

**Oversight Hearing  
Senate Human Services Committees**

**February 24, 2020 – 3:00 p.m.  
State Capitol Room 2040**

**State Oversight of Licensed Homes for Vulnerable Adults**

**Background Paper**

***Introduction***

Over 200,000 Californians who cannot live independently due to physical limitations or behavioral health needs depend on licensed residential care facilities for housing and assistance with activities of daily living (ALDs). These facilities, commonly referred to as board and care or assisted living facilities, are licensed by the California Department of Social Services (CDSS) Community Care Licensing Division (CCLD) as Adult Residential Facilities (ARFs) or Residential Care Facilities for the Elderly (RCFEs). ARFs and RCFEs serve an important role in providing housing, care and supervision to people who cannot safely live on their own. Often, these facilities are viewed as an alternative to Skilled Nursing Homes or hospitalization for these vulnerable Californians, providing lower cost housing and care while also allowing individuals to remain in the community. ARFs and RCFEs do not provide medical services, but rather provide 24-hour, assistance with ADLs, such as meals, help with toileting or bathing, transportation to appointments in the community, and medication management.

According to the California State Plan on Aging, California is home to more than seven million people age 60 or older. By 2060, that population is expected to reach 14.7 million, an increase of 88 percent from 2016. Furthermore, the number of Californians aged 85 and older is expected to grow from approximately 600,000 in 2010 to over 2.25 million in 2050.<sup>1</sup> As California's population ages and other factors (such as the opioid epidemic) increase the number of individuals with behavioral health needs, the demand for ARF and RCFE placements will increase. This is especially true as more and more communities struggle with individuals experiencing homelessness who need more than just housing. They also need care and supervision. These may be individuals with behavioral health needs, individuals with disabilities, or older adults who cannot live safely on their own. As a result, counties and other stakeholders see ARFs and RCFEs as part of the continuum of solutions to California's homelessness crisis.

While communities all over the state clamor for more housing options for a wide variety of populations, ARFs and RCFEs are well suited to meet the housing needs of older adults,

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<sup>1</sup> California State Plan on Aging: 2017-2021. California Department of Aging, 2017.

individuals with disabilities, and individuals with certain behavioral health needs. Yet, the need for ARF and RCFE beds must be balanced with the regulation of these facilities. In recent years, high profile allegations of wage theft,<sup>2</sup> human trafficking,<sup>3</sup> sexual assault,<sup>4</sup> and abandonment<sup>5</sup> at RCFEs highlights the importance of regular oversight of these facilities.

Regular and consistent oversight is critical to the health and safety of residents even when the extreme examples highlighted above are not occurring. For example, there is evidence that low performing facilities that serve very low income populations have been operating on shoestring budgets. These diminished budgets are believed to have detrimentally affected the quality of care as well as the condition of the facilities, to the point that residents live in squalor with few, if any, planned activities. Moreover, some of these facilities have documented episodes of bed bugs or other infestations as well as need for major facility renovations in order to remain safely inhabitable. CCLD plays a critical role in providing regulatory oversight and, when possible, assistance with improving conditions to these struggling facilities. This is not to suggest that oversight is only necessary for facilities that charge minimal fees. Residents who pay much higher rates are also vulnerable by definition and rely on CCLD's presence to protect their health and safety. Thus, this hearing will explore an array of issues currently facing these residential facilities as licensed and regulated by CCLD.

### ***“Board and Care Facilities”***

There is no universal definition for “board and care facilities.” Generally, the term refers to residential facilities that serve adults or seniors who cannot live safely on their own without personal care assistance and nonmedical care. They are typically privately operated facilities that serve individuals with varying needs. Clients may be older adults who cannot safely live on their own, persons with disabilities, cognitive impairments, or behavioral health needs.

Board and care facilities further divide into two categories, board and care homes and assisted living communities. Board and care homes typically refers to a house located within a residential neighborhood that provides 24-hour non-medical care and supervision, often including assistance with ADLs. These homes typically offer residents a bedroom of their own or a bedroom to share with another resident. Assisted living communities also provide care and supervision, but they do so in larger settings in which residents reside in their own units or apartments.

Board and care facilities differ from a room and board arrangement in that they offer care and supervision to residents. This requires that the facilities be licensed by CCLD as either an ARF or RCFE. Both ARFs and RCFEs are defined in California regulations as any residential facility of any capacity that provides 24-hour-a-day nonmedical care and supervision to either people between the ages of 18 to 59 (ARFs), or people age 60 and older (RCFEs), who have comparable

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<sup>2</sup> <https://www.latimes.com/business/la-fi-wage-theft-california-care-workers-20190521-story.html>;  
<https://www.revealnews.org/episodes/the-unpaid-cost-of-elder-care/>

<sup>3</sup> <https://www.latimes.com/local/lanow/la-me-ln-human-trafficking-20180907-story.html>

<sup>4</sup> Ibid.

<sup>5</sup> <https://www.kcra.com/article/state-seniors-were-abandoned-during-santa-rosa-wildfire/23017861>

needs and require the same level of care as other adult residential facility clients. Operating a licensed board and care facility requires the facility to provide residents specific services and also requires they observe, enforce, and implement residents' rights.<sup>6</sup>

Fundamental to board and care facilities is the "care and supervision" of their residents. Thus, RCFEs and ARFs provide assistance, as needed, to residents with ADLs and assume varying degrees of responsibility for the safety and well-being of residents. Care and supervision means any one or more of the following activities shall be provided by a person or facility to meet the needs of the residents:

- Assistance in dressing, grooming, bathing and other personal hygiene;
- Assistance with taking medication, as specified;
- Central storing and/or distribution of medications, as specified;
- Arrangement of and assistance with medical and dental care;
- Maintenance of house rules for the protection of clients;
- Supervision of client schedules and activities;
- Maintenance and/or supervision of client cash resources or property;
- Monitoring food intake or special diets; and/or
- Providing basic services as specified.

Moreover, these facilities provide assistance with ADLs, which may include assistance with dressing, grooming, bathing and other personal hygiene; assistance with taking medication; central storing and distribution of medications; arrangement of and assistance with medical and dental care (including transportation); maintenance of house rules for the protection of residents; supervision of resident schedules and activities; maintenance and supervision of resident monies or property; meal preparation; and monitoring food intake or special diets. If a facility is providing, or even presenting that it will provide, care and supervision or assistance with ADLs without a license to do so, that facility could potentially be operating as an unlicensed RCFE or ARF.

Since board and care facilities are typically privately operated, the costs and conditions of the facility vary greatly. Beyond the minimum care and supervision services, facilities may also offer organized outings, various daily activities or organized programming, or other services for residents. Depending on the level of services, location of the facility, level of care, and other market factors, the rates charged by ARFs and RCFEs range from over \$10,000 to as low as \$1,058 per resident per month. The \$1,058 rate is funded with a combination of state and federal dollars and made available to people age 65 or older, blind or disabled and meet income and asset tests to be eligible to receive Supplemental Security Income/State Supplementary Payment (SSI/SSP). These facilities typically offer little beyond minimum care and supervision services.

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<sup>6</sup> For more information on residents' rights see: <https://www.disabilityrightsca.org/publications/rights-in-adult-residential-facilities>

## *Community Care Licensing Division (CCLD)*

The mission of the CCLD is to “promote the health, safety, and quality of life of each person in community care through the administration of an effective and collaborative regulatory enforcement system.” According to CCLD, ensuring the health, safety, and quality of life of residents “requires that the physical conditions of facilities and the care and supervision provided by the staff support the health and safety of the individuals receiving care.”<sup>7</sup>

Individuals served by CCLD licensed facilities are often some of the most vulnerable in society. For example, infants and toddlers are cared for in childcare centers while their parents go to work; children who are victims of abuse or neglect are removed from their families and placed into various types of licensed residential facilities; children with extreme behavioral issues that their parents are not equipped to handle may also reside in licensed residential facilities; adults who are unable to take care of themselves, often due to physical or behavioral health limitations or developmental disabilities, reside in licensed adult residential facilities; and senior citizens, including those with dementia and Alzheimer’s disease, live in licensed residential care facilities for the elderly.

CCLD licenses approximately 74,700 community care facilities that serve children, adults, and older adults. Approximately 5,200 of these licensed facilities are ARFs with the capacity to serve approximately 37,240 Californians, and 7,360 are RCFEs with the capacity to serve approximately 188,700 Californians, as of June 2019. This means the average capacity for an RCFE is 26. For ARFs, the average capacity is seven. The division is responsible for conducting routine facility inspections, complaint investigations, and consultation to facilities on how to reach or maintain compliance.

### *Staffing and Policy Changes at CCLD*

Prior to 2003, CCLD was required to conduct annual unannounced licensing visits for most facility types. However, due to the state's budget deficit and declining revenues, it was deemed necessary to reduce costs throughout state government and, as a result of cuts to CCLD's staffing, the division’s presence in the community was significantly diminished when mandatory inspections of both ARFs and RCFEs was reduced to just once every five years. The extended length of time between visits caused CCLD’s oversight efforts to become complaint-driven, hindering their ability to form relationships with facility operators and work proactively with those operators to identify and address risks of harm or mismanagement.

Around the same time of the budget cuts, CDSS designed and implemented the key indicator tool (KIT), which is a shortened inspection checklist, for all of its licensed programs. The KIT was designed with the intent to standardize the inspection protocol between facilities and between inspectors; enhance the efficiency of the inspection process; and, appropriately identify whether a more comprehensive inspection is warranted. In 2017, the Legislature approved Supplementary Reporting Language that required the CDSS to meet with legislative staff and stakeholders to

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<sup>7</sup> PIN 19-06-CCLD

discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. In September 2017, the Department released a report detailing its plan to develop new inspection tools, which would replace the KIT.

The new inspection tools and procedures are part of CCLD's ongoing Inspection Process Project (IPP). The goal of the IPP is to build tools that provide a holistic view of a facility's overall health, informed by statistical analysis and risk assessment factors, and that are practical for CCLD staff to use. As a result, there are two types of inspection tools; a standard tool, which replaces the KIT, and domain focused tools. The standard tool includes regulations most critical to the health and safety of the individuals in that particular type of care facility. The domain focused tools are organized into broad categories, or "domains," such as "physical plant and environmental safety" and "personnel records and training." The domain focused tools facilitate deeper evaluation of the full array of statutes and regulations within the given domain. There are eleven domains included in the inspection tools for RCFEs. They are: operational requirements; physical plant/environmental safety; staffing; personnel records/staff training; resident rights/information; resident records/incident reports; food service; planned activities; incidental medical and dental; residents with special needs; and disaster preparedness.

The inspection tools replaced the KIT for all RCFEs as of November 2019 and CDSS reports plans to launch the new inspection tool for ARFs in June 2020. Currently, most RCFEs are inspected using the standard tool. However, if the licensing program analyst (LPA) notes violations involving certain health and safety risks, the more extensive domain-focused tool is triggered for the domain category where violations were found. If an inspection triggers two or more domain focused tools, comprehensive inspection is triggered. This requires the completion of all 11 domain-focused tools. The comprehensive tool is also used to inspect facilities that are in substantial noncompliance, on probation and other situations that CCLD determines would warrant a higher level of inspection.

The planned domains for ARFs are similar to those for RCFEs, except they do not include resident rights, planned activities or residents with special health needs. The domains for inspecting ARFs also include health-related services, and incidental medical services and emergency intervention, which are not part of the RCFE tools. These differences reflect variance in laws and regulations governing ARFs and RCFEs.

CCLD developed the tools with input from subject matter experts and California State University, Sacramento helped establish a validation process that includes statistical validation, risk assessment, and implementation factors, such as:

- Analyzing patterns of co-violations to determine which regulations to include in the (shorter) Standard Tool that will replace the KIT.
- Using risk factors, as identified by subject matter experts, to evaluate criticality (i.e., the likelihood of an event occurring, its severity, and the level of potential harm).
- Using pilot data from field staff and licensees, identify and address implementation issues so that inspections are both effective and efficient.

As these increased investments have been made in CCLD and new tools are developed and piloted, CCLD also shifted to operating with a broader regulatory approach that focusses on prevention, collaboration, and enforcement, rather than the primary focus on complaint driven enforcement that was adopted after the 2003 budget cuts. With these changes, CCLD aims to shift the organizational culture toward an approach that is more clearly linked to the health and safety of people under the care of licensed facilities through prevention, collaboration, compliance, and enforcement. Specifically, CDSS hopes the new inspection process will result in:

- Inspections through the implementation of standardized tools that are:
  - Consistent: Meaning the content of the inspections will be standardized, and LPAs will have a consistent process for performing inspections;
  - Thorough: Meaning that the full range of important domains is represented in each inspection;
  - Efficient: Meaning the tool covers all domains in a concise way; and
  - Effective: Meaning the tools are accurate in assessing overall facility health.
- Actionable information, by generating data on facility compliance as well as noncompliance, giving CDSS a more holistic and accurate picture of facility and system performance over time. CDSS will use this information to focus resources and develop strategies for division-wide policy and program actions.
- Identification of promising practices as well as areas of concern that may require training and improvement.
- Continuous Quality Improvement (CQI) processes that integrate multiple data sources to get the fullest picture possible of the health of a facility over time.
- Inspection procedures that emphasize prevention and enforcement of regulations that are key to the health and safety of the residents.

With implementation of the inspection tool, CCLD also launched several quality enhancements and improvements. These efforts are intended to:

- Create a more robust training program for licensing inspectors;
- Create a quality assurance unit with employees who are trained to detect instances of systemic noncompliance;
- Centralize and make more efficient the application and complaint intake process; and
- Create medical capacity at CDSS to begin considering the increasing medical needs of those in assisted living facilities.

Additionally, in recent years, as the state's economic and fiscal situation improved, the Legislature authorized additional resources for CCLD and the LPA staffing level has increased from 180 in Fiscal Year 2014-15 to 236 in Fiscal Year 2018-19. In December 2019, there were 18 vacant LPA positions in the unit that inspects ARFs and RCFEs. This investment was part of a larger Quality Enhancement initiative for CCL, which was first introduced in the Fiscal Year 2014-15 budget. As CCLD resources were increased the Legislature also incrementally increased the frequency of mandatory inspections for ARFs and RCFEs to once a year beginning in January 2019.

CCLD has also created a Technical Support Program (TSP), which is designed support to licensees and providers who are struggling to meet and maintain the requirements of operating a licensed facility. TSP is free, voluntary, and offers intense onsite assistance to licensees. In addition to hands on direct support for struggling facilities, TSP develops and publishes Resource Guides, which are intended to serve as tools to help licensees understand the requirements of compliance and provide best practice suggestions. The program also publishes a quarterly newsletter to relay official messages to, communicate with, and provide resources to licensees.

TSP engagement is an additional resource for licensees who have demonstrated a sincere desire to become compliant, but whose needs for assistance in correcting the causes of noncompliance are more time-intensive than can be easily accommodated by the case-carrying LPA. TSP does not replace the current consultation that an LPA already provides to the licensees in their caseload.

TSP services can include consultation, resources and best practice strategies for improving the quality of care being provided. Each engagement is customized based on each facility's unique needs. After the TSP engagement is over the TSP team is available for follow-up support, consultation, and on-site visits as needed.

CCLD has specific statutory authority to assist RCFEs with compliance. Health and Safety Code section 1569.12 states, "the department may provide consulting services upon request to any residential care facility for the elderly to assist in the identification or correction of deficiencies and in the upgrading of the quality of care provided by the facility." CCLD extends the same offer of assistance to AFRs, although the same authority does not appear to exist in current law.

There are 4 TSP analysts serving ARFs and RCFEs. In 2019, the residential TSP team received and completed 58 referrals, up from 33 in 2018.

Another example of CCLD efforts to provide technical assistance for licensees are the ongoing Mental Health Symposiums that began in 2016. The purpose of the symposiums is to educate CCLD staff on how to recognize and respond to a wide array of mental health related issues that may be encountered while conducting inspections or otherwise interacting with facilities. These symposiums provide CCLD staff a better understanding of the mental health system so that they can disseminate helpful information to licensees, when appropriate. CCLD collaborates with law enforcement, mental health professionals, medical professionals, advocacy groups and others to provide these trainings. Topics covered thus far included an overview of California's mental health system and current trends/issues; Alzheimer's disease; mental health crisis teams; CCLD's collaborative relationships with law enforcement, the Department of Mental Health, Adult Protective Services, and the Residential Placement Protocol Task Force; homelessness; the Mental Health Services Act; homelessness in the geriatric population; caregiver burnout; use of anti-psychotics; among others.

CCLD's efforts to increase LPA's knowledge and understanding of homelessness and mental health services demonstrates an understanding that CCLD's presence in the community and actions taken at the facilities have the potential to impact the larger needs of the population served

and the surrounding community. If LPAs can help a facility stabilize individual residents or improve the status of an entire facility that, in turn, benefits the surrounding community.

Furthermore, CCLD regularly works with stakeholders to develop new or update existing regulations. This collaboration allows the department to hear from licensees and resident advocates while new regulations are developed to respond to residents' needs in a manner that contemplates the regulations impact on licensed operators. For example, CCLD is currently working on a regulations that will establish a Uniform Assessment Tool for RCFEs, which was developed in compliance with Health and Safety Code (HSC) section 1562.62(c)(1). HSC Section 1562.62(c)(1) states: "the department shall develop a uniform resident assessment tool to be used by all residential care facilities for the elderly. The assessment tool shall, in lay terms, help to identify resident needs for service and assistance with activities of daily living." Major areas addressed in the tool include: assessment information, medical history and conditions, diet, social/family history, fall risk, and finances. CCLD is also working with stakeholders to develop additional regulations to assist facilities that care for patients with dementia and in other policy areas.

### *Enforcement Tools*

CCLD has a number of tools it can use to enforce applicable statutes and regulations: they have inspection authority; citation authority; authority to require a corrective action plan; authority to issue financial penalties; and, in extreme cases, they can revoke a license. LPAs working out of regional offices conduct inspections and complaint investigations. Their finding may result in any number of actions, as each situation is contemplated on a case-by-case basis. Seriously egregious violations may involve revocation of a license, whereas less extreme violations may warrant an informal consult or a citation with a fine.

Yearly, CCLD receives about 5,500 complaints involving ARFs and RCFEs. The two most common allegations are that a facility has violated the personal rights of a resident or that there was neglect or a lack of supervision. Examples of a personal right violation might involve a resident being left soiled for extended period of time, staff making an inappropriate comment to residents, dirty mattresses or a locked refrigerator. Complaints about lack of supervision could contain allegations that the facility staff is not physically taking care of resident, there is insufficient staff to meet needs of residents, or that staff are not assisting with ADLs. The third most common complaints type contain allegations of physical plant requirements violations, which could involve infestation, overall cleanliness of a facility, inoperable light fixtures, leaking roof, or other necessary repairs.

<b>Total ARF Complaints Received And Number of Allegations Fiscal Years 20145-15 to 2018-19</b>					
	<b>FY 2014-15</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>FY 2017-18</b>	<b>FY 2018-19</b>
Complaints Received	1,675	1,683	1,725	1,738	1,570
Crimes	7	5	12	0	4
False Statements	11	8	4	5	2
Financial Abuse	88	54	61	45	38
Financial Issues	34	27	31	20	18
Fire Clearance	19	15	6	7	5
Food Services	243	204	217	143	88
Level Of Care	36	40	33	21	20
License	15	8	8	6	13
Medication	205	220	253	171	162
Neglect/Lack of Supervision	581	545	548	454	442
Personal Rights	1,015	937	1,112	805	769
Physical Abuse/ Corporal Punishment	167	126	114	80	87
Physical Plant	422	382	401	293	292
Qualifications	104	63	67	34	30
Questionable Death	6	1	1	1	0
Record Keeping	70	60	74	52	33
Sexual Abuse	63	45	40	26	27
Unlicensed Care	86	54	44	25	44
Other	326	279	297	215	235
<b>Total</b>	<b>3,498</b>	<b>3,073</b>	<b>3,323</b>	<b>2,403</b>	<b>2,309</b>

<b>Total RCFE Complaints Received And Number of Allegations Fiscal Years 20145-15 to 2018-19</b>					
	<b>FY 2014-15</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>FY 2017-18</b>	<b>FY 2018- 19</b>
Complaints Received	3,590	3,933	4,212	4,305	4,090
Crimes	11	12	12	7	1
False Statements	34	16	13	19	11
Financial Abuse	152	99	116	69	54
Financial Issues	74	97	91	77	78
Fire Clearance	52	23	26	21	17
Food Services	542	497	555	415	355
Level Of Care	234	269	234	154	148
License	40	30	37	14	13
Medication	688	694	754	595	543
Neglect/Lack of Supervision	1,908	2,077	2,191	1,671	1,598

Personal Rights	2,112	1,854	2,210	1,577	1,642
Physical Abuse/ Corporal Punishment	134	99	105	80	83
Physical Plant	929	956	1,072	798	807
Qualifications	280	268	263	171	120
Questionable Death	32	15	9	10	13
Record Keeping	191	228	239	216	132
Sexual Abuse	53	29	37	32	37
Unlicensed Care	86	96	115	87	116
Other	1,027	1,026	1,158	815	939
<b>Total</b>	<b>8,579</b>	<b>8,385</b>	<b>9,237</b>	<b>6,828</b>	<b>6,707</b>

In 2019, CCLD staff issued over 17,300 citations to RCFEs and over 6,300 to ARFs for deficiencies, or non-compliance with regulations. For both facility types, the most common regulation cited was the requirement that facilities must be clean, safe, sanitary, and in good repair at all times.

### ***State Long-Term Care Ombudsman***

Another tool that serves to protect the health, safety and wellbeing of board and care facility residents is the State Long-Term Care Ombudsman, which was authorized by the federal Older Americans Act and the state's Older Californians Act. The Ombudsman Program is charged with resolving problems and advocating for the rights of residents in long-term care facilities (Skilled Nursing Facilities (SNFs), ARFs and RCFEs). The mission of the Long-Term Care Ombudsman Program is to seek resolution of problems and advocate for the rights of residents of long-term care facilities with the goal of ensuring their dignity, quality of life, and quality of care. All Ombudsman services are provided for free and all complaints are confidential. Local Ombudsman programs are staffed by a combination of paid and volunteer representatives who are specially trained to respond to concerns that an older adult or adult with a disability might be experiencing abuse or neglect. Representatives from the program assist residents with issues related to day-to-day care, health, safety, and personal preferences, such as issues regarding:

- Violation of residents' rights or dignity;
- Physical, verbal, mental, or financial abuse;
- Poor quality of care;
- Dietary concerns;
- Medical care, therapy, and rehabilitation issues;
- Medicare and Medi-Cal benefit issues;
- Improper transfer or discharge of a resident; and/or
- Inappropriate use of chemical or physical restraints.

Ombudsman Program representatives conduct quarterly visits to ARFs, RCFEs and SNFs throughout California. During these visits, they engage with residents and observe facility

conditions. When necessary, and with appropriate consent, they will refer problems to CCLD. They also share general concerns and observations about facilities with CCLD.

In Federal Fiscal Year 2018, the Ombudsman Program investigated 39,346 complaints and resolved or partially resolved 67 percent of them to the residents' satisfaction. They also act as a resource for facility operators and provide consultation on topics including resident rights and resident care issues.

In Fiscal Year 2019-20, the California state budget provided that the Ombudsman should provide residents with regular and timely access to services through quarterly facility visits. The budget included funding for this purpose.

## **Homelessness**

A U.S. Department of Housing and Urban Development's (HUD) 2019 Annual Homeless Assessment Report to Congress (Report) found that although much of the country experienced a combined decrease in homelessness in 2019, the West Coast saw significant increases in unsheltered and chronic homelessness. According to the Report, California's homeless population increased 16.4 percent, or an additional 21,306 individuals, experiencing homelessness from the state's numbers reflected in the 2018 Report. Additionally, the Report found that California has more than half of all unsheltered homeless people in the country, 53 percent or 108,432 individuals.

While the above data is helpful in providing an understanding of the scope of the homelessness problem in California, it is important to note that HUD's point-in-time count is commonly understood as reflecting an undercount. The numbers above are thus a useful estimate, and not an exact reflection of California's current homeless population.

Though not a population specifically reflected in the Report, HUD has seen the number of individuals 62 and older experiencing homelessness jump 68.5 percent from 2007 to 2017. Like other homelessness population trends, these changes are reflected in California's population of individuals experiencing homelessness. For example, in Los Angeles County older adult homelessness jumped 22 percent in 2018, reflecting an increase from just over 4,000 individuals experiencing homelessness age 62 and older to just over 4,800.<sup>8</sup> San Diego, San Francisco, and Sacramento Counties have all also reported increases in their homeless populations of people 55 and older. Furthermore, researchers predict that in Los Angeles County alone, the number of older adults experiencing homelessness could reach nearly 14,000 by 2030, if solutions are not found.<sup>9</sup>

Despite these increases, communities may not be prepared for meeting the unique needs of this population. For example, while reporting on the increase of homeless seniors in 2018, the Los Angeles Times found that Los Angeles County had not conducted a formal review and assessment of the needs of older adults, as they had done for other subpopulations. Since the time of that reporting, and in light of the population increase, Los Angeles County has begun making an effort

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<sup>8</sup> <https://www.latimes.com/local/lanow/la-me-ln-homeless-older-adults-20180719-story.html>

<sup>9</sup> <https://www.kpbs.org/news/2019/apr/25/senior-streets-little-chance-home/>

to address the needs of this population through rent subsidies, roommate arrangements and getting more older adults on affordable housing waitlists. These efforts began ramping up in the spring and summer of 2019. However, concerns remain over whether the systems set up to help older adults are properly connecting with those serving the homeless.

***Supply and Demand***

As conversations around board and care facilities have increased, in part due to the Governor’s 2020-21 Proposed Budget,<sup>10</sup> questions remain surrounding the scope of the supply and demand problem. Various stakeholders have expressed concerns surrounding reports that board and care facilities are closing at an increased rate. This is, in part, blamed on the low reimbursement rates for facilities that accept SSI/SSP recipients and facilities’ generally high operating costs. It is feared that this problem is particularly exacerbated in areas with high costs of living and high property values, because the owners of board and care facilities may choose to sell the property rather than continue operations. However, despite these growing concerns, questions remain regarding the severity of closures, reasons for closures, and what happens to residents when facilities close.

Further feeding into discussions around the overall state of board and care capacity is California’s well documented rapidly aging population. As highlighted by the Governor’s Master Plan on Aging, long terms supports and services are increasingly needed in growing numbers for California’s older adults. Board and care facilities play an important role in providing housing, care and supervision to this population. Due to limitations in data, it is currently unknown whether the availability of board and care placements has been keeping up with the needs California’s older adult population.

CCLD reports that from Fiscal Year (FY) 2014-15 to FY 2018-19 the number of licensed ARFs has increased by 132 facilities, while the capacity of these facilities has decreased by 1,572.<sup>11</sup> The number of licensed RCFEs has decreased by 187, but the capacity has increased by 9,159. This suggest newly opening RCFEs have larger capacity than those that closed, while newly opened ARFs have less capacity than those that closed. In San Francisco and Los Angeles Counties, where stakeholders report a high rate of closures because of the high costs of living in these areas, data provided by CCLD shows a loss of overall ARF capacity. Los Angeles saw an increase in RCFE capacity.

ARFs						
Location	# Licensed 2014-15	+/-	# Licensed 2018-19	Capacity 2014-15	+/-	Capacity 2018-19
Los Angeles	1,356	+11	1,367	12,491	-1,018	11,473
San Francisco	60	-19	41	599	-145	454
Statewide	5,074	+132	5,206	38,812	-1,572	37,240

<sup>10</sup> <https://www.gov.ca.gov/2020/01/10/governor-newsom-proposes-2020-21-state-budget/>

<sup>11</sup> To see a breakdown by county of number and capacity of licensed ARFs and RCFEs, see Attachments 1 and 2.

RCFEs						
Location	# Licensed 2014-15	+/-	# Licensed 2018-19	Capacity 2014-15	+/-	Capacity 2018-19
Los Angeles	1,393	-1	1,392	38,472	+745	39,217
San Francisco	80	-18	62	3,196	-25	3,171
Statewide	7,548	-187	7,361	179,558	+9,159	188,717

According to different data provided by CCLD, 4,006 ARFs and RCFEs closed between 2017 and 2019, 1,395 of them accepted SSI/SSP recipients as residents. During the same time period, 3,866 ARFs and RCFEs were newly licensed and 1,428 of them accept SSI/SSP recipients. This shows a gain of 33 facilities that accept SSI/SSP recipients. However, the data does not show capacity of these facilities nor does it reflect county specific changes.

Though the available CCLD data provides some indication of the state of board and care facilities, it does not provide a full picture or truly answer the concerns raised by stakeholders around closures. For example, this data does not separate out facilities that are vendorized through the state's Regional Centers, thus receiving a higher monthly payment to house and provide services to Regional Center consumers, or individuals with intellectual and developmental disabilities. Though a total loss of 1,018 beds in all of Los Angeles County may not seem drastic, if all 1,018 beds were in facilities that accepted SSI/SSP facilities that could represent a severe shortage for that specific, especially vulnerable population. The data available from CCLD does not speak to this specific dynamic, antidotal evidence from stakeholders suggests that facilities accepting SSI/SSP recipients are becoming increasingly harder to find.

It is also unclear as to what happens to the residents of board and care facility when their facility closes. Health and Safety Code Section 1569.686 requires a licensee notify CDSS when they are experiencing financial distress. This is so that CCLD can monitor the licensee's situation, identify any potential care concerns for their current residents, and see if the licensee has a plan to remedy the situation. Additionally, CCLD has the option to install a temporary manager to help right the facility or put them on a compliance plan. By requiring the reporting of financial distress, and also of plans for facility closures, CCLD may utilize the time provided by this notice to help identify new placements for the facility's current residents. Therefore, CCLD seems to sometimes play a role in ensuring the residents of a licensed board and care facility are not left without housing if the facility closes. However, it is unclear whether CCLD is able to help individuals' secure long term housing at another board and care facility or whether they simply ensure the individual has somewhere to go upon closure, regardless of how temporary that immediate placement may be. As the need for housing, care and supervision grows and the number of beds declines, it seems as though CCLD would likely have difficulty finding alternative arrangements for current residents regardless of their financial status.

Several counties have incorporated board and care facilities in their approach for providing services to vulnerable populations that need housing, care and supervision. Most commonly, counties appear to be utilizing board and care facilities to address the needs of individuals with a serious mental illness (SMI), some of whom may have been experiencing homelessness or be at

risk of homelessness. By utilizing board and care facilities, this population receives housing, care and supervision. However, the population targeted by counties is typically SSI/SSP recipients meaning board and care facilities only receive the Non-Medical Medical Out of Home Care (NMOHC) payment of \$1,058 per month. State regulations do not permit facilities to charge more than the SSI facility rate, limiting the amount a facility may charge an SSI/SSP recipient. Additionally, RCFEs are required to accept the SSI rate as payment in full.

As a result, few facilities will accept persons on SSI/SSP due to the SSI/SSP rate not matching the reported average cost of a board and care facility. Facilities report that their average operating costs range from \$2,500 to \$4,000 per month per a client, while above the \$1,058 they are allowed to charge SSI/SSP recipients. As a result, some counties have made efforts to provide additional funding to board and care facilities who accept SSI/SSP recipients who additionally have a SMI, are chronically homeless, or meet other criteria. This additional funding is typically provided as a “patch” or a supplemental payment of a certain dollar amount per a day for a qualifying individual. This is on top of the NMOHC SSI/SSP payment, thus patching the difference between the SSI/SSP and the actual costs of providing room, care and supervision for that individual.

The Social Security Administration (SSA) reports the number of SSI/SSP recipients who are receiving the NMOHC rate, which is a supplemental rate provided to SSI/SSP recipients who require additional personal care assistance beyond just a room rental and basic necessities. According to the SSA, the NMOHC rate is distributed for about 45,500 individuals statewide, of which CDSS estimates that about 21,000 reside in ARFs and about 9,800 reside in RCFEs<sup>12</sup>.

The NMOHC rate breaks down to approximately \$35 dollars per a day for the provision of housing and care and supervision services to board and care facilities who accept SSI/SSP recipients. County Behavioral Health Directors Association (CBHDA) and other stakeholders believe this low reimbursement rate is resulting in the closure of board and care facilities that accept SSI/SSP recipients.

CBHDA The conducted a survey of their members in October 2019 on their members’ use of board and care facilities, how many facilities counties are currently patching, and the amount of money provided through these patches. CBHDA received 21 responses to their survey, which provided the following:

- 17 of the 21 responding counties provide supplemental rates to board and care facilities, with one additional county saying they are in the planning phase of implementing a rate supplement;
- Together these 17 counties are supplementing 2,621 beds with supplements ranging from \$15 to \$200 dollars per a day per a supplemented individual;
- In FY 2018-19 responding counties were providing \$36,238,746 in supplemental funding to board and care facilities;

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<sup>12</sup> These estimates are based on the addresses to which the NMOHC payments are mailed.

- Counties provide patch funding with Realignment dollars (both 1991 and 2011), County General Fund, Mental Health Services Act, Mental Health Block Grant, and Whole Person Care funds;
- Responding counties have 178 individuals placed in board and care facilities outside their county due to a shortage of beds available within their county; and
- Responding counties identified that they need over 17,000 additional SSI beds to meet the needs of individuals with a SMI.

This is a lens through which CCLD must view its regulatory action and efforts to work with licensed facilities. CCLD's mission is to promote health and safety of residents. Closing a facility for non-compliance may cause residents to be displaced at best, or to become homeless, at worse. These outcomes would be counter to CCLD's overall mission and goals. When CCLD identifies a high needs facility – whether an SSI/SSP or high dollar – they must weigh the repercussion of enforcement decisions beyond just what may result from the areas of noncompliance the LPA sees during the course of their inspection.

### **Regulatory Structure**

The basic licensing structure for ARFs and RCFEs starts with the age and number of residents that live within each facility. More specified requirements for each facility type are developed as needed. For ARFs and RCFEs, as the number of residents increases, staffing and training requirements increase. There are also special requirements that recognize the nuances in the care needs of individuals that specify staff training that is intended ensure staff can adequately and safely provide that care. Facilities that serve clients who rely on others to perform all ADLs, are incontinent, have Alzheimer's disease, are on oxygen and/or are on hospice care must comply with applicable regulations. However, it has been asserted that additional regulatory guidance is necessary to oversee care for residents with increasing acuity levels. As the state's population has aged, and the state policy goal of caring for people in the least restrictive setting has been emphasized, the role of the RCFEs has also changed to include those with more acute medical conditions.

To that point, building a tiered level of care for RCFEs was contemplated as far back as 1992 when, the legislature passed SB 944 (Mello, Chapter 888, Statutes of 1991). This bill, among other things, provided legislative intent to develop and implement a plan to establish three levels of care under the residential care facility for the elderly license, subject to future Budget Act appropriations and statutory authorization to implement levels of care. The bill also provided guidelines for the development of three levels of care: Base care and supervision, nonmedical personal care and health related assistance. The level of care plan would include, among other things, a recommendation for a supplemental rate structure for residents who are recipients of SSI/SSP. The funding for creating this tiered structure has not been appropriated, therefore it has not been implemented. However, the statute (HSC 1569.70) still exists.

Separate from the tiered structure envisioned in HSC 1569.70, ARFs and RCFEs have established private pay fee structures that account for the levels of care and services required by each resident.

For example, a resident who is non-ambulatory and incontinent would be charged a higher rate for care than a resident who does not require such services. However, facilities that serve residents who are on SSI/SSP are not permitted to increase their fees as the level of the resident's need increases.

Another area that may warrant exploration is the difference between requirements for ARFs and RCFEs. Recent changes in laws that regulate RCFEs were not applied to ARFs. In 2014, a broad package of bills, referred to as the RCFE Reform Act of 2014, responded to growing concern regarding the oversight of and care provided by RCFEs. This body of new law increases civil penalties for licensed facilities throughout the state; prohibits problem licensees from admitting new residents; strengthens residents' personal rights; and expands training to increase compliance. Since then, additional bills have further expanded requirements for RCFEs, including enhanced disaster preparedness requirements and enhanced rights for residents who are Lesbian, Gay, Bisexual or Transgender. None of these policy changes have been applied to ARFs or their residents. Additionally, unlike for RCFEs, there are no specified hourly training requirements for ARF staff.

Given the current attention on board and care facilities, the Legislature may have an opportunity to explore options to modernize the regulation of residential facilities, smooth out funding streams and build policies that recognize the continuum of care needs and facilitate resident desire to age in place.