COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Mental Health Board

Regular Meeting: Monday, February 26, 2018, 7:00 PM – 9:00 PM
AFT Library, Community Meeting Room
at 1212 Merkeley Ave. West Sacramento, CA 95691

All items on this agenda may be considered for action.

CALL TO ORDER ----------7:00 PM – 7:15 PM

1. Welcome and Introductions
2. Public Comment
3. Approval of Agenda
4. Approval of Minutes from January 29, 2018
5. Member Announcements
6. Correspondence

TIME SET AGENDA ----------7:15 PM – 8:15 PM

7. MHSA 3 Year Plan Update Presentation – Resource Development Associates
8. Homeless Presentation – Aurora William, HHSA

CONSENT AGENDA ----------8:15 PM – 8:30 PM

9. Mental Health Director's Report – Karen Larsen
   a. Medication Assisted Treatment
   b. Public Guardian Update
   c. Growing the Mental Health Workforce
   d. Innovation Summit
   e. Assisted Outpatient Treatment (Laura's Law)
   f. CIT RFP
   g. Urgent Care
   h. MHSOAC RFP
   i. LPS Legislation
   j. Pine Tree Gardens
   k. Data Update
      - Inpatient Psychiatric Hospitalization
      - Length of Stay
      - Readmission Rates

REGULAR AGENDA ----------8:30 PM – 8:45 PM

10. Board of Supervisors Report – Supervisor Don Saylor
11. Chair Report – James Glica-Hernandez
    i. BOS Annual Update
12. Metrics Report on upcoming schedule of data presentations

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Health and Human Services Agency, LMHB@yolocounty.org or 137 N. Cottonwood Street, Woodland, CA 95695 or 530-666-8516. In addition, a person with a disability who requires a modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

CONTINUED ON REVERSE

PLANNING AND ADJOURNMENT---------- 8:45 PM – 9:00 PM – 9:00 PM

13. Future Meeting Planning and Adjournment – James Glica-Hernandez

    a. Long Range Planning Calendar Discussion and Review

    b. Next Meeting Date and Location – Bauer Building, Thomson Conference Room, 137 N. Cottonwood St. Woodland, CA 95695

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, February 23, 2018.

Iulia Bodeanu
Local Mental Health Board Administrative Support Liaison
Yolo County Health and Human Services Agency

Item 4.
Approval of Minutes from Jan. 29, 2018

COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

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Local Mental Health Board
Meeting Minutes

Monday, January 29, 2018, 7:00 – 9:00 PM
Mary L. Stephens Library, Blanchard Community Conference Room at 315 East 14th Street Davis, CA 95616

Members Present:	Richard Bellows, Nicki King, Reed Walker, Bret Bandley, Ajay Singh, Bret Anderson, Martha Guerrero, Laurie Ferns, Sally Mandujan, Gabriel Lochshin, Richard Bellows, James Glica-Hernandez, Robert Schelen
Members Excused:	Tom Waltz, Ben Rose
Staff Present:	Karen Larsen, HHSA Director and Mental Health Director Samantha Fusselman, HHSA Deputy Mental Health Director and Manager of Quality Management Services Harjit Singh Gill, HHSA Access and Crisis Services Manager Iulia Bodeanu, LMHB Administrative Liaison

CALL TO ORDER

1. **Welcome and Introductions:** The January 29, 2018 meeting of the Local Mental Health Board was called to order at 7:05 PM. Introductions were made.
2. **Public Comment** – No Public Comment
3. **Approval of Agenda**
   Motion: Nicki King made a motion to approve the agenda.
   Motion to approve: Nicki King **Second:** Richard Bellows **Vote:** Unanimous
4. **Approval of Minutes from December 4, 2017**

   Motion to approve: Laurie Ferns **Second:** Ajay Singh **Vote:** Unanimous
   Abstentions: Nicki King (did not attend the meeting)
5. **Member Announcements:** None
6. **Correspondence:** None
7. **MHOAC Video**

CONSENT AGENDA

8. **Mental Health Director's Report** by Karen Larsen, Health and Human Services and Mental Health Director.

   a. Child Homicides – Martha Guerrero inquired increased support to families who have experienced the loss of a child due to homicide. Martha asked about prevention or intervention services. The cases that have come before

the county were crimes perpetrated by the fathers, so we are taking a look at what types of services to provide that will support to fathers in our system. Karen Larsen stated she is very proud of the way that HHSA staff have worked with the schools, particularly the Washington School District. The county has in place the Child Death Review Team in the Sherriff's Office, which works with the Fetal Infant Mortality Review Team at HHSA. Recommendations emerge from these meetings for ways to address these issues.

e. CWDA Children's Committee – Child Abuse prevention was discussed at the last meeting and the utilization of public health integration. April is Child Abuse Prevention Month, perhaps the LMHB can plan something meaningful such as a community event to raise awareness.

b. CIP Update – Brad Anderson asked for an update on the RFP. Karen stated that the RFP is still open and out for review.

s. Homeless Count – Richard Bellows asked what the breakdown on homeless numbers are for the county. Karen will send the numbers broken down by individual cities.

TIME SET AGENDA

9. **5150 Presentation -** Samantha Fusselman, HHSA Deputy Mental Health Director and Harjit Singh Gill, HHSA Access and Crisis Services Manager

REGULAR AGENDA

10. Board of Supervisors Report – Supervisor Don Saylor

- Supervisor Saylor thanked Gabriel Lochshin for his service to the board and thanked him for completing the term he was appointed to. Sup. Saylor also thanked Karen for her Mental Health Director's Report. The community is excited to announce that the MHSA Housing on Cottonwood Street is slated for an October 2018 opening. Other projects happening in Davis are the development of homeless housing projects, a board and care, as well as a service center that will serve transition age youth through the wellness center. Earlier in the week Sup. Saylor and his deputies visited HHSA to take a closer look at the services and was amazed by the teams helping clients in Yolo County and is delighted to be a part of great initiatives taking place in the community.

11. Chair Report – James Glica Hernandez

- James Glica-Hernandez encouraged the board to participate in a conference call that is informational regarding board and care facilities put on by the Local Mental Health Boards and Commissions.

12. Calls to Supervisors

- James Glica-Hernandez stated that it is a good idea to have each of the board members reach out to their supervisors. James asked for a commitment for the board members to send an email to each of their supervisors summarizing their thoughts after each board meeting as a means of establishing stronger communication between the LMHB and the BOS as an advisory body.

13. Ad-Hoc Committees

- Data Notebook Ad-Hoc Committee met today and completed the Data Notebook.

- The Metrics Ad-Hoc Committee will meet to establish a regular meeting schedule to review progress on smart goals, develop a list of metrics reporting in various areas, review progress in the processing of consumer perception surveys and review staffing plans for AVATAR Database. Richard Bellows proposed to have the Metrics Ad-Hoc Committee meet through the end of 2018. James Glica-Hernandez proposed changing the name of the committee. The matter was discussed but no name change was determined. The committee is composed of James Glica-Hernandez, Richard Bellows, Nicki King and Martha Guerrero. Possible addition of an HHSA QM staff member to offer support to the committee was discussed.

- Site Visit Ad-Hoc Committee is comprised of James Glica-Hernandez, Brad Anderson, Ajay SIngh, and Ben Rose. The Committee will be meeting in the future to establish the structure, process and rubric for site visits.

- West Sacramento Ad-Hoc Committee is comprised of Martha Guerrero, Sally Mandujan and Robert Schelen. The Committee's intention is to develop outreach methods within West Sacramento, who has prioritized mental health services on their strategic plan. James Glica-Hernandez suggested having the committee bring an update to the next LMHB meeting.

PLANNING AND ADJOURNMENT

14. Future Meeting Planning and Adjournment: James Glica-Hernandez

- Long Range Planning Calendar Discussion and Review.

- Next Meeting Date and Location – February 26, 2018 at the Arthur F. Turner Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA 95691

- This meeting was adjourned at 9:07 PM.

Item 7.
RDA Presentation

YOLO COUNTY: MHSA ANNUAL UPDATE FY 18-19
LOCAL MENTAL HEALTH BOARD

February 26, 2018

Resource Development Associates (RDA)

Kelechi Ubozoh

Alejandra Barrio, MPP

Agenda

- MHSA Annual Update Overview
- Review of Community Input Meetings
- MHSA Annual Update Findings
- Next Steps

MHSA Annual Update Overview

MHSA Overview

- Mental Health Services Act (Proposition 63) passed November 2, 2004
- 1% income tax on income over $1 million
- Purpose of MHSA: to expand and transform mental health services in California

MHSA Annual Update

- County mental health programs shall prepare and submit an Annual Update for Mental Health Service Act (MHSA) programs and expenditures.

- Annual Updates must be adopted by the county board of supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after board of supervisor adoption.

Welfare and Institutions Code Section (WIC §) 5847

Annual Update Activities and Timeline

Phase I - Kickoff

- Kickoff with Yolo County HHSA and MHSA stakeholders
- Conduct Doc review

Phase II – Needs Assessment

- Conduct 4 community meetings
- Kick off with LMHB
- Attend Yolo MH Staff as stakeholders meeting
- Attend provider workgroup meeting

Phase III – Program Planning

- Synthesize stakeholder input on needs and services
- Identify updates to the MHSA Plan
- Conduct 4 community report back meetings

Phase IV – Develop Update

- Publicly post Annual Update for 30-day public comment
- LMHB convenes Public Hearing
- Present Update to LMHB
- Finalize Annual Update & send to BOS

September | **October** | **November-December** | **In Progress**

RDA

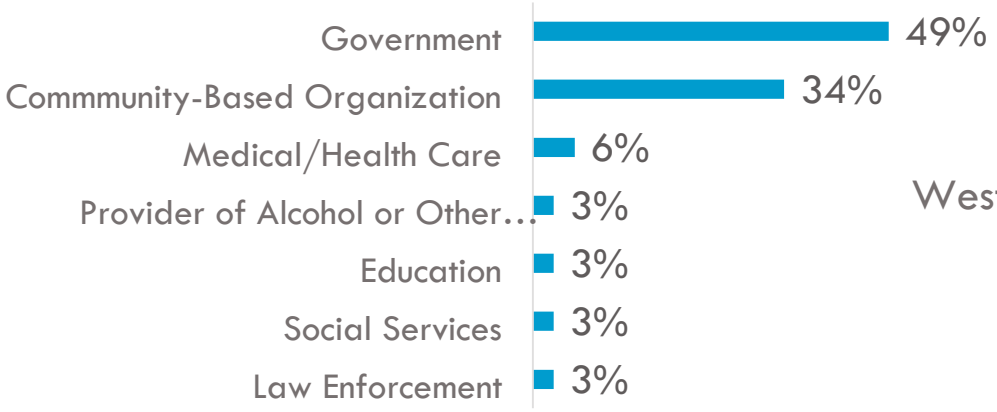
Review of Community Input Meetings

Community Meetings Summary

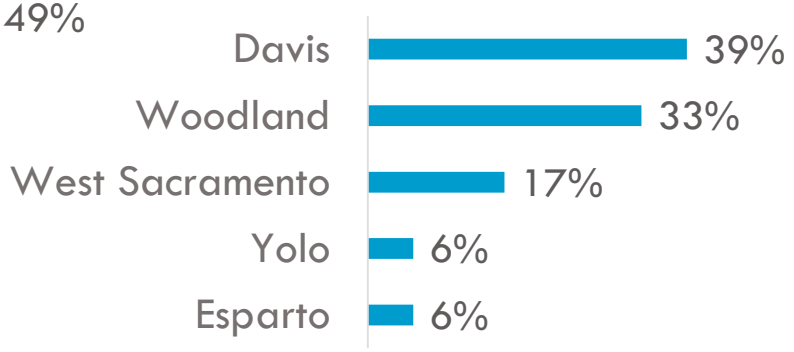
Community Input Meetings	Attendance	Location
Stakeholder Kickoff Meeting	22	Woodland
Staff Input Meeting	11	Woodland
Community Input Meeting (4)	15	Woodland, Esparto, Davis, West Sacramento
Provider Stakeholder Meeting	8	Woodland
Local Mental Health Board Meeting	12	Davis
Mental Health Staff Meeting	14	Woodland

A Total of 9 Meetings and 82 participants in Attendance

Stakeholder Affiliation



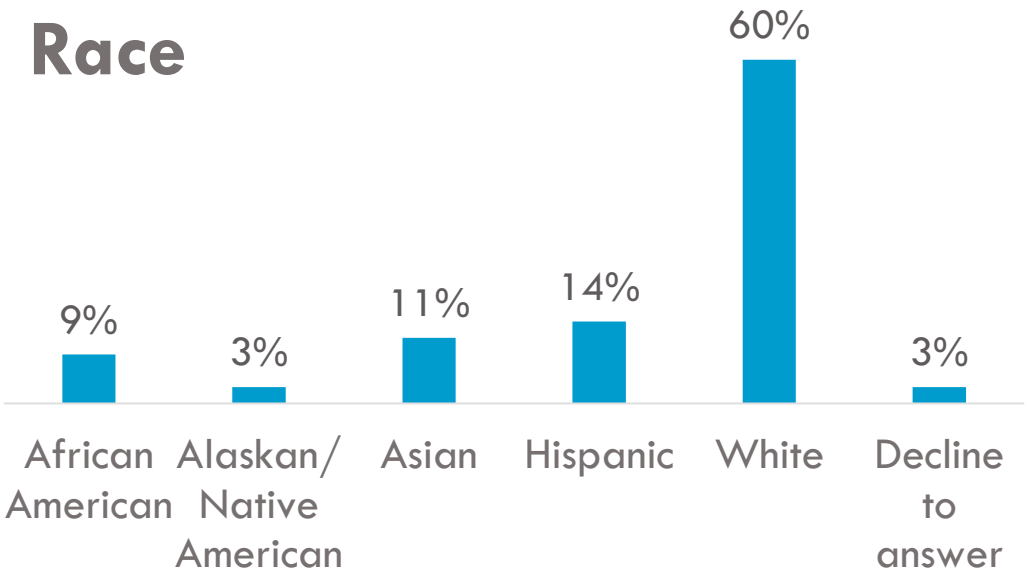
Area of Residence



Participant Demographics

Gender Identity

Race



Lived Experience

- 14% Consumers
- 36% Family Members
- 50% No

Sex

- 80% female
- 20% male

Age

- 69% 25-59 years old
- 31% 60+ years old

Disabilities

- 68% reported a disability
- 32% reported no disability

Veteran Status

- 97% non-veteran status
- 3% veteran status

MHSA Annual Update Findings

Crisis Response Services

Identified Need	Mental Health Update Action Items
• Continue Crisis Intervention Program, clinician/law enforcement mobile crisis response services. • Improve communication with LEAs during crisis response. • Expand afterhours services for emergency response.	• Modify Crisis Intervention Program hours of operations to focus on evenings, weekends, and holidays. • Continue start-up efforts for First Responders Initiative (approved INN project), including Mental Health Urgent Care Center. • Pursue additional funding options, including Round 2 of MHSOAC SB82 Triage Staffing Grant.
• Identify additional drop-off locations for consumers in crisis and their families.	

Access to Services

Identified Need	Mental Health Update Action Items
• Increase reliable transportation for consumers in get to services particularly for consumers living in Esparto and Davis.	• HHSA will implement ride share options [e.g. Uber/Lyft] for specialty mental health consumers. • HHSA is developing a community navigation center in Davis. • HHSA will leverage Telehealth efforts to minimize the need to travel to a service location.
• Implement outreach strategies to ensure consumers, families, and providers know about service availability and how to access services.	

Underserved Populations

Identified Need	Mental Health Update Action Items

Underserved Populations
• Children (0-15)
• Transition aged youth [16-24]
• Older adults and aging
• Consumers with substance-use issues
 	
• Increase services and outreach for:
  ○ Consumers with substance-use issues
  ○ TAY with complex needs
• Improve children's psychiatry by:
  ○ Strengthening referral processes, service linkages, and access for children including expanding service hours
  ○ Exploring incentives for child psychiatrists to work in Yolo County
	• HHSA will strengthen partnerships among mental health and substance-use service providers.
	• HHSA will leverage programs established in 3-year plan to address needs of children & youth, and aging/older adults.
	• HHSA will continue improve access to services for children & youth, including TAY hours at the new Davis service location.
	• HHSA will pursue opportunities to expand capacity for children's psychiatry.

Partnership with Justice Systems

Identified Need	Mental Health Update Action Items
• Strengthen collaboration with Yolo justice systems and law enforcement agencies to better serve justice-involved mental health consumers. • Establish mental health services for justice involved youth that are not in custody (e.g. boys of color who are on probation). • Implement Pre-release planning for mental health needs and services for reentry consumers.	• Continue participation in criminal justice cross-system work with Stepping Up Initiative, AB109, and Prop 47 partnerships. • Continue start-up efforts for INN First Responders Initiative, including development of Multidisciplinary Forensic Team and Mental Health Urgent Care Health Information Exchange.

Mental Health Data Collection and Reporting

Identified Need	Mental Health Update Action Items
• Improve capacity to collect, analyze, and report evaluation and outcome data. • Ensure HHSA compliance with new reporting requirements, including demographic and outcome data. • Establish data sharing mechanisms amongst contracted providers and hospitals. • Increase staffing capacity for data collection and outcome reporting. • Provide support for contractors and CBOs to improve data collection and reporting.	• Upgrade Avatar to support new reporting requirements and enhance reporting capabilities. • Develop or identify mechanism for PEI and INN data collection and reporting. • Continue and expand use of Results Based Accountability to measure and report on outcomes. • Provide training and technical assistance to HHSA staff and providers re: data and outcomes.

Next Steps

Present at Local Mental Health Board February 26, 2018-Today!

Submit update to Board of Supervisors: March 20, 2018

Closing

Contact Us for Questions:

Kelechi Ubozoh

kubozoh@resourcedevelopment.net

510.488.4345 x113

Item 9.
Mental Health Director’s Report

Mental Health Director's Report

February 22, 2018

Medication Assisted Treatment – In 2015, the Federal government approved a 5-year pilot project to expand substance use services that could be billed to Medi-Cal. This pilot project is called the Drug Medi-Cal Organized Delivery System Waiver. Counties that have chosen to participate in the Waiver are mandated by the State to provide an expanded set of specific treatment services, including a Narcotic Treatment Program. Yolo County intends to begin services under the Waiver on July 1 and has been conducting planning efforts, including monthly provider meetings since August 2015.

Additionally, in response to the opioid epidemic, the Department of Health Care Services released a grant to expand the amount of services available to treat those struggling with opiate addiction. C.O.R.E. Medical Clinic, Inc., in partnership with CommuniCare Health Centers, applied for and was awarded a grant to establish a Narcotic Treatment Program via a "hub and spoke" model of services. In the hub and spoke model, an experienced treatment provider acts as the "hub" and establishes a "spoke" site in a rural community. One requirement of the grant is that the "hub," (in Yolo, this is C.O.R.E.) establish a facility in the awarded county within 1 year of beginning services. This grant was awarded in September 2017, meaning that C.O.R.E. needs to have a facility within Yolo County by September 2018 to be in compliance with this grant. C.O.R.E is currently in discussions with the City of West Sacramento regarding a site.

Attached is a fact sheet that covers the opioid overdose numbers for Yolo County from 2014-2016, along with the number of Yolo County clients being served currently by Sacramento providers, that beginning July 1, will need to be served by a Yolo County contracted provider. The total numbers were gathered from the Department of Health Care Services and reflect 2015-16 data. Ian to provide update regarding CORE and data sheet

Public Guardian Update- In response to the Department of Financial Services review of Public Guardian office, we will be adding additional staffing. We have added an Accountant and will be adding a Guardian Technician. Additionally, one of our long time conservatorship officers, Barbara Madsen is retiring and we have already begun the recruitment process for her replacement.

Growing the Mental Health Workforce-The **Steinberg Institute** partnered with **Kaiser Permanente** last month to host a high-powered forum exploring challenges facing California's mental health workforce, and innovative strategies for rethinking and adapting our traditional models of care. Our speakers brought expertise from across the nation. The audience was composed of representatives for leading policymakers, hospital systems, health organizations, research institutes, mental health providers, government agencies and advocacy groups. And the day was devoted to solutions.
We heard about innovations already under way that could be replicated and scaled up: Fellowships to train primary care providers in basic psychiatry. Expanding the use and role of psychiatric nurse practitioners. Standardizing training for peer providers. Emergency rooms dedicated to psychiatric crisis. Technology that turns the smart phone into a counseling session.

I was honored to be included as a speaker along with Darrell Steinberg, Steinberg Institute founder and Mayor of Sacramento; Dr. Patrick Courneya**,** Executive Vice President and Chief Medical Officer at Kaiser Permanente; Dr. Don Mordecai**,** National Leader for Mental and Behavioral Health at Kaiser Permanente; and other distinguished researchers and innovators.

Innovate for Impact Summit- Innovate for Impact brought together California counties, mental health consumers, family members, providers, and community leaders to join the Mental Health Services Oversight and Accountability Commission of California, IDEO, and Verily to drive innovation in mental healthcare. During the one-day summit, participants gathered for a collaborative and immersive workshop to uncover the opportunities to innovate and evolve impactful mental health programs across the state.

Assisted Outpatient Treatment (Laura's Law) - On February 20, 2018, Turning Point provided an update to the Board of Supervisors regarding cost savings associated with the program. This update was in response to a prior Board item regarding AOT that did not include cost information. In terms of savings associated with Laura's Law (AOT), if we compare one year prior to enrollment to one year after enrollment and we look at Psychiatric Hospitalization, Incarceration, and Emergency Visits, this program has saved $366,794 over a 12 month period.

This savings does not account for the cost of the program. For example, each client slot costs us approximately $20,000 and we have approximately 5-7 clients per year served. So, if we subtracted this from the savings number our true savings to the system would be approximately $250,000 annually.

CIT RFP - Yolo County released a Request for Proposal for the Crisis Intervention Training (CIT) contract on February 7, 2018. Funded through the MHSA Prevention and Early Intervention funds, this program provides training to law enforcement and other first responders regarding serving persons experiencing a behavioral health crisis. Proposals are due March 7, 2018.

EQRO Review - The California External Quality Review Organization conducted its annual site review on February 14-15, 2018. Reviewers toured the STAY Well Center, held 18 focus groups, and met with over 50 stakeholders, including consumers, family members, staff, and community providers. The EQRO staff found participants to be forthcoming, enthusiastic, and committed to continuous quality improvement efforts. They also acknowledged existing challenges with infrastructure, particularly regarding limited resources for the Electronic Health Record. We anticipate receiving their draft report in April.

Urgent Care-On February 5, HHSA opened Yolo County's first Mental Health Urgent Care! The site, at 500 Jefferson, Building B, in West Sacramento is open from 12:00 to 9:00 p.m., 7 days per week (excluding County holidays). Services include crisis assessment, linkage to crisis residential care, case management assistance and safe discharge for every person who visits the Urgent Care. In our first few days of service, individuals have self-referred as well as been supported to the location by law enforcement and City Homeless Coordinators. Current staff have received training in safety protocols and CPR by Yolo County's Emergency Medical Services Administrator, Kristin Weivoda. Upcoming, the site staff will expand to include Nurse Practitioners and Peer Support Workers. Please save the date for our Open House/Ribbon cutting ceremony on April 4th 9:30-11am.

MHSOAC RFP- The Mental Health Services Oversight and Accountability Commission (Commission) is soliciting Applications for Investment in Mental Health Wellness Act of 2013 triage grant dollars aimed at crisis triage services for children, age 21 and under. The grant cycle will run for three fiscal years.

No less than $29.6 million is available through this Request for Application (RFA). Additional funding may become available and include unencumbered and unspent funds from the first round of triage grants.

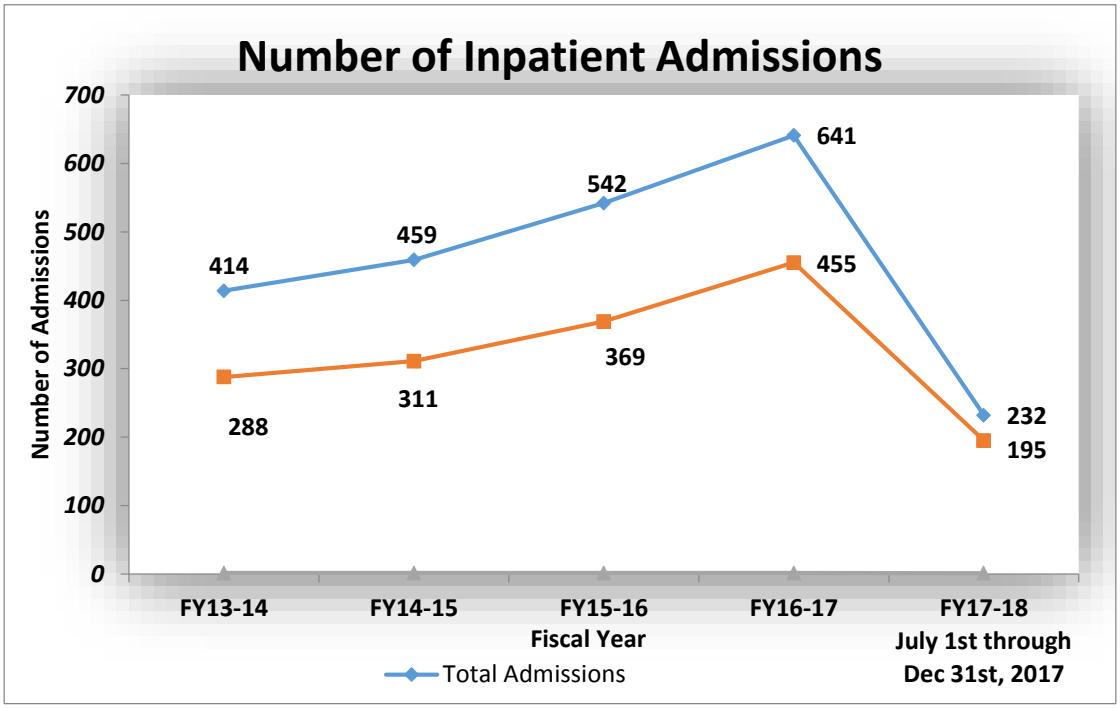
LPS legislation- There are several legislative proposals aimed at making changes to LPS laws. I have placed this item on the agenda to begin the discussion.

Pine Tree Gardens- Opened in 1986 and 1990 by the Williams family, the Pine Tree Gardens Adult Residential Facilities (East and West house) have provided a safe and therapeutic alternative to psychiatric hospitalization to adults living with severe mental illness. Turning Point has subsidized the expenses for these homes, about $135,000.00 annually, which does not address significant deferred maintenance of the properties. HHSA and Turning Point are discussing some options to mitigate the financial burden but will need additional resources to ensure that Pine Tree can continue to operate. This item has been placed on the agenda so we can begin planning community/stakeholder discussions.

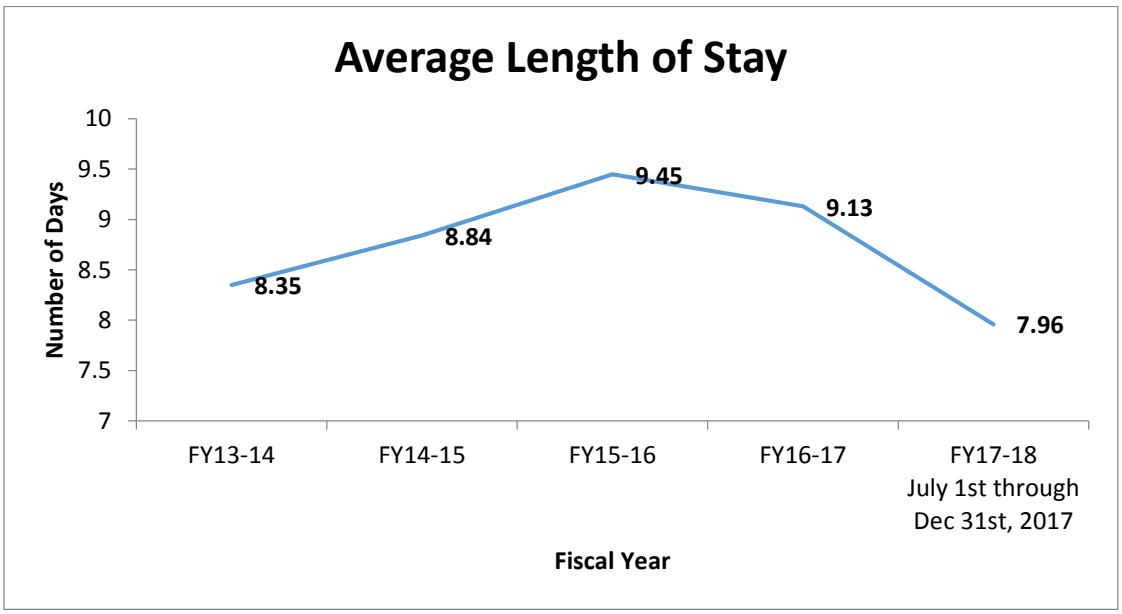
Data Update - The following data is inclusive of Yolo County Medi-Cal beneficiaries

Inpatient Psychiatric Hospitalization – There has been a 55% increase in psychiatric hospital admissions among Medi-Cal beneficiaries between FY13-14 and FY16-17; utilization for the first half of FY17-18 indicate this trend is slowing and may in fact decrease.

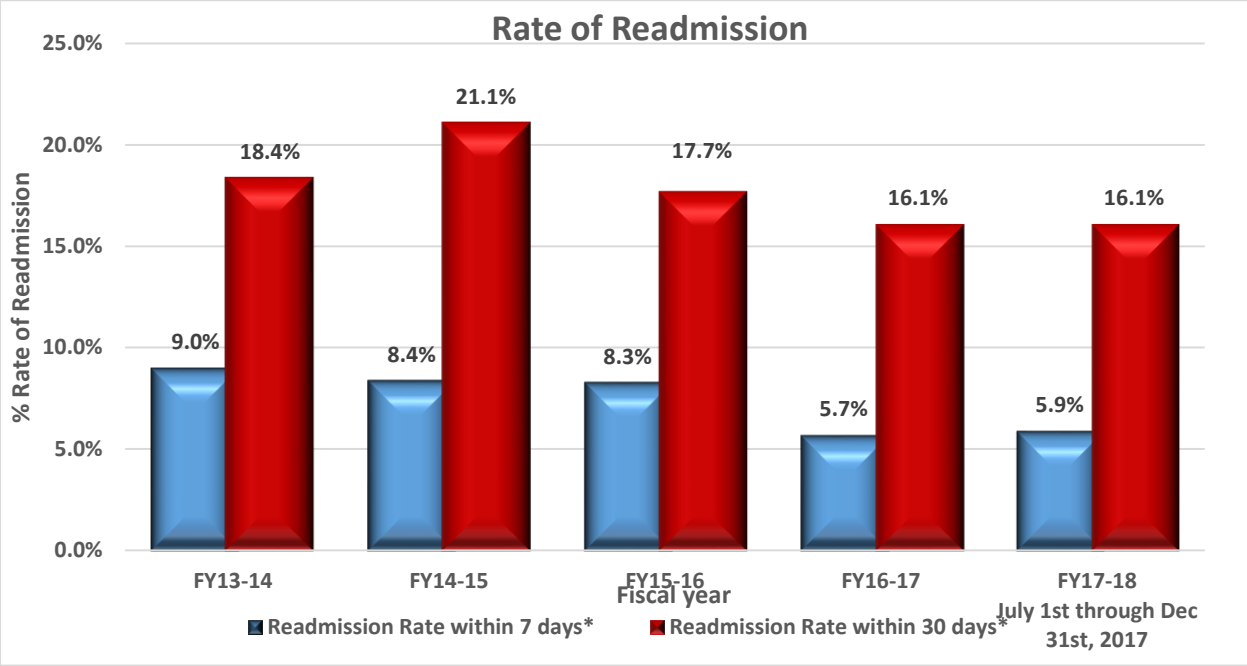
Data Source: TAR Logs, representing Yolo County Medi-Cal beneficiaries.



Length of Stay – While average length of stay had increased from FY13-14 to FY15-16, it has now returned to a level comparable to FY13-14.



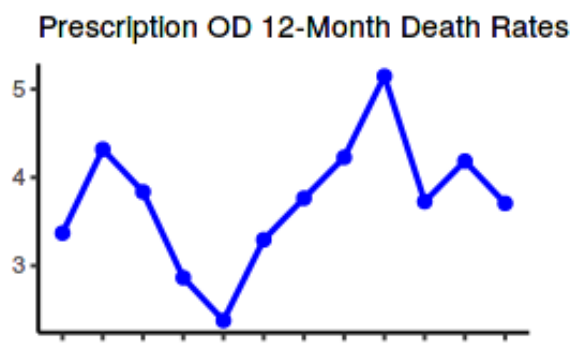
Readmission Rates – We had seen a steady decrease in the rates of readmission to inpatient hospitals between FY14-15 to FY16-17, but current year data indicates that more people are returning to the hospital within 7-days and 30-days following a discharge.

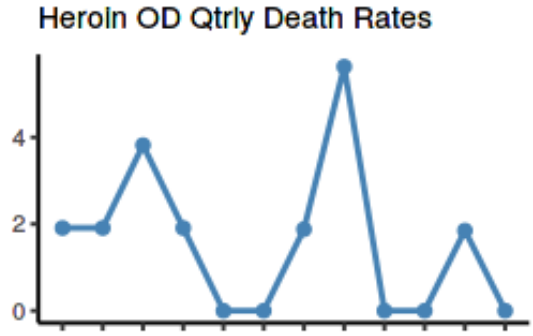


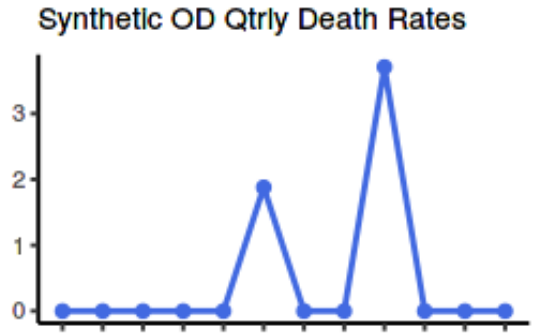
Prescription Drug Overdose Prevention Initiative

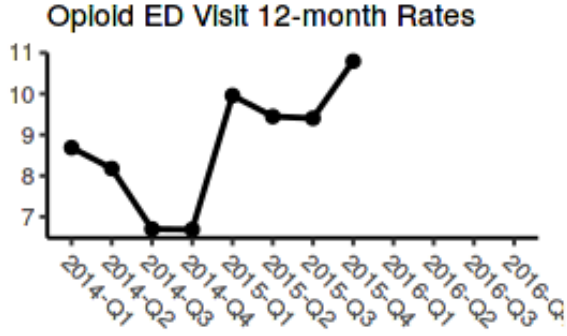
Yolo Opioid Overdose Snapshot: 2014-Q1 to 2016-Q4

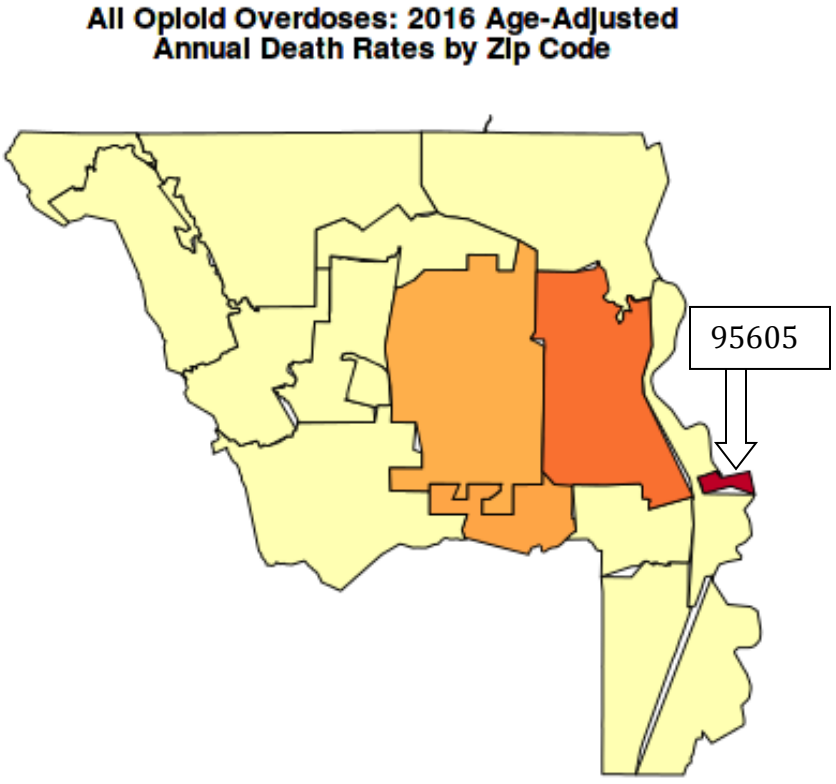
Yolo experienced 9 deaths due to all opioid-related overdoses in 2016, the most recent calendar year of data available. The annual crude mortality rate during that period was 4.2 per 100k residents. This represents a 32% decrease from 2014. The following charts present 12-month moving averages and annualized quarterly rates for selected opioid indicators. The map displays the annual zip code level rates for all opioid-related overdoses. Synthetic overdose deaths are likely to be largely represented by fentanyl.

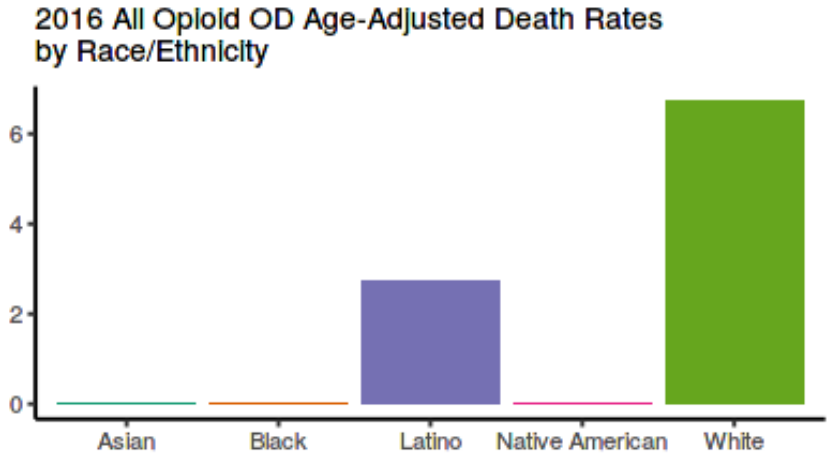








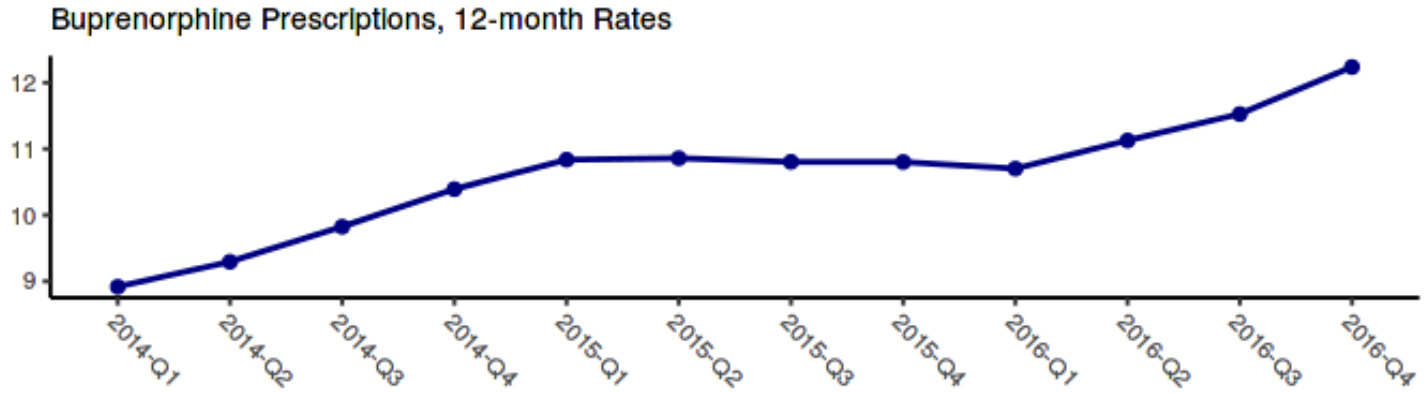




* Information obtained from CORE Medical Clinic, not the California Department of Public Health
** Information obtained from Department of Health Care Services, data not available by city
Footnotes: 12-month rates are based on moving averages; OD = Overdose; Qtrly = Annualized Quarter
Report produced by the California Opioid Overdose Surveillance Dashboard - https://cdph.ca.gov/opioiddasboard/

Treatment

Buprenorphine prescriptions in the county are used to gauge the expansion of medication-assisted treatment (MAT). The annual buprenorphine prescribing rate in 2016 was 12.2 per 1,000 residents. This represents a 13% increase in buprenorphine prescribing from 2014.



CORE Specific Treatment Numbers by City*

City of Residence	Methadone	Buprenorphine
West Sacramento	69	4
Woodland	15	0
Davis	8	5
Knights Landing/Esparto/Winters	1	2

Other Narcotic Treatment Provider (NTP) Numbers based on 2015-2016**

129 Yolo residents served

Total served by Sacramento NTP Providers: Approximately 233 Yolo County residents

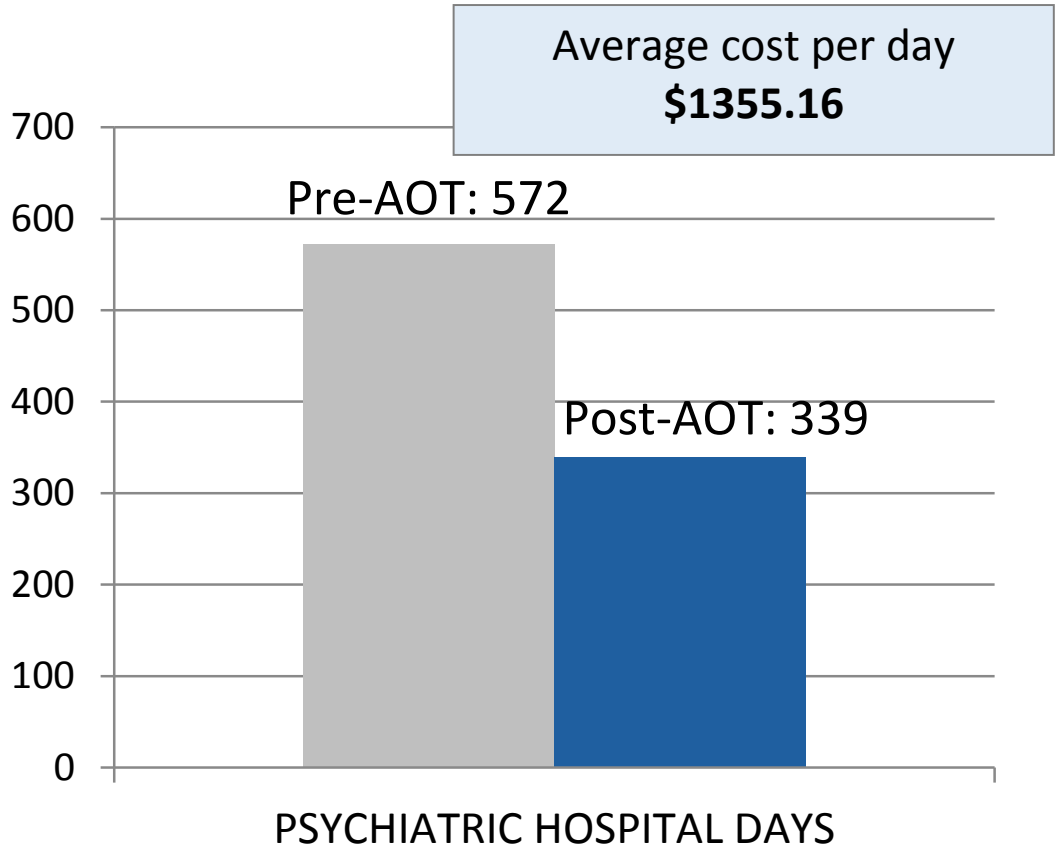
* Information obtained from CORE Medical Clinic, not the California Department of Public Health
** Information obtained from Department of Health Care Services, data not available by city
Footnotes: 12-month rates are based on moving averages; OD = Overdose; Qtrly = Annualized Quarter

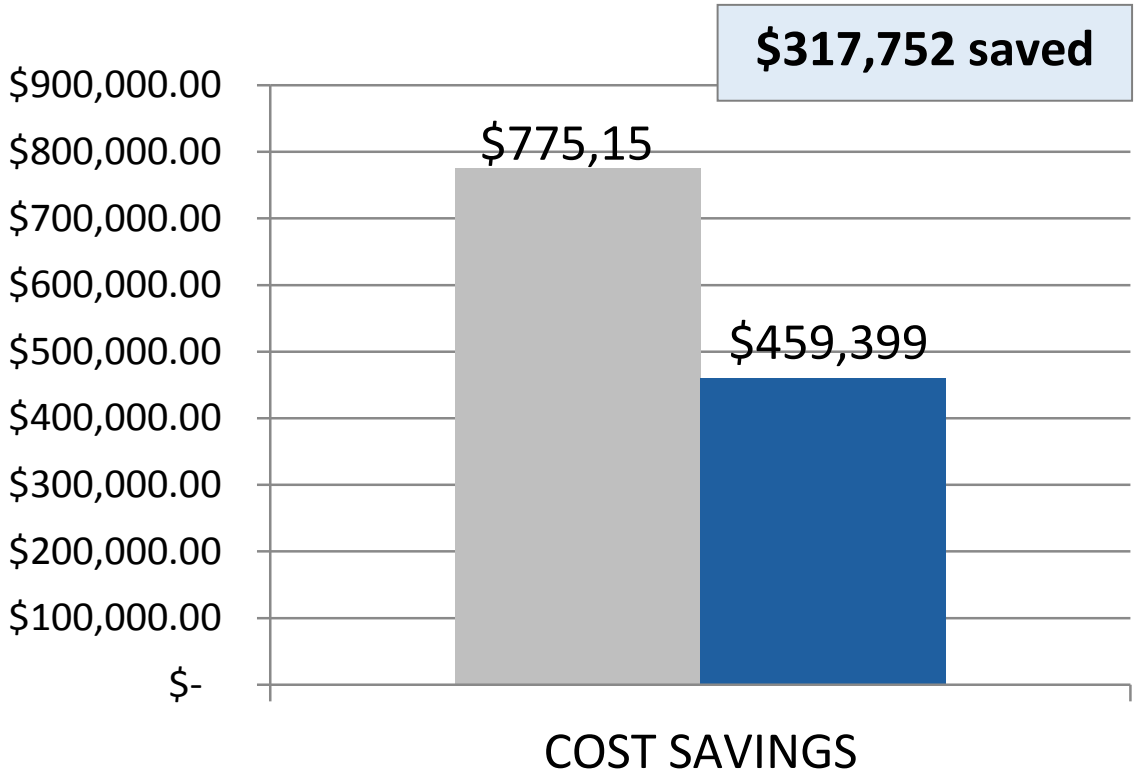
Yolo County Assertive Outpatient Treatment (AOT) Update

Presented by Turning Point Community Programs

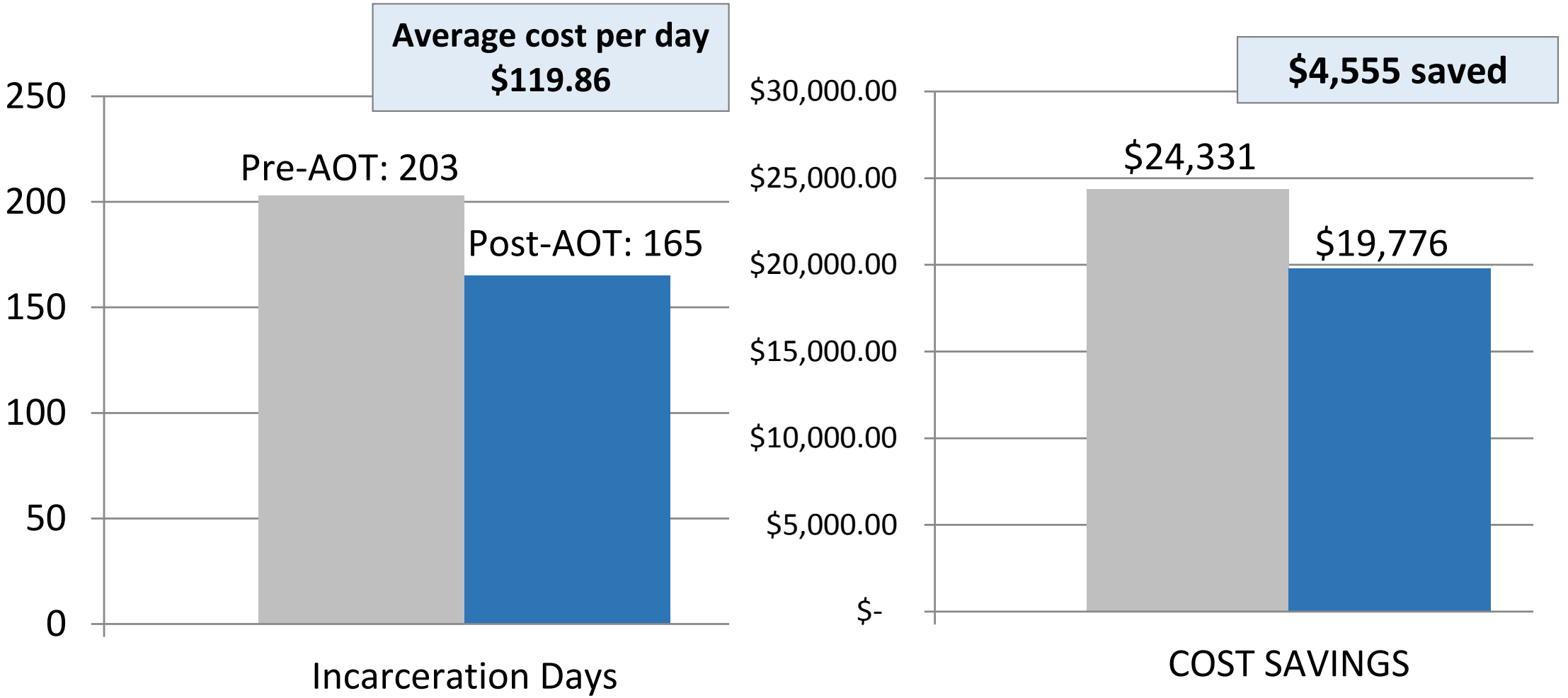
January 9, 2018

Psychiatric Hospitalization

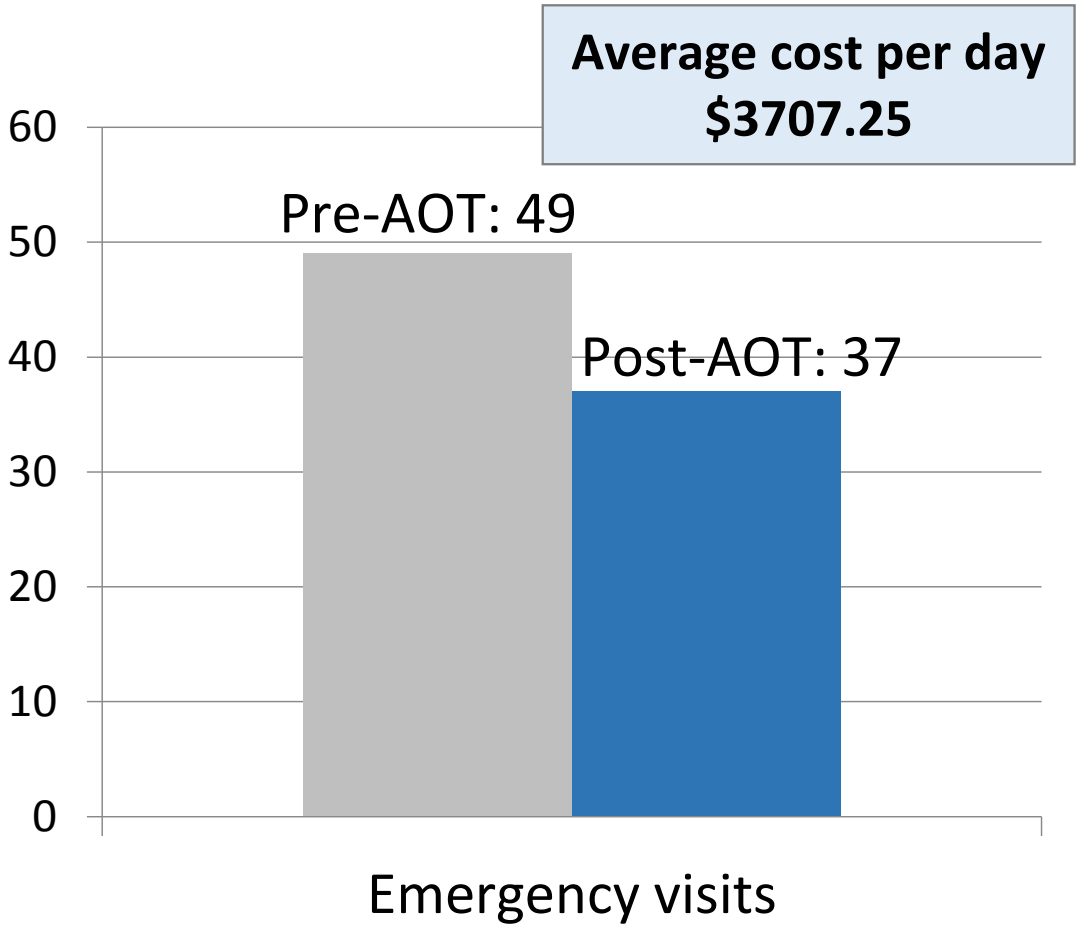


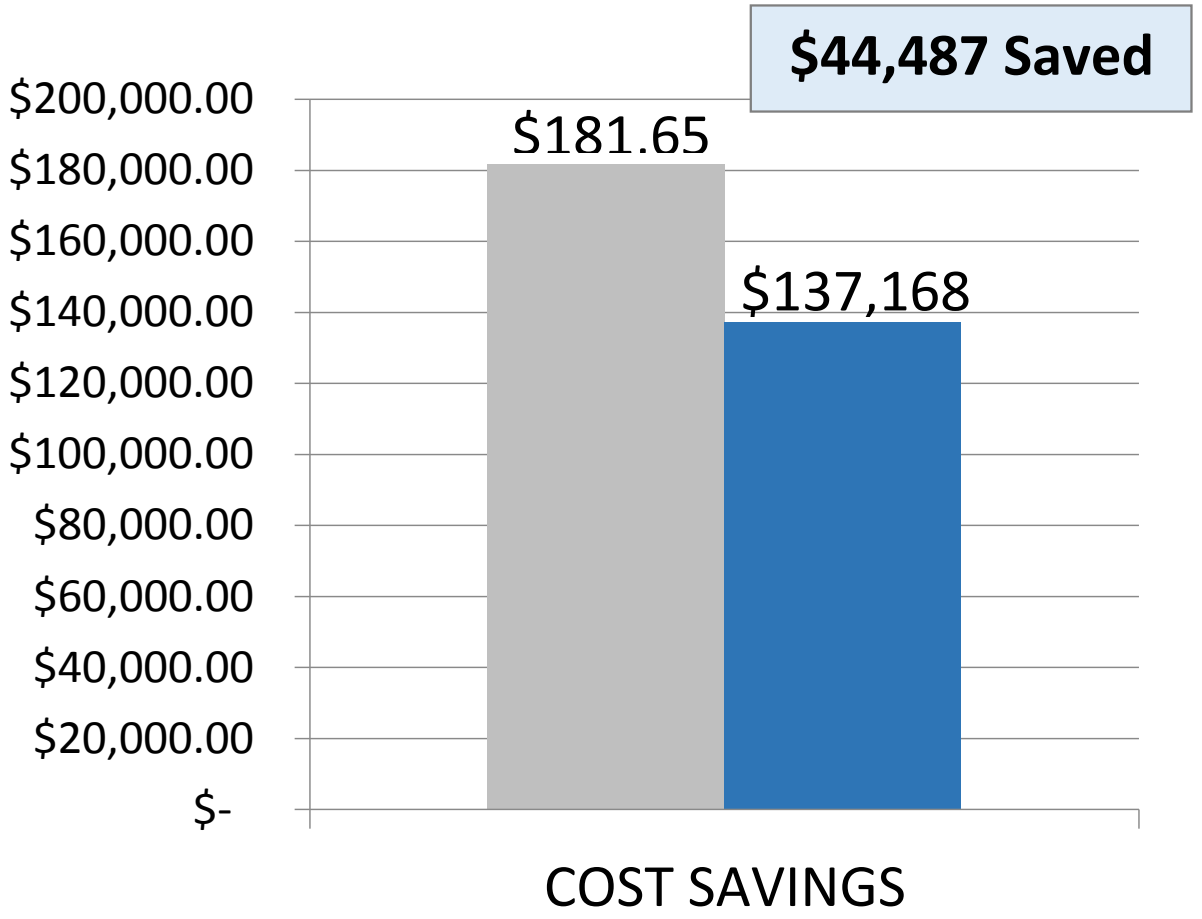


Incarceration

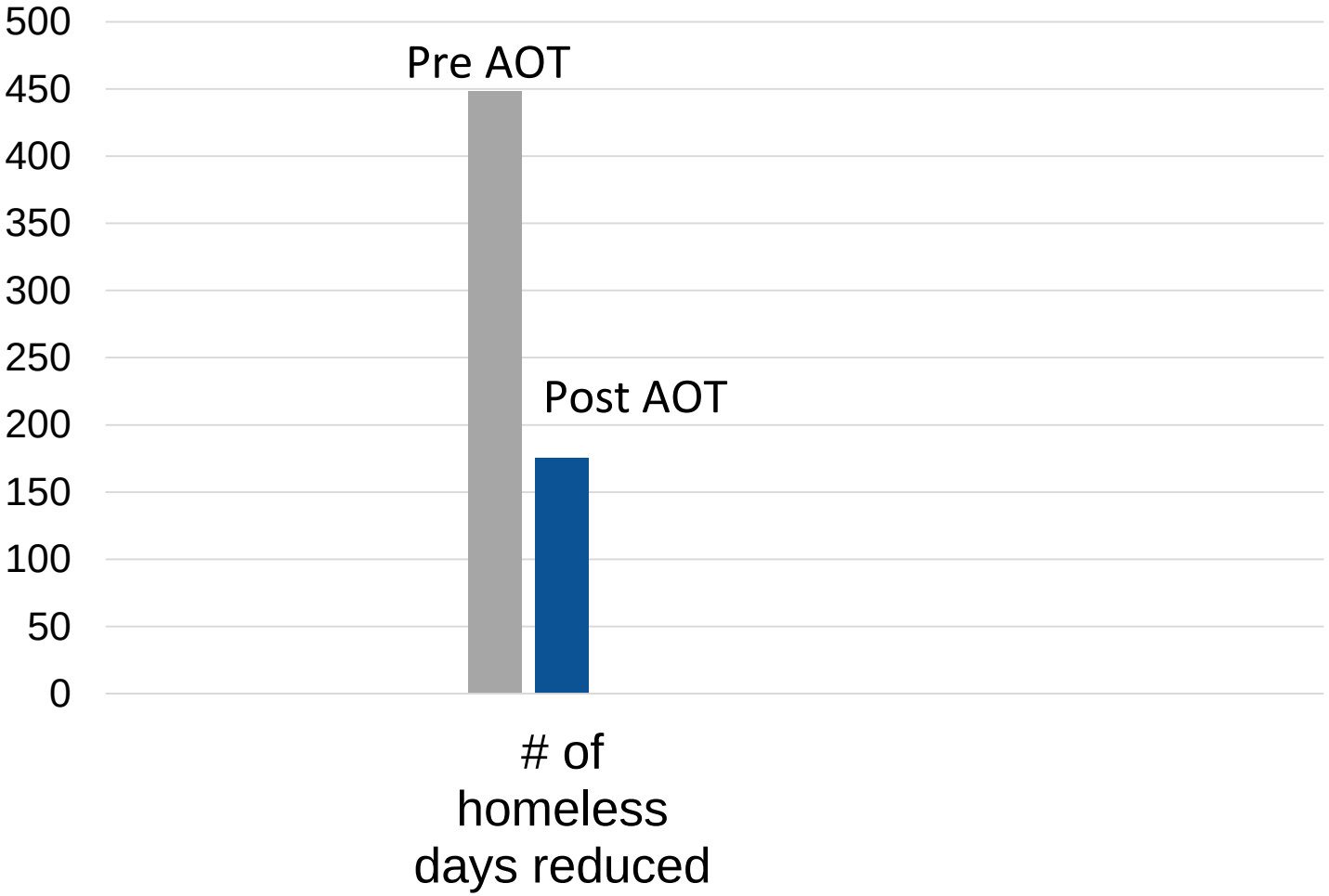


Emergency Visits





Homeless Days



Homeless Days are difficult to quantify in a dollar amount. Many factors can contribute to costs, including:

Police interactions

Emergency Services

Cost of cleaning the public parks and recreation centers

Community and Public safety

Questions?

California Mental Health Planning Council

- Advocacy
- Evaluation
- Inclusion

Adult Residential Facilities (ARFs)

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

The California Mental Health Planning Council (CMHPC) 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 CMHPC is also statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The CMHPC has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The CMHPC 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 Mental 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)[1] in California for adults (including seniors) with mental illness. This is an effort to generate dialogue to identify possible solutions to those barriers.

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

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

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

---

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

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

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

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

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

I. THE CRITICAL NEED

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

ARF Needs By County[4] (Chart 1)

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

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

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

County	Population[5]	Beds Needed	Beds Lost	Out of County[6]
Sierra	3,166	N/A	N/A	2
Colusa	22,312	?		7
Glenn	29,000	0	No	22
Amador	37,302	10	0	10
Siskiyou	44,563	N/A	0	Yes, not sure
Tuolumne	54,511	4	0	4
Nevada	97,946	10	0	?
Napa	141,625	18	8	22
Shasta	178,795	25	12	25
Imperial	184,760	10	0	8
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	2-3?
Kern	884,436	100	100	1
San Bernardino	2,127,735	40	246	Left blank
Riverside	2,331,040	200-300	50	Unknown
Orange	3,165,203	35-50	100	Left blank
TOTAL		**907**	**783**	

The information presented above represents only 1/3 of the total counties in California. The number of ARF beds needed is large and must be addressed. Additionally, the chart shows a large number of people who could return home if there were appropriate housing options (i.e. ARF in their home county.).

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 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

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

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

of the Social Security Income/State Supplemental Payment (SSI/SSP) amounts paid to Californian's with disabilities and who are unable to work. The SSI/SSP payment, as sole source of payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF especially when some amount of the SSI/SSP payment is set aside for personal needs of the individual. Therefore, subsidies, often called "patches" are needed.

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

To illustrate the financial challenges in real life, real time, three sample budgets are presented for a 6, 11, and 13 bed ARF in a very small northern county and a medium urban county. Jeffrey T. Payne, MBA, provided sample budgets for two facilities recently opened in Trinity County. The Willow Glen Care Center entered into contract with Trinity County in July 2014 to operate an ARF in Weaverville, California. An additional board and care facility is opening which will house adults in Full Service Partnerships. These facilities will allow 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 a small county in meeting the housing needs of residents who cannot live on their own and who need a little more care and supervision. Note that similar budgets in larger, more urban counties would require augmented facility rental, lease or purchase costs as well as increased salary costs for staff resulting, oftentimes, in insufficient revenue to cover the operating costs.

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

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

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

Example 2

Adult Residential Facility Twelve-Person Sample Budget

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

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

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

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

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

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

Items not included:

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

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

Residential Care Facility Sample Annual Budget (13 Person)

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

Printing and Postage	500	
Licensing and Permits	$1,711	
Property Taxes	$6,000	Presumes property purchased for $600,000 with $100,000 down payment
Advertising	500	
Total Operating Expenses	$113,294	
Rent or Loan Payments	$30,396	$500,000 loan for 30 years at 4.5%
Total Expenses	$415,724	
Total Net Income (Loss)	**(-399,668)**	(Revenue $160,056 minus Cost $415,724 = Loss $399,668)

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 (also 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 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 5 bedrooms. It is likely that a 13 bed or larger facility would need to be newly constructed.

III. IDEAS FOR DISCUSSION

1. **Tiered Level of Care System –** There could be tiered levels of care, with different licensing categories established to allow for higher rates to be paid to accommodate more care and supervision when required, for example, to meet the needs of individuals who are incontinent or non-ambulatory.

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

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

The California Mental Health Planning Council will examine the feasibility of implementing a similar structure to meet the RCF needs for adults with mental illness.

2. **Social Security Income (SSI) 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.

IV. 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 within 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 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 CMHPC will be convening more experts in this field, as well as, holding public forums on this topic to further explore barriers, possible solutions and to generate additional possibilities for action.

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.

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, "There are no B&Cs in the County. We do not have 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 4 persons currently at B&C as one is elderly, two are dual diagnosed with intellectual disability and mental illness, one has 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?

County	Out-of-County Placements
Sierra	Two (2)
Colusa	Seven (7)
Glenn	22
Amador	Average ten (10)
Siskiyou	Unsure, no RCF beds available within the county
Tuolumne	Four (4)
Nevada	One (1)

County	Out-of-County Placements
Napa	22
Shasta	25
Imperial	Eight (8)
El Dorado	25
Yolo	Average 13
Santa Cruz	20
San Luis Obispo	44
Monterey	45
Tulare	Number not provided
San Joaquin	16
San Mateo	Two (2) or Three (3)
Kern	One (1)
San Bernardino	Number not provided
Riverside	Unknown, not tracked
Orange	25

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

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

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

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

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

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

- "Referring strictly to locked psychiatric facilities, our county is in need of several more beds (perhaps up to 40 additional beds). Due to recent legislative changes (since 2014), there has been a voluminous increase in referrals for LPS evaluations and more persons placed on LPS conservatorship. We often need our clients to have treatment in State Hospitals or IMDs for a protracted period as we are seeing a

more seriously mentally ill profile in addition to a much more violent population. We also are seeing a trend of younger persons in need of this high level of care and some of the IMDs are disinclined to accept said group. Therefore, we need not only more beds, but facilities willing to accept this younger, more violent type of patient."

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

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

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

- "As older operators age out, the establishment of new facilities is cost prohibitive given the current SSI/SSP rates to provide "basic" care and supervision. Therefore, existing resources are diminishing each year and we are seeing faster turnover (open, then close) of new small facilities. Supplemental Rates are established to reimburse for "augmented" services in order to cover the additional cost for the operator. It is not designed to cover basic operating cost. The cost of property, related taxes, increased oversight by CCL and enforcement of labor laws (OT, Workman's Comp., Insurance, etc.) either requires the owner/operator of a 6 bed to work 24/7 or not operate (not enough funds to hire help). Reimbursement does not cover facility maintenance costs so a number of existing facilities are in major disrepair. This has resulted in very poor quality housing and increased CCL citations and fines that the owners do not have funds to address. As a result, the only viable fiscal option is to work to establish large homes (40 beds+) to achieve economies of scale and even then, it may not be fiscally viable without some type of augmentation. Larger facilities are generally more institutional in environment and, if new, face the challenge of NIMBY opposition."

ATTACHMENT B

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

Along with the basic board and care residential facility services that are provided for all ARF clients according to Community Care Licensing (CCL) requirements, counties contract for supplemental services for individuals who have on-going mental health issues, need assistance with daily living and are difficult to place. The RCF provider is expected to provide staffing above the required minimum by CCL to assist clients with medical and psychiatric needs. For these supplemental services, counties pay "patches", ranging from $64/day to $125/day per resident (in addition to the SSI that is paid of approximately $1026/month/resident[9]).

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. RCF should be customized to offer culturally specific programming, such as*

[9] 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.*

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[10], 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.).

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

ATTACHMENT C

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

EFFECTIVE JANUARY 1, 2017

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[11]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[12]
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

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

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[11]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[12]
4G	$5,364	$5,436
4H	$5,766	$5,845
4I	$6,334	$6,422

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

DEPARTMENT OF DEVELOPMENTAL SERVICES

COMMUNITY CARE FACILITY RATES
FOUR OR LESS BEDS PER FACILITY

EFFECTIVE JANUARY 1, 2017

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[13]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[14]
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

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

Service Level	Monthly Payment Rate Per Consumer Effective **7/01/2016**[13]	Monthly Payment Rate Per Consumer Effective **1/01/2017**[14]
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.

Item 13 a & b.
Long Range Planning Calendars

Yolo County Local Mental Health Board
Long Range Planning Calendar 2018

Meeting	Agenda Item	Agency/Presenter	Type	Timing
1/29/18	5150 Process Presentation	Harjit Singh Gill, Samantha Fusselman	Presentation	Past
2/26/18	MHSA 3-year Plan Update	RDA	Presentation	Past
2/26/18	Homeless Presentation	Aurora William	Presentation	Past
3/26/18	CCP Presentation	TBD	Presentation	Upcoming
3/26/18	Committee Workshop	All	Committee Meeting	Upcoming
4/30/18	Annual Report Approval	Executive Committee	Recommendation	Upcoming
4/30/18	Behavioral Health Services Budget Presentation	Connie Cessna-Smith, HHSA Fiscal Administrative Officer	Presentation	Upcoming
5/21/18	Public Guardian Presentation	Laurie Haas, HHSA Chief Deputy Public Guardian	Presentation	Upcoming
5/21/18	Annual Election of Officers	All	Adoption	Upcoming
6/25/18	MHSA Update	Resource Development Associates (RDA)	Presentation	Upcoming
6/25/18	Committee Workshop	All	Committee Meeting	Upcoming
8/27/18	Davis Wellness Center Remodel Update	TBD	Presentation	Upcoming
9/24/18	Committee Workshop	All	Committee Meeting	Upcoming
9/24/18	Approval of LMHB Recommendation on the BHS Recommended Budget	All	Recommendation	Upcoming
10/29/18	Presentation	TBD	Presentation	Upcoming
12/3/18	2018 LMHB Meeting Calendar Approval	All	Adoption	Upcoming

Last Updated 2/23/18

2018

January

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February

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25	26	27				

March

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April

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29	30					

May

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27	28	29	30	31		

June

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July

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16	17	18	19	20	21	22
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30	31					

August

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26	27	28	29	30	31	

September

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23	24	25	26	27	28	29
30						

October

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21	22	23	24	25	26	27
28	29	30	31			

November

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18	19	20	21	22	23	24
25	26	27	28	29	30	

December

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16	17	18	19	20	21	22
23	24	25	26	27	28	29
31	31					

Regular Meeting Committee Workshops County Holiday

Yolo County Local Mental Health Board

JANUARY 29, 2018 - DAVIS
Mary L. Stephens Library, Blachard Community Conference Room, 315 East 14th Street, Davis, CA 95616 *7:00 – 9:00 PM Regular Meeting*

FEBRUARY 26, 2018 - WEST SACRAMENTO
AFT Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA 95691
7:00 – 9:00 PM Regular Meeting

MARCH 26, 2018 - WOODLAND
Bauer Building, Thomson Conference Room, 137 N. Cottonwood St. Woodland, CA 95695
7:00 – 8:00 PM Regular Meeting / 8:00 – 9:00 PM Committee Workshops

APRIL 30, 2018 - DAVIS
Mary L. Stephens Library, Blachard Community Conference Room, 315 East 14th Street, Davis, CA 95616 *7:00 – 9:00 PM Regular Meeting*

MAY 21, 2018 - WINTERS
Putah Creek Conference Room, 111 East Grant Ave. Winters, CA 95694
7:00 – 9:00 PM Regular Meeting

JUNE 25, 2018 - WEST SACRMANTO
AFT Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA, 95691
7:00 – 8:00 PM Regular Meeting /
8:00 – 9:00 PM Committee Workshops

JULY - BOARD RECESS

AUGUST 27, 2018 - WOODLAND
Bauer Building, Thomson Conference Room, 137 N. Cottonwood St. Woodland, CA 95695
7:00 – 8:00 PM Regular Meeting

SEPTEMBER 24, 2018 - DAVIS
Mary L. Stephens Library, Blachard Community Conference Room, 315 East 14th Street, Davis, CA 95616 *7:00 – 8:00 PM Regular Meeting / 8:00 – 9:00 PM Committee Workshops*

OCTOBER 29, 2018 - WEST SACRAMENTO
AFT Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA, 95691
7:00 – 9:00 PM Regular Meeting

DECEMBER 3, 2018 - WOODLAND
Bauer Building, Thomson Conference Room, 137 N. Cottonwood St. Woodland, CA 95695
7:00 – 8:00 PM Regular Meeting