (e.g., food, transportation)	\$32,240	\$32,240	\$38,080
<b>TOTAL ANNUAL EXPENSES</b>	\$166,091	\$248,927	\$400,665
<b>MONTHLY BREAK EVEN RATE</b>	<b>A</b>	<b>B</b>	<b>C</b>
100% Occupancy	\$2,307	\$3,457	\$5,565
90% Occupancy	\$2,563	\$3,841	\$6,183

Source: Assisted Living Workgroup analysis, see Appendix B for detail

From a business perspective, this cost analysis underscores the difficulty that long-time board and care home operators face in maintaining their business, particularly those that have historically served a low-income population. SSI recipients residing in assisted living receive an enhanced benefit known as the Non-Medical Out of Home Care payment standard. This benefit totals \$1,173 and residents are

<sup>2</sup> See Appendix B for detail on costs included in each expense category and information source.

permitted to retain \$134, leaving \$1,058 available for ALF operators – less than half the break-even rate. From an ALF operator perspective, **it would not be feasible for a facility to accept the SSI rate for all residents or even a significant portion.** Moreover, for each resident that a facility accepts at a lower monthly rate, the cost difference must be made up in the rates charged to other residents.

Additionally, this analysis highlights that **it is unlikely that new board and care homes will open in San Francisco.** It is simply not a financially sustainable model unless the operator is the homeowner who lives onsite. As outlined in Scenario C, an investor entering the market anew would need to charge about \$6,000 per month to break even. At those rates, an individual could likely purchase a bed in a larger, more upscale facility. From an investment perspective, other private business ventures are more likely to be readily profitable.

**Shifting family dynamics and broader economic trends exacerbate these cost issues, particularly related to workforce.** Historically, small ALFs have been family businesses with family members helping out and eventually taking over the business. However, through the ALF operator survey, board and care home owners shared that their children are less interested in maintaining the family business, and increased property values offer a lucrative opportunity to cash in on an unexpected retirement windfall. The City's increasingly high cost of living and low unemployment rate make it difficult for ALF operators to find people willing and able to work for minimum wage. But it is difficult for small ALF operators to pay above minimum wage given their slim profit margin and increasing operating costs. A key factor is the local minimum wage increase and its impact on operating costs in comparison to revenue opportunities: since 2012, minimum wage has increased by 46% while the SSI rate for assisted living residents has only increased by 8%.

## COST IS – AND WILL REMAIN – A KEY BARRIER

As discussed in the prior section, cost estimates suggest that the **monthly break-even bed rate is over \$2,000 per bed in a board and care home, more than twice what a low-income SSI recipient would be able to pay**. This estimate was based on a minimal cost model in which the ALF administrator is the homeowner who does not take a salary. This cost estimate climbs quickly depending on mortgage status and staffing levels. Additionally, to make a profit, a facility must charge higher rates. While most respondents in the ALF operator survey reported charging under \$4,000 per month for a bed, they noted that their rates are largely defined by the state SSI rate and DPH subsidies. They shared that it is difficult to meet their business expenses, and this rate is not sustainable.

**It is unlikely that new ALFs will cater to low-income consumers.** As discussed in the prior finding, it is unlikely that many new small board and care facilities will open in future. Larger facilities tend to charge higher rates; they are profit-oriented businesses with all paid professional staff in newer facilities (often with significant costs associated with the building) and can attract a higher-paying clientele. The DAAS-funded Community Living Fund program provides a snapshot of market rate costs: on average, the full monthly rate for ALF placement is \$4,382.<sup>3</sup>

### Monthly ALF Placement Rate Comparison

Rate	Monthly Rate
State-Set SSI Payment for ALF Residents	\$1,058
Board & Care Home Break-Even Estimate	\$2,307
Average ALF Placement Rate*	\$4,382

\*Based on DAAS-funded Community Living Fund program (ALF placements in facilities of all sizes, from board and care homes to 100+ bed facilities)

It is evident from this information that **low-income individuals will need a meaningful additional subsidy to secure placement**. Given the disparity between the break-even rate and state funding level for SSI recipients, it is unreasonable to expect the market to provide ALF services for the low-income population – the cost and revenue does not pencil out to keep a facility in the black. In particular, this has implications for DPH. For clients with basic level of care needs, DPH provides a daily subsidy of \$22 per day (\$660 per month). It may be difficult for DPH to maintain access to this type of ALF placement in future. This is discussed further in the subsequent finding.

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<sup>3</sup> As described in the subsequent finding, the DAAS-funded CLF program provides monthly subsidies to a small number of intensive case management clients who require ALF placement to avoid institutionalization in a skilled nursing facility. This program data provides a small sample of RCFE rates charged for 22 CLF clients placed in San Francisco in June 2018. CLF subsidizes the difference between a client's ability to pay and negotiated facility rate (as detailed later in this report, the average CLF subsidy is \$2,943). Rates tend to be lower in smaller facilities. The maximum rate for a current CLF client is \$6,856; higher cost is based on increased level of care for clients with more complex needs. See Appendix C for more detail.

## THE CITY IS A KEY FUNDER OF ASSISTED LIVING

Assisted living is a critical support for San Francisco adults of all incomes and ages. While assisted living is primarily a private pay service, **many low-income individuals and clients enrolled in special programs are supported to secure ALF placement through City and other public programs.** These include:

- 586 locally-funded and managed subsidies:
  - 561 subsidies managed by Department of Public Health (DPH) for persons with behavioral health needs;
  - 25 subsidies managed by Department of Aging and Adult Services (DAAS) for persons at high risk of skilled nursing placement;
- Subsidies provided through the Medi-Cal Assisted Living Waiver program operated by the California Department of Health Care Services;
- 237 consumers supported through other specialized programs, including:
  - 120 placements managed by the Golden Gate Regional Center (GGRC); and
  - 117 clients in the Program for the All-Inclusive Care for the Elderly (PACE) program.

In total, at least 823 San Francisco seniors and adults with disabilities are currently supported with the financial cost of ALF placement. **The 604 clients placed locally in San Francisco account for 24% of ALF beds. This highlights the importance of this assisted living, its unaffordability for many people who need this level of support, and the role that public programs play in securing access to assisted living.**

**Through DPH and DAAS programs, the City directly supports 586 placements at an overall cost of approximately \$11.2 million per year.**<sup>4</sup> Of these placements, 367 are in San Francisco facilities, meaning that 15% of San Francisco's ALF beds are supported with a city-funded subsidy. This trend is particularly staggering among ARF beds, which serve adults under age 60: **42% of ARF beds are subsidized by DPH.**

**The nature of subsidy supply varies by program.** DPH, DAAS, and the Assisted Living Waiver subsidy programs are capped by available funding. When a client transitions off of a subsidy, a new consumer can be placed. The City-funded DPH and DAAS subsidy programs are impacted by placement cost; if subsidy costs increase (e.g., due to rate increase or higher level of care needs), the number of subsidies DPH and DAAS programs can support decreases. The state's Assisted Living Waiver program has a set number of slots to fill.<sup>5</sup> Conversely, the number of slots supported by GGRC and those whose care cost is paid by PACE is based on the needs of clients enrolled in their programs. Thus, the number of supported ALF placements may fluctuate over time if additional or fewer clients need ALF placement.

The **best opportunity to impact supply of subsidies is through the local and Medi-Cal programs.** The specialized programs are harder to influence and, by their nature, already required to be responsive to client needs. More specifics on these various subsidy programs are provided on the following pages.

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<sup>4</sup> Funding estimate based on subsidy rate alone and does not include administrative or related costs.

<sup>5</sup> In FY 2018-19, the Assisted Living Waiver increased from 3,744 to 5,744 slots.

## DEPARTMENT OF PUBLIC HEALTH

DPH provides **assisted living subsidies for persons with serious mental illness and San Francisco Health Network members with multiple complex characteristics** (e.g., mental health, substance use, medically compromised) with the goal of supporting stability in the most appropriate and least restrictive setting. In total, **561 DPH clients are subsidized for their ALF placements**. DPH spends approximately \$10.2 million on these placements each year; daily subsidy rates are based on the level of care needed.<sup>6</sup> Most clients receive SSI. They are permitted to retain \$134 per month for personal needs and contribute the remaining \$1,058 of their income to their monthly placement cost. The DPH subsidy is layered on top of this payment. For clients with higher income, DPH funds the cost difference to its negotiated rate.

### DPH Placements in ARF/RCFE – All Counties

Level of Care	ARF	RCFE	Total	Daily DPH Subsidy Rate	Monthly DPH Subsidy Rate
Basic	191	68	259	\$22	\$660
Specialty	77	139	216	\$65*	\$1,950*
Enhanced	12	74	86	\$105	\$3,150
<b>Total</b>	<b>280</b>	<b>281</b>	<b>561</b>	.	.

Source: DPH Transitions, August 2018 \*San Francisco rate (out of county rate varies)

Notably, **about 39% of DPH-supported ALF placements are in facilities outside of San Francisco**. Out of county placement may occur due to clinical determination (e.g., stability is better supported in a new environment away from factors that encourage destructive behaviors). However, this also indicates a level of demand for higher levels of care that is not met by the current system in San Francisco or is unattainable at current funding levels. Please see Appendix D for additional details, including a breakdown of in and out of county placements by level of care.

## DEPARTMENT OF AGING AND ADULT SERVICES: COMMUNITY LIVING FUND

Through the Community Living Fund (CLF) program, DAAS supports **people at risk of institutionalization (e.g., skilled nursing)** to live in the community. Since its creation in 2007, this program has supported 75 individuals to afford ALF placement and avoid or delay skilled nursing placement. In a given month, CLF funds ALF placement for approximately 25-30 clients. Historically, these subsidies have primarily been used to support individuals to transition out of Laguna Honda Hospital and Rehabilitation Center; in recent years, CLF has expanded its work to support transitions out of private skilled nursing facilities. The program focuses on placements in San Francisco.<sup>7</sup> Each month, CLF spends approximately \$75,000 on ALF placements; in total, the program spent \$926,000 on assisted living in FY 2017-18.

<sup>6</sup> See Appendix D for level of care definitions.

<sup>7</sup> Three current clients are placed out of county but were grandfathered in.

In June 2018, there were **25 clients receiving a monthly subsidy for ALF placement through CLF**. Clients receiving a subsidy are permitted to retain \$134 per month (in keeping with the SSI personal needs allowance rate) and contribute the rest of their income to the monthly rate. CLF then patches the difference between the client’s contribution and the ALF rate. The average monthly client contribution is \$1,312, slightly higher than the SSI rate. The table below provides detail about the average subsidy amount funded through CLF for 22 clients placed in San Francisco.

**Community Living Fund San Francisco ALF Placements**

Subsidy Rate	Average	Minimum	Maximum
Daily	\$98	\$25	\$195
Monthly	\$2,943	\$737	\$5,854

*Source: Community Living Fund, June 2018*

**MEDI-CAL ASSISTED LIVING WAIVER PROGRAM**

The Assisted Living Waiver (ALW) is a **Medi-Cal Home and Community-Based Services waiver program that supports individuals who require skilled nursing level of care** to delay placement into a skilled nursing facility and instead reside in a lower level of care, either an assisted living or public subsidized housing setting with appropriate supports. This allows Medi-Cal funding to be used to pay for ALF placement for a limited number of individuals. Daily subsidies range from \$65 to \$102 depending on level of care.

In FY 2018-19, the ALW program capacity will increase by 2,000 new slots for a statewide total of 5,744 slots. The slots are allocated on a first come, first served basis, with 60% of placements reserved for skilled nursing facility residents and 40% for individuals already residing in an ALF or living in another community placement. As of January 2019, there were about 4,000 people on the centralized ALW waitlist managed by the California Department of Health Care Services (DHCS). It currently takes an average of 12-15 months to reach the top of the list. **While DHCS was unable to provide the exact number of San Franciscans currently supported with an ALW subsidy in time for this report’s publication, they did share that 46 San Francisco residents are on the waitlist.**

Individual eligibility is assessed by state-certified Care Coordination Agencies (CCA), which are responsible for developing and implementing each client’s individualized service plan and supporting clients to make decisions regarding their choices of living arrangements. When an individual reaches the top of the waitlist, the CCA that initially assessed the client’s eligibility is responsible to help them secure ALF placement.

Facilities must also undergo a certification process for beds to be designated as ALW eligible. There is no limit on the number of facilities that can apply to become an ALW facility. **Currently, there are five San Francisco ALFs that have ALW-certified beds.** Because all are small board and care homes with six or fewer beds, the current supply of ALW-eligible beds located in San Francisco is relatively limited. An

individual may be placed in a facility outside of San Francisco if there are no available ALW-eligible beds within the City.

### **GOLDEN GATE REGIONAL CENTER**

The Golden Gate Regional Center (GGRC) is a state-funded non-profit organization that serves **individuals with intellectual disabilities**. Per state regulations, GGRC must vendorize or rent out an entire ARF to place clients under age 60 in assisted living. For senior clients age 60 and older, GGRC can vendorize a single bed rather than an entire facility. Facilities must meet specific criteria and requirements to provide residential care to people with developmental disabilities. As the Regional Center for San Francisco, Marin, and San Mateo counties, GGRC places clients in all of these counties. GGRC reports that they no longer vendorize new facilities in San Francisco due to cost and availability issues. In total, **GGRC has approximately 120 San Francisco clients placed in ALFs**.

### **PROGRAM FOR THE ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)**

The Program for the All Inclusive Care for the Elderly (PACE) is a **healthcare program for Medicare and Medicaid clients**. In San Francisco, On Lok Lifeways operates a PACE program, serving individuals aged 55 and older. As a capitated managed care benefit model, On Lok Lifeways provides a comprehensive medical and social service delivery system and is responsible for meeting all of its clients' care needs. PACE clients who require ALF placement typically pay a portion of the monthly rate for room and board; On Lok Lifeways may cover the care-associated costs based on the individual's care plan needs. Currently, there are about **117 PACE clients residing in RCFEs**.

## THERE IS UNMET NEED FOR AFFORDABLE ASSISTED LIVING

An individual's **need for assisted living level of care can develop under a variety of circumstances.**

These circumstances may be distinct but also can overlap, including:

- Living in the community but experiencing increasing personal care needs that make independent living no longer a safe option;
- Currently institutionalized or at risk of institutionalization in a skilled nursing facility; and/or
- Experiencing behavioral health challenges and unable to meet basic needs, living in the community, on the street, or in a mental health facility.

The Assisted Living Workgroup has explored many potential data sources in its attempt to identify and quantify demand for ALF placement, but this effort is hindered by a lack of available data. **When a service or support (like assisted living) is not an option, systems are typically not set up to document the need for that service.** Consequently, few programs and organizations track information about individuals who would benefit from ALF placement but for whom it is not an option (i.e., due to cost).

However, even without clear cut data on consumer demand, the **limited available data combined with key informant interviews provide a sense that there is significant unmet need for assisted living placement.** This manifests in a number of trends, including: increasing rates of self-neglect among consumers attempting to live independently longer than is safely feasible; waitlists for ALF subsidies; out of county placements; and delays in client movement between levels of care.

City programs do capture some information on unmet need for *affordable* assisted living. In August 2018, **DPH had 32 clients awaiting placement** and 10 empty beds, the result of a mismatch between client needs and the available level of care in facilities with vacancies. As of June 2018, the **DAAS-funded CLF program had 25 individuals waitlisted for ALF placement** – they need this higher level of support but the program does not have financial resources to subsidize their placement at this time.

There is also **unmet need for the state's Assisted Living Waiver program.** As of October 2018, there are 46 San Francisco residents on the waitlist for this program. It is possible that these individuals will be served through this year's 2,000 slot expansion of the Assisted Living Waiver program authorized by Governor Brown, but it is unclear how these slots will be allocated across counties and how San Francisco may benefit. Moreover, once people see new enrollment through the expansion and even if the waitlist is cleared, it may be the case that new requests will come forward.

**Hospitalized individuals** who are unable to privately pay for assisted living or ineligible for a subsidy may end up stuck at the hospital without a clear discharge solution. As part of the Post-Acute Care Collaborative, a point-in-time 2017 survey of hospitals found that 50% of 117 hospitalized individuals awaiting discharge needed custodial care and 24% could be accommodated at a lower level in the community. Many of these patients had behavioral health characteristics, including substance use, severe mental illness, and/or dementia, that can make it difficult to find an affordable placement.

# RECOMMENDED STRATEGIES

The Assisted Living Workgroup’s Strategies Research Group identified and vetted 16 ways for the City to potentially support ALF capacity in San Francisco. These ideas ranged from business factors to workforce support to models of care and payment. These strategies were evaluated to identify which had the greatest likelihood of meaningfully supporting and/or expanding the City’s supply of assisted living using the following criteria:

- **Cost:** What is the estimated cost or cost scale to implement the strategy?
- **Impact:** What level of impact is this strategy likely to have? For example, how many clients could be impacted? Will the strategy significantly improve the ability of ALF operators to stay in business?
- **Timeframe:** How long will it take to implement the strategy and see impact? Is the timeline: short (within six months), moderate (six to twelve months), or long-term (over a year)?
- **Feasibility:** Given competing priorities and needs in the City and State, how likely is the strategy to be implemented? Is there a clear path forward to implementation?

Based on these criteria, the ideas were prioritized and grouped into four main strategic areas with eight recommendations for specific ideas to support these goals.

**Assisted Living Workgroup: Recommended Strategies**

Strategy	Recommendation
<b>Sustain existing small businesses</b>	Support business acumen skills
	Develop workforce pipeline
<b>Increase access to existing ALF beds</b>	Increase the rate for City-funded subsidies
	Increase the number of City-funded subsidies
<b>Develop new models</b>	Pilot co-location of enhanced services and affordable housing
	Make space available at low cost for ALF operators
<b>Enhance state Assisted Living Waiver (ALW) program</b>	Increase use of existing ALW slots
	Advocate for ALW expansion (Assembly Bill 50)

The other eight potential strategies identified by the Assisted Living Workgroup’s Strategies Research Group are worth review and continued conversation. Please see Appendix E. These are ideas that hold promise but may be a heavier lift, require additional discussion to ascertain next steps towards implementation, or have lower (but still potentially meaningful) impact. For example, one of these ideas is to develop local property tax breaks for ALFs that accept low-income residents. Further analysis is needed to identify the tax break scale needed to achieve a meaningful impact and to determine local interest in instituting such a policy.

## SUSTAIN EXISTING SMALL BUSINESSES

Small facilities are a valuable resource, especially in providing more affordable placements. Particularly given that new board and care homes are unlikely to open in San Francisco, it would behoove the City to continue and expand its efforts to help sustain these businesses. The strategies within this recommendation are intended to empower small ALFs to remain viable for as long as possible by reducing costs and increasing revenue. These actions are all within the City’s purview, can be implemented quickly, and have the potential to immediately provide positive impact while other larger-scale and long-term strategies are pursued.

### RECOMMENDATION: SUPPORT BUSINESS ACUMEN SKILLS

Many small ALFs are long-held family businesses – a model based on private residents opening up their home to boarders. Outside of direct experience, many ALF operators do not have a background or formal training in business operation.<sup>8</sup> Moreover, they have indicated a desire for this type of support; 75% of ALF survey respondents indicated that business consultation support would be a useful resource.

The ALF Workgroup recommends that the City provide business acumen support to empower small ALFs to enhance their business skills and structure their practices to promote the overall viability of these facilities. There is precedent for this type of service. The Office of Economic and Workforce Development’s (OEWD) Small Business Development Center (SBDC) provides training and consulting support to business owners in San Francisco. This resource could potentially be leveraged to develop expertise specifically focused on the field of assisted living, which may be outside the industries with which the SBDC commonly works.

#### Prioritization Criteria – Business Acumen Skills

<b>Cost</b>	Low	Cost will vary based on scale and format of support (e.g., group training could be lower cost than one-on-one coaching), as well as ability to leverage existing resources, but should be relatively low cost in context of other recommended strategies.
<b>Impact</b>	Moderate	Business strategic support has potential to reduce costs and improve efficiency for small operators with lean budgets. Per ALF survey, ALF operators see value in this type of support and can be expected to make use of it.
<b>Timeframe</b>	Short-term	Support strategies could likely be rolled out within the next fiscal year, particularly if existing resources (e.g., OEWD SBDC) are leveraged.
<b>Feasibility</b>	Moderate	OEWD is available to guide implementation

<sup>8</sup> As an example, 81% of ALF operator survey respondents indicated a need for help publicizing their business, and about half identified long bed vacancies as a main concern impacting business sustainability. However, few have an online presence or outreach/publicity strategy. When unable to find a new client, ALFs may end up using a placement registry that connects clients to open ALF beds but charges 100%-150% of the first month’s rate for each placement. Using a placement registry three times per year can cost over \$15,000, increasing costs by up to 10% for a business with a very tight margin.

## RECOMMENDATION: DEVELOP WORKFORCE PIPELINE

At the same time that long-time ALF operators are aging and becoming more reliant on outside help to provide care to residents, procuring outside labor is becoming increasingly challenging due to minimum wage increases, low unemployment levels, and stricter staffing requirements (particularly for ARF). Having to train new caregiver staff, particularly for facilities experiencing frequent turnover, is an additional burden.

The Assisted Living Workgroup recommends that the City consider opportunities to leverage its workforce development programs to support the ALF industry. Existing job training and wage stipend programs provide a potential opportunity to both address the training needs and also help offset one of the main cost drivers that small ALFs cite as a key threat to their viability. There may be opportunities to build this type of program into a larger caregiver career ladder, such as a partnership with the In-Home Supportive Services program and/or San Francisco City College.

### Prioritization Criteria – Develop Workforce Pipeline

<b>Cost</b>	Moderate to High	Cost will vary based on scale. HSA’s Workforce Development Division typically provides a wage stipend for up to six months through the JobsNOW! program for clients participating in public benefit programs (e.g., CalWORKs Welfare-to-Work). Existing program infrastructure can be utilized with minimal additional administrative cost.
<b>Impact</b>	Moderate to High	Labor costs have been cited as a key challenge in business viability. While the wage stipend is time-limited, the cost savings could be quite meaningful for small facilities with a lean operating budget and help buy time while longer-term strategies are implemented. Moreover, this model reduces the burden on ALF operators to train new workers.
<b>Timeframe</b>	Medium-Term	While existing job placement programs can be utilized, it will require time to integrate new training curriculum into the program model and then to train the first cohort(s) of participants for placement.
<b>Feasibility</b>	High	This can likely be built off or implemented within existing workforce development programs.

## INCREASE ACCESS TO EXISTING ALF BEDS

As primarily a private pay service, assisted living is financially out of reach from many people who need this level of care. This can result in crisis situations for those unable to meet their needs in the community; it also contributes to capacity issues in higher levels of care, such as hospital and psychiatric beds, when persons ready to transition out are unable to afford assisted living or secure a subsidy. To ensure continued access to assisted living and to meet current demand, the Assisted Living Workgroup recommends a rate increase and also an increase in the number of City-funded subsidies.

### RECOMMENDATION: INCREASE RATE FOR CITY-FUNDED SUBSIDIES

The cost estimates included in this report suggest that a minimum monthly break-even bed rate for a small board and care home is over \$2,000 per month. Larger facilities tend to charge closer to \$4,400. However, the state-set rate for SSI recipients living in assisted living provides only \$1,058 per month for the ALF operators, leaving an operating cost gap of over \$1,200 per month. Low-income SSI recipients will need a meaningful subsidy on top of the SSI benefit to procure ALF placement. However, while small ALF operators identified the steadiness or reliability of City-funded subsidies as valuable, they described the rate as unsustainable, particularly for the “basic” level of care. Moreover, larger facilities (that charge higher rates) are unlikely to accept the lowest subsidy rates, particularly as their costs increase.

In particular, the Assisted Living Workgroup recommends that the City consider an additional rate increase for the “basic” level of care supported by DPH. Currently, there are 259 individuals in a basic level of care (all are placed in San Francisco). In July 2018, the subsidy rate was increased from \$19.75 to \$22 per day or \$660 per month as part of a \$1 million two-year budget enhancement from Mayor Breed. Even if this enhanced rate is continued, it will be difficult to continue securing placements at this rate.

The Assisted Living Workgroup does not make a specific recommendation regarding rate levels – leaving this to city policymakers and relevant departments to discuss in further detail – but notes that any rate increase would need to be funded with a new allocation to avoid an overall reduction in the number of subsidies available.

#### Prioritization Criteria – Increase Rate for City-Funded Subsidies

<b>Cost</b>	Moderate to High	Cost will depend on the number of subsidies impacted and scale of the rate increase. For example, a \$5 rate increase for the 259 current residents with a “basic” level of care would cost approximately \$437,000 per year.
<b>Impact</b>	Moderate to High	Current subsidy rates are the most often cited business challenge for ALFs. An increase would immediately impact all facilities that currently take DPH “basic” level of care placements.
<b>Timeframe</b>	Short-Term	This would support an existing program that could quickly implement a rate increase.
<b>Feasibility</b>	High	The primary challenge is funding availability (the subsidy program, partner facilities, and process for procuring beds are in place).

## RECOMMENDATION: INCREASE NUMBER OF CITY-FUNDED SUBSIDIES

Through DPH Transitions placement team and DAAS Community Living Fund, the City supports almost 600 ALF placements for low-income San Franciscans. While it is difficult to develop a comprehensive estimate of unmet need for assisted living due to lack of data, the information that is available suggests at least 103 individuals have expressed a need for affordable ALF placement. This includes 32 DPH clients in need of ALF placement but for whom there is not an appropriate bed that meets their level of care needs, as well as 25 individuals that have been assessed as in need of assisted living by the DAAS-funded CLF program.<sup>9</sup>

The Assisted Living Workgroup recommends that the City provide additional funding to increase subsidies for assisted living placement for low-income individuals. To determine an appropriate number and avenue for distribution will require additional discussion by city policymakers and relevant departments and programs.

### Prioritization Criteria – Increase the Number of City-Funded Subsidies

<b>Cost</b>	Moderate to High	Cost depends on number and rate of additional subsidies. For example, the Community Living Fund client population tends to have more complex needs; based on the average subsidy rate, it would cost about \$883,000 annually to support the 25 individuals waitlisted for ALF placement financial support.
<b>Impact</b>	High	This would immediately support consumer access to assisted living.
<b>Timeframe</b>	Short-Term	Existing programs are ready to implement.
<b>Feasibility</b>	High	The primary challenge is funding availability. The subsidy program, partner facilities, and process for procuring beds are in place.

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<sup>9</sup> An additional 46 individuals are on the state's Assisted Living Waiver waitlist.

## DEVELOP NEW MODELS FOR MEETING NEEDS

The loss in smaller ALF facilities is unlikely to be reversed, and the high cost of entry makes it likely that new ALF facilities will be targeted to a higher-income clientele. Even with a subsidy, high-end facilities may be hesitant to bring in residents with more complex behavioral needs or a history of homelessness. Given this, the City should consider alternative strategies to increase affordable assisted living supply beyond funding subsidies in existing facilities, particularly strategies that offer more control over the resident population (e.g., low-income or LGBTQ).

## RECOMMENDATION: CO-LOCATE ENHANCED SERVICES WITH AFFORDABLE HOUSING

Assisted living provides a level of support beyond what is typically available in the community, and most residents truly need the supervision and care provided around-the-clock. However, for individuals on the margin of needing assisted living, it may be the case that a more robust and coordinated community-based model of care can adequately meet needs and preempt or delay ALF placement. This diversion would benefit both the consumer (by providing a less restrictive option) and also the broader system of care (by preserving assisted living for those most in need and ultimately supporting client movement between levels of care).

The Assisted Living Workgroup recommends that the City explore and expand preventative models that provide enhanced, targeted, and coordinated long-term care services within the community to support independent living. Many existing services offer key components of the support provided in assisted living. However, to remain stable in the community, individuals on the verge of needing assisted living would benefit from enhanced or hybridized services and more defined coordination beyond what is currently available. These efforts may be: structured similarly to permanent supportive housing (e.g., with enhanced on-site care components); provided as targeted supportive services within a geographical area (e.g., same SRO or affordable housing building); or as a partnership with a specific affordable housing partner. The Assisted Living Workgroup notes that such a program would need to be structured carefully to avoid establishing an unlicensed ALF.

### Prioritization Criteria – Co-Locate Enhanced Services with Affordable Housing

<b>Cost</b>	Moderate	Depending on how the model is structured, existing programs may be leveraged to provide key resources (e.g., meal programs, home care through In-Home Supportive Services). However, there will also likely be new costs incurred, such as specialized case management, housing subsidies, and pilot program administration and evaluation.
<b>Impact</b>	Low (initially)	As a pilot program to start, the initial impact will be relatively low. If the pilot is successful, the program could be scaled up or replicated and achieve a higher impact.
<b>Timeframe</b>	Long-Term	It will take time to develop the pilot model, identify an appropriate residential location, and implement.
<b>Feasibility</b>	Moderate	Need to assemble a team to identify tangible next steps, barriers, opportunities to leverage existing programs, and potential funding sources.

## RECOMMENDATION: MAKE SPACE AVAILABLE FOR ALF OPERATION AT LOW COST

As with all businesses, a key barrier to entry in San Francisco is real estate; the cost to purchase or rent space can be prohibitively expensive and typically must be recouped through high costs passed on to the consumer. In the ALF world, new facilities are unlikely to be able to accept low-income residents who cannot afford to privately pay high rates for services – if they can afford to open at all.

The Assisted Living Workgroup recommends that the City consider supporting future ALFs (or existing facilities struggling to meet monthly real estate costs) by making space available at low cost to ALF operators. This could be implemented in many ways, such as making use of existing City-owned buildings, purchase of new sites, or including space for assisted living in plans for new developments. This could be modeled after the Mayor’s Office of Housing and Community Development’s Small Sites Program, making use of “in rem” properties available through property tax seizure, or early access to probate buildings. The City could also consider opportunities to partner with a foundation to develop a public-private partnership that supports the availability of low-cost space.

### Prioritization Criteria – Make Space Available for ALF Operation at Low Cost

<b>Cost</b>	Moderate to High	Overall cost will be dependent on costs to purchase, lease, and/or rehabilitate properties (all likely at market rates).
<b>Impact</b>	Moderate	Impact will depend on facility size (e.g., greater size will have greater impact).
<b>Timeframe</b>	Long-Term	Based on time to identify buildings, identify and interested ALF operator, carry out contracting process, and outfit space appropriately.
<b>Feasibility</b>	Moderate	It is unclear whether there are currently City-owned properties available and appropriate for this type of use or if there are foundation partners interested in this type of work. Each site would require significant work to identify and, where necessary, procure. The City has many competing priorities and populations for new housing projects and foundation partnerships. However, this may fit well into current or future strategic plans at City agencies. For example, many DPH-ALF clients are formerly homeless, so this may fit into a larger HSH strategic plan.

## ENHANCE STATE WAIVER PROGRAM

The Assisted Living Waiver (ALW) program provides a limited number of subsidies to delay skilled nursing placement for Medi-Cal clients. While this year’s addition of 2,000 new slots will help address the current 4,000 person waitlist, there are additional opportunities to maximize utilization of this program locally by increasing the number of San Francisco residents applying for slots coupled with supporting the availability of ALW-eligible beds within the City. The impact of such efforts will increase significantly should the state further expand the ALW program by passing AB 50.

## RECOMMENDATION: INCREASE USE OF EXISTING ASSISTED LIVING WAIVER SLOTS

Local ALW participation is driven both by client applications and facility certification of beds as ALW-eligible. As San Francisco residents rise to the top of the statewide ALW waitlist, they will be able to secure an ALW-subsidized placement (that is, the more San Franciscans who apply, the more that will be able to make use of this program). However, their ability to remain in San Francisco is impacted by the availability of ALW-eligible beds in San Francisco facilities. Currently, there are five San Francisco ALFs that have completed the state process to be certified as ALW eligible.

Another key component in the ALW process is the Care Coordinator Agency (CCA) that assesses for eligibility and works with a client to develop and implement an individualized service plan. Currently, there are three CCAs that support San Francisco ALW clients; however, none of these are actually based in San Francisco.

The Assisted Living Workgroup recommends the City develop a targeted strategy for maximizing the utilization of the ALW within San Francisco, both with regard to individual applications and facility certification as ALW eligible. While the immediate impact may be limited due to the current ALW waitlist, this lays a critical foundation for future access; moreover, the impact in San Francisco would be significant should AB 50 pass (see next recommendation).

### Prioritization Criteria – Increase use of Existing Assisted Living Waiver Slots

<b>Cost</b>	Low	The cost of ALW subsidy is paid by Medi-Cal. The City may need to provide technical support for ALFs to complete the state certification process.
<b>Impact</b>	Moderate	At minimum, increasing ALF participation within the program could increase the number of available beds. Should AB 50 pass and further increase the number of ALW slots, the impact would increase.
<b>Timeframe</b>	Moderate-Long Term	Further analysis is required to identify next steps, but it will take time for new applicants to reach the top of the waitlist and for ALF facilities to complete the certification process.
<b>Feasibility</b>	Moderate	Need to clarify a few key considerations, including what barriers prevent ALFs from participating within the ALW program and how best to support individual clients to apply for a slot.

**RECOMMENDATION: SUPPORT EXPANSION OF THE ASSISTED LIVING WAIVER PROGRAM**

The Assisted Living Waiver program reached its capacity of 3,700 participants in March 2017. In FY 2018-19, the program will be expanded by an additional 2,000 slots, authorized by Governor Brown. However, this growth is anticipated primarily to address the existing waitlist, which includes 46 San Francisco residents. Last year, Assemblymember Ash Kalra (AD-27, San Jose) introduced legislation to further expand the Assisted Living Waiver program by an additional 12,800 over five years, which would bring the total number of slots of 18,500. Though the state legislature passed the bill, it was vetoed by Governor Brown on the basis of allowing time for the 2,000 slot expansion to be implemented and assessed. Assemblymember Kalra has reintroduced his legislation this year as Assembly Bill 50.

The Assisted Living Workgroup recommends that the City advocate at the state level for the passage of AB 50. Further, the City should explore options to advocate for a significant number of slots to be assigned to San Francisco and for reimbursement rates to be regionally-based to account for the higher costs in urban counties.

**Prioritization Criteria – Support Expansion of the Assisted Living Waiver Program**

<b>Cost</b>	Low	Cost depends on scale of advocacy – existing processes and resources can likely be leveraged. If passed, Assisted Living Waiver slots will be funded by Medi-Cal funding and would not require City contribution.
<b>Impact</b>	Moderate	Dependent on the number of Assisted Living Waiver slots allocated to San Francisco but anticipated to increase capacity at some level.
<b>Timeframe</b>	Medium to Long Term	Dependent on 2019 state legislative process and care coordinator agency implementation process.
<b>Feasibility</b>	High	The City has existing advocacy processes and infrastructure that can be utilized for this recommendation.

# CONCLUSION

Assisted living facilities (ALFs) are a key component of the City's support network to ensure people are able to age in place and remain in the most independent and community-like setting. In particular, the availability of affordable assisted living is critical for many seniors and people with disabilities who are no longer able to live independently and safely in San Francisco. From a systems perspective, an adequate ALF supply supports the movement of consumers through medical and mental health systems, flowing between levels of support as appropriate for their individual needs.

In recent years, San Francisco has experienced a precipitous decline in smaller facilities, which historically have been a key resource for low-income individuals in need of ALF placement. Operating costs have increased, making the SSI rate for the lowest-income individuals not a viable payment for ALF operators to sustain their business. Shifting family interests and increased property values have interrupted the tradition of family-managed business passing down to younger generations.

The City can and should support the viability of these small facilities for as long as possible through the recommendations outlined in this report. At the same time, to support the long-term availability of affordable assisted living, the City must pursue additional solutions that include increasing access to existing ALF beds through City-funded subsidy programs, developing new models to support people with increased personal care needs, and enhancing the state's Assisted Living Waiver program.

# APPENDIX A. ALF OPERATOR SURVEY.

As both the Demand and Supply Research groups began their work, it became evident there was important information that work group members did not have access to, such as the monthly operating budget of ALFs, how operators determine rate models and whether those rates covered their monthly expenses, and what, if any, potential strategies or resources would ALFs be most interested in.

As a result, the workgroup decided to conduct a phone survey of board and care homes (ALFs with six or fewer beds) in San Francisco, as well as some larger ALFs known to accept City-subsidized placements, to better understand several key questions the workgroup had not been able to answer.

## METHODOLOGY

A phone survey was conducted with a total of 16 facilities<sup>10</sup> from October through November 2018. The survey consisted primarily of categorical, ordinal, and interval response questions with opportunities for respondents to provide open-ended comments. Respondents included 10 RCFEs (two facilities with 20 or more beds and eight facilities with six or fewer beds) and six ARFs (one facility with 20 or more beds and five facilities with six or fewer beds).

The focus was primarily on the small facilities (6 beds or less) as those facilities tend to serve more low-income residents than larger facilities, particularly those reliant on SSI. The group did decide to also include a small number of larger facilities, primarily to serve as a point of comparison.

## SURVEY KEY FINDINGS

Key findings from the survey are highlighted below:

- The majority of small facilities interviewed rely on City funded subsidies, primarily DPH but also CLF, GGRC, and On Lok (PACE Program);
- Finances were the primary concern with regards to financial sustainability, including current rates, staffing costs, and additional business costs such as mortgage, insurance, and required trainings; and
- Most facilities have been open for many years, have two or fewer staff (often bolstered by informal family support), and are operating within residential neighborhoods.

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<sup>10</sup> The Assisted Living Workgroup intended to survey a total of 30 facilities (15 RCFEs and 15 ARFs), with a primary focus on small board and care homes. However, the analysts conducting the survey encountered a number of challenges, including that some facilities had already closed or were in the process of closing and administrators who were unresponsive to outreach efforts or unwilling to talk. Still, the information gathered from the 16 facilities surveyed provides valuable insight into the experience of ALF operators in San Francisco.

- The survey confirmed anecdotal information that a majority of board and care homes are long-term family businesses in which operators develop family-like relationships with residents and typically charge much less than larger or newer facilities. Therefore, they generally serve a lower-income population (often times relying only on SSI residents).
- Conversation with ALF operators revealed a number of nuanced challenges or obstacles that are not captured by categorical survey questions. For example, one African-American operator noted the racial discrimination she faced from potential residents and/or their family. Many operators noted that their business was inherited from family but 50% of survey respondents said that there were no plans for future family to continue the business.
- While there are many challenges cited within this specific industry, the vast majority of operators expressed the desire to remain open and even expand if financially feasible.

## SURVEY QUESTIONS AND RESPONSES

### 1. Of your current clients, please estimate what percentages come directly from the following three places: hospital, home or community placement, or formerly homeless.

Placement prior to ALF	Respondents
Home or community	81%
Hospital (short or long term placements)	94%
Formerly homeless	94%

Responses reflect individual facilities responses to former placement, not total number of clients, and responses also differed among ARFs and RCFEs. For example, five out of six ARF operators said that the majority or all of their clients were from hospitals and/or formerly homeless. However, half of the RCFEs received residents primarily (or entirely) from either a community or hospital placement, while the other half received residents from a mix of the three placement locations.

### 2. Who is your preferred referral source and why?

Referring Agency	Respondents
City/County of San Francisco	50%
No Particular Agency	25%
Hospitals	13%
GGRC	6%
On Lok	6%

Of the four facilities that listed no particular agency as their preferred referral source, only one facility did not receive referrals from any agency. The key takeaway is that the vast majority of facilities interviewed (94%) works with at least one referring agency (of those listed above) to obtain new residents.

**3. Have you declined admission to your facility?**

A majority (64%) have denied admission of a resident, with the level of care needed by the resident as the most common reason (eight out of 10 operators). The second most common causes were problematic residents or no current openings (two out of 10 operators).

**4. Including yourself, how many full-time staff do you employ? And do you have any part-time staff? If so, how many?**

Staffing differed quite a bit among facilities. Among the small bed ALFs, 44% reported two staff. In addition to full time staff, 25% also reported relying on part-time staff, family members, or volunteers to supplement their staffing. For example, one RCFE with two full-time staff members also depended on her two adult children to help out but did not include them within the staffing count.

**5. How many of your beds are currently vacant? Is this a typical vacancy rate? On average, how long will a bed remain vacant?**

Current Vacancy Rate (out of 6 beds)	Respondents
0	54%
1	38%
2	8%

About half of facilities reported at least one vacancy at the time of the survey. However, most facilities (62%) reported that a more typical vacancy rate of zero. About 23% reported a typical vacancy rate of one bed, and 15% (two respondents) reported a typical vacancy rate of two beds.

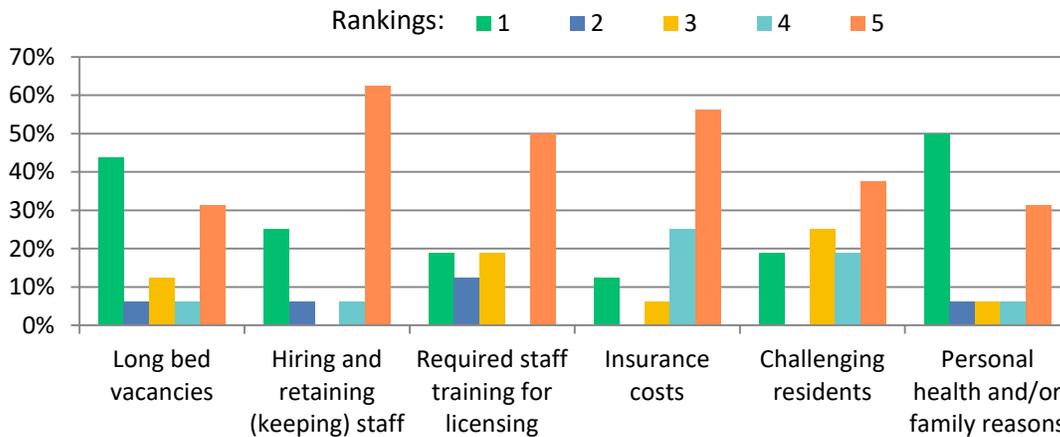
Most commonly, respondents indicated a vacant bed would be filled within a month (43% of board and care home participants). A small number (2) have had beds remain vacant for up to six months. A handful was unable to identify a common trend – vacancy length varies or they do not track this information.

**6. Can you describe the challenges experienced, if any, with filling a vacant bed?**

Small bed facilities were pretty evenly split between those that experience challenges filling an empty bed (54%) and those that do not (46%). Of the facilities that experience challenges, their reasons all differed and added insight into the unique experiences faced by ALFs. These included:

- Needing to fill a bed by gender;
- Placement varying by season, such as having a lower vacancy rate in the summer and a greater demand for beds during the winter holiday season;
- Relying on referral agencies for placements;
- Not being able to afford to accept SSI clients;
- Resident or family bias about placing in the Bayview District or with an African American operator; or
- Clients not abiding by facility rules or having greater ADL needs than facility could accommodate.

**7. Our current research shows six main concerns that impact business sustainability. Operators were asked to rate on a scale of one to five (with one being of little-to-no concern and five being a major concern):**



Above are a breakdown of all facility responses and their ranking. The following topics were listed as a primary concern with the highest ranking:

- Hiring and retaining staff (63% ranked as high concern);
- Insurance costs (56% ranked as high concern); and
- Required staff trainings (50% ranked as high concern).

Conversely, below are the issues of lowest concern to ALFs (ranked as a one), which include:

- Personal health and/or family reasons (50% ranked as a low concern); and
- Long bed vacancies (44%).

Notably, topics ranked as low concerns by some facilities were listed as high concerns by other facilities. By analyzing the individual responses, it became clear that all facilities struggle with all of these issues to some degree. This variability highlights that all of these factors have the potential to impact the City’s supply of small ALFs and support our original assumption, that these are the primary concerns faced by operators.

**8. Are there any additional barriers or challenges that make it difficult for you to sustain your business?**

Survey respondents did not identify any additional concerns beyond what was covered in prior question.

9. On a scale of one to five, how financially stable is your business for the next five years? (one being unstable/unsustainable and five being very stable)

Sustainability Ranking (1 being unstable to 5 being very sustainable)	Respondents
1 (Unstable)	6%
2	31%
3	25%
4	19%
5 (Very Stable)	19%

10. Based on available data, our staff have tried to capture the annual business costs of running a six bed in San Francisco and estimated it to be about \$425,000 a year (OR, costs of running a 20 bed in SF and estimated it to be about \$689,000 a year). Does that amount seem to you to be: Really high, a little high, about right, a little low or really low?

Answers reflect only the 13 small bed facilities:

- Four facilities felt the amount was “about right”
- Three facilities felt the amount was “a little high” or “really high”
- Three facilities felt the amount was “a little low”
- Three facilities skipped, weren’t sure, or had never considered tracking an annual budget

Notably, this was a harder question for which to capture adequate data; generally, respondents were not used to considering their average annual business costs or did not answer.

11. We understand that in the (RCFE/B&C/ARF) world, there are a variety of monthly rate models that facilities charge residents. For example:

- A flat rate or comprehensive fee;
- Base rate with additional costs for add-on services; or
- Tiered fee system based on the level of care a patient requires

From the three models listed what rate structure do you use and/or prefer?

Monthly Rate Model	Respondents
Flat rate system	53%
Tiered fee system	33%
Unclear/didn’t answer	20%

**12. What are your minimum and maximum rates for a single and shared room?**

The table below highlights responses from board and care operators only:

Monthly Rate Model	Shared Room	Private Room
Less than \$4,000 per month	77%	30%
Between \$4,000-6,000	15%	8%
Between \$6,000-8,000	0%	8%
Declined to State	8%	0%
N/A	0%	54%

This confirms the Assisted Living Workgroup sense that the small ALFs generally charge considerably less than larger facilities.

**13. Do these rates cover your business expenses? How frequently do you increase your rates?**

Response	Respondents
Rate <b>does</b> cover business expenses	56%
Rate <b>does not</b> cover business expenses	44%

The table below provides the frequency by which ALF operators increase their monthly rates.

6-12 Months	1-2 Years	2-5 Years	5+ Years	Did not respond
6%	31%	6%	13%	44%

**14. We are also assessing how current subsidy levels relate to business costs. Therefore I'd like to know if any of your residents receive a subsidy towards their monthly rates:**

Agency providing subsidy or patch	Respondents
Department of Public Health	75%
Golden Gate Regional Center	25%
On Lok (PACE Program)	13%
Community Living Fund	13%
Health Plan or Hospital	13%
No Subsidies/patches from any agency	25%

**15. If the answer to Question 14 was yes: By your estimate, what percentages of your total residents have a subsidy or monthly patch? If they answered no: is there a specific reason for that?**

Below is a summary of the responses specifically of the small bed facilities:

- 30% of facilities noted that a majority of their residents (80% or more) and 15% noted that a minority of their residents (20% or less) receive a subsidy from DPH;
- Only one facility mentioned a mix of subsidies for their residents; and
- 40% or five facilities did not respond.

**16. Which of the following resources do you think would be useful to support your business?**

Types of Potential Resources	Respondents
Low interest business loans	88%
Help with challenging clients	88%
Publicizing your business	81%
Providing required education and training to administrators and staff	81%
Support related to planning, building, and permitting processes	75%
Business consultation	75%
Workforce programs designed to onboard new staff	75%
Operating your business in a low-rent subsidized facility	44%

*Note:* There was no limit on the number of resources operators could choose, so many chose more than one.

**17. Have you considered, or are you interested in, expanding your business?**

Half of respondents (50%) answered yes and the other half (50%) answered no.

**18. With regards to your facility, do you own your building, have a mortgage, or rent your building?**

Building Ownership	Respondents
Own building (no mortgage)	21%
Own building (with mortgage)	64%
Rent building	14%

**19. Do you have any feedback, recommendations, or suggestions about how to best support ALFs in San Francisco? Is there anything else that is important for us to know?**

Below are a few additional or unique comments mentioned by facilities:

- Children are resistant to taking over the family business;
- Getting permits takes too long and causes delays in the building processes;
- Would like more places to take residents during the day;
- Need to know how to help clients quickly in an emergency;
- Needing additional support for clients with dementia; and
- SSI payments are not feasible for San Francisco

## APPENDIX B. COST ESTIMATES.

This appendix details the methodology underlying the board and care home cost estimates described in this report. As private businesses, ALF costs and rates are typically considered confidential proprietary information, and this information is not made publicly available, making it difficult to identify the true cost of operating a board and care facility. To estimate the cost of operating a small six-bed ALF, the Assisted Living Workgroup primarily drew on a March 2018 Adult Residential Facilities report by the California Behavioral Health Planning Council, the ALF Operator Survey, and one-on-one consultation with board and care home operators.

### ALF Cost Estimate Scenarios

Scenario	Description	Mortgage	Property Taxes	Administrator Salary	Direct Care Worker Wages
<b>A</b>	Family-owned and operated ALF with property owned outright (i.e., no mortgage). Owner serves as administrator and does not draw a salary. Facility is staffed by 2.0 FTE direct care workers; the administrator pitches in to help out as needed during the day and, since this is her home, lives onsite and addresses any needs that arise overnight.	\$0	\$9,420	\$0	\$62,400 (2 FTE)
<b>B</b>	Family-owned and operated ALF with property under mortgage. Owner serves as administrator and does not draw a salary. Facility is staffed by 2.0 FTE direct care workers; the administrator pitches in to help out as needed during the day and, since this is her home, lives onsite and addresses any needs that arise overnight.	\$82,836	\$9,420	\$0	\$62,400 (2 FTE)
<b>C</b>	Newer ALF with property under mortgage and providing a higher level of staffing: 1 paid administrator and 4.0 FTE direct care workers. This staffing level would support one paid direct care worker available at all times (that is, 24/7 paid staffing).	\$82,836	\$15,852	\$52,000	\$124,800 (4 FTE)

**Assisted Living Six-Bed “Board and Care Home” Cost Estimates by Expense Category and Scenario**

<b>EXPENSE</b>	<b>Cost</b>	<b>Notes</b>	<b>Source</b>	<b>A</b>	<b>B</b>	<b>C</b>
<b>Administrative Costs</b>	.	.	.	<b>\$30,490</b>	<b>\$30,490</b>	<b>\$30,490</b>
Contract Services	\$13,200	Includes legal and accounting	Consultation with ALF operators	\$13,200	\$13,200	\$13,200
Insurance (liability/property)	\$7,200	Property, professional, liability, general liability	Consultation with ALF operators	\$7,200	\$7,200	\$7,200
Other Supplies	\$4,380		CA Behavioral Health Planning Council, 2018 ARF report	\$4,380	\$4,380	\$4,380
Office Expenses	\$3,190		CA Behavioral Health Planning Council, 2018 ARF report	\$3,190	\$3,190	\$3,190
Payroll & Bank Fees	\$1,800	Payroll processing and bank fees	Consultation with ALF operators	\$1,800	\$1,800	\$1,800
Facility Licensing Fee	\$495		California Department of Social Services, Community Care Licensing (CDSS-CCL)	\$495	\$495	\$495
Administrator’s Continuing Education Units	\$175	Calculating as 50% of cost (required every 2 years)	Assisted Living CEU programs advertised online	\$175	\$175	\$175
Administrator Certification Fee	\$50	Calculating as 50% of cost (license is valid for 2 years)	CDSS-CCL	\$50	\$50	\$50
<b>Property Costs</b>	.	.	.	<b>\$22,346</b>	<b>\$105,182</b>	<b>\$111,614</b>
Mortgage Payment	varies	Scenario B based on refinanced mortgage; Scenario C based on cost to purchase new property at market rate	Property listings on Zillow	\$0	\$82,836	\$82,836
Property Tax	varies		Property listings on Zillow	\$9,420	\$9,420	\$15,852
Maintenance and Repairs	\$7,670		CA Behavioral Health Planning Council, 2018 ARF report	\$7,670	\$7,670	\$7,670
Utilities	\$5,256	Based on average home costs scaled for increased occupancy	California Public Utilities Commission	\$5,256	\$5,256	\$5,256

EXPENSE	Cost	Notes	Source	A	B	C
<b>Labor Costs</b>	.	.	.	<b>\$77,330</b>	<b>\$77,330</b>	<b>\$216,711</b>
Wages: Direct Care Staff	varies	Based on \$15/hr wage	Consultation with ALF operators	\$62,400	\$62,400	\$124,800
Wages: Facility Administrator	varies	Based on \$25/hr wage	Consultation with ALF operators	\$0	\$0	\$52,000
Worker's Comp	varies	Approximately 12% of wages	CA Department of Insurance, Workers Comp Base Rate	\$7,488	\$7,488	\$21,216
FICA/Medicare	varies	Based on 6.2% Social Security + 1.45% Medicare		\$4,774	\$4,774	\$13,525
Health/Dental/Life Vision Insurance	varies	Assuming \$600 month/employee. Rate is for minimal insurance.	CA Behavioral Health Planning Council, 2018 ARF report	\$1,800	\$1,800	\$3,000
Unemployment Insurance	varies	Max tax of \$344 per employee	CA Employment Development Department	\$868	\$868	\$2,170
<b>Staff Development</b>	.	.	.	<b>\$3,685</b>	<b>\$3,685</b>	<b>\$3,770</b>
Staff Development/Training	\$2,400		Consultation with ALF operators	\$2,400	\$2,400	\$2,400
Staff Recruitment/Advertising	\$1,200		Consultation with ALF operators	\$1,200	\$1,200	\$1,200
Staff Background Check	varies	\$85 per person; assumes half of staff turnover annually	Consultation with ALF operators	\$85	\$85	\$170
<b>Resident Supports</b>	.	.	.	<b>\$32,240</b>	<b>\$32,240</b>	<b>\$38,080</b>
Food		\$8/day x (clients + staff)		\$26,280	\$26,280	\$32,120
Transportation	\$3,360		CA Behavioral Health Planning Council, 2018 ARF report	\$3,360	\$3,360	\$3,360
Telephone/Internet/Cable	\$2,400	\$200 per month	Consultation with ALF operators	\$2,400	\$2,400	\$2,400
Subscriptions	\$200	Magazines, newspapers	Consultation with ALF operators	\$200	\$200	\$200
<b>TOTAL ANNUAL EXPENSES</b>				<b>\$166,091</b>	<b>\$248,927</b>	<b>\$400,655</b>
<b>Break-Even Rate at 100% Occupancy</b>				\$2,307	\$3,457	\$5,565
<b>Break-Even Rate at 90% Occupancy</b>				\$2,563	\$3,841	\$6,183

## APPENDIX C. DAAS-SUBSIDIZED ALF PLACEMENTS.

The DAAS-funded Community Living Fund (CLF) program provides monthly subsidies to a small number of intensive case management clients who require ALF placement to avoid institutionalization in a skilled nursing facility. This program data provides a small sample of RCFE rates charged for 22 CLF clients placed in San Francisco.

Clients receiving a subsidy are permitted to retain \$134 of their monthly income – in keeping with the Supplemental Security Income (SSI) personal needs allowance rate – and contribute the rest of their income to the monthly rate; CLF then patches the difference between the client’s contribution and the ALF rate.

The table below provides detail about the average subsidy amount funded through CLF for 22 clients placed in San Francisco. The average client contribution is \$1,312.

### Community Living Fund San Francisco ALF Placements

Subsidy Rate	Average	Minimum	Maximum
Daily	\$98	\$25	\$195
Monthly	\$2,943	\$737	\$5,854

Source: Community Living Fund, June 2018

CLF program data also provides a snapshot of the full monthly rate charged by ALFs in San Francisco. These rates are broken down in the table below by facility size. On average, the monthly rate for CLF clients is \$4,382. Rates tend to be lower in smaller facilities. The maximum rate for a current CLF client is \$6,856; higher cost is based on increased level of care for clients with more complex needs.

### Community Living Fund San Francisco RCFE Placements: Full Monthly Rate by Facility Size

Facility Size	# Clients	Average	Minimum	Maximum
1 to 6	1	\$2,073	\$2,073	\$2,073
7 to 15	0	.	.	.
16 to 49	3	\$3,597	\$2,790	\$4,000
50 to 99	9	\$4,943	\$2,735	\$6,856
100+	9	\$4,339	\$4,339	\$4,339
<b>Total</b>	<b>22</b>	<b>\$4,382</b>	<b>\$2,073</b>	<b>\$6,856</b>

Source: Community Living Fund, June 2018

# APPENDIX D. DPH-SUBSIDIZED ALF PLACEMENTS.

DPH provides assisted living subsidies for persons with serious mental illness and San Francisco Health Network members with multiple complex characteristics (e.g., mental health, substance use, medically compromised) with the goal of supporting stability in the most appropriate and least restrictive setting. In total, 561 clients are subsidized for their ALF placements. This appendix provides information about placements by county (i.e., in and out of county placements) and describes the level of care definitions that govern daily rate.

## DPH LEVEL OF CARE DEFINITIONS

- **Basic:** Provides only minimum standard services as laid out in the Title 22 ALF regulations
  - *Examples:* Transport assistance to 1-2 medical appointments per month, basic recreational activities (TV, board games, unstructured access to outdoor space, smoking area)
- **Specialty:** Provides above standard services as laid out in the Title 22 ALF regulations
  - *Examples:* Transport assistance to 3-4 medical appointments per month; accepts clients with moderate behavioral management issues, minimal-to-moderate redirection, medical conditions that require more time to provide med monitor/oversight (e.g., needs clear direction/cuing for blood glucose check/insulin self-administration), verbally abusive or generally loud clients, clients with hygiene issues; and/or hoarding/clutterers who are not resistant to direction.
- **Enhanced:** Provides additional staffing, supervision, and other services to address clients with functional impairment that requires enhanced behavioral supports, which are beyond the above categories and are laid out in the Title 22 ALF regulations.
  - *Examples:* Delayed egress/secure homes, provide unlimited transport assistance, have LVN/RN on staff so can assist with medication administration, most frequently insulin, willing to take O2 concentrators, accept high behavioral clients, such as mod-high redirection/frequent engagements, consistent verbal or threatening behaviors, hospice clients, offer rehab and pre-voc programming on site, offer substance use disorder treatment onsite, high hygiene issues.

## DPH PLACEMENTS BY LICENSURE, LEVEL OF CARE, AND COUNTY

### DPH Placements in ARF/RCFE – All Counties

Level of Care	ARF	RCFE	Total	Daily Subsidy Rate	Monthly Subsidy Rate
Basic	191	68	259	\$22	\$660
Specialty	77	139	216	\$65*	\$1,950*
Enhanced	12	74	86	\$105	\$3,150
<b>Total</b>	<b>280</b>	<b>281</b>	<b>561</b>	.	

Source: DPH Transitions, August 2018 \*San Francisco rate (out of county rate varies)

### DPH Placements in ARF/RCFE – San Francisco

Level of Care	ARF	RCFE	Total	Daily Subsidy Rate	Monthly Subsidy Rate
Basic	191	68	259	\$22	\$660
Specialty	8	29	37	\$65	\$1,950
Enhanced	0	49	49	\$105	\$3,150
<b>Total</b>	<b>199</b>	<b>146</b>	<b>345</b>	.	

Source: DPH Transitions, August 2018

### DPH Placements in ARF/RCFE – Out of County

Level of Care	ARF	RCFE	Total	Daily Subsidy Rate	Monthly Subsidy Rate
Specialty	69	110	179	\$40 to \$70/day	\$1,774
Enhanced	12	25	37	\$91 to \$191/day	\$3,556
<b>Total</b>	<b>81</b>	<b>135</b>	<b>216</b>	.	.

Source: DPH Transitions, August 2018

## APPENDIX E. ADDITIONAL STRATEGIES.

The Assisted Living Workgroup's Strategies Research Group identified and vetted 16 ways that the City could potentially support ALF capacity in San Francisco. These strategies were evaluated to identify which had the greatest likelihood of meaningfully supporting and/or expanding the City's supply of assisted living using the following criteria:

- **Cost:** What is the estimated cost or cost scale to implement the strategy?
- **Impact:** What level of impact is this strategy likely to have? For example, how many clients could be impacted? Will the strategy significantly improve the ability of ALF operators to stay in business?
- **Timeframe:** How long will it take to implement the strategy and see impact? Is the timeline: short (within six months), moderate (six to twelve months), or long-term (over a year)?
- **Feasibility:** Given competing priorities and needs in the City and State, how likely is the strategy to actually be implemented? Is there a clear path forward to implementation?

In total, eight of the strategies were prioritized as immediate recommendations by the Assisted Living Workgroup. Grouped by overarching strategic area, these ideas are discussed in the body of this report.

This appendix describes the other eight potential strategies identified by the Assisted Living Workgroup's Strategies Research Group. These ideas are categorized by type: business factors, workforce supports, and models of care and payment. These strategies hold promise but may be a heavier lift, require additional discussion to ascertain next steps towards implementation, or have lower (but still potentially meaningful) impact. The City and key partners should review and continue to consider opportunities to pursue these ideas.

## BUSINESS FACTORS

### LICENSING/REGULATORY CHALLENGES

Strategy	Support with licensing and/or permitting processes	
<b>Description</b>	Provide support with state licensing and/or local permitting process, which can be particularly complex for new applicants. A primary burden is the lengthy state approval timeline.	
<b>Considerations</b>	<p>Many possible options to consider:</p> <ul style="list-style-type: none"> <li>a. Support with initial application (e.g., accuracy, business acumen). The CA Department of Social Services-Community Care Licensing Division (CDSS-CCL) has expedited in past for specialty ALFs, such as dementia and non-ambulatory beds.</li> <li>b. Advocate for CDSS-CCL resources to improve processing time.</li> <li>c. Develop and publicize a “how to” guide (could be developed and promoted in partnership with CDSS-CCL, 6Beds Inc, OEWD, small business associations)</li> <li>d. Publicize opportunities and support transfer of existing license</li> </ul> <p><i>Note: City services can only advise; business entity remains liable</i></p>	
<b>Key partners</b>	OEWD, DPH, Office of Small Business	
<b>Cost scale/estimate</b>	Low	Cost will vary based on method. One-on-one support may be absorbable through existing programs.
<b>Impact</b>	Low	It is unlikely that many new small facilities will try to newly open – due to large barriers to entry (i.e., cost, processing time) and limited anticipated revenue. The main impact opportunity is likely to support the license transfer process to a new owner, which would provide a big impact for small number of existing residents (option d above).
<b>Timeframe</b>	Short-term	Could be implemented relatively quickly
<b>Feasibility</b>	High	Somewhat dependent on strategy/strategies implemented, but most of these ideas can leverage existing resources.
<b>Priority</b>	Moderate	While unlikely to have significant impact on overall supply, these strategies are relatively low cost and have potential to help at the margin. In particular, the license transfer process (option d) preserves supply for existing clients and mitigates the initial entry barriers.

## CAPITAL-RELATED COSTS

Strategy	Develop business and/or property tax breaks	
Description	Explore opportunities to reduce costs through local business and property tax policies.	
Considerations	Potentially would want to limit tax break eligibility by facility size or population served (e.g., facilities that accept X% low income). Requires additional analysis to determine tax break size needed to achieve impact. Board and care (B&C) facilities are exempt from business taxes (such as registration fee, gross receipts, payroll, etc.). <sup>11</sup>	
Key partners	Controller's Office	
Cost scale/ estimate	Further research required	Further analysis needed to identify scale of tax break needed to have meaningful impact and corresponding cost to City.
Impact	Low	B&C currently receive a business tax break. Property tax break impact dependent on property tax cost; 35% of B&C licensed pre-2000.
Timeframe	Moderate/ Long-term	Requires financial analysis (beyond the scope of this project) and then would have to go through political/government process to implement
Feasibility	TBD	Depends on city interest and cost
Priority	Low	Due to potential cost and amount of time needed to implement

Strategy	Make City-owned land available for private ALF development	
Description	Make city-owned land available for businesses to build and operate new ALF	
Considerations	This could be limited to ALF operators who commit to serving certain target populations (e.g., percentage of low income, dementia, and/or non-ambulatory residents)	
Key partners	Dept. of Real Estate; Fly Away Home model; Northern California Community Loan Fund	
Cost scale/ estimate	Moderate	Building costs to be incurred by developer/not city, but there is an opportunity cost – what else could land be used for?
Impact	Moderate	Dependent on size of facility (greater size will have greater impact)
Timeframe	Long-term	Requires significant time to identify land and interested builders, navigate city process, and then time to construct
Feasibility	Low	Unclear how much city-owned land is available and appropriate for this type of project (e.g., park space, industrial area). The City has many competing priorities and populations for new development projects, particularly land available for housing construction.
Priority	Low	Due to potential cost, feasibility, and amount of time needed to implement

<sup>11</sup> California Community Care Facilities Act, Article 7: Local Regulation 1566.2.

## OPERATING-RELATED COSTS

Strategy	Compliance costs related to labor law	
<b>Description</b>	Explore compliance cost of labor laws and opportunities to streamline, minimize, and/or alleviate costs while still fully complying with requirements (e.g., minimum wage, unemployment, other SF specific)	
<b>Considerations</b>	The primary cost is increasing minimum wage <sup>12</sup> . However, there are other costs that the City could potentially help defray by: <ul style="list-style-type: none"> <li>a. Continuing education requirements: Publicize city-funded opportunities for Continuing Education Units and make available to ALF operators for a low fee</li> <li>b. Background check costs: Subsidize or cover these costs for small facilities</li> </ul>	
<b>Key partners</b>	CCSF	
<b>Cost scale/estimate</b>	Low	CEU estimated cost per year: <sup>13</sup> Approximately \$8,400 per year for six beds (\$13,000 per year if all facilities with fewer than 16 beds included)
<b>Impact</b>	Low-Moderate	While these costs (CEU, background check) are not large in comparison to labor and mortgage expenses, could be useful for small ALF with lean budget
<b>Timeframe</b>	Short-term	If funding is made available, funding mechanism could likely be identified relatively easily
<b>Feasibility</b>	Moderate	Cost is low. Funding mechanism would need to be identified.
<b>Priority</b>	Moderate	Low cost for City but could be meaningful for small ALFs with lean operating budget.

Strategy	Joint purchasing power	
<b>Description</b>	Small facilities could potentially benefit from joint purchase agreements to develop economies of scale and reduce costs	
<b>Considerations</b>	ALF Workgroup discussed potential topics (see below) but identified that ALF facilities (through 6Beds, Inc) are best suited to identify needs and helpful strategies. <ul style="list-style-type: none"> <li>--Food: Club/membership model (but how would this be different than Costco?)</li> <li>--Insurance: Small business coalition; some B&amp;C have found Covered CA to be cheapest option; could potentially use 6Beds, Inc as non-profit organization to buy in through Nonprofits Insurance Alliance Group</li> </ul>	
<b>Key partners</b>	TBD	
<b>Cost scale/estimate</b>	Low	
<b>Impact</b>	Low	Low cost options are already available through other sources (e.g., Costco, Covered CA)
<b>Timeframe</b>	Moderate-term	Time required to determine ALF interest and preferred structure, identify facilitator, and establish joint venture.
<b>Feasibility</b>	Moderate	Unclear how this would be facilitated (e.g., establishment of co-op)
<b>Priority</b>	Low	Unlikely to significantly improve on existing systems and resources that provide this type of purchasing power.

<sup>12</sup> This topic is addressed in Workforce category strategies.

<sup>13</sup> ALF administrators are required to complete continuing education courses every two years. Estimates based on cost estimate of \$350 for 20 in-person and 20 online hours.

## WORKFORCE

### STAFF HIRING AND RETENTION

<b>Strategy</b>	<b>Sector training/workforce development</b>	
<b>Description</b>	Provide training to prepare current and future staff for home care work, reducing a burden for ALF operators to find and train staff	
<b>Considerations</b>	This could be an opportunity for City College partnership, perhaps as part of a career ladder program. Existing homecare training programs could potentially be leveraged, such as homecare trainings for IHSS providers. Such a program might provide incentive for larger facilities to partner with DPH/DAAS to place clients.	
<b>Key partners</b>	OEWD, HSA Workforce Development Division, IHSS contractors	
<b>Cost scale/estimate</b>	Moderate	May vary based on mechanism but can be anticipated as ongoing cost
<b>Impact</b>	Low-moderate	From the ALF operator survey, most facilities employ small number of staff. Historically, small ALFs have often hired family members. However, this trend may be shifting. Approximately 75% indicated workforce programs designed to onboard new staff would be helpful.
<b>Timeframe</b>	Moderate-term	May vary based on mechanism – leveraging existing training resources would be faster than developing new partnerships and curriculum
<b>Feasibility</b>	Moderate	Potential to leverage existing resources
<b>Priority</b>	Moderate	The strategy to provide subsidized job placement would provide more support

## MODELS OF CARE AND PAYMENT

### PAYMENT STREAMS AND CLIENTS

<b>Strategy</b>	<b>Identify and advocate for new additional CMS waiver options</b>	
<b>Description</b>	Analyze alternate Medicaid waiver options, including 1915c and 1115, for applicability and assess feasibility for advocating for local application and implementation.	
<b>Considerations</b>	First step will be to research how other states use other waiver programs and assessing their feasibility for California and San Francisco	
<b>Key partners</b>	DHCS, possibly policy bodies such as the California Area Agencies on Aging (C4A), etc	
<b>Cost scale/estimate</b>	Low	The primary cost would be staff time to conduct research. Advocacy for implementation of new waivers could entail new costs. However, as a Medicaid waiver, ALF placement would be covered by Medi-Cal.
<b>Impact</b>	Low	Would not address current residents (likely a 2-4 year time investment, at the very minimum)
<b>Timeframe</b>	Long-term	In addition to the initial research, this effort would likely require advocating for state level policy.
<b>Feasibility</b>	Low	Developing consensus and passage at state level of a separate ALF waiver option would likely be challenging, particularly given existence of ALW program.
<b>Priority</b>	Low	Clear next steps with possible long-term impact but only if an appropriate waiver and a coalition of advocates are identified

<b>Strategy</b>	<b>Insurance Plans as Payers of ALF Placements</b>	
<b>Description</b>	Explore opportunities for residents in need of ALF to utilize existing Life Insurance policies as a means of payment, such as swapping Life Insurance for Long Term Care Insurance, and help publicize this option to increase public awareness.	
<b>Considerations</b>	The City’s primary role in this area would be to publicize and potentially help educate individuals about these options. There may be existing advocacy efforts on this topic with which the City could partner.	
<b>Key partners</b>	AARP, Leading Age, and representatives of the insurance industry (such as the SF Insurance Professionals)	
<b>Cost scale/ estimate</b>	Low	Public awareness efforts would likely be low cost. The majority of the cost related to this strategy would be borne by the insurance company or policy holder if/when individuals access benefits.
<b>Impact</b>	Low	It is unclear how many people would benefit from this resource. Those holding insurance policies are likely not low-income, so need may not be as urgent, and this is on the outer bounds of this project scope.
<b>Timeframe</b>	Long-Term	Requires developing partnership with new organizations/ profession to better understand the need and options available. Would require outreach to build awareness and have impact; those impacted would likely be City residents who do not actually need this service yet.
<b>Feasibility</b>	Low	This would require partnering with more experienced agencies or organizations already familiar with insurance.
<b>Priority</b>	Low	A moderate priority if there already exists an option within existing insurance plans to fund ALW and next steps primarily involve increased outreach to existing policy holders. Considered a low priority if option does not currently exist or it is determined that a limited number of SF residents would benefit from this option.

## Appendix 2

**Non-Medical Out-of-Home Care (NMOHC)  
Payment Standard for Individuals-Licensed Facility or  
Without In-Kind Room and Board  
Effective January 1, 2019**

Supplemental Security Income (SSI)	\$ 771.00
State Supplementary Payment (SSP)	\$ <u>423.37</u>
Total *NMOHC Payment Standard	\$ 1,194.37*

The NMOHC Payment Standard includes the following components:

Room and Board	\$ 514.37
Care and Supervision (maximum)	\$ <u>544.00</u>
<b>Amount Payable for Basic Services</b>	<b>\$ 1,058.37<sup>1</sup></b>
Personal and Incidental Needs Allowance (minimum) (Must be provided to the recipient)	\$ <u>136.00</u> \$ 1,194.37

\*Amounts are double for SSI/SSP couples – NMOHC Licensed Facility or Without In-Kind Room & Board.

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<sup>1</sup> NOTE: Recipients who have income in addition to their SSI/SSP check (for example, a pension, Social Security retirement, or disability benefits) can be charged the **\$1058.37** amount for basic services plus an additional \$20. Because federal rules do not count the first \$20 of a recipient's income against his/her SSI/SSP grant, an SSI/SSP recipient with other income has an extra \$20 that people who receive only an SSI/SSP check do not have. Neither federal nor state law restricts the recipient in how this additional \$20 amount is spent. Thus, if the recipient agrees in the admission agreement to pay the additional \$20 for basic services, the facility may charge the additional amount.

## Appendix 3



# Adult Residential Facilities (ARFs)

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

March 1, 2018

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

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

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

- (a) To advocate for effective, quality mental health programs;
- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

#### Acknowledgements

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## ADULT RESIDENTIAL FACILITIES

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

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

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

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

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

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

<sup>2</sup> CA Code of Regulations (Westlaw), [§ 58032. Residential Care Facility definition \(link\)](#)

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

A robust continuum of community-based housing, including ARFs for adults with mental illness, is critically needed. ARFs are an essential component of this housing continuum, providing services and supports to meet a complex set of behavioral, medical and physical needs<sup>3</sup>. Along with this component, many of the alternative supportive housing options require additional resources to successfully provide community-based long-term housing for adults with serious mental illness.

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

## **I. THE CRITICAL NEED**

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

### **ARF Needs By County<sup>4</sup> (Chart 1)**

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

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

<sup>4</sup> Twenty-two of the fifty-eight counties responded by November 2016. See Attachment A.

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

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

## II. CHALLENGES

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

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

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

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

illness cannot survive financially on a small scale (under 15 beds) without substantial subsidies. For the most part, monthly rates charged by ARFs are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) amounts paid to Californians with disabilities and who are unable to work. The SSI/SSP payment, as sole source of payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF especially when some amount of the SSI/SSP payment is set aside for personal needs of the individual. Therefore, subsidies, often called “patches” are needed.

On a larger scale, some residential care homes can be financially viable without additional subsidies, but that is dependent on the level of care provided to residents. Residents requiring higher levels of care and support will necessitate additional care providers and/or equipment resulting in increased operational costs. Rarely is the SSI/SSP amount sufficient to cover the costs. Even in a facility of 45 beds or more, a subsidy paid by the county in amounts ranging from \$64/day to \$125/day per resident may be required to maintain fiscal viability.

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

### **Example 1**

#### **Adult Residential Facility Six-Person Sample Budget**

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

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

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

**Example 2**

Adult Residential Facility Twelve-Person Sample Budget

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

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

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

Generally defined, a patch is an extra daily or monthly payment (subsidy), made to a residential care home operator, to cover the cost of extra services to a resident or to accept a resident who may be hard to place. In general, patches would not be Medi-Cal billable typically, related to extra care and supervision (See Attachment B). Patches range from a low of \$15 to a high of \$125/ resident/ day depending on level of service needed for the resident or difficulty of placement.

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

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

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

Items not included:

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

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

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

Title	Amount	Comment
<b>Revenue</b>		
<b>Resident Fees</b>	\$160,056	\$1026/month for 13 residents at 95% occupancy
<b>Total Revenue</b>	<b>\$160,056</b>	
<b>Personnel Expenses</b>		
<b>Line Staff</b>	\$182,000	4.5 Staff at \$15/hour covers single coverage 7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors, admissions, grocery shopping, etc. at \$20/ hour.
<b>Landscaping</b>	\$2400	\$200/month
<b>Relief Staff</b>	\$15,600	Fill-in for sick/vacation employees at 20 hours/week
<b>Total Wages</b>	\$200,000	Presumes 9 sick days, 14 vacation days, 8 holidays/employee/year
<b>Salary Related Expenses</b>		
<b>Health/Dental/Life/Vision Insurance (HSA)</b>	\$39,600	\$600 month/employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance.
<b>Unemployment Insurance</b>	\$1,482	
<b>Worker's Compensation Insurance</b>	\$13,836	
<b>FICA/Medicare</b>	\$15,116	
<b>Total Salary Related Expenses</b>	\$70,034	
<b>Other Personnel Expenses</b>		
<b>Training</b>	\$2000	
<b>Total Other Personnel Expenses</b>	\$2000	
<b>Total Personnel Expenses</b>	<b>\$272,034</b>	
<b>Operating Expenses</b>		
<b>Legal and Other Consultation</b>	\$1000	
<b>Household Supplies</b>	\$10,000	Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods
<b>Office Supplies</b>	\$2,250	
<b>Computer/Office Furnishings</b>	\$1000	
<b>Utilities</b>	\$20,238	
<b>Maintenance – Building and Equipment</b>	\$12,000	Presumes that this line item includes furniture and appliance replacement
<b>Vehicle Maintenance</b>	\$6,000	Presume one vehicle for use at \$550/month
<b>Food</b>	\$40,880	\$8 person/day plus one staff eating
<b>Insurance</b>	\$8,215	
<b>Telephone/Internet/Cable</b>	\$3000	
<b>Printing and Postage</b>	500	

<b>Licensing and Permits</b>	\$1,711	
<b>Property Taxes</b>	\$6,000	Presumes property purchased for \$600,000 with \$100,000 down payment
<b>Advertising</b>	500	
<b>Total Operating Expenses</b>	\$113,294	
<b>Rent or Loan Payments</b>	\$30,396	\$500,000 loan for 30 years at 4.5%
<b>Total Expenses</b>	\$415,724	
<b>Total Net Income (Loss)</b>	<b>(-\$255,668)</b>	(Revenue \$160,056 minus Total Expenses \$415,724 = Total Net Income Loss \$255,668)

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

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

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

## IDEAS FOR DISCUSSION

- 1. Tiered Level of Care System** – There could be tiered levels of care, with different licensing categories established to allow for higher rates to be paid to accommodate more care and supervision when required, for example, to meet the needs of individuals who are incontinent or non-ambulatory. The Department of Developmental Services Community Care Facility Reimbursement Rates<sup>7</sup> for consumers with developmental disabilities, offers four [Service Level Tiers](#) ranging from \$1,026 to \$7588 per consumer per month.<sup>8</sup> The California

<sup>7</sup> See Attachment C or go to [Dept. of Developmental Services Reimbursement Rates](#).

<sup>8</sup> This includes the SSI/SSP pass through effective January 1, 2017.

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

2. **State Supplemental Payment (SSP) Rate** – Currently, ARF monthly fees are set by the maximum SSI/SSP rates for clients in non-medical out-of-home care. The state could consider varying levels of the state supplemental payments that would correlate to the tiered level of care to address the financial challenges faced by the ARFs in order to meet the needs of people who require this higher level of housing with care and supervision.
3. **Data** – Currently, the California Department of Social Services (CDSS), Community Care Licensing (CCL) Division serves this population “through the administration of an effective and collaborative regulatory enforcement system.”<sup>9</sup> Although the CDSS/CCL collects data on the **types** of facilities, the data is not detailed enough to illustrate how the facilities are utilized and by whom. There is no way to extrapolate the number of behavioral health beds versus those specifically for substance use disorders versus individuals solely receiving Social Security benefits. The Legislature should consider mandating the Department to restructure its data collection to incorporate essential demographic needs. As a State, California should have a working baseline of the type of facilities along with the types of individuals utilizing those facilities. We really need to understand the breadth of the situation we are dealing with.

### III. CONCLUSION

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

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

It is essential to provide appropriate community-based long-term residential options that include the necessary supports to address mental illness. As part of a robust supportive housing continuum, there is a critical need to have ARFs that are adequately financed

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<sup>9</sup> California Department of Social Services, [Community Care Licensing Division website](#)

and staffed. With the number of older adults growing each year, this type of housing is paramount.

Addressing the financial, community and staffing challenges affecting ARF sustainability could require: 1) Changes to the current licensing structure to accommodate a tiered level of care system; 2) Increasing SSP benefit amounts to correlate to the tiered level of care; and 3) ongoing dialogue and strategic planning regarding siting of affordable and appropriate housing.

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

## **V. ADDENDUM**

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

### **A. Barriers**

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

- a. Increases in Licensed Facilities electing to become “Unlicensed,” yet continue to house the same population. There is not enough oversight and/or advocates aware of all the facilities transitioning. Many individuals residing in these environments are often unaware of their civil or tenant rights.
  - b. The California Department of Social Services, Community Care Licensing is not required to collect more specific data on the individuals or types of issues these individuals face. Updating the regulations to have the Department to collect more appropriate data will assist in more clearly identifying the numbers of persons with severe mental illness/emotional disturbance, substance use disorders, medical and/or physical limitations.
3. *Programming/Life Skills*: Many advocates advised many individuals in these settings often are not provided on-going programming or life skills/training to assist in personal development and growth. A significant number of individuals want to live beyond the ARF level of care. These individuals do not possess the skills necessary to function more independently, yet have the desire and capacity. They just need to be taught and/or exposed to the skills needed to reside independently or in supportive housing. The current milieu/structure does not enhance an individual’s potential. It merely warehouses them.
  4. *Antiquated Culture*: Many attendees advised of owner/operators unwilling to learn about the populations they are now serving. They are refusing to participate in trainings, that could potentially increase the quality of care provided in existing facilities.
  5. *Political ill will*: Attendees in Southern and Northern California expressed the anguish of working with County Boards of Supervisors and combating the ever-present “Not In My Backyard-isms (NIMBYisms).” There was a collective outcry to educate the greater community at-large that “those people” could one day be each one of us. Typically, the individuals in this population do not have bipartisan support nor an influential political voice. Therefore getting this stigma to shift is often arduous at best.

## **B. Solutions**

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

2. *Outside-the-Box Funding Options:* The attendees in both meetings stressed the need to obtain funding beyond current mechanisms. Suggestions ranged from better utilization of Medicaid dollars; more collaborative efforts with the private sector and corporate partnerships; accessing unspent Mental Health Services Act funds; alternative uses of property taxes; redirect Emergency Department and Institutional savings, etc.
3. *Case Management:* Many individuals with Developmental Disabilities have a Case Manager (CM). The CM typically has performed a thorough assessment and provided the Regional Center with a determination of the individual's needs. The individual typically has a reoccurring assessment to determine the appropriateness of the supports in place. Individuals with severe mental illness, serious emotional disturbance and/or substance use disorder, typically do not have such continuity of care, unless involved with a system (e.g. Child Welfare, Juvenile Justice, Criminal Justice or State Hospital).
4. *History:* The use of recent and historical information on how our communities cared for this population in positive ways can and should be investigated and utilized when possible. Hence, do not repeat mistakes, but take the lessons learned to do better.
5. *Promising Practice:* The use of Peer Support Specialists within the Adult Residential Facility industry has far-reaching attributes beyond being "cost-effective." The role of Peer can provide valuable information, continuity of care and services, that speak to many concerns related to greater public safety concerns. Three programs in California are utilizing Peers in rather innovative ways. Santa Clara County has the *Community Living Coalition (CLC)*<sup>10</sup>, San Bernardino County has the *Peer-Driven Room & Board Advisory Coalition*<sup>11</sup>, and San Diego County has the *Homeless Services and Supportive Housing Council*<sup>12</sup>. Each organization was started from differing perspectives. However, each program seeks to ensure an appropriate, safe and adequate living environment for individuals living with serious mental illness in Adult Residential Facilities and Board and Care Facilities. This ARF white paper is primarily focused on Adult Residential Facilities (licensed) and not Board and Care Facilities (unlicensed) due to the complexity of the regulations. It is our hope that

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

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

<sup>12</sup> Homeless Services and Supportive Housing Council – Simonne Ruff, Director, [Corporation for Supportive Housing-San Diego](#)

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

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

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

FINAL DRAFT

## ATTACHMENT A

### 2016 RCF SURVEY RESPONSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- “Referring strictly to locked psychiatric facilities, our county is in need of several more beds (perhaps up to 40 additional beds). Due to recent legislative changes (since 2014), there has been a voluminous increase in referrals for LPS evaluations and more persons placed on LPS conservatorship. We often need our clients to have treatment in State Hospitals or IMDs for a protracted period as we are seeing a more seriously mentally ill profile in addition to a much more violent population. We also are seeing a trend of younger persons in need of this high level of care and some of the IMDs are disinclined to accept said group. Therefore, we need not only more beds, but facilities willing to accept this younger, more violent type of patient.”
- “Land in our county is too expensive to develop. Labor costs are too high. Cannot hire or retain trained and experienced staff. A “Not In My Backyard” mentality of prospective neighbors” hinders increasing the number of board and care facilities in our county.
- One County stated it does not have B&C beds/facilities other than the six bed ARF. Over the last two years, three separate providers have become Room and Boards in a neighboring county, which is one of its larger neighbors. The County further stated it has been difficult to find licensed facilities that are operated by trusted providers in the larger county that can meet the needs of the individuals being served.
- “Lack of in-county board and care availability (specifically, enhanced board and care beds) results in the county having to place large numbers of clients out-of-county. This can cause many challenges related to providing effective case management/treatment and occasionally poses challenges to family members of clients who are placed out of county. There is most definitely a need for more in-county board and care facilities (specifically enhanced board and care beds) to serve the needs of County clients who are often older and facing significant physical health concerns in addition to their intensive mental health related needs.”
- “As older operators age out, the establishment of new facilities is cost prohibitive given the current SSI/SSP rates to provide “basic” care and supervision. Therefore, existing resources are diminishing each year and we are seeing faster turnover (open, then close) of new small facilities. Supplemental Rates are established to reimburse for “augmented” services in order to cover the additional cost for the

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

FINAL DRAFT

## ATTACHMENT B

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

Along with the basic board and care residential facility services that are provided for all ARF clients according to Community Care Licensing (CCL) requirements, counties contract for supplemental services for individuals who have on-going mental health issues, need assistance with daily living and are difficult to place. The RCF provider is expected to provide staffing above the required minimum by CCL to assist clients with medical and psychiatric needs. For these supplemental services, counties pay “patches”, ranging from \$64/day to \$125/day per resident (in addition to the SSI that is paid of approximately \$1026/month/resident<sup>13</sup>).

Patches are paid for the following services:

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

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<sup>13</sup> In the case where a resident is not SSI eligible, counties additionally pay an “unsponsored patch”, covering what SSI would pay (approximately \$1026/month). *If SSI is approved retroactively, the county can be reimbursed by the ARF for the daily-unsponsored facility rate, back to the date when the resident was granted retro SSI eligibility.*

*RCF should be customized to offer culturally specific programming, such as linking clients to cultural activities outside of the home. ARF should serve culturally specific meals as necessary.*

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

- a. Diabetic Individuals: *Assistance with all necessary blood work to include reading and interpreting their blood sugar level. Some residents will require finger sticking and basic self-care required to stabilize blood sugar levels. ARF should serve nutritionally appropriate meals to address diabetic and/or other health needs.*
- b. High Blood Pressure Medical Issues
- c. Medically Frail - significant medical issues that affect mental health conditions such as COPD<sup>14</sup>, obesity, renal disease, individuals needing total care (daily assistance with hygiene, grooming and dressing). In addition, residents with specialized equipment may need one-to-one assistance with these devices and require one-to-one supervision of the equipment. (E.g. sleep apnea machines, electric wheelchairs, and colostomy bags, etc.).

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<sup>14</sup> Chronic obstructive pulmonary disease (such as chronic bronchitis and emphysema.)

## ATTACHMENT C

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

EFFECTIVE JANUARY 1, 2017

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

<sup>15</sup> Includes the SSI/SSP pass through effective January 1, 2015.

<sup>16</sup> Includes the SSI/SSP pass through effective January 1, 2017.

Service Level	Monthly Payment Rate Per Consumer Effective <b>7/01/2016</b> <sup>15</sup>	Monthly Payment Rate Per Consumer Effective <b>1/01/2017</b> <sup>16</sup>
4G	\$5,364	\$5,436
4H	\$5,766	\$5,845
4I	\$6,334	\$6,422

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

DEPARTMENT OF DEVELOPMENTAL SERVICES  
 COMMUNITY CARE FACILITY RATES  
**FOUR OR LESS BEDS PER FACILITY**

EFFECTIVE JANUARY 1, 2017

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

<sup>17</sup> Includes the SSI/SSP pass through effective January 1, 2015.

<sup>18</sup> Includes the SSI/SSP pass through effective January 1, 2017.

## **Appendix 4**

# **A Call to Action: The Precarious State of the Board and Care System Serving Residents**

**Living with Mental Illness in Los Angeles County**

**1/22/18**

**Prepared by the**

**Los Angeles County Mental Health Commission**

**Ad-hoc Committee on LA County's Board and Care System**

### **Members**

Caroline Kelly, Immediate Past Chair LA County Mental Health Commission

Barbara B. Wilson, LCSW

Kerry Morrison, Stanton Fellow 2016-17

Brittney Weissman, NAMI LA County Chapter

Table of Contents

I.	Statement of the Problem	3
II.	Solution Snapshot	3
III.	Background	4
	<ul style="list-style-type: none"> <li>a. Residential Options for Persons Living with Mental Illness</li> <li>b. Types of Adult Residential Facilities (ADF's)</li> <li>c. Inventory of ADF's</li> <li>d. Trends</li> <li>e. Financial Realities for Operators of ARF's                             <ul style="list-style-type: none"> <li>i. Case Studies                                     <ul style="list-style-type: none"> <li>1. Golden State Lodge</li> <li>2. Villa Stanley</li> </ul> </li> </ul> </li> </ul>	
IV.	Call to Action	11
V.	Exhibits and Appendices	
	<ul style="list-style-type: none"> <li>• Community Care Licensing Division (CCLD) report to the L.A. County Mental Health Commission, April 27, 2017. Presented by Claire Matsushita, Assistant Program Administrator</li> <li>• Memo from Dr. Jay Plotzger to Caroline Kelly, May 4, 2017 re/ notes from 4/27/17 MHC Meeting</li> <li>• Golden State Lodge 2017 budget</li> <li>• Disparities in Reimbursement Rates, chart prepared by Barbara B. Wilson, LCSW, 2016</li> </ul>	
VI.	References	
	<p><i>Insane Consequences: How the Mental Health Industry Fails the Mentally Ill.</i> DJ Jaffe. Prometheus Books, New York. 2016.</p> <p>California Mental Health Planning Council: Adult Residential Facilities (ARF's): Highlighting the critical need for adult residential facilities for adults with serious mental illness in California. October 2017.</p>	

CA Association of Local Behavioral Health Boards & Commissions October 11, 2017  
Older Adult / Residential Care Facility Ad Hoc Committee. ISSUE BRIEF: Adult Residential  
Care Facilities – The Critical Need

## STATEMENT OF THE PROBLEM

Board and care homes (technically referred to as Adult Residential Facilities) represent a precious and affordable housing resource for individuals suffering from mental illness. These facilities range in size from 6 beds (in a single-family home) to 100+ beds. They are privately operated by homeowners or for-profit corporations. Adult Residential Facilities are 24-hour, non-medical community facilities regulated by the state Community Care Licensing Division. Residents present a continuum of need, ranging from those able to hold down a job on one end of the spectrum, to those who have been released from locked psychiatric facilities on the other end of the spectrum. Yet despite this continuum of need, the daily “rent” paid to a board and care operator in LA County is \$35.<sup>1</sup> Operators of board and care homes are increasingly questioning the sustainability of this business model in the face of increasing costs on all fronts (increases in minimum wage, insurance costs, utility increases and accumulated deferred maintenance).

In a preliminary canvassing of board and care operators, the Department of Mental Health believes that in Service Area 2 alone, there may be a closure and loss of as many as 400 beds over the next 18 months. Extrapolated across the county, this results in a significant loss that outpaces the additional housing currently being planned.

Further, given the service needs of this population, the meagre reimbursement does not provide for any type of therapeutic enrichment, community-building or case management.

The board and care system for mentally ill residents is a non-sustainable business model and does not contribute to a meaningful treatment environment which will contribute to a quality of life and/or prevent residents falling back into homelessness. Absent a corrective action, this housing resource will continue to erode.<sup>2</sup>

### I. SOLUTION SNAPSHOT

There needs to be an infusion of resources – this year -- into the board and care system to ensure its survival. Supplemental funding, above and beyond what the residents can pay through their government benefits,<sup>3</sup> would provide incentives to operators to continue housing people living with mental illness. The infusion needs to be substantial enough to forestall the loss of precious beds through: (1) the closure of these facilities, (2) the sale of these properties for residential or commercial

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<sup>1</sup> For this reimbursement, the board and care must provide three meals a day plus two snacks, a room and bedding, laundry, a well-maintained and safe facility, money management and access to health or psychiatric care professionals.

<sup>2</sup> The long-awaited study from the California Mental Health Planning Council (CMHPC), October 2017, started its report by saying: “This issue paper is the beginning of an effort to highlight a significant public health issue: **the lack of adult residential facilities as housing options for individuals with serious mental illness in California.**”

<sup>3</sup> According to the CHMPC October 2017 report, “monthly rates charged by ARF’s are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) amount paid to Californian’s with disabilities and who are unable to work. The SSI/SSP payment, as sole source of payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF especially when some amount of the SSI/SSP payment is set aside for personal needs of the individuals. Therefore subsidies, often called “patches” are needed.” Page 6.

development, or (3) the conversion of these facilities to those serving other populations which offer a higher daily rental rate (e.g., \$85 – \$150 for homes for individuals with intellectual disabilities).<sup>4</sup>

Four options are worth exploring to provide these supplemental resources:

- a. Reestablishment of the supplemental funding that was made available to LA County board and care facilities up until approximately nine or ten years ago when the head of county DMH Dr. Marvin Southard eliminated this program—and not just to a few places that will take more special cases;
- b. Allocation of a portion of the “No Place Like Home” \$2B funding that will become available, representing a re-direction of funds already available through the Prop 63 Millionaire’s Tax. These funds could be deployed to counteract the deferred maintenance associated with many of these facilities and serve as a source of capital investment.
- c. Tapping into a portion of the funds that have been made available through Measure HHH, the LA City general obligation bond to support permanent supportive housing for chronically homeless individuals, which city voters approved in November 2016;
- d. Tapping into county funds raised Measure H, passed by county voters on the March 2017 ballot.

## II. BACKGROUND

### a. Residential Options for Persons Living with Mental Illness

People living with a serious mental illness account for less than six percent of the population<sup>5</sup>. With the shift away from state institutions that commenced in the last 1970’s, and the lack of community-based treatment programs and facilities that were promised as an alternative, hundreds of thousands of individuals in the US suffering from mental illness have either been “reinstitutionalized” in prisons and jails, or are homeless. The remainder who have housing are primarily in one of three places:

- Living at home with family
- Living in permanent supportive housing as part of the “Housing First” movement to move people experiencing homelessness from the street into a living unit
- Living in privately operated “board and care” facilities.

In Los Angeles County, where [the most recent point-in-time homeless count](#) identified 57,794 homeless people, the number of people living with mental illness far exceeds the housing options available. The 2017 demographic survey conducted by the Los Angeles Homeless Authority (LAHSA) identified that 30 percent of the homeless population in Los Angeles County suffers from a serious mental illness. That would amount to approximately 15,728 people.

Further, the Los Angeles County jail is generally characterized as one of the largest mental institutions in the country, with over 4,700 inmates incarcerated suffering from mental illness.

<sup>4</sup> “Disparities in Reimbursement Rates.” Chart prepared by Barbara B. Wilson, LCSW, is attached as an Exhibit.

<sup>5</sup> Source: *Insane Consequences* by DJ Jaffee, referencing research conducted at the time SAMHSA’s Center for Mental Health Services was created. The definition defines serious mental illness in adults as, “those mental illnesses that met the criteria of [latest edition of] DSM and ... resulted in functional impairment which substantially interferes with or limits one or more major life activities.”

With the expressed city/county goal to end chronic homelessness in LA County, which is a national objective as well, attention must be paid to all housing options available, or in the pipeline, to house people living with mental illness.

This report shines a light on the state of the board and care system in L.A. County, which represents a precious housing resource for people living with mental illness. The board and care system provides a residential setting for adults and provides supervision, support, protection and security in a group setting. The provider must be licensed by the Department of Health and Human Resources, Office of Health Facilities Licensure and Certification.

Last year, Los Angeles County managed to house over 14,000 people, a record amount and yet still ended up with an increase of 23% in its homeless population. Analysis points to many reasons with significant ones being the erosion of current affordable housing stock and issues of NIMBYism when it comes to the development of more affordable housing.

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 LA County with residents exiting board and cares back into homelessness and/or board and care facilities no longer being available to accept new residents.

#### b. Types of Adult Residential Facilities (ARF's)

Adult Residential Facilities<sup>6</sup> are regulated by the Community Care Licensing Division (CCLD) of the State of California. The provisions are articulated in the Community Care Facilities Act of the Health and Safety Code. Typically, the services provided by an ARF include lodging, food service, care and supervision<sup>7</sup>, assistance with taking medications in accordance with a physician's order, assistance with transportation to medical and dental appointments, planned activities, housekeeping, laundry service and maintenance or supervision of cash reserves.

The Community Care Licensing Division oversees several types of residential and day facilities (e.g., Residential Care Facilities for the Chronically Ill, or Residential Care Facilities for the Elderly, to name just two) but for the purposes of this report, we are focusing on what is typically referred to as a board and care, or ARF, in the vernacular of the state.

ARF's may serve people suffering from a mental illness, people with developmental disabilities or elderly residents. They generally do not provide skilled nursing services, with some exceptions.<sup>8</sup> Some facilities

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<sup>6</sup> An Adult Residential Facility means any facility of any capacity that provides 24-hour a day nonmedical care and supervision to the following: (A) persons 18 years of age through 59 years of age; and (B) persons 60 of age and older only in accordance with Section 85068.4 (Acceptance & Retention Limitations) [Source: Community Care Licensing Division (CCLD) report presented by Claire Matsushita, Asst. Program Administrator, to LA County Mental Health Commission on April 27, 2017.]

<sup>7</sup> "Care and Supervision" means those activities which, if provided, shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of the residents. [Source: CCLD report]

<sup>8</sup> According to the CMHPC report, "Residential care facilities are not allowed to provide skilled nursing services, such as give injections nor maintain catheters nor perform colostomy care (unless there is a credentialed RN or

are exempted from the CCL licensing process, and there is anecdotal evidence that some formerly licensed board and care homes are shifting to the unlicensed domain. For example, a home or facility that supplies room and board only, with no elements of personal care, is not licensed. These facilities operated “under the radar” and are not subject to any type of regulatory oversight. Recovery houses for persons recovering from substance abuse are also not licensed.

### c. The Inventory

The challenge of this research has been to identify the trends with respect to available beds for persons suffering from mental illness. Anecdotal evidence suggests that board and care operators are closing down their facilities and selling their property *at an alarming rate*. While the department has kept track of board and care facilities that it has contracts with, this pool is small compared to all inventory. In meetings with DMH department staff in Q4 2017, we asked for:

- Trends over a two to five-year period documenting number of facilities closing and number of beds impacted.
- Breakdown of current inventory of housing for mentally ill as compared to elderly or intellectual disabilities.
- Information about all board and care facilities in the county, not just those with whom the county has an agreement.

As they say, you can’t manage what you don’t measure, so the lack of data is an impediment to any effort to stem the loss of more beds for this population.

DMH is in the process now of ramping up its efforts to track this information. This positive development is in part due to the internal resetting of priorities and emphasis under the new Director. We also believe that this invigorated effort is in part in response to this Ad Hoc Committee’s work. The timing and request of the recent motion by the Board of Supervisors to track housing for a real time data base has also been a significant factor. In response to the Board Motion DMH has assigned staff to move forward with soliciting and developing a resource manager and locator for 24hr services. They are currently doing a process improvement analysis to help determine what the scope and functionality of the application needs to be. They still will need to use that scope to find the best application for this need.

***This process is not yet complete though and we ask the Board to continue to expect, encourage and enable the department to gather this information.***

The Mental Health Commission organized presentations on this topic at the April 27, 2017 general commission meeting. At that time, which is still the most current data we have, **CCLD reported that in Los Angeles County there are 1,283 Adult Residential Facilities with a bed capacity of 11,979.**

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LVN individual working in the home), but they can provide assistance with all daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care.” P. 3.

What we have not been able to determine is the breakdown of population served by these facilities. At a minimum, these would be important data points to track:

- Current number of facilities serving people suffering from mental illness. Number of beds and ***how this has changed over time.***
- Current number of facilities serving people living with intellectual disabilities and change over time.
- Current number of facilities serving adult elderly or other needs and change over time.

Absent this data, it is impossible to provide a snapshot of trends. Anecdotal evidence, however, suggests that there is an erosion of bed availability for persons with mental illness due to either closure of facilities for economic reasons, shift to an unlicensed facility<sup>9</sup> or conversion to serve a population where the reimbursement rate is higher. This anecdotal trend also begs the question: are there any new facilities coming on line to add beds to a system that appears to be stressed? If not, what is the reason for lack of entry into this market?

Further, it would be important to know how many *unlicensed* board and care facilities in the county serve persons with mental illness. An unlicensed facility will sometimes recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. These facilities will vary wildly in quality and in the degree of services provided. Over the years DMH has had many conversations with County Counsel and the Auditor-Controller about unlicensed facilities. They have raised some concerns including monitoring and quality of care issues. And yet, we know that many of our residents are living in these facilities. We do not know how many of these facilities would be willing to become licensed if certain impediments were removed, education and training of what it would entail to be licensed were provided or incentives were offered.

#### d. Trends

Concern about the relative fiscal health of the board and care system is not unique to Los Angeles County. In 2016, the CA Mental Health Planning Council initiated a statewide review of Residential Care Facilities in the state. They surveyed all 58 counties in CA, and 22 responded. (Los Angeles county was not one of the respondents.) The counties responded that 907 beds were needed, and 783 were lost over the past several years.<sup>10</sup> The respondents also indicated that in approximately 15 counties, beds had to be sought in another county because of the deficit in the home county.

According to the Planning Council, in their 2017 report, there were three main reasons why the shortage persists: (1) Financial; (2) Community Opposition, and (3) Staffing. Their data relative to the financial realities associated with running an adult residential facility will be described in greater detail below.

Another entity, the California Association of Local Behavioral Health Boards & Commissions, published an issue brief on ARF's in October, 2017 which outlined concerns about the "revolving

<sup>9</sup> It has been suggested that some licensed facilities are converting to unlicensed status. Such a facility may recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. However, less services are provided. It is hard to obtain details about specific locations, as these facilities prefer to remain "off radar."

<sup>10</sup> Source: CMHPC October 2017 report; page. 5.

door” when there are limited options for people coming out of acute in-patient treatment programs, transitional living or the correctional system.

In Los Angeles County, we assert that we are facing a crisis with respect to the survival of these precious housing resources. In just the past year, this ad-hoc commission received word that 11 board and care homes, ranging from 6 to 100+ beds, have closed, converted their operations or are considering closing. **This is just a small sample, pulled from our own network.** Examples of recent closures include:

- Brentwood Manor. This facility, located at 12311 West Santa Monica Blvd. was [purchased in March, 2017 by a developer](#) with the intention to transform it into a boutique hotel
- Western Ferndale Board and Care located at 1745 N. Western Avenue in Los Angeles
- Villa Poinsettia, 823 N. Poinsettia Pl, Los Angeles

These are facilities who have expressed concerns about their ability to continue their operations under the current scenario:

- Sunland Manor (approximately 100 beds), 10540 Sherman Grove Avenue, Sunland CA.
- Sepulveda Residential (approximately 80 beds). 8025 Sepulveda Blvd, Van Nuys, CA.
- Sharp Board & Care (6 beds), 10537 Sharp Avenue, Arleta, CA.
- Amigo Board & Care (two homes at 6 beds each), 8238 Amigo Avenue, Reseda and 23601 Vanowen, West Hills, CA.
- Blake Family Home (6 beds), 606 Jackman Street, Sylmar, CA.
- Alma Lodge (80 beds), 1750 Colorado Blvd, Eagle Rock, CA.
- Hartsook Board & Care (16 beds), 11045 Hartsook, North Hollywood, CA
- Golden State Lodge (14 beds), 11465 Gladstone Way, Lakeview Terrace, CA

Many of these have been in these neighborhoods for years. Owners who have run these businesses as family operations are now finding that the land is worth more than the business itself and are choosing to sell to developers. Not only are beds lost but opposition to opening other facilities in some of these communities proves insurmountable due to both the NIMBY mentality, changes in zoning and increased land and construction costs. Current board and care inventory ends up being used to re-house these displaced residents, further limiting options for homeless or new clients.

#### e. Financial Realities

With a reimbursement or rental rate of \$35/day<sup>11</sup>, a board and care operator is hard pressed to meet their obligations to provide the full array of services required under their licensing arrangement, with no relief in sight.

Further, the \$134 that remains for the resident (from their social security disability check) must cover all their discretionary expenses including: clothing, transportation and travel, entertainment, cigarettes, and miscellaneous life expenses. This amounts to about \$4 a day – a challenging amount for anyone to consider. This explains why residents of board and care homes, who don’t have access to supplemental funding from family or friends, may resort to panhandling to make ends meet.

<sup>11</sup> As of January 1, 2018, the rates have changed ever so slightly. SSI rates for clients are \$1037 plus \$20 if they receive disability. Personal spending for incidentals is \$134.

DMH has initiated two strategies for addressing the financial viability and program needs of Board & Care facilities.

- 1) Under Whole Person Care DMH is currently amending contracts with existing Community Care Residential Facilities for a \$25 per day patch for clients that have been determined to have higher needs.
- 2) In addition, DMH will be releasing a Request for Applications (RFA) Specialized Supplemental Care Program (SSCP) in the spring 2018 to offer funding for augmented supports to all licensed adult residential facilities across the county. The RFA will allow DMH to augment the Basic Rate to fund additional staffing needed to serve individuals that have a serious mental illness and, due to their level of functioning, symptoms, and psychiatric history require service interventions that are in addition to or often more time-intensive to deliver than Basic Services. The payment of a supplemental rate will enable more placement options to individuals waiting to be transitioned from a higher level of care to the most appropriate residential setting based on their ability to function independently. The supplemental rate programs correspond to the level of service and/or staff. Funding will be offered for two different tiers of service: \$25/day and \$40/day.

Neither of these strategies has been fully implemented. And, as presented below, it is not clear that it will be enough. That is why it is essential that other community partners join in this effort.

The CA Mental Health Planning Council, in their October 2017 report presented a sample budget for a 13-resident facility. It documents in stark terms that the “rent” paid by residents does not even come close to covering the basic aspects of staffing, services and the facility costs. A break-even rent for this facility would require \$2,805 per month. This budget is included as Table 1.

Table 1  
Residential Care Facility Sample Annual Budget (13 Person)

Title	Amount	Comment
Training	\$2,000	
<b>Total Other Expenses</b>	<b>\$2,000</b>	
<b>REVENUE</b>		
Resident Fees	\$102,600	\$1026/month for 13 residents at 95% occupancy
<b>Total Personnel Expenses</b>	<b>\$272,034</b>	
<b>Total Revenue</b>	<b>\$160,056</b>	
<b>d. Operating Expenses</b>		
<b>EXPENSES</b>		
Legal and Other Consultation	\$1,000	
a. Household Supplies	\$10,000	Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods
a. Personnel Expenses	\$182,000	4.5 Staff at \$15/hour
Li. Staff Office Supplies	\$2,250	7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors
Computer/Office Furnishings	\$1,000	admissions, grocery shopping, etc. at \$20/hr.
Utilities	\$20,238	Presumes that this includes furniture and appliance
Maintenance – Building and Landscaping	\$12,000	\$200/month
Equipment	\$2,400	Replacement
Vehicle Staff	\$15,600	Fill-in for sick/vacation employees at 20 hours/week
Vehicle Maintenance	\$8,000	Presume one vehicle for use at \$550/month
Food	\$208,880	Presumes 9 sick days, 4 vacation days, 8 holidays/employee/year
Food	\$40,880	\$8 person/day plus one staff eating
b. Insurance Related Expenses	\$8,215	
Telephone/Internet/Cable	\$3,000	
Health/Dental/Life/Vision Insurance	\$39,800	\$600 month/employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance.
Printing and Postage	500	
Licensing and Permits	\$1,711	
Unemployment Insurance	\$1,482	
Property Taxes	\$6,000	Presumes property purchased for \$600,000 with \$100,000 down payment
FICA/Medicare	\$15,116	
Advertising	\$70,899	
<b>Subtotal</b>	<b>\$113,294</b>	
<b>Total Operating Expenses</b>	<b>\$113,294</b>	
<b>c. Rent or Loan Payments</b>	<b>\$30,396</b>	\$500,000 loan for 30 years at 4.5%

<b>Total Expenses</b>	<b>\$415,724</b>	
<b>Total Net Income (Loss)</b>	<b>(255,668)</b>	(Revenue \$160,056 minus Cost \$415,724 = Loss \$255,668)

Source: CA Mental Health Planning Council, October 2017 report, page 9.

f. Case Studies

1. Golden State Lodge

In an example close to home, The Golden State Lodge, which has announced its intention to close, created a simple spreadsheet to document the fiscal strain that makes it impossible to operate without some additional source of funds. In this scenario, the assumptions are predicated upon a census that ranges between 10 to 13 guests per month. **A break-even scenario would require a monthly rent of \$2,500 per person.** The full budget is included in the Appendix, but this abridged analysis documents the dilemma.

**Table 2**  
**Golden State Lodge 2017 budget**

Category	Amount	Total
<b>Revenue</b>		
Resident rent	\$ 122,100	
Total revenue		\$ 122,100
<b>Expenses</b>		
<b>Administration</b>		
Payroll	\$ 123,954	
Payroll taxes	\$ 1,399	
Workers comp	\$ 11,515	
Liability insurance	\$ 9,757	
Property insurance	\$ 9,900	
Employee insurance	\$ 15,400	
Property taxes	\$ 17,600	
Amortization	\$ 41,800	
Continuing education	\$ 2,200	
<b>Total admin</b>		\$ 233,525
<b>Operations</b>		
Food	\$ 19,500	
Utilities	\$ 19,393	
Repairs/mtce.	\$ 10,700	
Laundry	\$ 2,750	
Housekeeping	\$ 3,300	
Misc	\$ 7,700	
<b>Total operations</b>		\$ 63,343
<b>Total</b>		\$ 296,868
<b>Profit/Loss</b>		\$ (174,768)

2. Villa Stanley

At the April 27, 2017 hearing of the County Mental Health Commission on the topic of the board and care system, Dr. Jay Plotzker, Administrator for two facilities, presented specific information about the costs of running the two facilities, the demographics of the residents and the needs.

His company runs two ARF's. Villa Stanley, licensed as an ARF in 1989, has 80 beds and is for non-ambulatory mentally ill clients. Villa Stanley East, licensed in 1999, has 62 beds. Residents are referred to Villa Stanley through social work personnel at area hospitals, families, social service agencies or DMH district offices.

**Table 3**  
**Villa Stanley Census**

<b>Tenure of Residents</b>	Five years or more <sup>12</sup>	50%
	One to five years	30%
	Less than one year	20%
<b>Gender</b>	Male	80%
	Female	20%
<b>Ethnicity</b>	Caucasian	60%
	Hispanic	10%
	African American	22%
	Asian	8%
<b>Age</b>	18 – 35 years	20%
	35 – 60 years	60%
	60 and above	20%
<b>Benefits</b>	MediCal and SSI only	60%
	Medi-Medi SSI and SSA	25%
	VA	15%
<b>Ongoing Therapy</b>	Medi-Medi w/ PHP access	7%
	Veterans w/ MHICM or DDTP	5%
	FSP or Inter. Funding/DMH	15%
	No ongoing therapy	70%

In his testimony to the Commission, Dr. Plotzger outlined the demands placed upon the facilities. His prime concern is financial. In his words: “The board and care is paid for all its services a total (SSI basic rate) of \$1,026.37 per month. That works out to \$33.74 per day. That is an absurd amount given all that we provide to care, support and assist clients.”

Dr. Plotzger provided the Commission with some insight into the service demands placed upon the board and care operator. With respect to client care, they have to tend to their financial issues in resolving SSA, VA or family-related payments.

They must also tend to their client’s mental health needs – emergency and routine – even for those who have no ongoing relationship with a service provider. Because no more than 30 percent of the residents are receiving therapy at any given time, there is a tremendous need for the remainder to have access to case managers, doctors, clinical therapists.

There is a lack of access to educational, vocational or life-skills education. Particularly for younger residents, who might have an opportunity to wean themselves off government support, there is no support for vocational training.

They must tend to the routine and emergency maintenance needs of their facilities and be responsive to licensing requirements. They also have to stay connected with the community, to address the issues that typically come up in the neighborhood.

<sup>12</sup> According to Dr. Plotzker, some have lived at Villa Stanley for up to 20 years.

The reimbursement does not keep up with inflation. For example, he reports, the cumulative Consumer Price Index (CPI) for the LA area, since 2010, was 11.4%. Since 2010, the cumulative SSI/SSP increase has been only 6.4%. He suggested that with even a \$5 or \$10 per resident, per day increase, “there is much that we can do.”

The future financial picture looks bleak. He expressed concern about the mandated increase in the minimum wage, and how that will impact their ability to comply with mandatory staffing of an ARF, as per Community Care Licensing guidelines. He anticipates increases in the cost of food, and related staffing costs related to preparation. He foresees increasing insurance costs (liability and medical) as well as Worker’s Compensation. And finally, there are the ongoing costs associated with building repairs and maintenance. His facilities (as is the case with many others in the county) are aging and there are limited funds to handle capital improvements. He cited an example whereby two years ago, he had to pay \$50,000 to replace an elevator.

In sum, if this system were funded more adequately, he suggested that the clients would have access to more therapy and services, activities, better food and nicer surroundings.

g. Quality of Facilities

This Ad-Hoc committee has limited its focus, for the most part to the financial issues facing board and care facilities and the critical need to stop the loss of these types of beds. There remains a real issue about the quality of life of those who live at facilities. Many of these facilities are run down and have multiple deferred maintenance needs. Owners will say that the money doesn’t exist for them to do needed repairs, much less improve the cosmetic appearance of these facilities.

Financial pressures prevent most of these facilities from also providing any type of programming, therapeutic or otherwise. Many residents spend their days with little to do. Ironically, DMH and facilities have had to be careful in what they offer because of concerns of triggering the Federal IMD Exclusion. The exclusion prohibits Federal Financial Participation funds from being drawn down for mental health services if an owner of a facility is also the service provider on the site. That being said, DMH has developed some innovative programs such as the enriched residential facilities that enable providers to comply with regulations while offering treatment to clients, albeit at a nearby clinic site. We would argue that more can be done in this realm and hope that it will remain a topic of concern and focus.

III. CALL TO ACTION

First, it is important the county make a commitment to data collection to understand the trends relative to beds available for people with mental illness. The housing shortage is at a crisis level in L.A. County, and it is important to track this inventory to understand gaps and needs. The data collection, at the very least should:

- Identify the current inventory of ARF beds available for people living with serious mental illness today, and compare, to the extent possible, how the inventory has changed over the last one to five years;
- Identify the extent to which beds lost over the last one to five years have disappeared due to:
  - Conversion to another demographic group which offers greater subsidy
  - Conversion to unlicensed status
  - Sale of property for another use
  - Closure of home
- Identify if any new facilities have come on line in the last one to five years

Second, a sustainable commitment to enhanced funding needs to be identified to forestall additional shutdowns and to enhance quality of life for individuals living in these homes. It is estimated that “patches” or subsidies ranging from \$64/day to \$125/day (according to the CMHPC) would be necessary to maintain fiscal viability.<sup>13</sup> This will require more than just what is currently proposed for patches by DMH and other community partners must step in. The county should conduct an audit of ARF’s of various sizes to ascertain what the extent of that patch would be in L.A. County to protect this housing inventory.

Third, 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 are often not considered eligible for permanent supportive housing.

Fourth, in addition to shoring up the financial viability of board and care homes, it is critical to look beyond just the “brick and mortar” sustainability of these facilities and aspire to investing in opportunities for an enhance quality of life for those who live within this system. Patches above and beyond what is necessary to mitigate against closure will be required to invest in critical human needs including transportation of residents, linkage to day-time services and activities, and training for staff. Enrichment opportunities may also be generated by linkages to community services, adult schools, churches and volunteers, and this will require staffing and coordination.

Fifth, the Department of Mental Health should commit to a formalized liaison relationship with the board and care operators in order to provide support, training and an opportunity to dialogue about needs and aspirations.

Sixth, the county should identify a liaison with the California Mental Health Planning Council who has embraced this issue as a critical priority. The CMHPC has identified some state-level solutions that may require county policy support. Included in those recommendations is consideration for a “tiered level of

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<sup>13</sup> This recommendation is echoed by the CA Assoc. of Local Behavioral Health Board & Commission’s report that indicates a patch of \$64 to \$125/day is needed to sustain operations for facilities >45 beds.

care system” which would allow for different levels of reimbursement based upon resident needs (similar to what is done for residents with developmental disabilities.) The Planning Council has also recommended advocating for a higher State Supplemental Payment (SSP) rate.

## Appendix 5

### DEPARTMENT OF DEVELOPMENTAL SERVICES COMMUNITY CARE FACILITY RATES FOUR OR LESS BEDS PER FACILITY EFFECTIVE JANUARY 1, 2019

Service Level	Monthly Payment Rate Per Consumer Effective <b>1/01/2018</b> <sup>1</sup>	Monthly Payment Rate Per Consumer Effective <b>1/01/2019</b> <sup>2</sup>
1	\$1,039.37	\$1,058.37
2-Owner	\$3,478	\$3,674
2-Staff	\$3,839	\$4,035
3-Owner	\$3,524	\$3,725
3-Staff	\$3,994	\$4,195
4A	\$4,636	\$4,847
4B	\$4,913	\$5,140
4C	\$5,186	\$5,429
4D	\$5,534	\$5,793
4E	\$5,885	\$6,165
4F	\$6,249	\$6,550
4G	\$6,686	\$7,008
4H	\$7,139	\$7,488
4I	\$7,784	\$8,170

The Personal and Incidental (P&I) expenses effective with the January 1, 2019, SSI/SSP payment standard increased from \$134.00 to \$136.00.

<sup>1</sup> Includes the SSI/SSP pass through effective January 1, 2018.

<sup>2</sup> Includes the SSI/SSP pass through effective January 1, 2019.

DEPARTMENT OF DEVELOPMENTAL SERVICES  
COMMUNITY CARE FACILITY RATES  
**FIVE OR MORE BEDS PER FACILITY**  
**EFFECTIVE JANUARY 1, 2019**

Service Level	Monthly Payment Rate Per Consumer Effective <b>1/01/2018</b> <sup>1</sup>	Monthly Payment Rate Per Consumer Effective <b>1/01/2019</b> <sup>2</sup>
1	\$1,039.37	\$1,058.37
2-Owner	\$2,456	\$2,586
2-Staff	\$2,716	\$2,846
3-Owner	\$2,873	\$3,040
3-Staff	\$3,210	\$3,377
4A	\$3,709	\$3,887
4B	\$3,965	\$4,159
4C	\$4,218	\$4,428
4D	\$4,525	\$4,751
4E	\$4,855	\$5,102
4F	\$5,193	\$5,461
4G	\$5,583	\$5,872
4H	\$6,005	\$6,320
4I	\$6,601	\$6,953

The Personal and Incidental (P&I) expenses effective with the January 1, 2019, SSI/SSP payment standard increased from \$134.00 to \$136.00.

<sup>1</sup> Includes the SSI/SSP pass through effective January 1, 2018.

<sup>2</sup> Includes the SSI/SSP pass through effective January 1, 2019.

DEPARTMENT OF DEVELOPMENTAL SERVICES  
 COMMUNITY CARE FACILITY (CCF) RATES  
 FIVE OR MORE BEDS PER FACILITY  
 EFFECTIVE JANUARY 1, 2019<sup>1</sup>

**CCF RATES FOR VENDORS FORFEITING ABX2 1 INCREASE**

Service Level	Monthly Payment Rate Per Consumer Effective <b>10/2/2018</b> <sup>2</sup>	Monthly Payment Rate Per Consumer Effective <b>1/1/2019</b> <sup>3</sup>
1	\$1,039.37	\$1,058.37
2-Owner	\$2,294	\$2,424
2-Staff	\$2,536	\$2,666
3-Owner	\$2,684	\$2,851
3-Staff	\$2,998	\$3,165
4A	\$3,463	\$3,641
4B	\$3,702	\$3,896
4C	\$3,939	\$4,149
4D	\$4,226	\$4,452
4E	\$4,534	\$4,781
4F	\$4,850	\$5,118
4G	\$5,214	\$5,503
4H	\$5,609	\$5,924
4I	\$6,166	\$6,518

The Personal and Incidental (P&I) expenses effective with the January 1, 2019, SSI/SSP payment standard increased from \$134.00 to \$136.00.

<sup>1</sup> This rate schedule applies to service providers not in compliance with Assembly Bill X2 1 reporting requirement pursuant to Welfare & Institutions code, section 4691.10(b)(4).

<sup>2</sup> Includes the SSI/SSP pass through effective January 1, 2018.

<sup>3</sup> Includes the SSI/SSP pass through effective January 1, 2019.

Service Level	Monthly Payment Rate Per Consumer Effective <b>7/01/2016</b> <sup>17</sup>	Monthly Payment Rate Per Consumer Effective <b>1/01/2017</b> <sup>18</sup>
4H	\$6,788	\$6,962
4I	\$7,395	\$7,588

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

FINAL DRAFT

## **Appendix 6:**

### **California Behavioral Health Planning Council Adult Residential Facility (ARF) Project Workgroup Regulatory Barriers March 13, 2019**

- 1) Excluding residents because of their risk of elopement. Because they are unlocked facilities, CCL requires a vague standard of care and supervision that means that operators should exclude anyone where there may be any danger of suicide risk, elopement, etc.
- 2) Issues regarding self-care and management of diabetes, incontinence, etc.
- 3) Food monitoring: how many days' worth of eggs and milk must be on hand, everything must be dated in the refrigerator. If you allow clients to cook, you can be cited if someone leaves the butter uncovered in the refrigerator.
- 4) Mentally ill individuals are not allowed to reside in an older adult facility. This calls for a need for special programs to be created for older adults with schizophrenia or other serious mental illnesses.
- 5) Reporting incidents can often lead to being cited and fined – which deter persons from filing reports at the risk of being fined. These fines are unnecessary and take money from the board and care operators, and ultimately the population for which is being served.
- 6) CCL approval for licensing upon opening a facility can take several months, clients are unable to be served until the licensed is granted. Difficult to arrange for staff to visit the facility which is largely the reason for months of delay.
- 7) CCL may conduct random visits, but are not reporting the outcomes so that if any changes need to be made are unavailable to the board and care operator.
- 8) Licensing Program Analysts (LPAs) are often lacking inadequate training and are not educated on regulations – which leads to differing interpretations and enforcement of regulations.

## **Appendix 7**

### **A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness**

Authors: Dennis Culhane, Steve Metraux, Randall Kuhn

With support from the New York and Boston study teams: Dan Treglia, Maryanne Schretzman, Eileen Johns, Kelly Doran, and Tom Byrne.

December 7, 2018

## I. INTRODUCTION

This report examines health services use and population dynamics among the aging homeless population in Los Angeles. Evidence suggests that adverse health outcomes lead to homelessness, and the conditions related to homelessness lead to or exacerbate a range of health problems (Hwang, 2001). In addition, the barriers to accessing preventative and primary care while homeless lead to receipt of healthcare only when morbidities are more acute, (Reid, Vittinghoff, & Kushel, 2008; Kushel, Gupta, Gee, & Haas, 2006; Lim, Andersen, Leake, Cunningham, & Gelberg, 2002) meaning that there is a disproportionate use of inpatient hospitalization and other costly medical and behavioral health services among persons experiencing homelessness (Doran et al., 2013; Hwang, Weaver, Aubry, & Hoch, 2011; Kushel, Perry, Bangsberg, Clark, & Moss, 2002; Salit, Kuhm & Hartz, 1998). As a result, homelessness is expensive for healthcare systems and for society as a whole (Latimer et al., 2017; Flaming, Burns, & Matsunaga, 2009; Culhane, 2008). Given this, interest in using healthcare systems as a platform to address homelessness has grown in recent years. Strategies include efforts to identify homeless patients in healthcare settings in order to link them with housing and social services (Garg, Toy, Tripodis, Silverstein, & Freeman, 2015; Gottlieb, Hessler, Long, Amaya, & Adler, 2014); the creation of accountable care organizations that seek to coordinate healthcare and social services for persons experiencing housing instability (Mahadevan & Houston, 2015); and the development of new financing mechanisms geared towards using healthcare dollars to support housing stability (Burt, Wilkins, & Locke, 2014).

Here we focus on healthcare use among older homeless individuals, a group that is particularly vulnerable to adverse health outcomes. Recent evidence has shown a cohort effect in the single adult homeless population, where persons born between 1955 and 1964 have faced a disproportionate risk of homelessness over the past two decades (Culhane, Metraux, Byrne, Stino, & Bainbridge, 2013). As a result, studies have documented substantial increases in the size of the older adult homeless population, such that they represent an increasing share of all homeless adults (U.S. Department of Housing and Urban Development, 2016). Persons in this cohort are now between the ages of 49 and 60, and, given current trends, there is likely to be substantial growth over the next decade in the number of older adults experiencing chronic homelessness.

Prior research demonstrates that older homeless adults have medical ages that far exceed their biological ages. Indeed, they experience geriatric medical conditions at rates that are on par with those among their housed counterparts who are 20 years older (Brown et al., 2017; Brown, Kiely, Bharel, & Mitchell, 2012). This means that older homeless adults are likely to be heavy users of healthcare services in general, especially long-term care services such as nursing homes. Moreover, with homeless persons having an average life expectancy of 64 years (Metraux, Eng, Bainbridge, & Culhane, 2011), the current cohort of older homeless individuals will experience old-age related mortality prematurely, and will reach their life expectancy over the next 5–15 years. The effects of premature morbidity and mortality, coupled with increases in the size of the older adult homeless population, will mean pronounced further increases in the high healthcare costs already linked with homelessness.

Addressing the healthcare needs that accompany these trends means shifting the current focus on remedial healthcare services to one more oriented toward social determinants of health. This would

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

mean an increased role for housing that could preserve functional independence among members of this population. Studies show that placement of individuals experiencing chronic homelessness in permanent supportive housing (PSH)—a housing model that provides subsidized housing matched with supportive services—can lead to substantial and sustained improvements in housing stability (Goering et al., 2014; Tsemberis & Eisenberg, 2000), and large reductions in their utilization of costly acute healthcare services (Byrne & Smart, 2017; Ly & Latimer, 2015; Larimer et al., 2009). This has created growing interest in ways to use Medicaid funds to help finance housing interventions for this population. States have, in recent years, sought Medicaid waivers to pay for supportive services for PSH tenants (Burt, Wilkins, & Locke, 2014), and there have been increasing calls for using healthcare dollars to pay directly for housing costs (Bamberger, 2016).

This report uses Los Angeles County as a case study to examine future trends in healthcare use among an older homeless population through combining analyses of current healthcare use with projected aging trends among Los Angeles County's homeless population. In doing so, we address the following objectives:

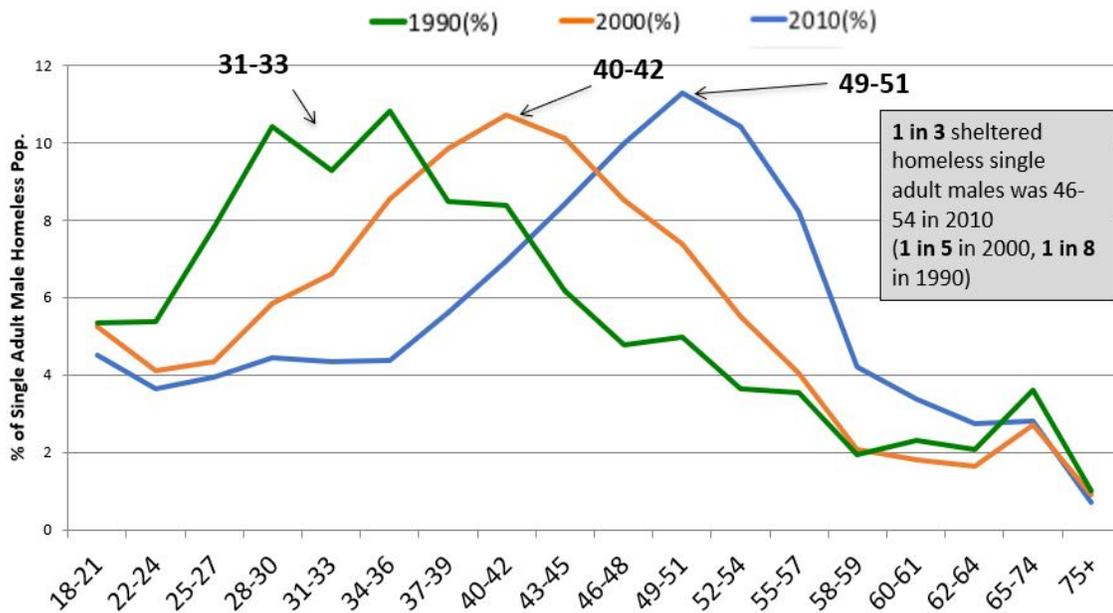
1. Project aging dynamics for sheltered homeless population using LAHSA HMIS data (2009-15) and demographic forecasting methods
2. Apply age-group specific healthcare and shelter cost estimates to population projections for likely future cost dynamics
3. Use cluster analysis to match sheltered sub-populations to different housing interventions and estimate related service costs
4. Draw upon prior research to estimate potential cost offsets associated with housing under different scenarios
5. Compare costs of housing interventions to cost offsets

This is one of three studies, with companion projects in Boston and New York City, that describe the aging trends in local homeless population, healthcare utilization by homeless persons, and the potential returns on investment associated with identifying and intervening with this population.

## II. AGING DYNAMICS AMONG THE LOS ANGELES SHELTERED HOMELESS POPULATION

Aging among both national and selected local homeless populations is, by now, a well-documented trend. Figure II-1 illustrates how the single adult homeless population has been aging over the past three decades. Using Census data from the last three decennial censuses, Culhane et al. (2013) show a distinct cohort effect whereby the age distribution becomes noticeably older over time. Figure II-2 presents a similar trend, this time among changes in the age distribution for the sheltered single adult homeless population in LA County over a seven-year span (2009-2015).

In this section, we use data on the single adult sheltered population, collected by the Los Angeles Homeless Services Authority (LAHSA), to extend these findings into the future. Just extending the aging trends from Figures 1 and 2 into the future would portend more and more homeless persons aging into their sixties, seventies, and beyond in the upcoming years. This conjecture will be more systematically assessed based upon applying demographic methods to age specific shelter data over time to forecast aging dynamics among the homeless population through 2030.



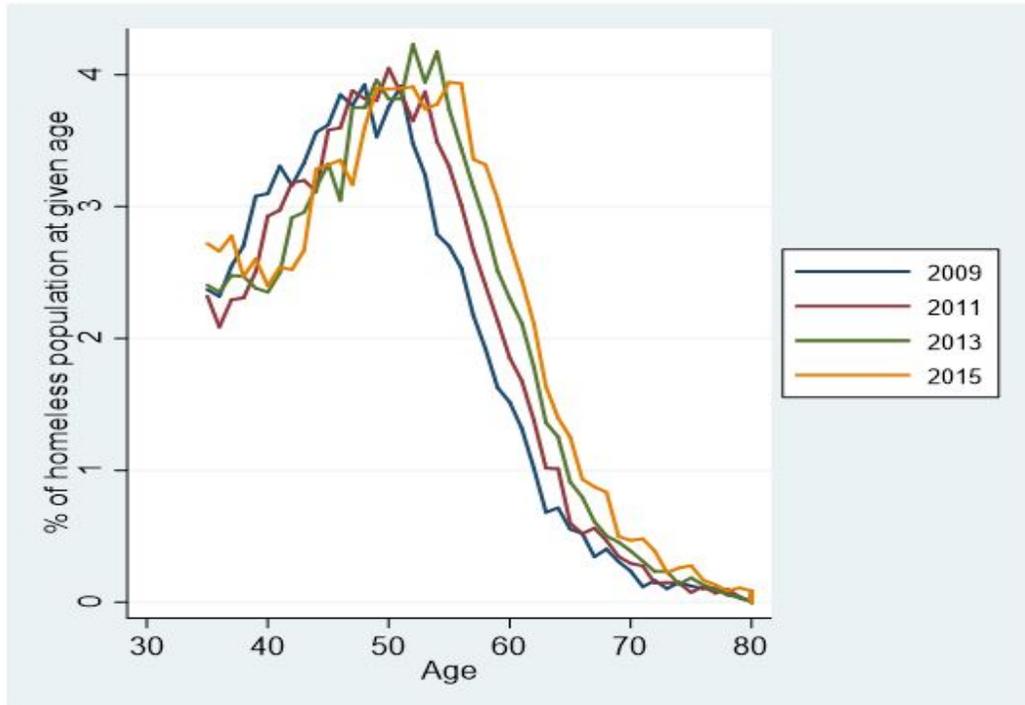
Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

**Figure II-1 – Age Distributions of Male Shelter Users**

Data for this forecasting comes from two different data sources, both maintained by the Los Angeles Homeless Services Authority (LAHSA). LAHSA administers a homeless management information system (HMIS) database which provides records of shelter stays by adults over age 30 in the years 2008 through 2015, as well as aggregate age distributions of unsheltered homeless persons based upon their 2017

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

point-in-time (PIT) count and survey. The PIT is an annual event in which LAHSA systematically seeks to assess the size of the homeless population, including hard-to-count populations such as the unsheltered homeless. A sizeable majority of LA County's single adult homeless population is unsheltered, and the unsheltered tend to be substantially younger than the sheltered, perhaps due to greater need or incumbency advantages



**Figure II-2 – Age distribution of the sheltered population in Los Angeles County: 2009-2015.**

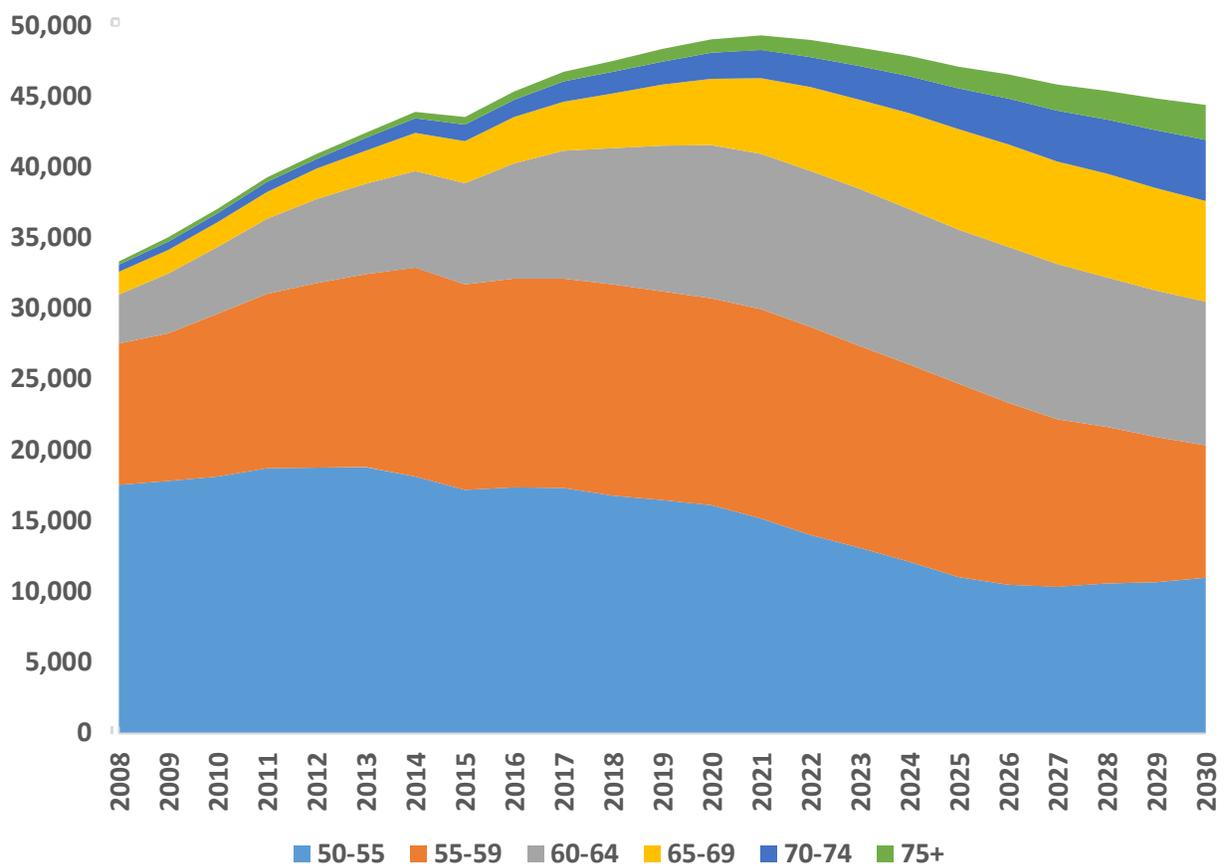
The analytic approach employed for forecasting uses the HMIS data to develop population-level estimates. This entailed separately developing population-level estimates of the expected trajectory of health care costs for persons age 55 and above for the 2016-2030 period for the sheltered population. PIT data were then used to adjust these estimates for the entire homeless population.

In order to forecast changes in the size and age composition of the older homeless adult population, an age-period-cohort model of year-to-year persistence in the shelter was employed. These analyses were performed on the sheltered population using the HMIS data, as it contained information both on individuals' ages and their entries into and exits from shelter. The persistence is defined as the ratio of stock of homeless individuals in a single-year age cohort (i.e., adults born in 1960) who are present in year  $n+1$  divided by the number present in year  $n$  (i.e. those remaining in 2018 as a share of those present in 2017). The ratio is analogous to the individual probability of persistence or exit, though in this case persistence may reflect a combination of individuals who remain in the shelter as well as new entries. An extensive exploratory analysis of prior trends in homeless shelter persistence by age, period and cohort was conducted. Following this, age-period-cohort spline Poisson regression models were conducted using the `apcspline` procedure in Stata 15. These models were then used to predict the

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

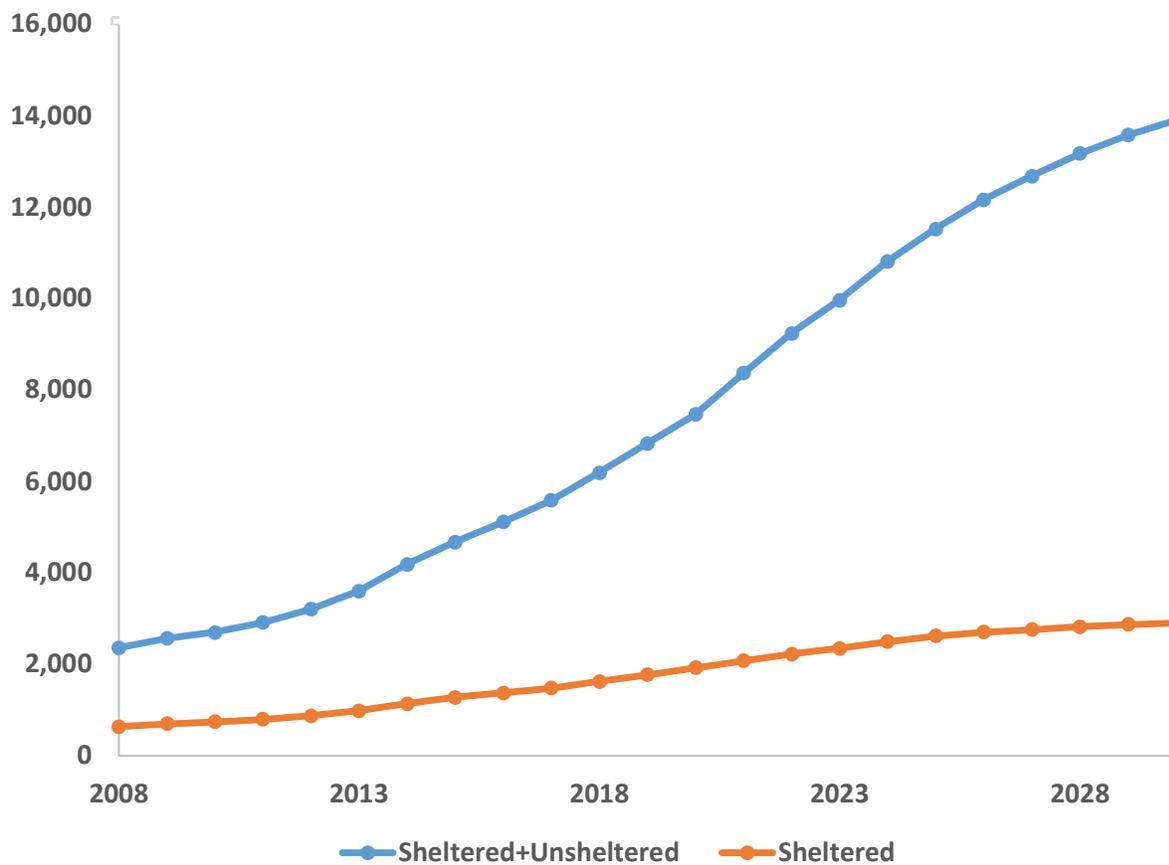
annual probability of persistence for each single-year age group controlling for age and period for 2016 to 2030. To account for uncertainty in the true nature of the age-period-cohort pattern and test the sensitivity of our results to different assumptions, we developed an ensemble of possible statistical models in which we varied a range of model assumptions including 1) the shape of the age effect, 2) the shape of the period effect, 3) the shape of the cohort effect, 4) the base year of the model, 5) model estimation based on all ages or only ages under 69, and 6) models based on raw population counts or population shares.

The final step involved taking the existing age-specific homeless population for the base year 2015, and applying single-year age-specific persistence rates for each year from 2017 to 2030 to extend the trend of shelter population change, extending the observed trend from 2009 to 2015. We produced estimates based only on the sheltered population, but we report estimates that adjust to also account for the unsheltered population. We took the simple approach of adjusting the base year population in 2015 to include the unsheltered by adjusting the population to account for the unsheltered-to-sheltered ratio in each five-year age group. In addition to capturing the full extent of homelessness in LA where  $\frac{3}{4}$  of homeless individuals are sheltered on any given night, it also accounts the relatively younger unsheltered population. As a result, the current LA age distribution more similar to distributions observed in parallel forecasts in New York and Boston. We report central estimates of the aged homeless population from 2016 to 2030.



**Figure II-3 – Total homeless (sheltered and unsheltered) population forecast; age 50+: Actual counts (2009-2015) and forecast (2016-2030)**

Figure II-3 illustrates findings (2009-2015) and forecasts (2016-2030) for five-year age groups, starting at age 50, among the total homeless population. The actual projections are available in Appendix A. The youngest age group has declined somewhat and is expected to shrink substantially after 2016, the 50-55-year age group is forecast to maintain a roughly steady number, and the older cohorts are expected to increase more dramatically, though their relatively small sizes will limit their absolute growth. This growth among the over-65 population is shown on Figure II-4, both for the overall homeless population and only the sheltered population. The former is expected to triple in the 22-year period covered here, while the sheltered population over age 65 would grow 2.3-fold.



**Figure II-4 - Forecast growth in total and sheltered homeless population age 65+, Los Angeles, 2008-2015 (actual) and 2016-2030 (forecast)**

To summarize, the demographic forecast for LA County’s homeless population, both sheltered and overall, predicts substantial aging through 2030, with the largest amount of proportional growth occurring among persons over age 65. These projections, based upon LAHSA data on both sheltered and unsheltered individuals, are consistent with observations that the homeless population is aging. These forecasts provide more specific data on what that aging might look like. Age-specific estimates from

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

these forecasts will be applied to historic age-specific health care utilization measures to provide parameters on the health care costs that are expected to be incurred by this aging population.

### III. AGE-GROUP SPECIFIC HEALTHCARE AND SHELTER COST ESTIMATES

This section estimates the use of and corresponding costs associated with six different types of health services, as well as shelter costs, for sheltered persons age 55 and over. Individuals that meet these criteria are selected from shelter records in the HMIS database maintained by LAHSA. These records are matched based on personal identifiers to an array of health services records. Depending upon the data source, these records were available for different years and the analyses vary based on the data source and the time periods covered. For each type of health service, summary statistics are provided on the mean use and cost of services.

#### *Demographic and Disability Statistics*

**Table III-1 – Demographic and Disability Characteristics of the Study Group**

<b>CATEGORY</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Number in Cohort</b>	20,970	23,453	21,139	18,446	16,103	16,259	16,203
<b>Age in 2011</b>							
<b>Under 55</b>	80.6	78.1	75.7	73.3	70.4	66.7	64.8
<b>55-59 (%)</b>	10.7	12.2	13.4	14.4	15.5	17.5	17.6
<b>60-64 (%)</b>	5.3	5.9	6.8	7.8	8.8	9.4	10.3
<b>65-69 (%)</b>	2.1	2.2	2.5	2.9	3.2	3.9	4.4
<b>70+ (%)</b>	1.3	1.5	1.7	1.7	2.1	2.6	3.0
<b>Median Age (years)</b>	46	47	48	48	49	50	51
<b>Sex</b>							
<b>Male (%)</b>	72.0	70.6	70.3	70.8	71.9	71.8	71.4
<b>Race</b>							
<b>Black (%)</b>	47.7	46.5	47.7	49.3	48.0	47.5	47.1
<b>White (%)</b>	42.2	44.1	43.9	43.9	45.0	45.6	45.2
<b>Other/Multi/Unk. (%)</b>	10.1	9.3	8.5	6.9	7.0	7.0	7.7
<b>Ethnicity</b>							
<b>Hispanic (%)</b>	26.6	26.4	24.6	23.1	23.4	24.5	24.5
<b>Disability Status</b>							
<b>Disability Indication (%)</b>	45.0	44.4	47.5	48.1	47.8	46.9	47.5

Table III-1 presents an overview of demographic characteristics and a disability indicator for annual prevalence cohorts of the sheltered population between 2009 and 2015. The findings are for the entire sheltered population, and, in the descriptions that follow we also provide corresponding findings for the subpopulation of interest, those age 55 and over (which are not shown on the table). The source for these statistics is LAHSA HMIS records that were provided for this study and described in the previous section.

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

The key findings from Table III-1 include:

- A clear aging trend in the shelter population over the seven years covered by these data. The median age increased just under one year of age per prevalence year (from 46 to 51 over the seven years included). Whereas over four-fifths (80.6%) of the sheltered population was under age 55 in 2009, this proportion was under two-thirds (64.8%) in 2015. The two oldest subgroups on the table, those age 70 and over and those aged 65 to 69, had their shares of the shelter population more than double, from 1.3% to 3.0% and from 2.1% to 4.4%, respectively, over this time period.
- The overall cohorts were consistently around 71% male. The age 55 and over subgroup was proportionately somewhat more male at around 75%.
- Racial proportions between Black and White did not change much over time with the prevalence population being consistently slightly more of Black race.
- Persons of Hispanic ethnicity made up between 23% and 27% of the overall prevalence populations while comprising about 18% of those in these populations that were age 55 and over.
- Persons in the overall prevalence populations with a positive disability indicator in the HMIS records ranged between 44% and 48%.<sup>1</sup> Not surprisingly, among the age 55 and older subpopulation, the corresponding proportion was higher, fluctuating around 57%.

### Health and Shelter Services Use

The remainder of this section examines various types of health and shelter services use, and corresponding costs, among sheltered cohorts of those aged 55 and older. Findings for each type of service will be presented in separate subsections, which will also contain brief descriptions of the data used to determine these use and cost estimates. For each service and only for years that services records were available, records for individuals who were in shelter in a given calendar year were matched to service records for that same calendar year.<sup>2</sup> The resulting service use findings are grouped into discrete calendar year units for each person that are referred to throughout this report as “person-shelter years.” An individual who was sheltered during multiple years would contribute multiple person-shelter years to the data used here.

This allows service use to be grouped by age, and to be so grouped across different calendar years. To illustrate, if a person had a record of shelter stay during 2011 when he was age 57 then any service stays (inpatient hospital, emergency department, outpatient, etc.) that occurred in 2011 would be associated

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<sup>1</sup> No further details on the nature, extent or determination of these disabilities were available.

<sup>2</sup> For all services but nursing homes, services in a particular calendar year will be linked to individuals who were in a shelter at some point during that calendar year. For nursing homes, since such placements usually follow shelter stays, a nursing home placement will be linked to an individual if it occurs in a 365-day period following the individual’s first day in a shelter in a given year.

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

with this person-shelter year unit, and would be grouped with all other person-shelter years with ages between 55 and 59 to assess services use. If he also was in shelter during 2012 (at age 58) then that person-shelter year (with any service use) would also be aggregated into the same age group. Aggregated results for each age group will be shown for various services.

*Nursing Home Stays* subsequent to shelter stays were derived from a match between the Minimum Data Set (MDS) of nursing home stays and persons with LAHSA shelter stay records. MDS contains data from a standardized resident assessment instrument that is collected on residents of Medicare- and Medicaid-certified nursing homes. The LAHSA data cover 80,188 adults who were recorded in the HMIS as having stayed in a shelter sometime between 2009 and 2015. Data were matched based upon common personal identifiers (name, social security number, and date of birth).

MDS data are a collection of patient assessments and do not have specific dates that demarcate entries and exits from nursing home care. As a result, estimates of stay durations were created based upon the dates of MDS assessments. A set of pre-determined decision rules were applied to the assessment records, and stays were estimated for all persons identified as having stayed in nursing homes. The start and end dates for these stays covered only the time for which there was a reasonable certainty that the person was staying in the nursing home. Thus, these records were conservative, almost certainly underassessing the actual lengths of stay for the study population.

Once the stay dates were estimated, the methodology was similar to that of the other services, which is briefly described in the beginning of this subsection (also see footnote #2). Complete data coverage is available for the years 2011 through 2015. Table 2 presents data on nursing home use by the previously described shelter year metric for persons in shelter during this time period. A per diem cost of \$206<sup>3</sup> is applied to the mean inpatient days to estimate the corresponding cost.

**Table III-2 – Nursing home days (2011-14) for persons over age 55 who used shelters: 2009-2011**

<b>Age</b>	<b>% Person-Shelter Years with Nursing Home Placements</b>	<b>Mean Annual Nursing Home Placements (all person-shelter years with at least 1 inpatient day)</b>	<b>Mean Annual Nursing Home Placements (all person-shelter years)</b>	<b>Estimated Mean Annual Nursing Home Cost (all person-shelter years)</b>
<b>55-59</b>	3.8%	76.33	2.93	\$603
<b>60-64</b>	5.4%	88.60	4.76	\$980
<b>65-69</b>	14.0%	86.86	12.16	\$2503
<b>70+</b>	19.0%	106.60	20.23	\$4164

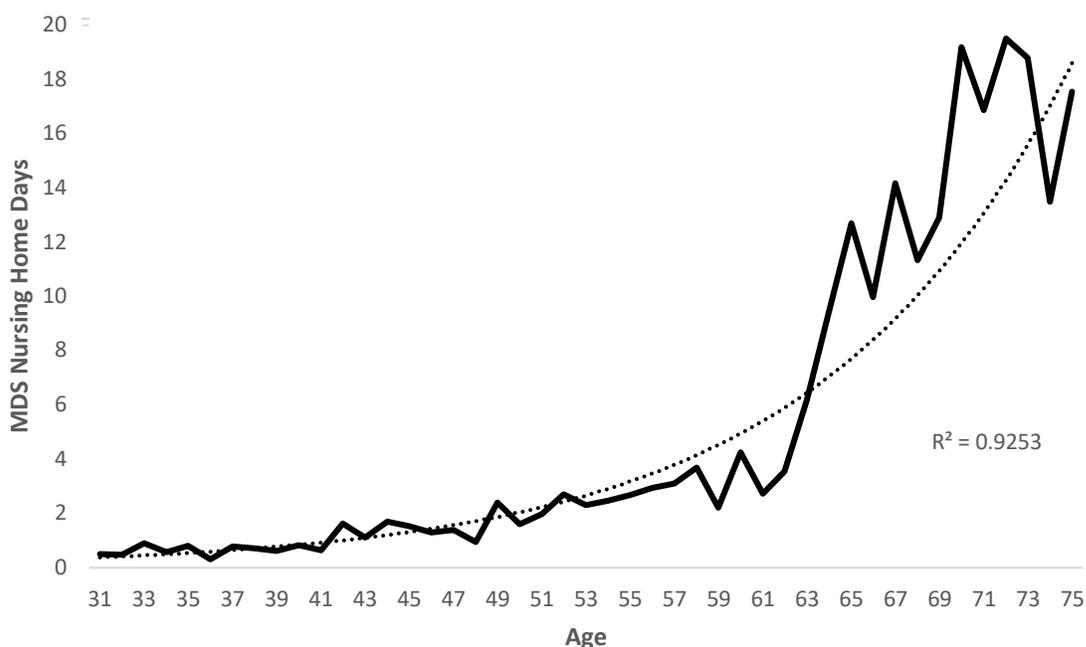
Table III-2 shows that the proportion of person-shelter years that included a nursing home stay increased substantially by age group, from 3.8% (ages 55-59) to 19.0% (ages 70+). The mean number of nursing home days per person-shelter year also increases with age. Thus, as would be expected, the use of nursing homes increases with age, both in the proportion of sheltered persons using nursing homes and the number of days in which they use nursing homes. The mean cost per person-shelter year

<sup>3</sup> Based upon a 2015 estimated Medi-Cal per diem reimbursement rate of \$205.87 as reported by the California Association of Health Facilities (2017).

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

(regardless of whether it included an actual nursing home stay) increased from \$603 for the age 55-59 group to almost seven times that (\$4,164) for the age 70+ group.

Figure III-1 illustrates how nursing home use among persons in shelter increases with age. The mean number of nursing home days per person-shelter year is tracked for individual years of age from 31 to 75. The increase shown in the figure is a result of increases in both the proportion of users and the number of nursing home days used as age increases. This pattern of increase closely fits an exponential trend line, meaning that the increase in mean days is gradual in the younger years and then increases much more sharply from about age 55 on.



**Figure III-1 – Average number of nursing home days per person-shelter year broken down by individual years of age**

*Inpatient Hospital Services* received by individuals while they stayed in a shelter in the years 2009 through 2011 were derived from matched records of two administrative data sources: Los Angeles County's Department of Health Services (DHS) and the State of California's Office of Statewide Planning and Development (OSHPD). DHS is the County's publicly funded health care provider and offers an array of health services across a network of hospitals and other facilities. OSHPD collects records and maintains databases of healthcare use from more than 5,000 California Department of Public Health-licensed healthcare facilities. As such, OSHPD draws upon health service providers beyond the DHS system. Records that are both in the DHS and OSHPD databases were unduplicated prior to the analyses. Per diem rates for inpatient stays are the DHS rate for all inpatient stays (\$3,849), a rate based upon Los Angeles County documentation (Wei & Stevens, 2016) and adjusted to 2017 dollars.<sup>4</sup>

<sup>4</sup> The DHS per diem inpatient rate (\$3,849) is based upon findings from the LA County Chief Executive's Office (Wu & Stevens, 2016) that report total costs and total inpatient days consumed by 3,940 homeless persons in fiscal year 2014-15, and adjusted for inflation to 2017 dollars.

**Table III-3 – Annual inpatient hospital days, per year in shelter and broken down by age group, for persons over age 55 who used shelters: 2009-2011**

Age	% Person-Shelter Years with Inpatient Stays	Mean Annual Inpatient Days (all person-shelter years with at least 1 inpatient day)	Mean Annual Inpatient Days (all person-shelter years)	Estimated Mean Annual Inpatient Cost (all person-shelter years)
55-59	11.9%	15.6	1.85	\$7,121
60-64	12.6%	16.2	2.04	\$7,852
65-69	14.7%	16.0	2.35	\$9,045
70+	17.3%	13.2	2.28	\$8,776

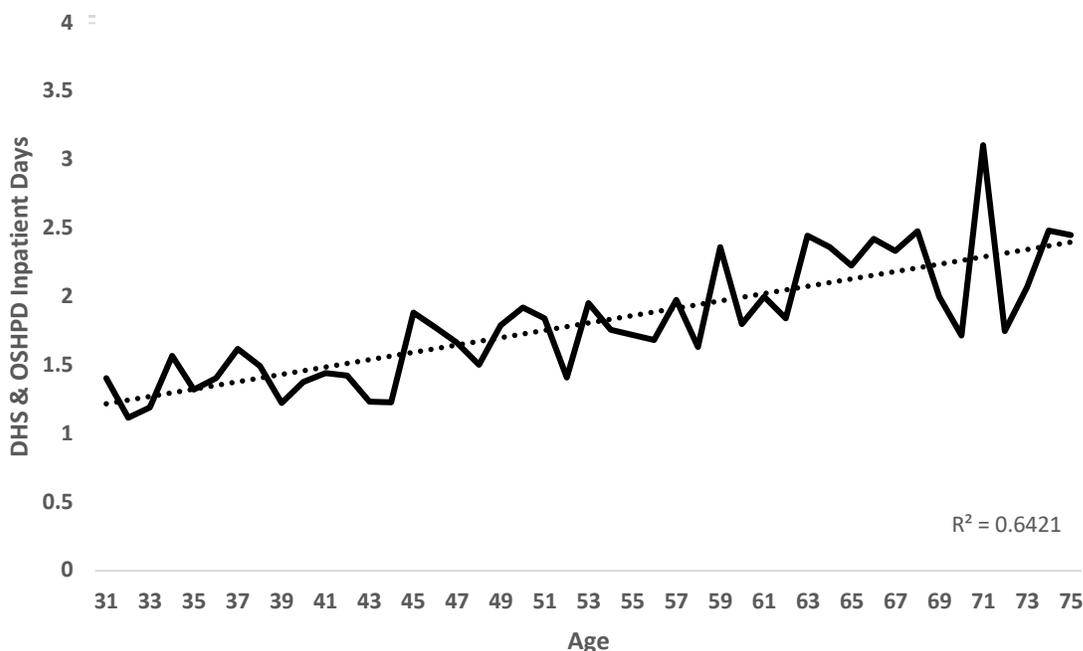
Table III-3 shows that as the age groups got older, the proportions experiencing inpatient hospital stays increased, and mean inpatient days (and corresponding costs) also increased, except among the oldest (70+) age group. This decline in the 70+ age group reflects an increase in the proportion of persons using inpatient care annually that was offset by a sharper decrease in the mean number of inpatient days per person. This corresponds to mean inpatient cost per person that increased from \$7,121 per year for the youngest age group (55-59) to \$9,045 per year for the 65-59 age group and then, for the oldest age group (70+), decreased somewhat to \$8,776.

Figure III-2 shows the mean annual inpatient hospital days per person-shelter year for each individual year of age, starting at age 31. The increase adheres reasonably close to a linear trend line and indicates a steady rise of inpatient hospital use based upon age.

*Emergency Department (ED) Services* received by individuals while they stayed in a shelter were based upon the same OSHPD and DHS databases and covered the same years (2009 through 2011) as the use of inpatient hospital days. Cost data for ED use were unavailable, and costs were estimated by applying an average per ED visit rate of \$1,370.<sup>5</sup>

<sup>5</sup> This cost estimate was based upon Los Angeles County documentation (Wu & Stevens, 2016) and adjusted to 2017 dollars.

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness



**Figure III-2 – Average days of inpatient hospital use per person-shelter year broken down by individual years of age**

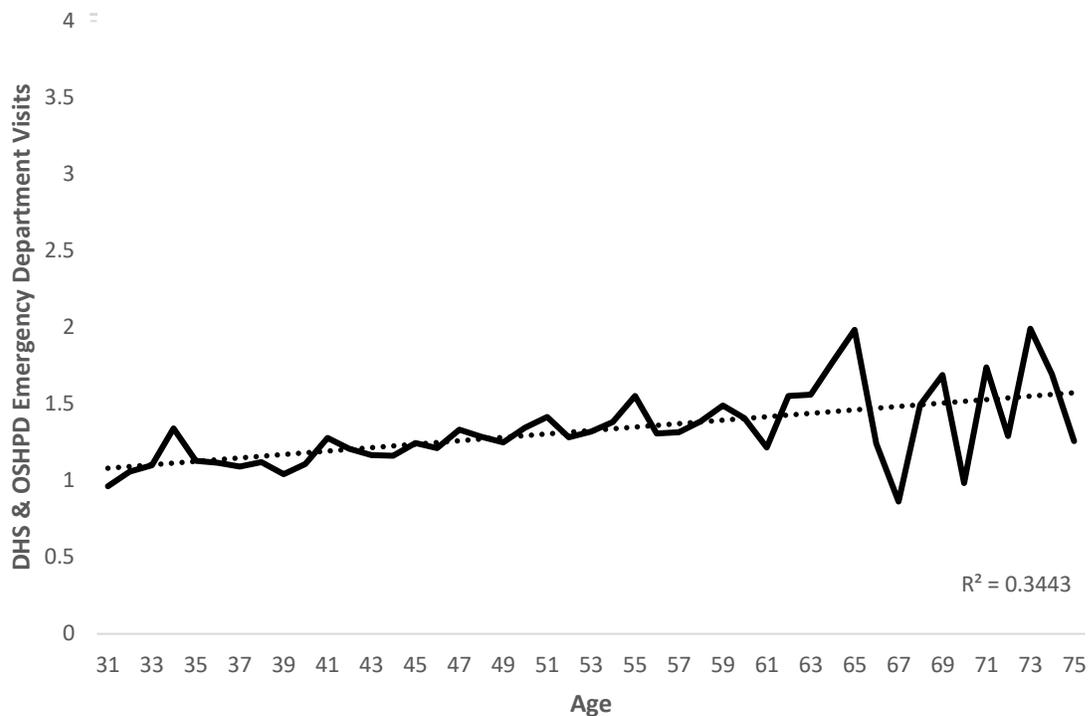
Table III-4 shows ED visits by age group. There were not substantial variations between the four over-55 age groups, with roughly 30% of all person-shelter years containing at least one ED visit. For those person-shelter years where there was an ED visit, the mean number of visits was between four and five. This led to an overall mean number of ED visits per person-shelter year of roughly 1.4, and an associated cost of around \$2,000.

**Table III-4 – Annual emergency department visits, per year in shelter and broken down by age group, for persons over age 55 who used shelters: 2009-2011**

Age	% Shelter Years with ED Visits	Mean Annual ED Visits (all shelter years with at least 1 inpatient day)	Mean Annual ED Visits (all shelter years)	Estimated Mean ED Visits Cost (all shelter years)
55-59	29.3%	4.82	1.41	\$1,934
60-64	29.5%	4.97	1.46	\$2,007
65-69	31.2%	4.66	1.45	\$1,991
70+	32.0%	4.34	1.39	\$1,901

The relative lack of fluctuation among these age groups belies the gradual increase found in ED use as age increased from 31 shown on Figure III-3. While the increase is steady with earlier ages and reasonably holds to a linear trend, the variation becomes more pronounced in later years and, as indicated in Table III-4, a smoothed trend for these later years would not show substantial differences in ED use past age 55.

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness



**Figure III-3 – Average number of emergency department visits per person-shelter year broken down by individual years of age**

*Outpatient Health Care Services* used by individuals while they were in shelter in the years 2009 through 2011 were available only through DHS records (i.e., not OSHPD). Otherwise, the data source is the same as that for the inpatient and ED services. L.A. County’s DHS system, by itself, would have provided a substantial though undetermined proportion of total outpatient services for those in the homeless population. Estimated mean per visit costs, adjusted to 2017 dollars, were \$862 per visit (see footnote 5).

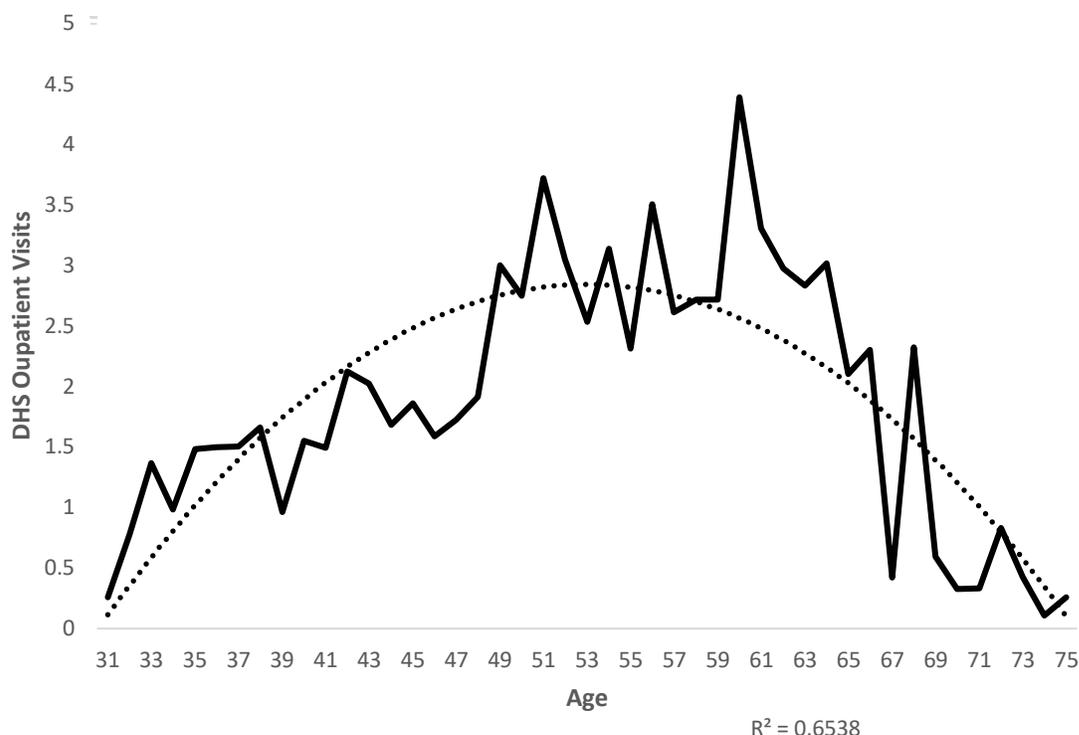
**Table III-5 – Annual outpatient visits, per year in shelter and broken down by age group, for persons over age 55 who used shelters: 2009-2011**

Age	% Person-Shelter Years with Outpatient Visits	Mean Annual Outpatient Visits (all person-shelter years with at least 1 inpatient day)	Mean Annual Outpatient Visits (all person-shelter years)	Estimated Mean Outpatient Visits Cost (all person-shelter years)
55-59	17.9%	15.54	2.78	\$2,392
60-64	18.1%	18.88	3.41	\$2,943
65-69	12.5%	14.71	1.84	\$1,582
70+	8.3%	4.35	0.36	\$312

Looking at Table III-5, the proportion of sheltered persons with outpatient visits, as well as the mean number of outpatient visits per person using this service, both dropped in the 65-69 age group and dropped more precipitously in the 70+ age group. Figure III-4 depicts the average visits per person-

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

shelter year from age 31 on, showing a trend that best fits an exponential distribution, where outpatient use increased from age 31, peaked among persons aged in the mid-50s, and then declined with increased age after that.



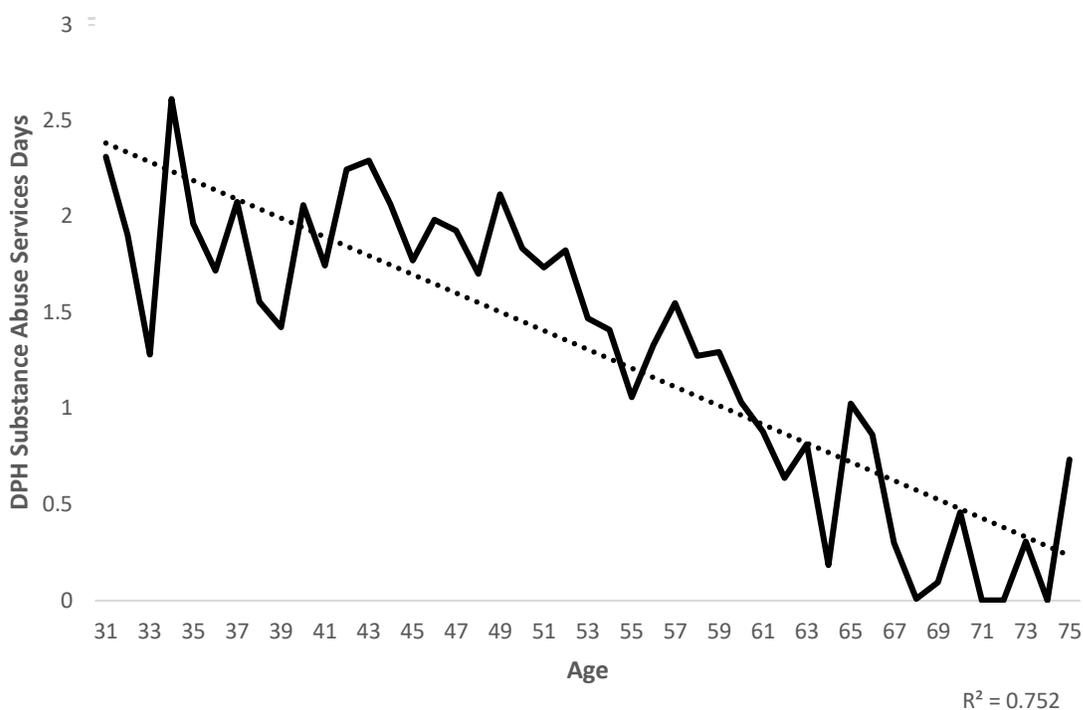
**Figure III-4 – Average number of outpatient visits per person-shelter year broken down by individual years of age**

*Substance Abuse Treatment Services* were examined based upon records from the LA County Department of Public Health’s (DPH) Substance Abuse Prevention and Control division. This study looks at the three services most widely provided by this division between 2009 and 2014—residential, inpatient drug treatment, and detoxification services. Mean residential and inpatient services costs, on a per diem basis, were set at \$121 in 2017 dollars (Wei & Stevens, 2016), while the corresponding rate for detox services was \$55 (United Way of Greater LA, 2009). Both per diem rates were adjusted for inflation to 2017 dollars. The costs for residential, inpatient drug treatment, and detox services will be combined into one measure of DPH substance abuse treatment services.

As shown in Table III-6, the proportion of sheltered adults that use these DPH services is small: 2.5% among those in the 55-59 group and declining thereafter to where virtually no one among the over age 70 group used these services. Days used per person also declined somewhat with age. All totaled, the average cost per person-shelter year becomes minimal when spread over the whole over-age 55 group, ranging from \$151 for the age 55-59 group to \$22 for the over age 70 group. Figure III-5 illustrates the trends shown in Table III-4 cast over a broader age group. Here the average days per person-shelter year declined in a linear fashion with age.

**Table III-6 – Annual use of substance abuse services (Residential Treatment, Inpatient Drug Treatment, and Detoxification) provided by the LA County Department of Public Health per year in shelter and broken down by age group, for persons over age 55 who used shelters: 2009-2014**

Age	% Shelter Years with SA Service Days	Mean Annual DPH SA Services days (all shelter years with at least 1 SA service day)	Mean Annual SA Service Days (all shelter years)	Estimated Mean SA Service Days Cost (all shelter years)
55-59	2.5%	50.85	1.29	\$151
60-64	1.7%	45.41	0.77	\$89
65-69	1.6%	38.93	0.62	\$74
70+	0.4%	43.80	0.17	\$22



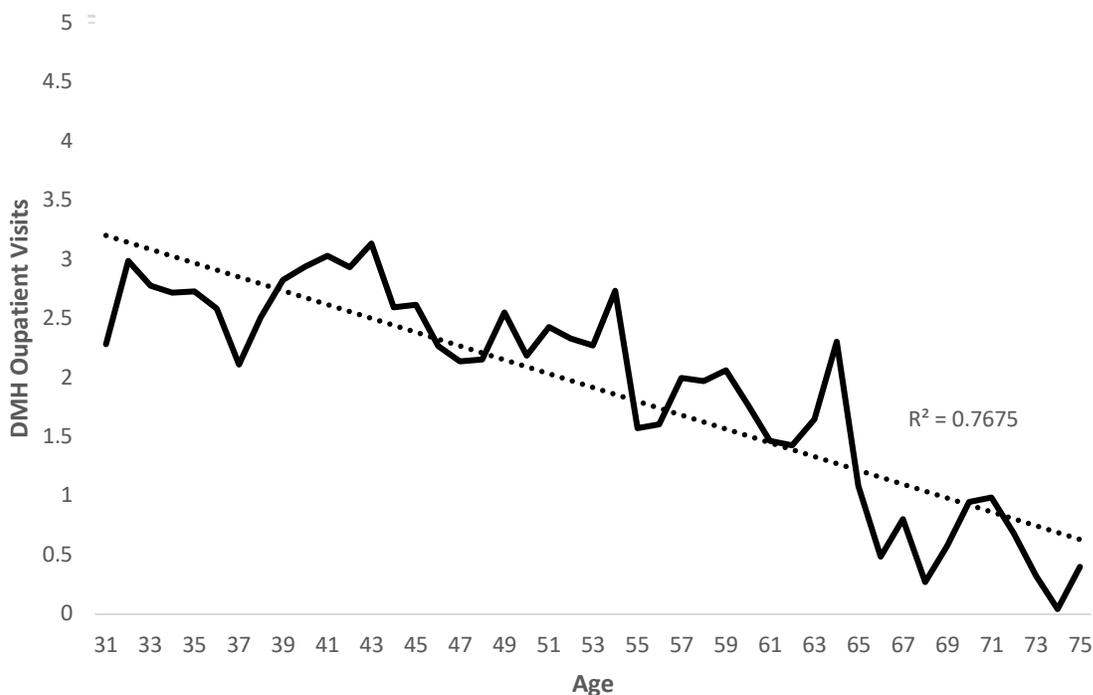
**Figure III-5 – Average days of DPH substance use per person-shelter year broken down by individual years of age**

*Outpatient Mental Health Services* were from records provided by the LA County Department of Mental Health (DMH). Psychiatric inpatient care, other than what was shown in the OSHPD and DHS inpatient records, was not available. The per visit cost of outpatient services was \$202 in 2017 dollars (Wei & Stevens, 2016; see footnote 4). The DMH data covers the years 2011 through 2014.

**Table III-7 – Annual use of mental health outpatient services provided by the LA County Department of Mental Health per year in shelter and broken down by age group, for persons over age 55 who used shelters: 2011-2014**

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

Age	% Shelter Years with SA Service Days	Mean Annual DPH SA Services days (all shelter years with at least 1 SA service day)	Mean Annual SA Service Days (all shelter years)	Estimated Mean SA Service Days Cost (all shelter years)
55-59	7.0%	25.78	1.81	\$383
60-64	6.4%	26.37	1.68	\$371
65-69	4.3%	16.52	0.71	\$169
70+	4.1%	18.56	0.76	\$253



**Figure III-6 – Average number of DMH outpatient visits per person-shelter year broken down by individual years of age**

Table III-7 illustrates that usage patterns for DMH outpatient mental health services also generally decline with age. It shows low and declining proportions of sheltered individuals over age 55 receiving services, and demonstrates that use for people receiving services declines inconsistently across age groups. This leads to a mean cost per person-shelter year for all shelter users that declines from \$383 (55-59 age group) to \$169 and then rises somewhat to \$253 for those in the 70+ age group. Figure III-6 is consistent with these findings as it shows a declining linear trend as age increased from age 31.

*Shelter Use*, the final service tracked, was assessed through LAHSA data for 80,188 adults who were recorded in the HMIS as having stayed in a shelter sometime between 2009 and 2014. Shelter use represents the number of days, on average, that persons stayed in a shelter in a one-year period during time periods starting between 2009 and 2014. For each of these years, the total number of shelter days is tallied in the 365-day period starting with the initial day spent in a shelter. Stays beginning in previous

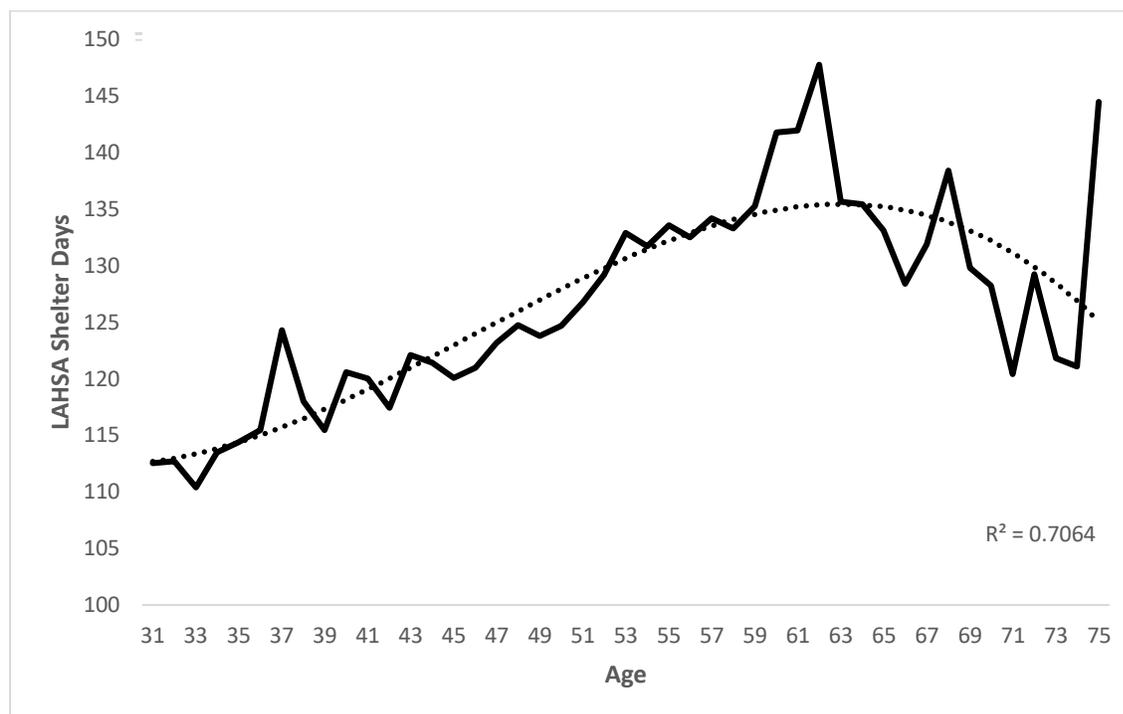
A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

years were set to commence on January 1 of the year in question. This approach is similar to the tracking of nursing home days that is described in footnote 2. Cost of shelter is estimated by applying the per diem cost of a shelter bed to the mean days stayed which, in 2017 dollars, was \$40 (LAHSA, 2017).

**Table III-8 – Annual use of LAHSA shelter days in a year broken down by age group, for persons over age 55 who used shelters: 2009-2014**

Age	Mean Annual LAHSA Shelter Days	Estimated Mean Annual Shelter Days Cost
55-59	135.0	\$5,400
60-64	140.0	\$5,600
65-69	131.4	\$5,256
70+	127.5	\$5,100

Table III-8 shows the mean number of shelter days used per person-shelter year broken down by age groups. This table differs from previous tables in that all persons in the study group stayed in shelters. Mean days increased up to age 65 and then declined for the older two age groups. As seen in Figure III-7, the table shows the end of a more general increase in shelter days used with advancing age, which peaks between ages 60 and 65 and then declines in the older age groups. As such, this pattern roughly follows an exponential distribution.



**Figure III-7 – Average number of LAHSA shelter days per person-shelter year broken down by individual years of age**

*Summary of costs.* Table III-9, the final table of this section, summarizes the costs accrued across the healthcare service types that were just reviewed. Combined with shelter use, the cost of homelessness

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

across the systems tracked here, for a year in which a person used at least some shelter, was \$17,984 in the 55-59 age group, and increased to where the combined costs exceeded \$20,000 among the 65-69 and 70+ age groups.

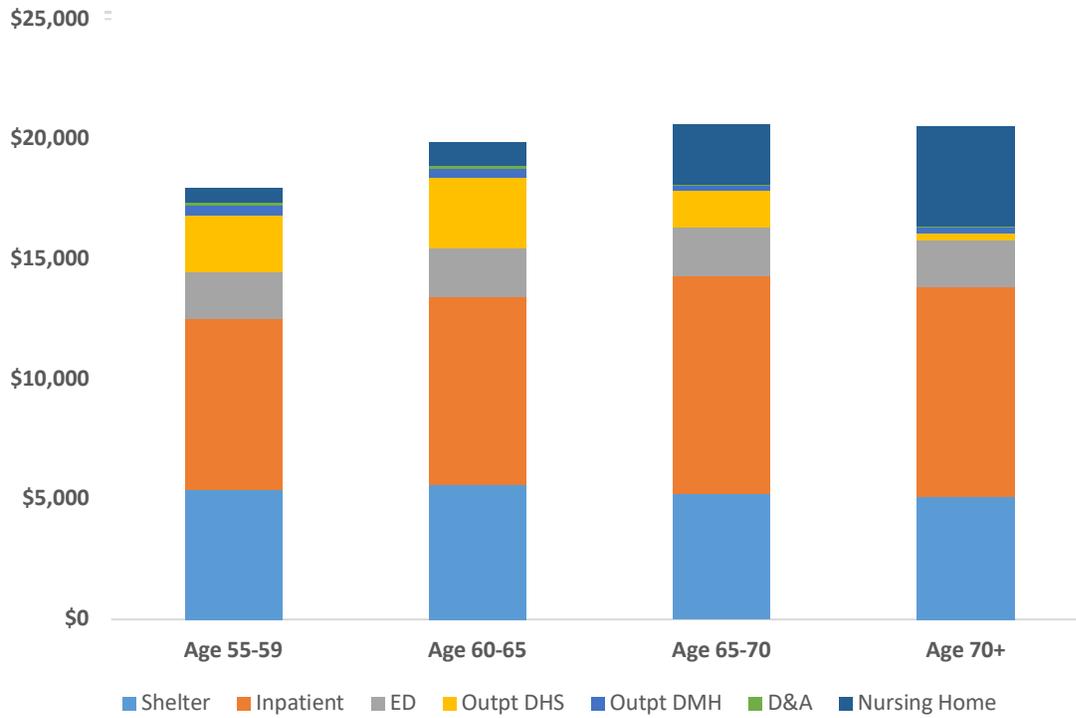
The health care costs tracked with the data available for this study, when combined, increased as the age groups got older. The largest proportion of the costs across all age groups was from inpatient care. However, considerably higher nursing home costs among the 70+ group offset declines in some other types of health care costs, most notably outpatient services costs. Inpatient and nursing home use and costs rose steadily. Other health services that were used much less across the population (DPH substance abuse and DMH outpatient services) declined with increased age, while DHS outpatient use and LAHSA shelter use increased up to around age 65 and then declined. Taken together, the substantial increase in nursing home use among the older age groups might have supplanted use of other health care services.

Figure III-8 shows the differences in average cost per person across age groups. This figure also highlights the proportions represented by each different service in making up the whole, and the differences in the mix of service costs that make up the total cost for each age group.

**Table III-9 – Combined cost of health care and shelter services per year in which shelter was used for sheltered individuals aged 55 and over, grouped into four age groups**

Service	55-59	60-64	65-69	70+
<b>MDS – Nursing home</b>	\$603 (2.93 days)	\$980 (4.76 days)	\$2,503 (12.16 days)	\$4,164 (20.23 days)
<b>DHS &amp; OSHPD – Hospital Inpatient</b>	\$7,121 (1.85 days)	\$7,852 (2.04 days)	\$9,045 (2.35 days)	\$8,776 (2.28 days)
<b>DHS – Outpatient</b>	\$2,392 (2.78 stays)	\$2,943 (3.41 stays)	\$1,582 (1.84 stays)	\$312 (0.36 stays)
<b>DHS &amp; OSHPD – Emergency Dept.</b>	\$1,934 (1.41 visits)	\$2,007 (1.46 visits)	\$1,991 (1.45 visits)	\$1,901 (1.39 visits)
<b>DPH – Drug &amp; Alcohol (Residential , Tx, &amp; Detox)</b>	\$151 (1.29 days)	\$89 (0.77 days)	\$74 (0.62 days)	\$22 (0.18 days)
<b>DMH – Mental Health (Outpatient)</b>	\$383 (1.81 visits)	\$371 (1.68 visits)	\$169 (0.71 visits)	\$253 (0.76 visits)
<b>COMBINED HEALTH COSTS</b>	<b>\$12,584</b>	<b>\$14,242</b>	<b>\$15,364</b>	<b>\$15,428</b>
<b>LAHSA Shelter Days</b>	<b>\$5,400</b> (135.0 days)	<b>\$5,600</b> (140.0 days)	<b>\$5,256</b> (131.4 days)	<b>\$5,100</b> (127.5 days)

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness



**Figure III-8 – Total average services cost per person among four age groups in LA County shelter population, as well as proportional representations of each health care and shelter service included in the total**

## IV. MATCHING SHELTERED SUB-POPULATIONS TO DIFFERENT HOUSING INTERVENTIONS AND ESTIMATED SERVICE COSTS BASED UPON CLUSTER ANALYSIS

Even after they are broken down by age group, older adults experiencing homelessness remain a heterogeneous population with respect to their housing, health care, social, and other needs. While there is an elevated level of health care need among older, homeless adults compared with both their younger homeless and their contemporary housed counterparts, there remains substantial variation in their need for and use of health care services within this subpopulation (Flaming, Burns & Matsunaga, 2009). Also, homeless persons in general have different patterns of shelter use, with most people's total homeless experience lasting for one or two short episodes, but with substantial minorities experiencing longer and more frequent periods of homelessness (Kuhn & Culhane, 1998). Given this information, it was hypothesized that similar variation would be seen in this study group in both health care and shelter service utilization. This means that, to address both housing and health care needs, different individuals will require different types of housing interventions in order to obtain housing stability and promote health. This section uses a cluster analysis technique to place a large cohort of elderly adults who were in LA shelters during 2011 into subgroups based upon health and shelter measures. After assessing if these cluster-based subgroups are sufficiently distinct, each group was then matched to a suitable housing model based upon aggregate housing and health needs.

For the 4,495 individuals who had a shelter record in 2011 and who were over age 55, LAHSA shelter data were used to compute the number of days spent in shelter and episodes of shelter stay (delimited by at least a 30-day absence from a shelter). These were calculated over a three-year period starting with the first recorded day of shelter beginning in 2011. Those whose first day was prior to 2009, meaning that they had been in shelter for over three years, were taken out of the study group. This reduced the total to 3,985. The other criterion used to sort the study group was the complexity of treated health conditions. Medical complexity was assessed using a combined comorbidity score from an algorithm developed by Gagne et al. (2011) based on ICD-9 codes to identify 20 different medical conditions; each of these were assigned a weight based on their estimated association with risk of mortality. This medical comorbidity score was developed specifically for an older adult population. In following the approach used by Gagne et al. (2011), the comorbidity score was calculated based on the full year of 2011 claims data.

These criteria—the number of emergency shelter episodes and shelter days and the medical comorbidity score—served as the basis for conducting *k*-means cluster analysis to identify distinct sub-groups based on health conditions and shelter use. Similar methods have been used to designate typologies among homeless populations (e.g., Lee et al., 2016; McAllister, Lennon, & Kuang, 2011; Kuhn & Culhane, 1998). Different cluster solutions were tested, and it was determined that the 3-cluster solution provided the most clearly delineated groups.

Table IV-1 summarizes the results of this cluster analysis. In addition to presenting summary information on the variables used in the cluster analysis (i.e., comorbidity score, days in shelter, and shelter episodes), and also presents average annual health care costs for each cluster and the share of persons

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

in each cluster with a nursing home stay. Clusters #1 and #3 have very similar shelter usage (means of 237 and 250 days; 1.7 and 1.4 episodes, respectively, over three years) but have very different comorbidity scores (7.62 and 0.38, respectively) and health care costs (\$46,317 and \$10,639, respectively). Cluster #1 is the smallest cluster (7% of total), while cluster #3 is by far the largest (82%). Cluster #2, with 11% of the study group, has more extensive shelter stays (means of 392 days and 3.7 episodes) than the other two groups, and a comorbidity score of 1.28 that is higher than cluster #1 but still relatively low and close to the comorbidity score of 1.23 observed in a general population sample of adults age 65 and above (Gagne et al., 2011). In line with their comorbidity scores, persons in cluster #1 had substantially higher levels of nursing home records (55%) than clusters 2 and 3 (20% and 14%, respectively).

**Table IV-1 – Cluster designations for 2011 prevalence cohort of individuals age 55 and older**

Cluster	Cohort Share	Gagne Index Comorbidity Score (mean)	Shelter days	Shelter episodes	Mean 2011 Health Services Cost	Nursing Home Records (2011-15)	Population Summary
1	7%	7.62	237	1.7	\$46,317	55%	Highest comorbidity & lower shelter use
2	11%	1.28	392	3.7	\$14,598	20%	Low/Mid-level comorbidity & highest shelter use
3	82%	0.38	250	1.4	\$10,639	14%	Lowest comorbidity & lower shelter use

The housing and health care use patterns for each of the three cluster groups correspond to three widely used housing assistance approaches. Each of these approaches have been implemented in practice with older adults experiencing homelessness, although the degree of evidence of their impact on housing stability and health care costs varies.

The largest and (comparatively speaking) healthiest group, cluster #3, has modest levels of shelter use and relatively low health care use. This cluster has the highest proportion of individuals with low to moderate health needs who would likely be able to live in independent housing in the community with limited supports. Housing interventions, if any were needed, would be “light touch” approaches that might include rapid rehousing or short-term, shallow rental subsidies plus stabilization services. Medicaid funds might cover certain housing transition and stabilization services. The housing needs of this group would be addressed using a 4-tiered progressive engagement approach as follows:

- **Tier 1:** One third of this cluster would presumably self-resolve their lack of housing. Housing research consistently determines that up to 80% of the homeless population are “transitionally homeless” and stay homeless for relatively short periods of time (Kuhn & Culhane, 1998). Therefore, in any homeless population, a substantial proportion will exit homelessness with minimal to no assistance. People who self-resolve would most likely be from this cluster, and the

estimated size of this cluster subgroup is conservative. There would be no added cost associated with this tier.

- **Tier 2:** 22% of the cluster would benefit from rapid re-housing (RRH). The goal of RRH is to provide supports necessary to help individuals quickly exit homelessness and move back into stable community housing. This entails case management and a variety of services such as move-in and other initial rent and moving costs; linking clients with community services; and ongoing, short or medium-term rental and housing subsidies to facilitate stabilization. This study assumes that, on average, it will cost \$3,872 per person to provide RRH to persons in this tier, which is the average cost per household served by the VA's Supportive Services for Veterans and Families (SSVF) program, the nation's largest RRH provider (U.S. Department of Veterans Affairs, 2017).
- **Tier 3:** Another 22% of the cluster would benefit from shallow rent subsidies accompanied by moderate case management supports. These subsidies are time-limited rental assistance that help stabilize households and gives them time and support to develop the means for maintaining housing self-sufficiency. The level and duration of this shallow subsidy varies; here a \$500 monthly subsidy (approximately half of fair market rent in LA County for an efficiency apartment) is assumed for twelve months. Case management services would cost an additional \$125 per month. The annual cost per person for this tier of assistance would be \$7,500.
- **Tier 4:** The final 22% of this cluster would fare best under an ongoing, more traditional housing voucher structure such as what is provided through HUD's Housing Choice vouchers. The cost for such vouchers is estimated by subtracting the tenant contribution from the cost of rent. Based on this formula, the rent for an efficiency apartment (\$1,067 is fair market rent in 2018 in LA County) minus the tenant rent contribution (benchmarked at one-third of the maximum monthly individual SSI amount of \$911, or \$304) leads to an estimated monthly cost of \$764, or \$9,168 annually (HUD Economic and Market Analysis Division, 2018).

The weighted average of the costs for these four tiers is \$4,580, which represents the average cost of housing people in this cluster under one of the housing models described here.

Cluster group #2 (11% of the total) was also relatively healthy but had high levels of shelter use. Based primarily on the latter, persons in this group could benefit from permanent supportive housing (PSH). PSH provides ongoing subsidized housing with flexible health, behavioral health, social, and other supportive services. PSH, as a flexible means to provide housing while accommodating a range of disability and health needs, is well-suited for elderly homeless adults (Corporation for Supportive Housing, 2011). There is strong evidence demonstrating its effectiveness at improving housing stability and reducing shelter, health care, and other public service costs. Furthermore, PSH provides housing in the community and can function as an alternative to more costly and unnecessary institutional options such as nursing homes and assisted living (Goldberg, Lang, & Barrington, 2016). Nonetheless, PSH is a relatively high cost intervention, though the cost can vary depending on the intensity of supportive services needed. Medicaid funds can be used to pay for the supportive services component of the intervention. The PSH cost estimate is based on prior research in LA County. Adjusted to 2017 dollars,

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

the annual housing, operating, and service costs after tenant contribution would be \$15,800 per person (Hunter et al., 2017; Flaming et al., 2013; Flaming, Burns, & Matsunaga, 2009).

Finally, those in the smallest group (cluster #1 at 7%) had the most extensive medical needs. The literature on PSH shows that this housing intervention has the capacity to provide a “high-quality and cost-effective option” for older homeless adults in place of assisted living arrangements (Bamberger & Dobbins, 2015) and as an alternative to skilled nursing facilities for elderly homeless persons who have significant health issues. Details on PSH were described for the previous cluster and estimated to cost \$15,800 per person annually—\$10,400 for the housing component and \$5,400 for operating and service costs. Here, in recognition of the increased service needs that this population is likely to incur in conjunction with their increased level of comorbidity, the estimated operating and services costs<sup>6</sup> were doubled for those in this cohort, thereby increasing the total annual cost per year of housing for people in this cluster from \$15,400 to \$21,200.

These interventions do not represent an exhaustive list of suitable and available housing models for older persons experiencing homelessness. Rather, they were selected as exemplars likely to correspond with the general level and intensity of housing and other needs of different segments of the older homeless adult population.

**Table IV-2 – Cluster groups, corresponding housing models, and related costs**

Cluster	Intervention	Overall need	Overall average housing and service cost
1 - Highest comorbidity & lower shelter use	Nursing home and assisted living (tier 1) and PSH (tier 2)	7%	\$21,200
2- Low/Mid-level comorbidity & highest shelter use	Permanent Supportive Housing (PSH)	11%	\$15,800
3 - Lowest comorbidity & lower shelter use	Self-resolve (tier 1); rapid rehousing (tier 2); shallow rent subsidy (tier 3); subsidized housing (tier 4)	82%	\$4,580
Total		100%	\$6,978

To recapitulate, based on the relative size of each cluster group and the housing intervention assumed to be most appropriate for each, overall, a total of 7% of older homeless adults are estimated to require medical respite/hospice/palliative care or PSH; 11% are estimated to require PSH; and 82% are estimated to need short term/shallow subsidies plus stabilization services. Table IV-2 summarizes this, and presents a total estimated weighted average housing cost, per person in 2017 dollars of \$6,978. These clusters and housing designations, along with the estimated health care costs related to homelessness as well as housing costs related to ending homelessness, will be addressed in the next

<sup>6</sup> Operating and services costs are taken from Flaming et al. (2013) and adjusted to 2017 dollars for a cost of \$5,400, and are doubled for this high medical needs cluster.

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

section as the bases for projecting how much health care and shelter services costs could be offset by these housing placements.

## V. POTENTIAL COST OFFSETS ASSOCIATED WITH HOUSING MODELS, BASED ON PRIOR RESEARCH

This section focuses on estimating the likely impact on the projected future health care and emergency shelter costs of providing these housing interventions at scale to all older homeless adults in LA County. In doing so, we sought to mirror the conceptual approach of a meta-analysis, which is a statistical procedure for combining data from multiple studies that have examined the impact of the same intervention to arrive at an overall estimate of the effect of that intervention. In the present context, information was aggregated from 15 previously published studies that have examined the impact of permanent supportive housing interventions for persons experiencing homelessness on healthcare and emergency shelter utilization and costs. This analysis is based solely on studies that have examined permanent supportive housing, as there is a fairly robust body of literature in this area, whereas the number of studies examining the impact of other housing interventions for persons experiencing homelessness on health services use and costs remains highly limited.

The studies that were included in constructing these scenarios varied in terms of their methodological rigor, the locations in which they were conducted, the populations and specific interventions that they considered, and the type of health care costs that they considered. They also varied in terms of whether, and, if so, by how much they were able to reduce health care costs for participants. As such, the cost reduction scenarios used in this study, as well as the resulting estimates of future reductions in costs, should be interpreted somewhat cautiously and be considered rough estimates of what might be expected.

The cost reductions scenarios were constructed based on studies that were included in a systematic review of studies examining the relationship between permanent supportive housing and public service costs (Ly & Latimer, 2015) as well as those summarized in another recent study (Richter & Hoffman, 2017). Additional, relevant studies that were not included in either of the two previously mentioned sources were also identified by the study team for consideration. In constructing the cost reduction scenarios presented in this paper, only studies that conducted tests of statistical significance when examining the relationship between placement in permanent supportive housing and healthcare costs/services utilization were included. Additionally, studies were excluded that did not disaggregate healthcare cost by treatment modality. For example, if a study reported the impact of permanent supportive housing on mental healthcare costs, but did not distinguish between inpatient and outpatient mental health service use or costs, it was not included in our analysis. As a result, a total of 15 studies were used to construct the cost reduction scenarios described in this paper. Additional information on these studies is listed in Appendix B.

After identifying these 15 studies, the percent change in healthcare and shelter utilization and costs associated with PSH were extracted from each study. In some cases, this information was reported directly in the study report. In other cases, changes were calculated based on information reported in the study. Information was extracted separately for each category (e.g., mental health, substance abuse) and/or type (e.g., inpatient, outpatient, emergency department) of cost reported in the study, and only included service categories/types for which the change in cost or service use could be calculated (or

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

approximated) based on information reported in the study. Where possible, information about percent change was extracted based on units of service utilization (e.g., number inpatient hospitalization days, number outpatient visits), rather than cost to account for potential variation in healthcare costs across regions/counties and time. Finally, each study was assigned a weight based on its methodological rigor. Studies using an experimental design were assigned a 3; those involving a quasi-experimental design with a comparison group were assigned a 2; and those involving a quasi-experimental design with a single group pre/post comparison were assigned a 1. These weights were subsequently used in developing pooled estimates of the relationship between housing placement and healthcare costs under the different scenarios.

After extracting the information described above from each of the 15 studies, information from across the studies was combined to develop pooled estimates of potential cost reductions associated with housing placement for two different scenarios:

- **Scenario 1 (More conservative):** Scenario 1 is considered more conservative in terms of its estimates of healthcare cost reductions. It was constructed by calculating a weighted average of the percentage change in healthcare utilization/costs associated with housing placement observed in all prior studies considered for inclusion, which encompasses studies that did not identify a statistically significant change and those that identified statistically significant increases in utilization/costs. In calculating this average, studies that did not identify a significant change were assigned a “0” and studies were weighted based on their methodological rigor score.
- **Scenario 2 (Less conservative):** Scenario 2 is considered less conservative in terms of its estimates of healthcare cost reductions. It was constructed by calculating a weighted average of the percentage change in healthcare utilization/costs associated with housing placement that were observed in all studies that identified a significant reduction in healthcare costs. In other words, this scenario represents cost reductions that might be expected should the implementation of the housing interventions described above have an effect more in line with what studies identifying relatively larger impacts have found. Once again, in calculating this average, studies were weighted such that those with stronger methodological rigor were assigned a larger weight.

Separate pooled estimates were then developed under each of these scenarios for the cost categories and types (e.g. inpatient medical, inpatient behavioral health, nursing home) considered in this study. Because the cost categories and types used in the previous research differed from the cost categories in the present study, the cost categories had to be aligned. Table A4 summarizes how the cost categories included in Table A3 were matched with the cost categories considered in the present study.

Given that prior studies have consistently identified a large effect of housing interventions for persons experiencing homelessness on emergency shelter utilization and costs, it was assumed that reductions in emergency shelter costs would be consistent across both cost reduction scenarios. To determine the estimated reduction in shelter costs, the pooled average was calculated across all studies that reported information on shelter costs. Table V-1 shows the resulting estimates for cost offsets that, taken

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

together, provide a range between the more and less conservative assessments of the results provided by the research literature.

**Table V-1 - Summary of health care and shelter cost reduction scenarios**

<b>Cost Category</b>	<b>Scenario 1 (more conservative)</b>	<b>Scenario 2 (less conservative)</b>
Inpatient medical	-18%	-33%
Emergency Department	-6%	-45%
Outpatient medical	-6%	-45%
Outpatient behavioral health	+48%	-29%
Inpatient behavioral health	-35%	-56%
Nursing home	-42%	-90%
Shelter	-71%	-71%

These estimates of cost offset proportions will be used as a basis for the offsets incurred with the provision of housing services to homeless individuals that are estimated in the following section. Estimates are now complete for four factors: population change, costs of services use, mix of housing types (and associated costs) needed for the age 55+ homeless population, and (now) offsets to health and shelter services costs associated with housing. Combining these will allow an assessment of the potential impacts that the provision of different configurations of housing and services could have on the costs of providing selected health care and shelter services to this population.

## VI. COMPARING COST OFFSETS TO COST OF HOUSING INTERVENTIONS, RESULTS AND DISCUSSION

This section builds upon the previously described analyses for a comparison of the costs and cost-offsets related to providing various housing and service configurations to homeless adults aged 55 and over. These findings contribute to a discussion on the possible economic feasibility of making housing and related support services a more available resource to address the homelessness of elderly adults. As such, the implications of these findings will follow the presentation of the offset results.

### Individual Cost Offsets



**Figure VI-1 – Estimated average individual cost offsets associated with permanent housing placement for use of health and shelter services, for four age groups**

Individual cost offsets for services used by an average shelter-using person over one year in each of the four age groups examined are provided in Figure VI-1. These offsets are based on the estimated individual costs presented in Table III-9 and the estimated cost reduction scenarios presented in Table V-1. The estimated offsets are compared to the weighted average cost of \$6,978 for providing the three

types of housing discussed in Section IV (weights and costs are shown in Table IV-2). Figure VI-1 shows how the estimated housing and services cost is just above the estimated cost offsets using the more conservative estimates, and substantially below the estimated cost offsets using the less conservative estimates. This means that the cost of the housing and services falls within the range of potential cost offsets estimated here and, depending on the estimate used, could either mostly or completely be recouped by corresponding reductions in shelter and healthcare systems included here. Put more simply, the housing costs fall within the range of plausible offset assumptions.

### Discussion

The key finding of this study is that reductions in the use of shelter and healthcare services costs stand to substantially, if not completely, offset the cost of providing housing and related services for shelter-using, elderly homeless adults (i.e., adults age 55 and older). Study results show that the elderly homeless incur greater costs in conjunction with their use of health care services (mostly inpatient services and nursing home use) as they age, and when shelter costs supplement these healthcare costs in the systems available for this study then these combined costs can potentially offset the costs related to providing housing and related services costs.

This role of shelter cost in estimating the offsets of housing has potential implications for expanding this analysis to an unsheltered elderly homeless population. Roughly 20% of elderly individuals experiencing homelessness access any shelter services at some point over a year. For the remaining—unsheltered homeless persons—living homeless outside of a shelter would obviate shelter costs. For the offsets that we use here, this would mean taking out the shelter expenses. Without any shelter costs to discount, the offsets would be lower, and would appear to weaken the economic case for providing housing to this population.

However, there are almost certainly substantial extra costs that go along with being homelessness in unsheltered circumstances that are not captured in this study. This includes a range of public costs including but not limited to law enforcement, emergency services, and social services. Additionally, subsisting in unsheltered circumstances has been associated with excess morbidity, meaning that the health care costs found here would likely be higher for the unsheltered portion of Los Angeles's elderly homeless population (Montgomery et al., 2016; Nyamathi Leake & Gelberg 2000; Gelberg & Siecke 1997). Taken together, the differences in services use costs between the sheltered (examined here) and unsheltered (not examined here) subpopulations is unknown, but we would posit them to be similar, if not higher for the unsheltered portion of this population.

The assessment of healthcare costs measured here are not comprehensive, and the estimated cost offsets would likely have been higher if more systems were involved. A particular example is inpatient behavioral health, which is only partially covered with the DHS and OSHPD records. It is impossible to capture all health services, and this limitation keeps healthcare costs on the conservative side.

Other cost dimensions involved in this study were inexact, though based upon the best data available. Limitations on the MDS (nursing home) data required some estimation of the number of days consumed, and the calculation erred on the side of being conservative when estimating lengths of stay.

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

Per diem and per service estimates were also used to estimate costs, which is less exact than billing data but was all that was available. Some assumptions involving housing costs and extent of offsets were also limited to available data and research, and so were estimated conservatively whenever possible.

While these results are estimates, at least for the unsheltered population, the cost of providing housing and related services for elderly homeless individuals appears to fall roughly into the range of shelter and health care expenditure offsets. Costs and cost offsets should not be the primary justification for providing housing. However, when combined with other arguments for housing people in the study group, effectively reducing the cost of housing is a powerful tool for scaling up the availability of this housing, especially when the alternative is high health and nursing home costs and continued homelessness.

Examining healthcare costs in conjunction with providing housing also has implications for financing services in both these domains. Various states have services related to housing as potentially reimbursable under Medicaid, as well as options for using Medicaid for nursing home avoidance, and reduced acute care. Managed care providers may also consider investing in housing as a means to realize savings in healthcare costs while also facilitating improved quality of life.

## REFERENCES

- Bamberger, J. (2016). Reducing homelessness by embracing housing as a Medicaid benefit. *JAMA Intern Med.*, 384(9953), 1529-1540. doi:10.1001/jamainternmed.2016.2615.
- Bamberger, J.D., & Dobbins, S.K. (2015). A research note: Long-term cost effectiveness of placing homeless seniors in permanent supportive housing. *Cityscape*, 17(2), 269-277. <https://www.huduser.gov/portal/periodicals/cityscpe/vol17num2/article11.html>
- Brown, R.T., Hemati, K., Riley, E.D., et al. Geriatric conditions in a population-based sample of older homeless adults. (2017). *Gerontologist*, 57(4), 757-766. doi:10.1093/geront/gnw011. (n/u)
- Brown, R.T., Kiely, D.K., Bharel, M., & Mitchell, S.L. (2012). Geriatric syndromes in older homeless adults. *J Gen Intern Med.*, 27(1), 16-22. doi:10.1007/s11606-011-1848-9.
- Burt, M.R., Wilkins, C., & Locke, G. (2014). *Medicaid and permanent supportive housing for chronically homeless individuals: Emerging practices from the field*. Washington, DC: U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy.
- Byrne, T., & Smart, G. (2017). *Estimating cost reductions associated with the Community Support Program for people experiencing chronic homelessness*. Boston, MA.
- California Association of Health Facilities. (n.d.). *Guide to long-term care*. Sacramento, CA.
- Corporation for Supportive Housing. (2011). *Ending Homelessness among older adults and elders through permanent supportive housing*. New York, NY. [https://www.csh.org/wp-content/uploads/2012/01/Report\\_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing\\_112.pdf](https://www.csh.org/wp-content/uploads/2012/01/Report_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing_112.pdf)
- Culhane, D. (2008). The costs of homelessness: A perspective from the United States. *Eur J Homelessness*, 2(1), 97-114.
- Culhane, D.P., Metraux, S., Byrne, T., Stino, M., & Bainbridge, J. (2013). The age structure of contemporary homelessness: Evidence and implications for public policy. *Anal Soc Issues Public Policy*, 13(1), 228-244. doi:10.1111/asap.12004.
- Doran, K.M., Ragins, K.T., Iacomacci, A.L., Cunningham, A., Jubanyik, K.J., & Jenq, G.Y. (2013). The revolving hospital door: Hospital readmissions among patients who are homeless. *Med Care*. 51(9):767-773. doi:10.1097/MLR.0b013e31829fafbb.
- Duncan, P. (2017). Strategy 6E: Homeless navigation centers. [Unpublished memo]. Los Angeles, CA: Los Angeles Homeless Services Authority. <http://cao.lacity.org/Homeless/hsc20171026c.pdf>
- Flaming, D., Burns, P., & Matsunaga, M. (2009). *Where we sleep: Costs when homeless and housed in Los Angeles*. Los Angeles, CA: Economic Roundtable. [https://economicrt.org/wp-content/uploads/2009/11/Where\\_We\\_Sleep\\_2009.pdf](https://economicrt.org/wp-content/uploads/2009/11/Where_We_Sleep_2009.pdf)

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

- Flaming, D., Burns, P., Sumner, G., & Lee, S. (2013). *Getting home: Outcomes from housing high cost homeless hospital patients*. Los Angeles, CA: Economic Roundtable.  
<https://economicrt.org/publication/getting-home/>
- Gagne, J.J., Glynn, R.J., Avorn, J., Levin, R., & Schneeweiss, S. (2011). A combined comorbidity score predicted mortality in elderly patients better than existing scores. *J Clin Epidemiol*, *64*(7), 749–759. doi:10.1016/j.jclinepi.2010.10.004.
- Garg, A., Toy, S., Tripodis, Y., Silverstein, M., & Freeman, E. (2015). Addressing social determinants of health at well child care visits: A cluster RCT. *Pediatrics*, *135*(2), e296-304.  
doi:10.1542/peds.2014-2888.
- Gelberg L., & Siecke N. (1997). Accuracy of homeless adults' self-reports. *Med Care*, *35*(3), 287–290. doi: 10.1186/s12888-016-0758-0
- Goering, P., Veldhuizen, S., Watson, A., et al. (2014). *National at home/chez soi final report*. Calgary, AB: Mental Health Commission of Canada.
- Goldberg, J., Lang, K., & Barrington, V. (2016). *How to prevent and end homelessness among older adults*. Washington, DC: Justice in Aging. [www.justiceinaging.org/homelessness/](http://www.justiceinaging.org/homelessness/).
- Gottlieb, L., Hessler, D., Long, D., Amaya, A., & Adler, N. (2014). A randomized trial on screening for social determinants of health: The iScreen Study. *Pediatrics*, *134*(6), e1611-e1618.  
doi:10.1542/peds.2014-1439.
- Hunter, S.B., Harvey, M., Briscoe, B., & Cefalu, M. (2017). *Evaluation of housing for health permanent supportive housing program*. Santa Monica, CA: Rand Corporation.  
[https://www.rand.org/pubs/research\\_reports/RR1694.html](https://www.rand.org/pubs/research_reports/RR1694.html).
- Hwang, S. (2001). Homelessness and health. *Can Med Assoc J*, *164*(2), 229-233.
- Hwang, S.W., Weaver, J., Aubry, T., & Hoch, J.S. (2011). Hospital costs and length of stay among homeless patients admitted to medical, surgical, and psychiatric services. *Med Care*. *49*(4), 350-354. doi:10.1097/MLR.0b013e318206c50d.
- Kuhn, R., & Culhane, D.P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. *Am J Community Psychol*, *26*(2), 207-232. doi:10.1023/A:1022176402357.
- Kushel, M.B., Gupta, R., Gee, L., & Haas, J.S. (2006). Housing instability and food insecurity as barriers to healthcare among low-income americans. *J Gen Intern Med.*, *21*(1), 71-77. doi:10.1111/j.1525-1497.2005.00278.x.
- Kushel, M.B., Perry, S., Bangsberg, D., Clark, R., & Moss, A.R. (2002). Emergency department use among the homeless and marginally housed: Results from a community-based study. *Am J Public Health*, *92*(5), 778-784. doi:10.2105/AJPH.92.5.778.

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

- Larimer, M.E., Malone, D.K., Garner, M.D., et al. (2009). Healthcare and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA*, *301*(13), 1349-1357. doi:10.1001/jama.2009.414.
- Latimer, E.A., Rabouin, D., Cao, Z., et al. (2017). Costs of services for homeless people with mental illness in 5 Canadian cities: A large prospective follow-up study. *C Open*, *5*(3), E576-E585. doi:10.9778/cmajo.20170018.
- Lee, C.T., Guzman, D., Tieu, L., & Kushel, M. (2016). Residential patterns in older homeless adults: Results of a cluster analysis. *Social Science & Med*, *153*, 131-140. doi:10.1016/j.socscimed.2016.02.004.
- Lim, Y.W., Andersen, R., Leake, B., Cunningham, W., & Gelberg, L. (2002). How accessible is medical care for homeless women? *Med Care*, *40*(6), 510-520.
- Ly, A., & Latimer, E. (2015). Housing first impact on costs and associated cost offsets : A review of the literature. *Can J Psychiatry*, *60*(11), 475-487.
- Mahadevan, R., & Houston, R. (2015). *Supporting social service delivery through Medicaid accountable care organizations: Early state efforts*. [https://www.chcs.org/media/Supporting-Social-Service-Delivery-Final\\_0212151.pdf](https://www.chcs.org/media/Supporting-Social-Service-Delivery-Final_0212151.pdf). Accessed September 20, 2017.
- McAllister, W., Lennon, M.C., & Kuang, L. (2011). Rethinking research on forming typologies of homelessness. *Am J Public Health*, *101*(4), 596-601. doi: 10.2105/AJPH.2010.300074.
- Metraux, S., Eng, N., Bainbridge, J., & Culhane, D.P. (2011). The impact of shelter use and housing placement on mortality hazard for unaccompanied adults and adults in family households entering New York City shelters: 1990–2002. *J Urban Heal*, *88*(6), 1091-1104. doi:10.1007/s11524-011-9602-5.
- Montgomery, A.E., Szymkowiak, D. Marcus, J, Howard, P, & Culhane, D.P. (2016). Homelessness, unsheltered Status, and risk factors for mortality; Findings from the 100,000 Homes Campaign. *Public Health Rep*, *131*(6), 765–772. doi: 10.1177/0033354916667501
- Nyamathi AM, Leake B, Gelberg L. (2000). Sheltered versus nonsheltered homeless women: differences in health, behavior, victimization, and utilization of care. *J Gen Intern Med*, *15*(8), 565–572. doi: 10.1046/j.1525-1497.2000.07007.x
- Poulin, S.R., Maguire, M., Metraux, S., & Culhane, D.P. (2010). Service use and costs for persons experiencing chronic homelessness in Philadelphia: A population-based study. *Psychiatr Serv*, *61*(11), 1093-1098. doi:10.1176/appi.ps.61.11.1093.
- Reid, K.W., Vittinghoff, E., & Kushel, M.B. (2008). Association between the level of housing instability, economic standing and healthcare access: a meta-regression. *J Healthcare Poor Underserved*, *19*(4), 1212-1228. doi:10.1353/hpu.0.0068.

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

- Richter, D., & Hoffman, H. (2017). Independent housing and support for people with severe mental illness: systematic review. *Acta Scandinavica*, 136(3), 269-279. doi: 10.1111/acps.12765
- Salit, S., Kuhn, E., & Hartz, A. (1998). Hospitalization costs associated with homelessness in New York City. *N Engl J Med.*, 338(24), 1734-1740.
- Tsemberis, S., & Eisenberg, R. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatr Serv.*, 51(4), 487-493. doi:10.1176/appi.ps.51.4.487.
- U.S. Department of Commerce Bureau of Economic Analysis. (2016). *Consumer spending*. [http://www.bea.gov/national/consumer\\_spending.htm](http://www.bea.gov/national/consumer_spending.htm). Accessed June 29, 2016.
- U.S. Department of Housing and Urban Development. (2016). *The 2015 annual homeless assesment report to Congress: Part 2-Estimates of homelessness in the U.S.* Washington, D.C.
- U.S. Department of Housing and Urban Development, Economic and Market Analysis Division. (2018). *FY 2018 fair market rent documentation*. Washington, D.C. [https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2019\\_code/2019summary.odn](https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2019_code/2019summary.odn)
- U.S. Department of Veterans Affairs. (2017). *Supportive services for veteran families, FY 2016 Annual Report*. Washington, D.C. [https://www.va.gov/HOMELESS/ssvf/docs/SSVF\\_FY2016\\_Annual\\_Report\\_508c.pdf](https://www.va.gov/HOMELESS/ssvf/docs/SSVF_FY2016_Annual_Report_508c.pdf)
- United Way of Greater Los Angeles. (2009). *Homeless cost study*. Los Angeles, CA. [homeforgoodla.org/wp-content/uploads/2015/01/Homeless-Cost-Study.pdf](http://homeforgoodla.org/wp-content/uploads/2015/01/Homeless-Cost-Study.pdf)
- Wodchis, W.P., Austin, P.C., & Henry, D.A. (2016). A 3-year study of high-cost users of healthcare. *CMAJ*, 188(3), 182-188. doi:10.1503/cmaj.150064.
- Wu, F., & Stevens, M. (2016) *The services homeless single adults use and their associated costs an examination of utilization patterns and expenditures in Los Angeles County over one fiscal year*. Los Angeles CA: County of Los Angeles Chief Executive's Office. <http://www.aisp.upenn.edu/wp-content/uploads/2015/03/LACountyHomelessness2016.pdf>

**APPENDIX A: Forecast of total (sheltered and unsheltered) homeless population by five-year age group, Los Angeles 2008-2015 (actual) and 2016-2030 (forecast)**

<b>Year</b>	<b>50-55</b>	<b>55-59</b>	<b>60-64</b>	<b>65-69</b>	<b>70-74</b>	<b>75+</b>	<b>Total</b>
<b>2008</b>	17559	9991	3444	1632	505	222	33353
<b>2009</b>	17822	10467	4206	1682	569	313	35058
<b>2010</b>	18171	11512	4713	1750	615	330	37092
<b>2011</b>	18729	12332	5305	1880	707	326	39277
<b>2012</b>	18793	13018	5934	2185	666	358	40956
<b>2013</b>	18817	13621	6412	2347	868	390	42455
<b>2014</b>	18163	14755	6804	2702	1043	442	43909
<b>2015</b>	17211	14527	7130	2990	1153	534	43546
<b>2016</b>	17402	14750	8108	3300	1194	622	45377
<b>2017</b>	17364	14776	9015	3493	1423	667	46738
<b>2018</b>	16805	14949	9582	3879	1544	768	47527
<b>2019</b>	16477	14750	10305	4332	1620	878	48362
<b>2020</b>	16153	14590	10829	4703	1809	952	49035
<b>2021</b>	15191	14769	10992	5353	1995	1023	49324
<b>2022</b>	14008	14730	11003	5948	2113	1178	48982
<b>2023</b>	13118	14237	11122	6314	2349	1303	48442
<b>2024</b>	12118	13951	10976	6787	2622	1408	47860
<b>2025</b>	11071	13668	10855	7121	2846	1555	47115
<b>2026</b>	10522	12861	11004	7226	3242	1699	46553
<b>2027</b>	10361	11847	10968	7229	3600	1852	45857
<b>2028</b>	10592	11071	10582	7303	3818	2054	45421
<b>2029</b>	10716	10228	10363	7208	4103	2267	44885
<b>2030</b>	11005	9357	10147	7127	4301	2475	44413

## APPENDIX B: COST OFFSET STUDIES

INPATIENT SERVICE USE								
Study	Population	Design	Weight	Substance use	Mental health/ Psychiatric	Physical / Medical	Behavioral health	Total
Aubry et al. (2015) <sup>1</sup>	Homeless individuals with mental illness and high needs	Experimental	3		-	-		
Basu et al. (2012)	Homeless individuals with chronic medical conditions	Experimental	3	-68%				-23%
Rosenheck et al. (2003) <sup>3</sup>	Homeless Veterans with mental illness	Experimental	3		NS	NS		NS
Stergiopoulos et al. (2015) <sup>1</sup>	Homeless individuals with mental illness and moderate needs	Experimental	3					NS
Byrne et al. (2017) <sup>a,2</sup>	Chronically homeless individuals	Quasi-experimental (w/comparison group)	2			-22%	-56%	
Culhane et al. (2002)	Homeless individuals with severe mental illness	Quasi-experimental (w/comparison group)	2		-49.2%			-24% <sup>5</sup>
Gilmer et al. (2009) <sup>a,2</sup>	Homeless individuals with serious mental illness	Quasi-experimental (w/comparison group)	2					-46% <sup>6</sup>
Larimer et al. (2009) <sup>a,3</sup>	Chronically homeless individuals with serious alcohol disorders	Quasi-experimental (w/comparison group)	2	~90%				
Martinez & Burt (2006)	Homeless individuals with two of following: serious mental illness, substance abuse disorder or HIV/AIDS	Quasi-experimental (w/comparison group)	2		NS	NS		-44%
Seligson et al. (2013)	Various populations	Quasi-experimental (w/comparison group)	2		-94%			
Srebnik et al. (2013)	Chronically homeless adults with medical illness and high prior acute service use	Quasi-experimental (w/comparison group)	2	-86%				NS
Byrne et al. (2017) <sup>a,4</sup>	Chronically homeless individuals	Quasi-experimental (pre/post no comparison group)	1			-12%	-13%	
Hunter et al. (2017)	Homeless individuals with complex medical and behavioral health issues	Quasi-experimental (pre/post no comparison group)	1	NS	NS	-61%		
Mares & Rosenheck (2009)	Chronically homeless individuals	Quasi-experimental (pre/post no comparison group)	1					-53%
Thomas et al. (2015)	Chronically homeless adults with behavioral or health issues	Quasi-experimental (pre/post no comparison group)	1					-62%

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

Wright et al. (2016) <sup>a</sup>	Homeless individuals with complex medical and mental health issues	Quasi-experimental (pre/post no comparison group)	1			NS		-84%		
OUTPATIENT SERVICE USE										
Study	Population	Design	Weight	Substance use	Mental health/ Psychiatric	Physical/ Medical	Behavioral health	Primary Care	Other	Total
Aubry et al. (2015) <sup>1</sup>	Homeless individuals with mental illness and high needs	Experimental	3	+155%	+59%					+76%
Basu et al. (2012)	Homeless individuals with chronic medical conditions	Experimental	3		+32%	NS				
Rosenheck et al. (2003) <sup>a</sup>	Homeless Veterans with mental illness	Experimental	3							+
Stergiopoulous et al. (2015) <sup>1</sup>	Homeless individuals with mental illness and moderate needs	Experimental	3			-19%	-29%			
Byrne et al. (2017) <sup>a,2</sup>	Chronically homeless individuals	Quasi-experimental (w/comparison group)	2							+76%
Culhane et al. (2002)	Homeless individuals with severe mental illness	Quasi-experimental (w/comparison group)	2							+14%
Gilmer et al. (2009) <sup>a,2</sup>	Homeless individuals with serious mental illness	Quasi-experimental (w/comparison group)	2							
Larimer et al. (2009) <sup>a,3</sup>	Chronically homeless individuals with serious alcohol disorders	Quasi-experimental (w/comparison group)	2							
Martinez & Burt (2006)	Homeless individuals with two of following: serious mental illness, substance abuse disorder or HIV/AIDS	Quasi-experimental (w/comparison group)	2							
Seligson et al. (2013)	Various populations	Quasi-experimental (w/comparison group)	2							
Srebnik et al. (2013)	Chronically homeless adults with medical illness and high prior acute service use	Quasi-experimental (w/comparison group)	2			-36%	-7%			
Byrne et al. (2017) <sup>a,4</sup>	Chronically homeless individuals	Quasi-experimental (pre/post no comparison group)	1	NS	-44%	47%				
Hunter et al. (2017)	Homeless individuals with complex medical and behavioral health issues	Quasi-experimental (pre/post no comparison group)	1							-34%
Mares & Rosenheck (2009)	Chronically homeless individuals	Quasi-experimental (pre/post no comparison group)	1							+53%
Thomas et al. (2015)	Chronically homeless adults with behavioral or health issues	Quasi-experimental (pre/post no comparison group)	1				NS	NS	-42% (Outpat. speciality care)/ -53% (outpat.	

A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

									labs & radiolog)	
Wright et al. (2016) <sup>a</sup>	Homeless individuals with complex medical and mental health issues	Quasi-experimental (pre/post no comparison group)	1	+155%	+59%					+76%
OTHER SERVICES										
Study	Population	Design	Weight	Emergency Dept.	Pharmacy	Nursing home	LTSS	Other	Emergency Shelter	
Aubry et al. (2015) <sup>1</sup>	Homeless individuals with mental illness and high needs	Experimental	3							-
Basu et al. (2012)	Homeless individuals with chronic medical conditions	Experimental	3	-33%		-42% <sup>7</sup>				NS
Rosenheck et al. (2003) <sup>a</sup>	Homeless Veterans with mental illness	Experimental	3							-50%
Stergiopoulous et al. (2015) <sup>1</sup>	Homeless individuals with mental illness and moderate needs	Experimental	3	NS						
Byrne et al. (2017) <sup>a,2</sup>	Chronically homeless individuals	Quasi-experimental (w/comparison group)	2		NS		NS	NS		
Culhane et al. (2002)	Homeless individuals with severe mental illness	Quasi-experimental (w/comparison group)	2							-61%
Gilmer et al. (2009) <sup>a,2</sup>	Homeless individuals with serious mental illness	Quasi-experimental (w/comparison group)	2	-46% <sup>6</sup>						
Larimer et al. (2009) <sup>a,3</sup>	Chronically homeless individuals with serious alcohol disorders	Quasi-experimental (w/comparison group)	2							~90%
Martinez & Burt (2006)	Homeless individuals with two of following: serious mental illness, substance abuse disorder or HIV/AIDS	Quasi-experimental (w/comparison group)	2	-56%						
Seligson et al. (2013)	Various populations	Quasi-experimental (w/comparison group)	2							-97%
Srebnik et al. (2013)	Chronically homeless adults with medical illness and high prior acute service use	Quasi-experimental (w/comparison group)	2	-53%						
Byrne et al. (2017) <sup>a,4</sup>	Chronically homeless individuals	Quasi-experimental (pre/post no comparison group)	1		NS		+9%	NS		
Hunter et al. (2017)	Homeless individuals with complex medical and behavioral health issues	Quasi-experimental (pre/post no comparison group)	1	-80%						-59%
Mares & Rosenheck (2009)	Chronically homeless individuals	Quasi-experimental (pre/post no comparison group)	1							
Thomas et al. (2015)	Chronically homeless adults with behavioral or health issues	Quasi-experimental (pre/post no comparison group)	1	-81%						
Wright et al. (2016) <sup>a</sup>	Homeless individuals with complex medical and mental health issues	Quasi-experimental (pre/post no comparison group)	1	-40%	NS				-61%	

## A Data-based Re-design of Housing Supports and Services for Aging Adults who Experience Homelessness

Notes: NS = not statistically significant;

-/+ = study reported significant decrease/increase, but it was not possible to calculate exact magnitude of decrease/increase from available data;

a-Percent reduction based on reported change in costs, not units of service use;

1-Based on cross-site results from At-Home/Chez Soi study;

2-Based on difference-in-difference analysis reported in study. For difference in difference analysis percent change in costs calculated by comparing observed cost in “post” period for intervention group with assumed counterfactual post period cost (i.e. observed post period cost + observed pre/post cost difference for comparison group);

3-Cost reduction estimates are approximate and based on rate ratios displayed in Figure 2 in study, as exact reductions were not reported.

4-Based on fixed effects models using log-transformed cost as dependent variable (reported in study Appendix)

5-Based on Medicaid inpatient days

6-Study groups together inpatient and emergency department costs; same estimate is used for both categories

7-Statistically significant at  $p < .01$  level

Appendix 7, continued

# The Aging Homeless Population in LA County

## Projected Costs, Housing Models and Cost Offsets Results

March 11, 2019

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Randall S. Kuhn, PhD, University of California Los Angeles  
Stephen Metraux, PhD, University of Pennsylvania

*With support from our New York and Boston Collaborators:*

Dan Treglia, PhD, University of Pennsylvania  
Thomas Byrne, PhD, Boston University  
Kelly Doran, PhD, New York University

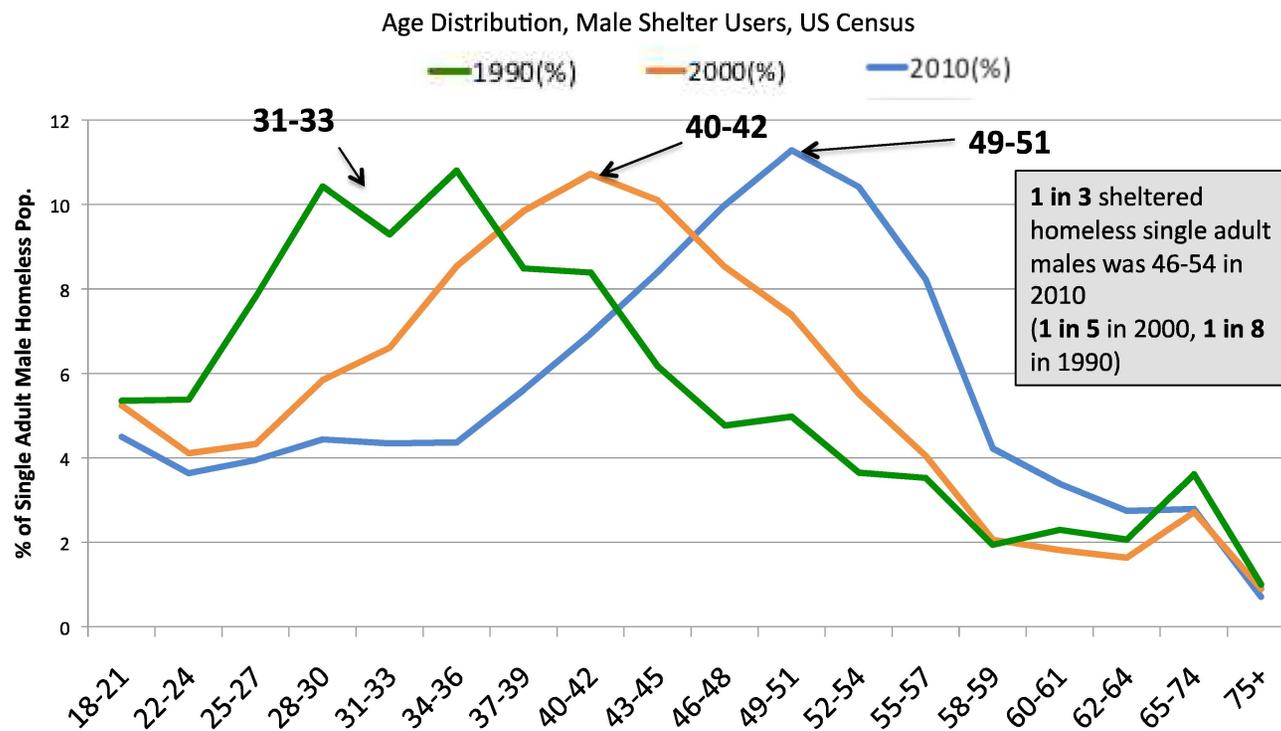
Funding provided by the Conrad N. Hilton Foundation and the Aileen Getty Foundation

## Objectives

1. Project aging dynamics for sheltered homeless population using LAHSA HMIS data (2009-15) and demographic forecasting methods.
2. Apply age-group specific health care and shelter cost estimates to population projections for likely future cost dynamics
3. Use cluster analysis to match sheltered sub-populations to different housing interventions and estimate related service costs
4. Draw upon prior research to estimate potential cost offsets associated with housing under different scenarios
5. Compare costs of housing interventions to cost offsets

# Homelessness, A Birth Cohort Phenomenon

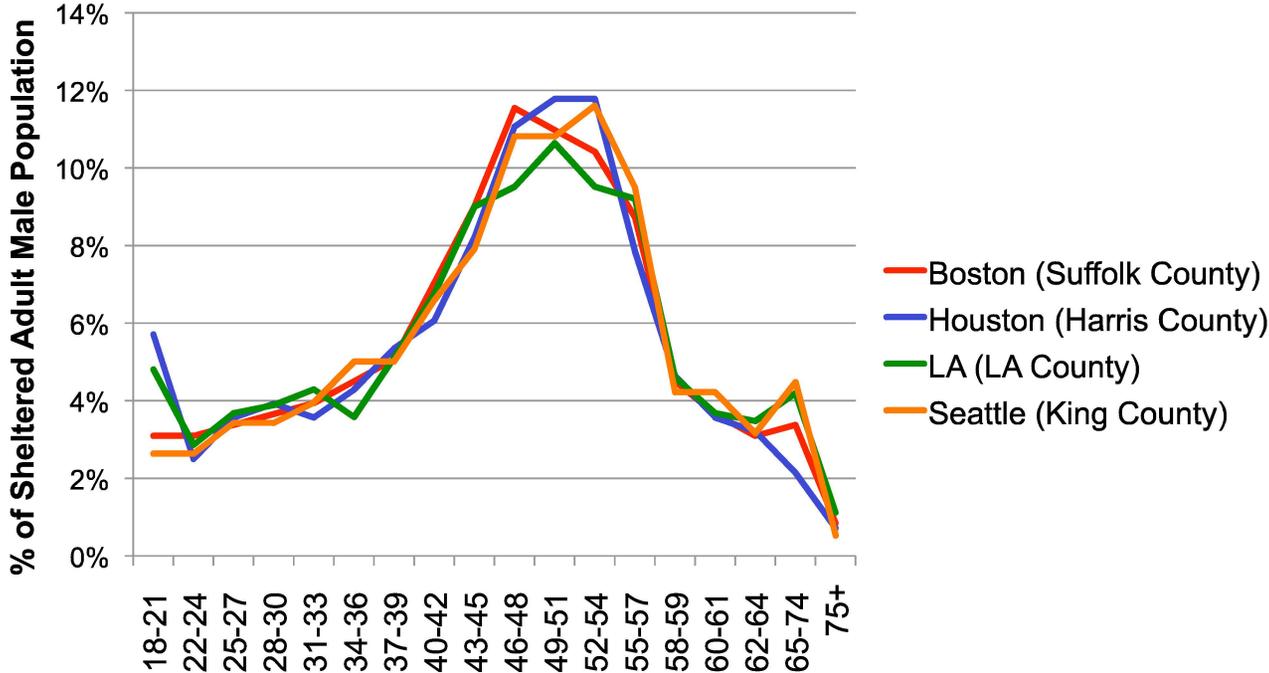
## Mostly Persons Born 1950-1965



Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

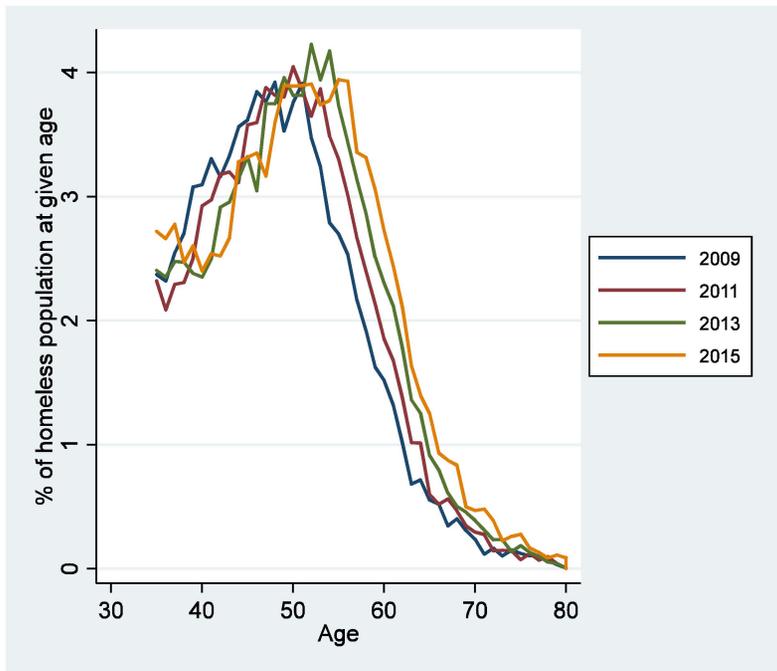
# Aging Trend Consistent Across Cities . . .

### Age Distribution of Sheltered Adult Male Population, 2010

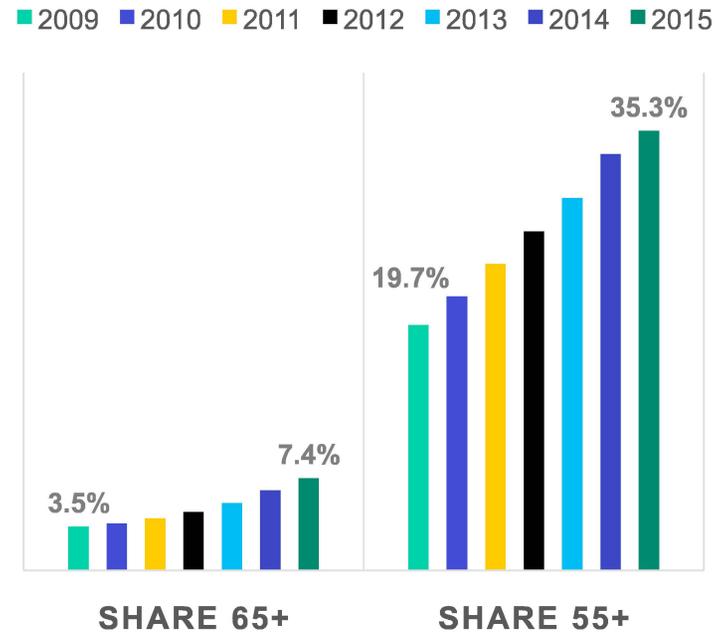


# LA County HMIS Population Is Aging Over Time

## Age distribution of sheltered population, 2009-2015



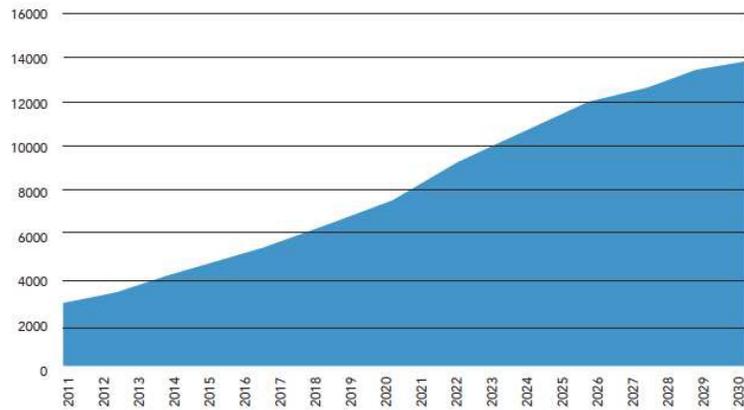
## Share age 55+ and 65+, 2009-2015



# Shelter Population Forecasts Age 55+ and 65+

Actual Counts (2011-2015) and Forecast (2016-2030)

## Age 55+

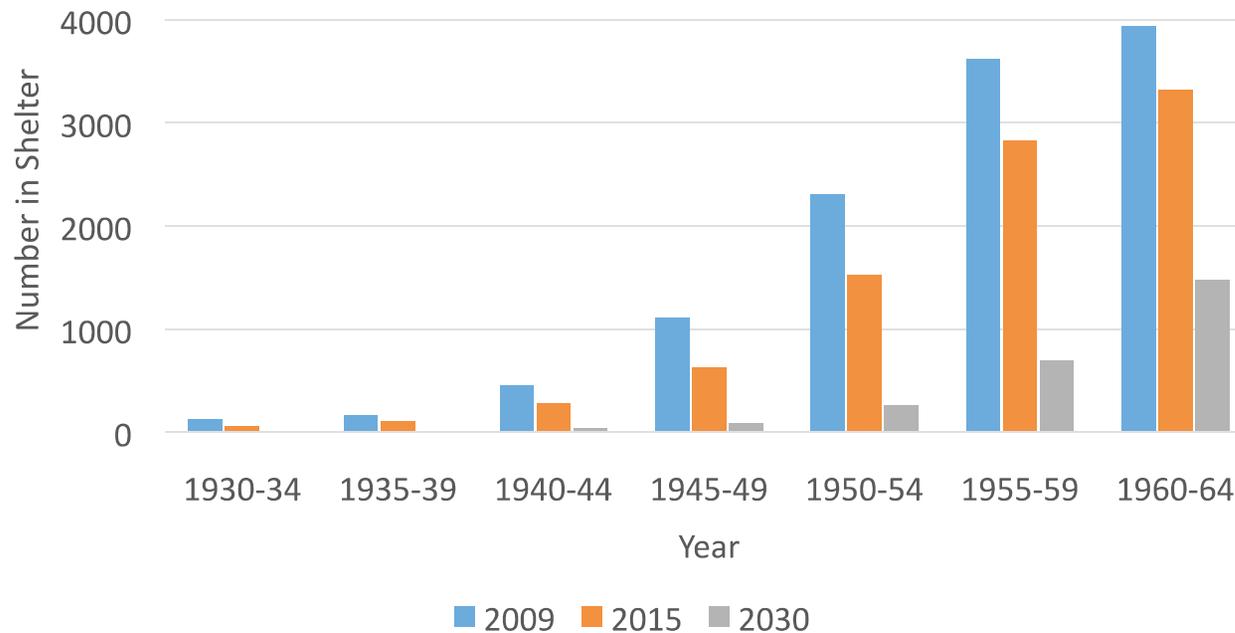


## Age 65+



# Cohort Succession

Small, older cohorts replaced by large 1950-64 cohorts



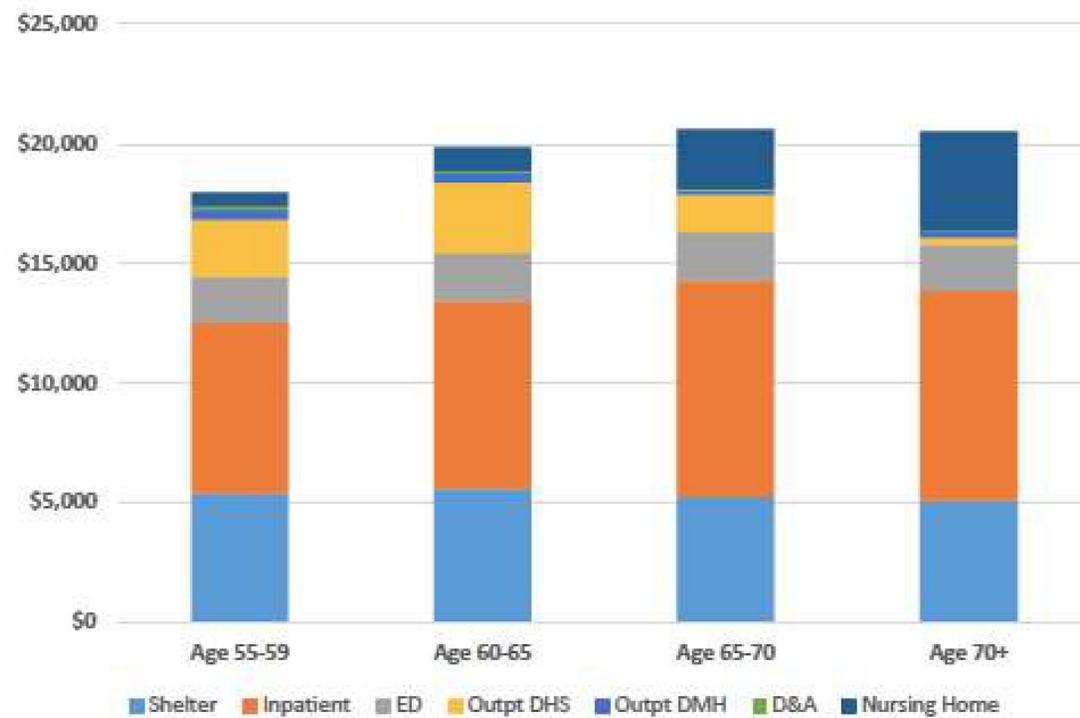
# LA Shelter and Health Care Services Data Sources

- LA Homeless Services Authority (LAHSA)
  - HMIS Shelter Use data: 2009-15
- US Dept of HHS, Centers for Medicare & Medicaid Services (CMS)
  - Minimum Data Set (nursing home patient assessments): 2011-15
- CA Office of Statewide Health Planning & Development (OSHPD)
  - Inpatient & ED Services: 2009-11
- LA County Dept. of Health Service (DHS)
  - Inpatient, ED & Outpatient Services: 2009-14
- LA County Dept. of Public Health (DPH)
  - Residential, Treatment & Detox Services: 2009-14
- LA County Dept. of Health Service (DHS)
  - Outpatient Mental Health Services: 2009-14

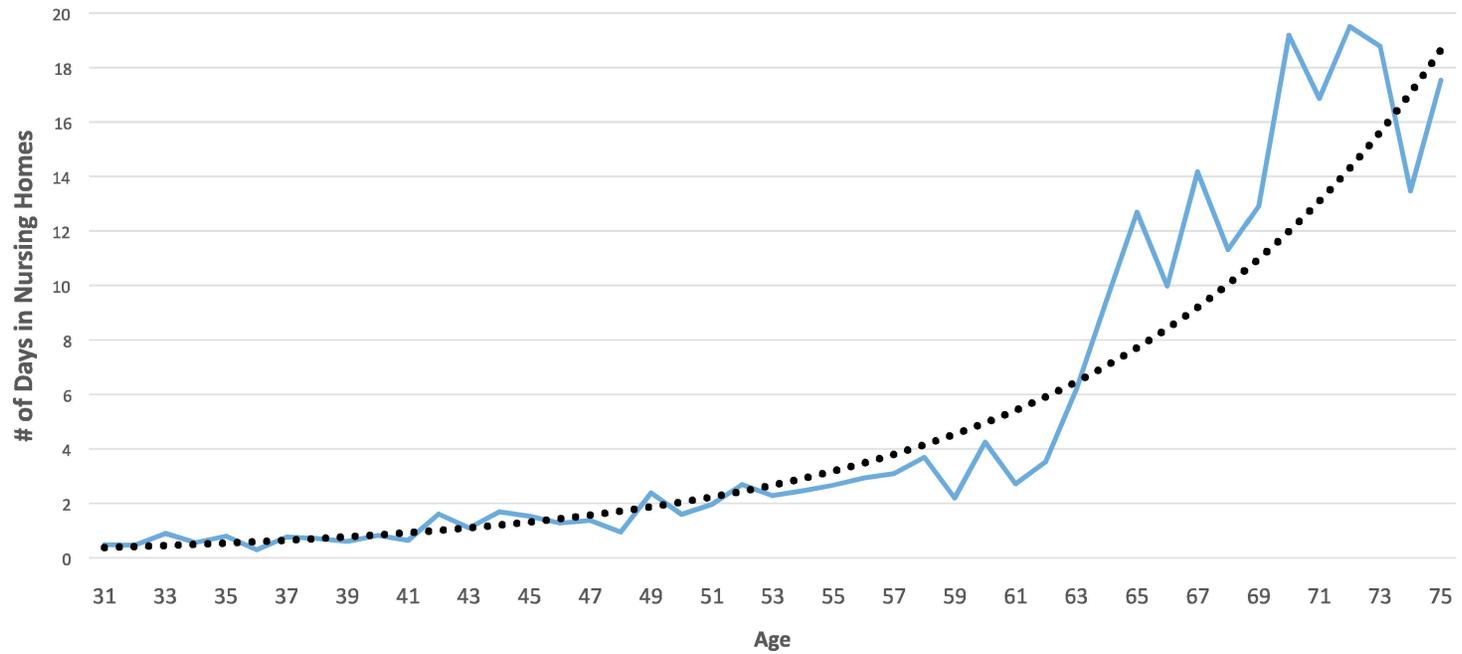
## Characteristics of Age 55+ Shelter Users in 2017

CATEGORY	2017 (n=5,964)
Sex	
Male	<b>76.1%</b>
Race	
Black	<b>50.1%</b>
White	<b>42.0%</b>
Other/Multi/Unknown	<b>7.9%</b>
Ethnicity	
Hispanic	<b>19.2%</b>
Age in 2011	
55-64	<b>79%</b>
65+	<b>21%</b>
Median Age	<b>60 years</b>
Disability Status	
Disability Indication	<b>56.4%</b>

# Age Group Specific Cost Estimates



# Nursing Home Use by Age in LA County



# Cluster Analysis Results

Cluster	Cohort Share	Gagne Index Comorbidity Score (mean)	Shelter days	Shelter episodes	Mean 2011 Health Services Cost	Nursing Home Placement (2011-15)	Population Summary
1	7%	7.62	237	1.7	\$46,317	55%	Highest comorbidity & lower shelter use
2	11%	1.28	392	3.7	\$14,598	20%	Low/Mid-level comorbidity & highest shelter use
3	82%	0.38	250	1.4	\$10,639	14%	Lowest comorbidity & lower shelter use

## Notes:

- Cluster analysis data from LAHSA (2009-13), LA County & OSHPD data (2009-2011); nursing home placement data from CMS MDS (2011-15)
- Mean Gagne Index comorbidity score in general population sample of adults 65+ is 1.23

# Housing Models

Cluster	Intervention	Overall Need	Overall average housing and service cost
1 - Highest comorbidity & lower shelter use	Nursing home and assisted living and PSH	7%	\$21,200
2- Low/Mid-level comorbidity & highest shelter use	Permanent Supportive Housing	11%	\$15,800
3 - Lowest comorbidity & lower shelter use	Self-resolve (33%); rapid rehousing (22%); shallow rent subsidy (22%); subsidized housing (22%)	82%	\$4,580
Total		100%	\$6,978

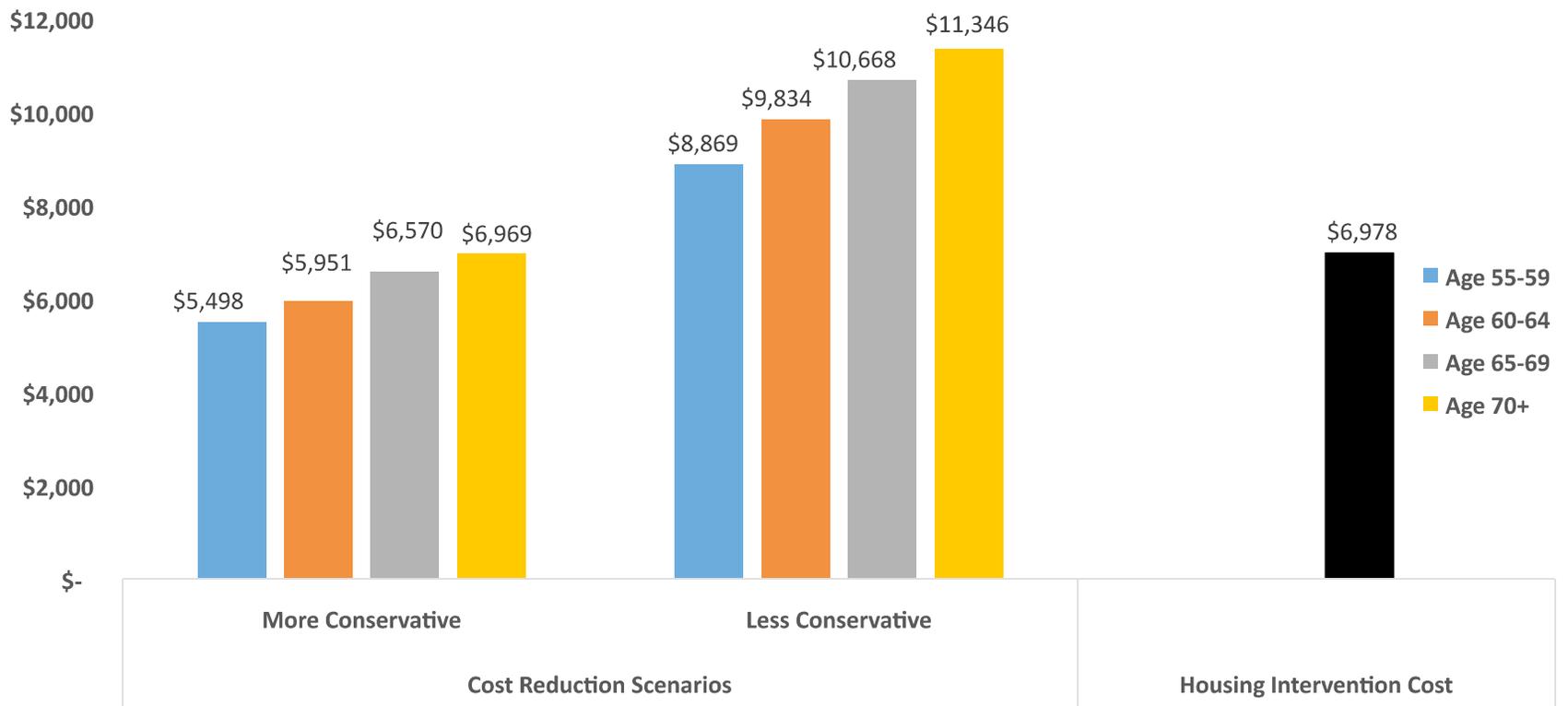
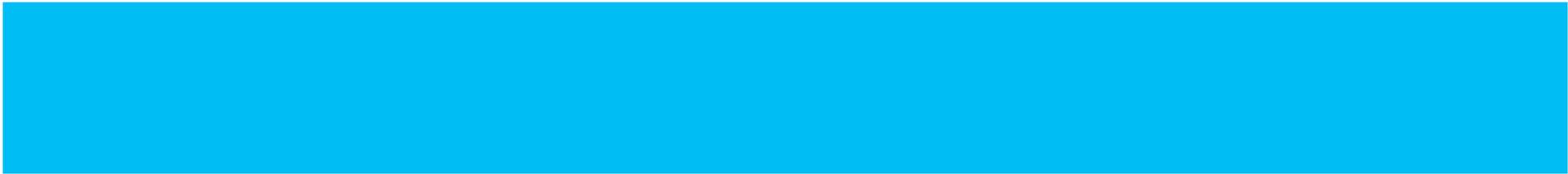
- LA-specific PSH housing and services costs from Hunter, Harvey, Briscoe and Cefalu (RAND, 2017), assuming tenant rent contribution at 30% of SSI.
- Shallow subsidy estimated at \$500 monthly, assuming tenant rent contribution from SSI.

## Cost Offset Scenarios

Developed cost offset scenarios based on 15 prior studies of impact of PSH on costs/services

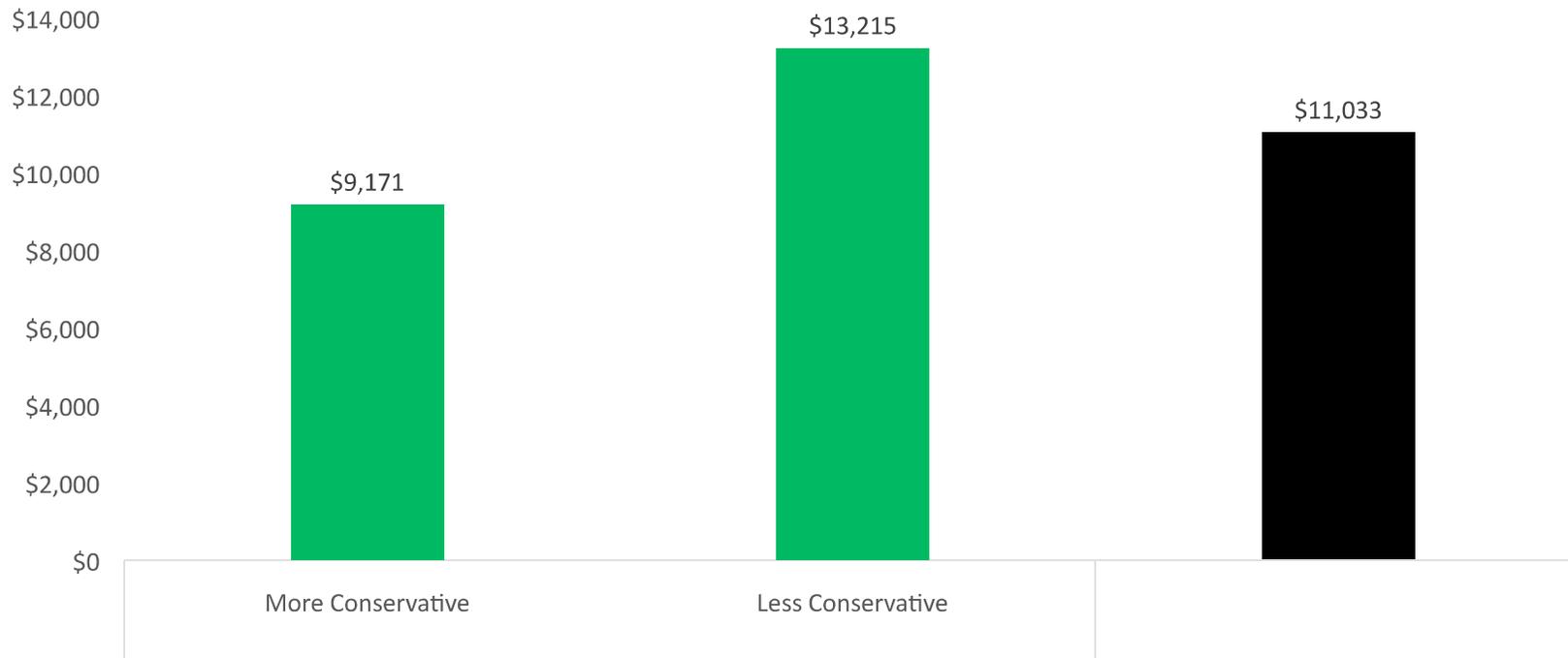
- 🏠 **Scenario 1 (More conservative):** Based on a pooled average of the percentage change in health care costs associated with housing placement that were observed in all studies that we reviewed. Studies were weighted so those with stronger methodological rigor had larger weights and greater impact on the pooled average.
- 🏠 **Scenario 2 (Less conservative):** Based on a pooled average of the percentage change in health care costs associated with housing placement that were observed in all studies that identified a significant reduction in health care costs.

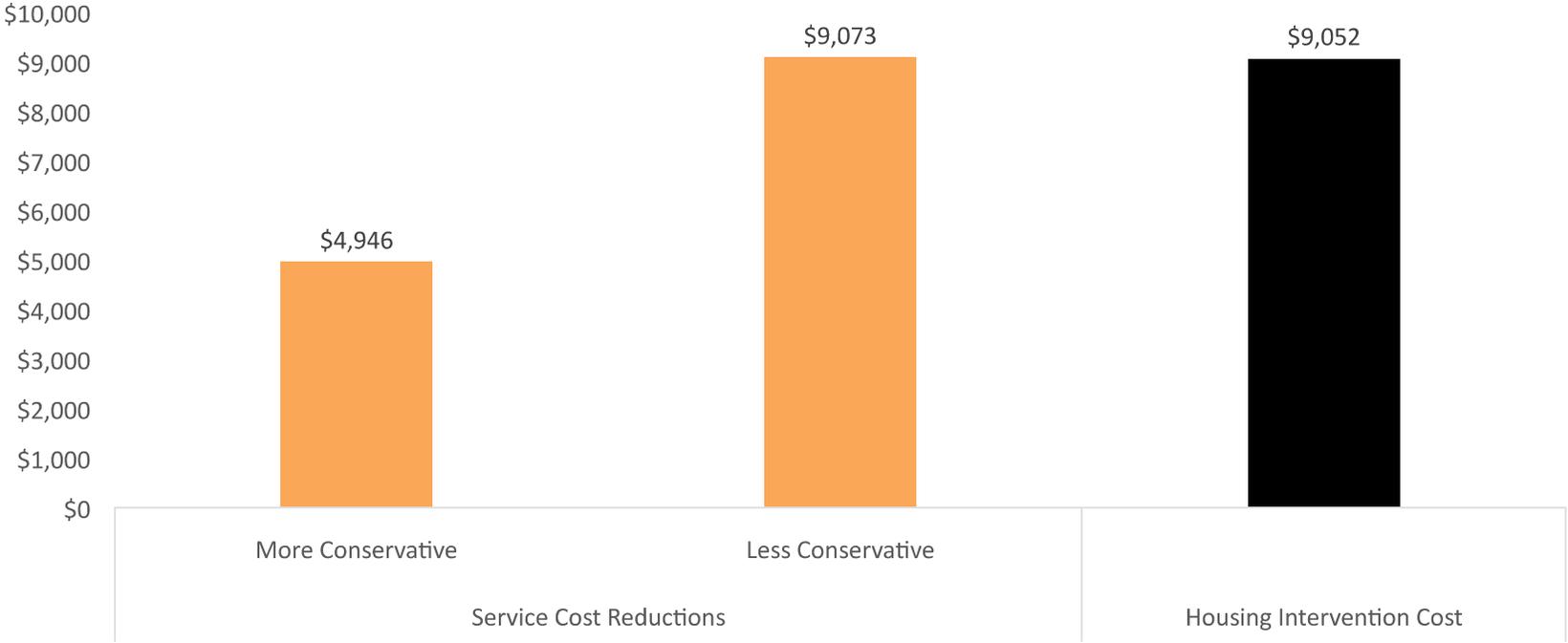
<b>Cost Category</b>	<b>Scenario 1 (more conservative)</b>	<b>Scenario 2 (less conservative)</b>
<b>Inpatient hospital</b>	-18%	-33%
<b>Emergency department</b>	-6%	-45%
<b>Outpatient DHS</b>	-6%	-45%
<b>Outpatient behavioral health</b>	+48%	-29%
<b>Substance Use Services</b>	-35%	-56%
<b>Nursing home</b>	-42%	-90%
<b>Shelter</b>	-71%	-71%



# Cost Reduction Possibilities in NYC

Average Per Person Per Year





# Annualized Average Projected Costs & Potential Cost Reductions

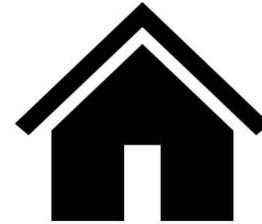
(in millions of \$)

	Service Costs without an Intervention	Intervention Costs	Average Service Cost Reductions	Net Offsets (Service Cost Reductions – Intervention Costs)	Return Per Dollar Spent
New York City	\$408	\$157	\$177	\$20	1.13
Boston*	\$67	\$39	\$30	-\$9	.77
LA County	\$621	\$241	\$274	\$33	1.14

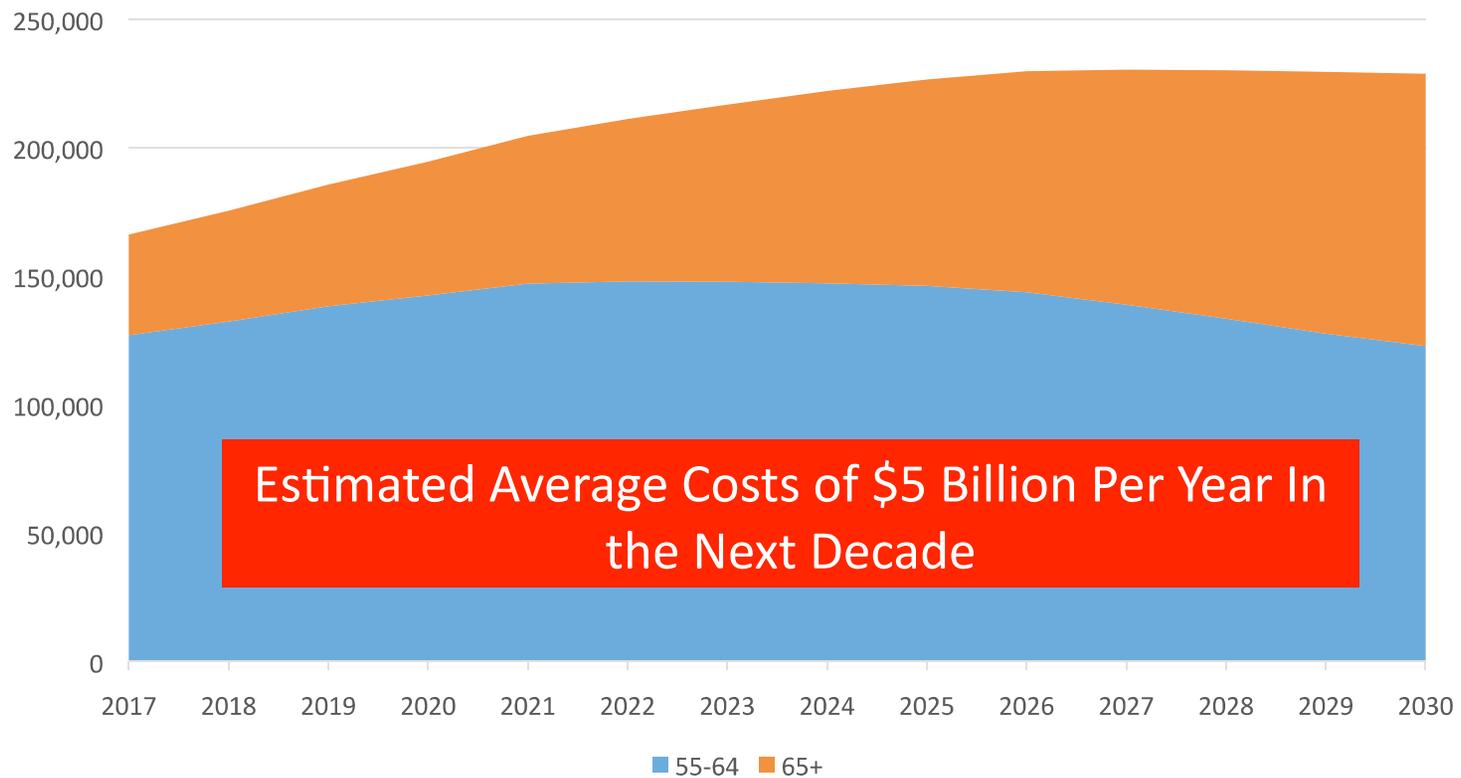
\*Boston service costs and cost reductions exclude Medicare-reimbursed services. A forthcoming analysis estimating Medicare costs suggests that an intervention would be break-even or provide net savings

# Could Housing Solutions be Funded by Service Cost Reductions?

**YES**



# National Projections (with cautions)



## Key Stakeholders

- U.S. HUD & VA
- U.S. DHHS – CMS
- State Medicaid Regulatory Agencies
- Medicaid Managed Care Organizations
- Hospitals & Nursing Homes
- Homeless Service Providers (CoC's)
- Housing Authorities
- Local Area Agencies on Aging

## Some Policy Considerations

- How to advance fund the housing “investment”?
- MCOs as rapid rehousing funder under a critical time intervention model?
- Start now targeting hospital and ER discharges and nursing home diversion?
- Ramp up over time, starting with 65+ or 62+ to gain momentum and develop policies and procedures?
- Federal challenge grant program to states for pilots?
- Local/state pay for shallow subsidies as alternative to shelter, and sunseting over time?
- Hospitals as key local leaders and conveners? Dissuade from “medical respite” push?

**For Assisted Living Services** provided in either

**Residential Care Facility, Adult Residential Facility, or in a Public Housing Setting** serviced by a **Home Health Agency**

<b>Tier 1</b>	\$58.00 per participant per day	(Service Code/Modifier T2031, U1)
<b>Tier 2</b>	\$69.00 per participant per day	(Service Code/Modifier T2031, U2)
<b>Tier 3</b>	\$80.00 per participant per day	(Service Code/Modifier T2031, U3)
<b>Tier 4</b>	\$92.00 per participant per day	(Service Code/Modifier T2031, U4)
<b>Tier 5</b>	\$200.00 per participant per day	(Service Code/Modifier T2031, U5)

**Residential Habilitation: \$6.75 per 15 minutes** (Service Code/Modifier T2017, U4)

**Residential Habilitation Services:** Available to all tiers, these services require prior approval from DHCS Nurse Evaluator and provides for additional, appropriate staff to assist in acquiring, retaining, and improving the self-help, socialization, and adaptive skills as needed by the participant. See Assisted Living Waiver, Appendix C, C-1/C-3 for Services Specifications: [Assisted Living Waiver, effective 3/01/14 to 2/28/19](#)

## **Room and Board**

**All Assisted Living Facility Providers** receive room and board payments from the Waiver participants. The current room and board rate for Residential Care Facilities providing assisted living is as follow:

- For a monthly Social Security income (or a Supplemental Security Income) of \$1173.37, \$1039.37 is dedicated to housing and \$134.00 allowance for the participant's personal needs.
- For a monthly income of \$1193.37 or greater, \$1059.37 is dedicated to housing and \$134.00 allowance for the participant's personal needs.

## **Care Coordination and Nursing Facility Transition**

**Care Coordination Compensation** is \$320.00 per participant per month.  
(Service Code G9002)

- For Transitional Care Coordination from a Nursing Facility, the coordinator receives a one-time fee of \$1000.00 per participant (Service Code G9001).

**Augmented Plan of Care:** A systematic assessment of a participant's conduct that identifies functional and dysfunctional behaviors, followed by the development of a written behavior plan, and the training of personnel to implement the behavior plan, monitor the effectiveness, and modify the plan if necessary. Approval must be received from DHCS prior to billing for Augmented Plan of Care Development and Follow-up (Service Code T2024). See page 3 of Assisted Living Waiver for Services Specifications: [Assisted Living Waiver, effective 3/01/14 to 2/28/19](#)

## Appendix 9:

### Resolution passed by the Los Angeles County Democratic Party on February 12, 2019 regarding Adult Residential Facilities that Serve Adults with Serious Mental Illness

#### Protecting licensed Adult Residential Facilities

WHEREAS State Licensed Adult Residential Facilities (ARF's) provide community based care to adults with serious mental illness and other disabilities, thereby preventing homelessness, incarceration or over utilization of emergency medical centers; and

WHEREAS these crucially important facilities are closing statewide due to low SSI reimbursement rates for this vulnerable population; and

WHEREAS increased state supplements are needed to continue to provide quality care, supervision and housing for those suffering from serious mental illness;

THEREFORE BE IT RESOLVED the Los Angeles County Democratic Party calls on state legislators to protect Licensed Adult Residential Facilities serving people with serious mental illness and other disabilities from shutting down and adequately subsidize these facilities to keep these venerable individuals from becoming homeless and losing vital care; and

BE IT FURTHER RESOLVED that this resolution will be sent to Governor Gavin Newsom, Speaker Anthony Rendon and President pro Tem Toni G. Atkins.

SUBMITTED BY: Michael Kulka AD 38

AUTHOR: Barbara Wilson