City & County of San Francisco

Expanding Behavioral Health Placements for a Complex Population

Findings and Recommendations of the Residential Care and Treatment Workgroup

Prepared by

OFFICE OF THE CONTROLLER

CITY PERFORMANCE

January 7, 2025

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RAFAEL MANDELMAN

January 7, 2025

The failure to humanely care for indigent individuals suffering from severe mental illness is not unique to San Francisco, but it is one that is uniquely visible in San Francisco, and it is one that must be addressed for San Francisco to succeed. The tale of the closure of California's mental institutions has been told many times over, but that common understanding does not diminish the reality that the over-representation of severely mentally ill people on our streets, in our emergency rooms and in our jails is the legacy of de-institutionalization and the State's failure to make good on the promise to find a better alternative.

Since joining the Board of Supervisors in July 2018, San Francisco's mental health and substance use crises have been among my highest policy priorities. One of the first pieces of legislation I authored was an ordinance to have San Francisco opt in to the State's then-new housing conservatorship law. And I have strongly supported SB 43 and other efforts to expand the authority of counties to care for people who cannot care for themselves. But in my time in office it has become abundantly clear to me that without additional treatment capacity (i.e. appropriate beds and the staffing to support those beds) changes to our conservatorship laws will only be of limited effect.

That is why I have also strongly supported the effort to build out the City's treatment bed capacity under Mental Health SF, an expansion which has resulted in the addition of nearly 400 beds since 2020, bringing the county's total capacity to approximately 2,600 beds across the residential continuum of care. Nonetheless, and notwithstanding the value of these additional resources, San Francisco and its residents continue to suffer from a shortage of beds that is most acute for those with the greatest needs – those who need to be placed in a locked facility or an adult residential facility (also known as a board and care).

In January 2024 I proposed to Mayor Breed the formation of a behavioral health beds workgroup to address this challenge, and in March, following passage of Proposition 1, the Mayor and I announced the formation of the San Francisco Residential Care and Treatment Workgroup. The Workgroup, which I co-chaired, held its first meeting on May 29, 2024, and between May and November, the Workgroup brought together local and regional leaders to develop strategic recommendations to guide the City's response to our shortage of longterm beds for people with severe mental illness.

Even prior to issuance of the final report, the City has already taken important steps to implement its recommendations. On December 13, 2024, the Department of Public Health submitted an application to the State of California for Proposition 1 grant funds to cover the capital costs of six behavioral health

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residential and outpatient projects that would include more than 100 new locked subacute treatment beds, a significant addition to the 140 such beds currently available to the City.

Proposition 1, which the Mayor and I strongly supported, presents San Francisco with a generational opportunity to invest in behavioral health infrastructure that is sorely needed and has been deferred for far too long. The measure also raises significant questions about how the services the counties will be asked to provide in those facilities can be sustained over time. These were among the topics explored by our Workgroup.

I want to express my profound gratitude to Mayor Breed and her departments (notably Public Health and the Human Services Agency) for their partnership in prioritizing this urgent work. I also want to thank the Controller's Office, the members of the Workgroup, and the clinical providers, Adult Residential Care Facilities (ARF) and Residential Care Facilities for the Elderly (RCF-E) operators, and hospital executives who agreed to be interviewed to inform the Workgroup's deliberations and to help produce this report.

For many decades, California has left too many of its most severely mentally ill residents to fend for themselves outdoors. The outcomes have been terrible for those residents and for our State, and San Francisco has borne the brunt of it. With the passage of SB 43 and Proposition 1, we may finally have arrived at a moment where we can begin to live up to our obligations to this population. It is my profound hope that the work of this Workgroup can help us finally begin to fulfill that promise.

Sincerely,

Rafael Mandelman
Supervisor, District 8
San Francisco Board of Supervisors

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Executive Summary

The City and County of San Francisco (City) has expanded its residential care and treatment programs by over 400 beds since 2020. However, the City experiences persistent challenges in placing clients with the most complex needs into appropriate treatment facilities, especially longer-term placements.

Mayor London Breed and Supervisor Rafael Mandelman convened the Residential Care and Treatment Workgroup (Workgroup) in May 2024 to create a framework to address the shortage in appropriate long-term residential placements for individuals with complex behavioral health needs. The Workgroup considered how the City should expand residential treatment with a goal to position the City to be ready to apply for new resources as they become available, including new funding resulting from the passage of State Proposition 1 (March 2024).

Among the Workgroup's findings and recommendations, key themes emerged:

- The City has focused on expanding the number of behavioral health treatment beds in its portfolio. Nonetheless, Workgroup feedback confirmed recent City modeling which identified a significant outstanding need for additional long-term placements for San Franciscans with severe mental illness. Specifically, the modeling indicates a need to add 75 to 135 beds in the coming two years among long-term locked care and residential care settings. Notably, and notwithstanding the expansion in placements over the last four years, the City continues to face significant barriers placing clients with the most complex characteristics and health care needs. The City must focus not just on the number of beds available, but also on adding or reprogramming beds **specifically designed and reserved for the hardest to serve clients** who may be denied placement in other settings.

- Unlike skilled nursing facilities, for which the cost of placements is often reimbursable through Medicaid or Medicare, San Francisco must cover the cost of expanding and operating the types of placements studied by the Workgroup through local funding sources and the General Fund due to current State and federal funding limitations. Though the State, through Proposition 1, will offer limited, one-time capital funds for expanding certain types of facilities, the Workgroup acknowledged that the operational costs of added placements must be borne by county general funds or local sources, and this creates a strong disincentive and **budgeting challenge for San Francisco** or any other county looking to expand its supply of these high-cost beds.

- The Workgroup systematically explored opportunities for San Francisco to collaborate with other local jurisdictions, many of which face similar bed placement and capacity challenges. The Workgroup concluded that, while this approach would be worthwhile, if left to individual counties to negotiate a regional approach among peers, the financial, legal, and political hurdles make it unlikely that such a collaboration will succeed on a timeline and at a scale required to meet urgent behavioral health needs. To fulfill the full promise of Proposition 1, **the State must take a proactive role in regional and statewide solutions** and support cross-county financing and collaboration.

Local Context

Though the City has significantly expanded treatment options over the last several years, the need for these services continues to grow. As the national fentanyl crisis persists, a study found that emergency department visits for non-fatal overdoses in California increased by 30% between 2018 and 2023 and another found that San Francisco experienced a recorded high of 806 deaths in 2023, with 653 from fentanyl. Local clinical experts report that severe substance use disorders can exacerbate clients' mental health and physical health concerns, adding to the complexity of their care needs.

Several new State laws aim to address the crisis. In October 2023, San Francisco enacted the State-mandated CARE Court to divert individuals with severe mental health disorders from more restrictive conservatorships or incarceration. California's Senate Bill 43 (SB 43), enacted in San Francisco in January 2024, expanded conservatorship criteria to help gravely disabled individuals with mental health and substance use disorders receive care. To fully realize the goals of both the CARE Court mandate and SB 43, **the City must be ready with sufficient treatment capacity**, particularly in locked settings and the residential care settings individuals step down to as they recover.

Despite efforts to make the City's behavioral health system more accessible and coordinated, like other California counties, San Francisco is struggling to match residential treatment capacity with the evolving needs of individuals with highly complex behavioral and substance use issues. The City is at a pivot point: to take full advantage of tools like CARE Court and SB 43, and thus to prevent individuals from getting stuck in jails, hospitals, and/or the streets, the City needs to find ways expand its residential treatment capacity for individuals at the highest acuity levels, including locked facilities and long-term residential care options for when they are ready to re-enter the community.

The Workgroup

The Mayor's Office and Supervisor Mandelman convened the Workgroup in partnership with the Department of Public Health (DPH) and the Department of Disability and Aging Services (DAS), and selected leading subject matter experts to participate, including local hospital executives, labor representatives, criminal justice representatives, and health officials. Each member has a key role in the system of care and brought deep expertise in the needs of clients, ways clients interact with and flow through City and other systems and impacts of gaps in care.

From May to November 2024, the Controller's Office facilitated a series of meetings of Workgroup members to share data, consider options and discuss solutions. Workgroup members discussed current behavioral health program capacity and gaps, key operational barriers and pain points that could be drivers of service gaps, and costs associated with operating and expanding residential care programs. They shared input about policy and legislative changes needed as well as insights into partnership development.

Mental Health Rehabilitation Centers

A "MHRC" offers 24/7 intensive psychiatric care, nursing care, and psychosocial rehabilitation services to adults with severe mental illness and/or placed under conservatorship. A MHRC is a type of locked sub-acute treatment (LSAT) facility.

Adult Residential Facilities

An "ARF" is a non–medical facility that provides basic care and supervision for adults ages 18-59 who need assistance with daily living. Programs contracting with the City may add enhanced behavioral health care in addition to basic services.

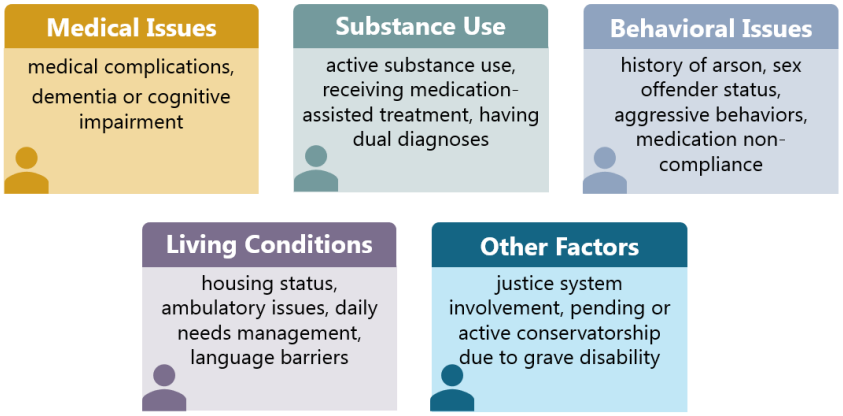
Residential Care Facilities for the Elderly

An "RCF-E" is similar to an ARF but serves people 60 years old or older. Programs contracting with the City may add enhanced behavioral health care in addition to basic services.

Understanding Complex Clients

DPH's residential treatment portfolio offers approximately 2,600 behavioral health treatment beds across its continuum of care. While DPH projects a need for new residential treatment capacity across its system, the Workgroup focused on three specific levels of care where the City experiences persistent challenges in placing complex clients into care: Mental Health Rehabilitation Centers (MHRCs), Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCF-Es) [see figure above for definitions].

DPH offers an array of residential care and treatment for clients with behavioral health needs. However, DPH has the most difficulty placing clients in care when they also have complex characteristics. Clinical experts note that a majority of their clients present with one (or often multiple) of these complexity factors, including medical complications, substance use disorders, behavioral issues, living conditions, justice involvement, and other issues (see figure on right).



Local Solutions

In 2023, DPH updated its behavioral health bed modeling and identified capacity gaps and treatment expansion goals across its system of care. When considering ARFs, RCF-Es and MHRCs, the Workgroup determined there is **both a capacity gap and a placement gap** for these programs. The capacity and placement gaps at the higher end of acuity create bottlenecks that impede the timely placement of clients into the correct level of care across the system, and lead to delays or denials of appropriate care to severely ill individuals.

DPH contracts with programs to deliver residential care to behavioral health clients, but **even if the program has an available bed, these programs may decline placements when a client has additional complex characteristics** that may make them difficult or inappropriate to serve in that setting. The City's placement challenges for the most complex clients could be considered a **market failure**. Facilities have discretion on who they accept as clients and the market has failed to compel them to accept the most complex clients, even with higher payment rates for serving those individuals.

> The Workgroup recommends that the City should add **20 to 40 ARF or RCF-E program slots, and 55 to 95 MHRC program slots by December 2027**. To see the most impact on the overall system, and to address placement gaps, these beds must be available for **the hardest to serve clients**, who may be denied placement in other settings.

The City should closely track its bed expansion efforts over time to optimize the system: increasing MHRC capacity by 55-95 beds may result in the need to further increase RCF-E and ARF capacity in the future and may change needed capacity at other levels of care.

Strengthening the City's ability to place clients in care is paramount in its bed expansion plans. The City should **prioritize acquisition and contracting strategies designed to counter the market forces** that have resulted in difficulty placing complex clients. For example, the City should conduct a review of existing City-owned behavioral health treatment facilities and, with labor partners and facility licensing experts, **reprogram these existing facilities to serve San Francisco's most complex clients** who often cannot be placed in existing programs. This would allow the City to retain contracted programs (which are more market-constrained) for less complex clients. Similarly, with advice of legal experts, the City should implement new contract terms that offer incentives or penalties based on a provider's acceptance of complex clients.

Regional Issues Requiring Increased State Support

The challenge to place complex clients in care is not unique to San Francisco. Jurisdictions across California face similar placement and capacity challenges. San Francisco and other counties cannot achieve a sustainable expansion without increased support from the State.

The Workgroup concluded that the State must play a larger role in supporting county collaboration to increase bed supply for the hardest to serve clients, including incentivizing collaboration through the planning and roll-out of Proposition 1. A key goal of the Workgroup was to explore opportunities for cross-county collaboration to increase overall bed supply – an approach that has been discussed for a number of years but rarely explored rigorously. The City engaged a consultant to conduct research with other peer jurisdictions in part to identify whether and how San Francisco might partner with one or more of them on expansion efforts. However, the response from county health officials was lukewarm. While some officials expressed interest in collaboration, they also cited "money and politics" as possible barriers. There are legal and financial disincentives, as most counties would need to bring any collaboration through a legislative process and complicated agreements.

While it seems likely that greater collaboration among counties could help to address the market failures identified in this report, the Workgroup's process has also made it clear that **relying in individual counties to drive the collaborative process will not yield results on the scale and timeline required**. To fulfill the promise of Proposition 1, the State must invest in regional and statewide solutions and support counties to collaborate.

Local and regional capacity gaps are also impacted by a decrease in State Hospital bed availability. The story of de-institutionalization in California and the closure of State Hospitals going back to the 1960s has been told elsewhere. Even with that context, it is worth noting that the **State Hospital census has decreased even in the last five years,** while local need for this intensive level of care has increased. The City serves highly complex justice-involved and conserved individuals that need a locked setting to receive mental health care. When the State reduced State Hospital bed allocations, it increased pressure on San Francisco's system of care. The Workgroup recommended that the State sufficiently fund the State Hospital system to appropriately meet the needs of

Fiscal Year (FY)	Estimated Overall State Hospital Census[1]
FY19-20	6,317
FY20-21	6,270
FY21-22	5,913
FY22-23	5,740
FY23-24	5,724

[1] Estimated State Hospital census data as of June of that fiscal year; https://www.dsh.ca.gov/About_Us/DSH_Budget_Information.html, retrieved December 5, 2024.

counties. Further, the State should ensure that counties receive access to beds at State Hospitals commensurate with local levels of need.

The State should also support local jurisdictions through increased funding and regulatory oversight.

- **Increased Funding:** The current lack of State funding for the operations of longer-term behavioral health facilities creates strong disincentives for individual counties to significantly expand bed capacity for California residents with the greatest behavioral health needs and who must rely on the government for their care. The State should take steps to ensure it adequately supports local jurisdictions to provide behavioral health care for vulnerable populations. While institutions providing skilled nursing care can draw down Medi-Cal reimbursement, local governments must cover the full cost of intensive behavioral health care delivered through MHRCs, as well as the cost of expanding and operating essential behavioral health step-downs in care, like ARFs and RCF-Es.
- **Regulatory Oversight:** The State has a role in setting regulations on the care of highly vulnerable people, including individuals conserved for grave mental health disabilities. To counter market constraints, the State should lead efforts to reform placement practices, such as establishing new regulations to improve access for complex clients needing placement in a MHRC.

Conclusion

San Francisco must urgently address the capacity, placement, and funding constraints across its residential care and treatment programs, and the Workgroup recommendations outline how the City, local and regional hospital partners, neighboring counties, and the State and federal governments can work towards resolving these systemic challenges.

The City has already taken key steps to achieve its expansion goals. In December 2024, the City submitted applications for Proposition 1 Bond Behavioral Health Continuum Infrastructure Program (Bond BHCIP) funding for one-time capital funds for several new projects. If awarded, these grants would result in an increase of as many as 100 new MHRC treatment beds added to the system of care. Workgroup members remarked that each additional MHRC bed, by providing a more appropriate placement into higher levels of care, will help relieve logjams in other parts of the City's system of care, potentially freeing up placements at other levels of need as well. Thus, one participant observed, a hundred additional MHRC beds might result in greater capacity to serve many multiples of that number throughout the system.

Through the Workgroup, experts helped design a robust set of recommendations to expedite the expansion of essential treatment services, sustain that treatment ongoing, and address the placement barriers faced by the most complex patients. When acted on, the Workgroup's recommendations will help San Francisco better care for some of the most vulnerable individuals in our City.

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Introduction

The City and County of San Francisco (City) has expanded its behavioral health residential care and treatment programs by over 400 beds across a variety of treatment types since the publication of a 2020 bed optimization study that projected these expansion needs. However, the City experiences persistent challenges in placing clients with the most complex needs into appropriate treatment facilities.

LOCAL CONTEXT

Though the San Francisco Department of Public Health (DPH) has significantly expanded treatment options over the last several years, the need for these services continues to grow. As the national fentanyl crisis persists, a study found that emergency department visits for non-fatal overdoses in California increased by 30% between 2018 and 2023 and another found that San Francisco experienced a recorded high of 806 deaths in 2023, with 653 from fentanyl. Local clinical experts stated during interviews that severe substance use disorders can exacerbate clients' mental health and physical health concerns, adding to the complexity of their care needs.

Several new State laws aim to address the crisis. In October 2023, San Francisco enacted the State-mandated CARE Court to divert individuals with severe mental health disorders from more restrictive conservatorships or incarceration. California's Senate Bill 43 (SB 43), enacted in San Francisco in January 2024, expanded conservatorship criteria to help gravely disabled individuals with mental health and substance use disorders receive care.

The City has a policy to support individuals with behavioral health needs in the least restrictive settings possible; however, when an individual has severe co-occurring medical, mental health and substance use concerns, involuntary treatment may be necessary to meet their basic needs and prevent decompensation. While early data shows modest increases in conservatorship in San Francisco (from 685 active conservatorships in December 2023, prior to implementation of SB 43, to 713 active conservatorships in May 2024, several months into enactment), to fully realize the goals of SB 43, **the City must be ready with sufficient treatment capacity**, particularly in locked settings and the residential care settings individuals step down to as they recover.

The City has key gaps in capacity in several levels of care, including at **Mental Health Rehabilitation Centers** (MHRCs), **Adult Residential Facilities** (ARFs) and **Residential Care Facilities for the Elderly** (RCF-Es), among other levels of care (see figure). These capacity gaps worsen when clients have more complex needs, such as dual diagnoses, justice system involvement, medical or cognitive complexities, and other factors.

With insufficient treatment capacity at key levels of care and the challenges of treating complex co-occurring

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conditions, many individuals with mental health and substance use disorders experience housing insecurity and/or become justice-involved, and can cycle through jails or hospitals. Gaps in capacity at one or more levels, including within MHRCs, ARFs or RCF-Es, creates bottlenecks across the system.

The City is at a pivot point: it must support its most vulnerable residents while keeping pace with an evolving mental health and substance use crisis. To prevent individuals from getting stuck in jails, hospitals, and/or the streets, the City must provide sufficient intensive services to treat individuals at the highest acuity levels, as well as long-term residential care options for when individuals are ready to re-enter the community.

RESIDENTIAL CARE AND TREATMENT WORKGROUP

In March 2024, the state passed Proposition 1, which provides new, one-time bond funding to counties for acquisition and expansion of facilities. That same month, Mayor London Breed and Supervisor Rafael Mandelman announced the creation of a workgroup to consider how the City should expand capacity to meet the long-term residential care needs of people with severe mental illness and position the City to be ready to apply for new State resources as they become available.

The Mayor's Office and Supervisor Mandelman first convened the Residential Care and Treatment Workgroup (Workgroup) in May 2024 in partnership with the San Francisco Department of Public Health (DPH) and the Department of Disability and Aging Services (DAS). City officials selected leading stakeholders including local hospital executives, labor representatives, legal system representatives, and health officials to serve on the Workgroup (see Appendix 1).

From May to November 2024, the Controller's Office facilitated a series of Workgroup meetings to share data, consider options and discuss solutions. The Workgroup focused its discussion on MHRC, ARF and RCF-E settings where the City experiences the most challenging constraints, including the following topics:

- **Behavioral health program capacity and gaps** among MHRCs, ARFs, and RCF-Es (see Appendix 4).
- **Operational barriers and pain points driving service gaps**, including market pressures, staffing constraints, system barriers, and challenges with real estate acquisition (see Appendix 5).
- **Costs associated with operating and expanding residential care programs** (see Appendix 6).

The Controller's Office conducted or engaged the following analysis to support the Workgroup's discussions:

- Interviews with **local ARF and RCF-E operators** in contract with DPH to understand their challenges in serving complex clients at this level of care (see Appendix 2).
- Focus groups and interviews with **behavioral health treatment providers** for considerations about client complexity, client service needs, and the system of care overall (see Appendix 2).
- Interviews with **local hospital executives** to understand how gaps in care for complex clients may be impacting their systems (see Appendix 2).
- **Regional Market Research.** The Controller's Office engaged a consultant to conduct interviews with other county health officials to understand how their systems are addressing service needs and expansion efforts for ARF, RCF-E and MHRC levels of care, including cost, utilization and market analysis. This work also included consultation with a statewide MHRC operator (see Appendix 5).

This report provides a summary of the Workgroup's discussion about results of this analysis, high-level findings affirmed by the Workgroup, and specific recommendations to address the shortage of long-term

care facilities for San Francisco residents with severe mental illness who must rely on government assistance to receive care, and to address the particular placement challenges for complex clients.

Workgroup Findings

1. While San Francisco has expanded behavioral health residential care capacity by 20% since 2020, recent modeling indicates that the City needs additional ARF, RCF-E and MHRC treatment capacity.

DPH has a current treatment program portfolio that offers approximately 2,600 beds across the residential continuum of care, including a total of **140 MHRC beds and 640 ARF and RCF-E beds** that serve clients with high levels of behavioral health needs. In 2020, DPH conducted the first bed optimization study, and as a result expanded programs by approximately 400 beds over the last four years, though a majority of this expansion occurred in programs that are not the focus of the Workgroup. In 2023, DPH updated its behavioral health bed modeling.[2] That analysis recommends DPH add **153-225** new behavioral health residential care and treatment beds across several levels of care.

Specifically, the model recommends adding **55-95 MHRC beds** and **20-40 Behaviorally Complex Therapeutic beds**. Depending on the program model, Behaviorally Complex Therapeutic beds could be licensed as an ARF or an RCF-E. While the modeling did not recommend an increase in the *total* ARF and RCF-E bed count, there is limited availability of ARF and RCF-E beds for clients with complex needs.

Residential Type	Additional Beds Needed	Considerations
Mental Health Rehabilitation Centers (MHRC) / LSAT	Estimated 55-95	• Given current wait times • Potential for increase in demand under SB 43
Behaviorally Complex Therapeutic (Enhanced Residential Care / Residential Care for the Elderly	Estimated 20-40	• Highly specialized level of care for complex, high-need clients difficult to place in care.

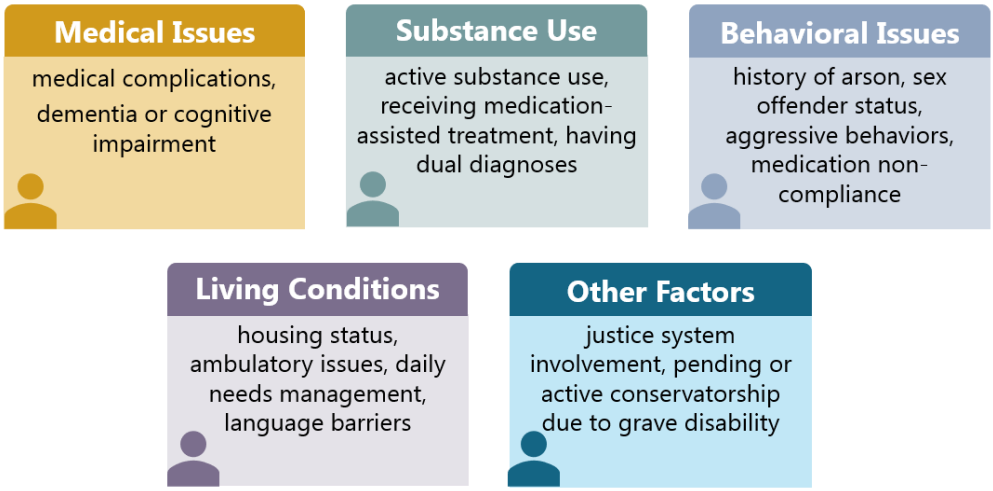
The Workgroup considered these results, as did other stakeholders the Controller's Office interviewed. Workgroup members and several interview participants affirmed the need for more MHRC, ARF and RCF-E beds. However, some individuals speculated that the model may reflect an undercount of the true need as it relates to MHRCs, while others would like more data to refine the model's assumptions about the types of clients not able to be placed in ARF or RCF-E settings.

[2] DPH first reported these results at a February 2024 Board of Supervisors' hearing, see: https://sanfrancisco.granicus.com/player/clip/45493?view_id=10&meta_id=1047306&redirect=true; https://sfgov.legistar.com/View.ashx?M=F&ID=12694517&GUID=5CFC2D44-69D9-4F39-AC19-823BF447515F; https://sfgov.legistar.com/View.ashx?M=F&ID=12694786&GUID=FB5606B7-197F-4AB7-9020-FF7DDA081D7C.

2. The City has both a capacity challenge and a placement challenge, with highly complex clients proving difficult to place even when a bed is available.

While DPH has identified treatment bed expansion goals and capacity gaps across its system of care, DPH has identified both a **capacity gap** and a **placement gap** for ARF, RCF-E and MHRC programs. DPH projects it may need 75 to 135 total beds in these facilities, but these expanded beds must be **targeted to a behaviorally complex population** that DPH has the most difficulty placing in facilities even when facilities have capacity.

In interviews, clinical providers identified that a vast majority of their clients have multiple intersecting issues that make them highly complex and difficult to place in treatment settings. These include medical complications, ambulatory issues, aggressive behaviors, justice system involvement, and more (see figure for commonly cited complexity factors).



While DPH contracts with programs to deliver residential care to behavioral health clients, these programs may decline placements when a client has additional complex characteristics that may make them difficult or inappropriate to serve in that setting. Several clinical providers highlighted that clients with medical complications are often the most challenging as there are few settings that can offer both behavioral health and medical supports across various levels of care.

Operators of residential care facilities discussed challenges with accepting complex clients, including being unable to serve them adequately if they do not have the appropriate physical spaces, e.g., accommodations for individuals who are non-ambulatory, or skilled staff such as clinicians trained in substance use disorders. They also cited the perceived increased risk of taking on individuals with histories of violence, substance use, or who are registered as sex offenders, especially co-locating them with their existing clients who may have less complexity.

Several Workgroup members affirmed that individuals with justice system involvement, including those who are under probation supervision, are among the hardest to find placements for in residential care facilities since they frequently have multiple complex characteristics in addition to justice system involvement.

Conservatorship adds another element of complexity: individuals under Lanterman-Petris Short (LPS) conservatorship[3] are deemed "gravely disabled" due to a mental health disorder or chronic alcoholism and the Department of Disability and Aging Services (DAS), which serves as the Public Conservator, has a mandate to place conserved clients in care or treatment best suited to their needs. With the passing of Senate Bill 43 (SB 43), which expanded the eligibility for conservatorship, DAS reported a slight increase in the number of conserved individuals from 686 in January 2024 to 715 in May 2024.[4]

Active LPS Conservatorships

Year	Month	T-Cons	P-Cons	Total
2023	May	35	635	670
2023	June	31	637	668
2023	July	26	645	671
2023	August	30	648	678
2023	September	31	647	678
2023	October	31	651	682
2023	November	23	662	685
2023	December	28	657	685
2024	January	35	651	686
2024	February	35	654	689
2024	March	46	655	701
2024	April	56	653	709
2024	May	59	656	715

Despite SB 43 implementation, clinicians, residential care providers, and hospital executives identified that it can be difficult to place conserved individuals. One hospital executive noted that conserved patients with severe conditions might stay in a hospital setting longer than needed while waiting for a lower level of care after being stabilized for a medical condition, which slows patient bed flow in other parts of the system of care.

Interviewed stakeholders all agreed that behaviorally complex clients, whether conserved or not conserved, were difficult to place given that residential care facilities often require patients to be mentally and medically stable for placement, which is a barrier to entry for many patients with complex needs.

3. The market does not sufficiently encourage placement of behaviorally complex clients into residential care, despite supplemental funding.

The City's placement challenges for the most complex clients could be considered a **market failure**. Facilities have discretion on who they accept as clients and the market has failed to compel them to accept the most complex clients. Both local and regional health officials identified that it is challenging to understand the market given the lack of real-time demand and utilization reporting on the statewide residential care bed inventory; that reporting also does not provide the reasons facilities choose not to take on a client. However, according to research performed for the Workgroup, peer counties in California report struggling with the interrelated issues of overall costs, program closures, and bed and staffing shortages.[5]

Counties provide daily **"patch" payments** to augment baseline staffing at ARFs, RCF-Es and MHRCs. Patch rates may vary as counties also attempt to account for uncertain market drivers (e.g., to incentivize operators to accept complex clients). Counties may determine daily patch rates (or an added, client-specific differential rate) based on level of patient acuity, with rates increasing for higher levels of care or specialized needs. For example, daily patch rates for MHRCs are significantly higher than for ARFs and RCF-Es. However, rates may

[3] An LPS conservatorship is a legal arrangement that gives an adult (the conservator) the authority to make decisions for a mentally ill adult (the conservatee) who is unable to care for themselves.
[4] DAS provided Active LPS Conservatorship data as of June 2024. Temporary conservatorship (T-Cons), Permanent conservatorship (P-Cons), and total conservatorship figures are displayed in the table by month and year.
[5] See Appendix 5 for more on peer counties and interview results.

also be impacted by the market, with higher-cost markets driving higher patch rates. Operators also receive revenue from a clients' monthly social security payment.[6]

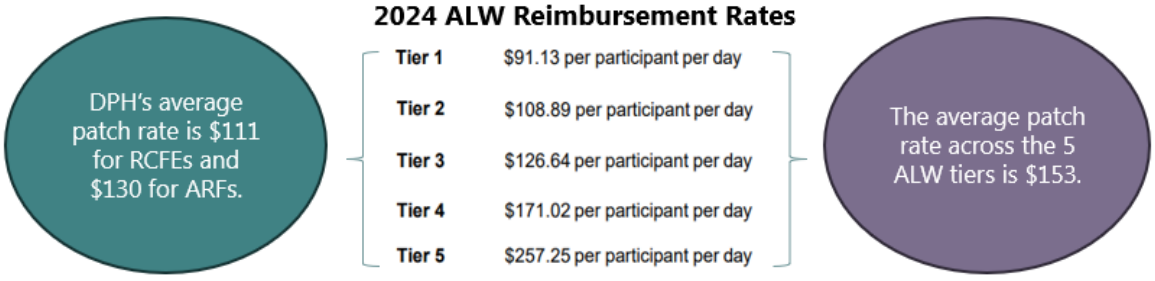
Despite having a competitive daily patch rate compared with several peer counties in California, San Francisco continues to struggle to find placements for its more complex clients (see chart below for daily patch rates per program type as reported by counties).

Daily Patch Rates among California Peer Jurisdictions							
	San Francisco	**Alameda**	**Napa**	**Sacramento**	**San Diego**	**San Mateo**	**Santa Clara**
ARF/ RCF-E	$46-$250 *ARF avg: $130 RCF-E avg: $111*	$33-$230 *4 Tiers*	$173-$241 *Avg: $201*	$65	Base: $46 Enhanced: $60	In County: $40.56 Avg. Enhanced: $184	Base: $104
MHRC	$313-577 *Avg: $506*	$510-$575	$261-$504 *Avg: $363*	$350	$345-$485 *3 Tiers*	$280-$460	$350

The State offers the Assisted Living Waiver (ALW) program, which functions similarly to a county patch, covering basic care and supportive living services for Medi-Cal eligible people aged 21 and older. A combined federal and State-funded waiver, the ALW offers an alternative to long-term nursing facility placement and offsets costs that would otherwise likely be covered by the county.

Historically, **San Francisco participation in the program has been low** due to program complexity and how the State has implemented the program. Additionally, California's ALW program has had significant waitlists dating back to 2019 and is now at capacity. ALW utilization by county is not publicly available, though DAS requested this information in 2019 and found that **fewer than 20 San Francisco residents were enrolled**. This is compared to other counties like Sacramento, which has 77 facilities with 1,867 total beds participating in the ALW program.

ALW rates are tiered based on staffing and service needs by patient acuity, with the average ALW rate across tiers only slightly higher than San Francisco's average rates for enhanced ARF and RCF-E patches.



The analysis conducted for the Workgroup indicates that local, State, and federal funding interventions have not counteracted existing market forces. Gaps in data mean that even with augmented funding, there is

[6] ARFs and RCF-Es receive $1,398 per month from SSI; MHRCs receive $1,050 per month from SSI. San Francisco pays a daily patch rate of $150 for basic services at an ARF (or about $4,500 per month), and up to $577 at a MHRC (or about $17,310 per month) for a much higher level of specialized care.

more to understand about the market and other non-market barriers in order to sufficiently address placement challenges.

4. San Francisco must cover the cost of expanding and operating ARF, RCF-E and MHRC programs through local funding sources and the General Fund due to current state and federal funding limitations.

Medi-Cal does not reimburse counties for non-medical expenses and thus, unlike many residential treatment programs (e.g., a 90-day mental health treatment program), Medi-Cal does not cover long-term stays at ARF and RCF-E programs. While San Francisco may be able to receive Medi-Cal reimbursement when a resident at an RCF-E receives a medical visit, the City must cover the costs for basic daily care and facility space through unreimbursed local sources.

On average, DPH reports that its behavioral health clients stay in an RCF-E for an average of **4.4 years** and in an ARF program an average of **6.8 years**. San Francisco pays an average patch rate of between $111 and $130 per day per client, with the current average patch for more complex clients closer to $150 per client per day. On average, the City may need to use General Fund or local sources to pay $241,000 for a single client's 4.4-year stay in an RCF-E or $372,000 for a single client's 6.8-year stay in an ARF. Based on the current portfolio of 640 ARF and RCF-E beds, the City pays approximately **$35 million annually** on these services.

Similarly, federal Medicaid regulations prohibit the use of federal funding for "Institutions for Mental Diseases" (IMDs), which includes institutional facilities with more than 16 beds primarily focused on mental health care. This includes MHRCs that have more than 16 beds. All of the City's MHRC contracts are IMDs.

When the City places a client at a MHRC, the MHRC receives nearly all of a clients' social security payment each month, and the City adds a daily patch negotiated based on the complexity of a client. That patch must be covered entirely by local funding, as the **IMD exclusion prevents the City from receiving Medicaid reimbursement for this intensive type of treatment**.

On average, clients stay in a MHRC program for about **two years**. San Francisco pays an average patch rate of $506 per day per client, or approximately $370,000 using General Fund or local sources for a two-year stay at a treatment program. Based on the current portfolio of 140 MHRC beds, the City pays approximately **$26 million annually** on these services.

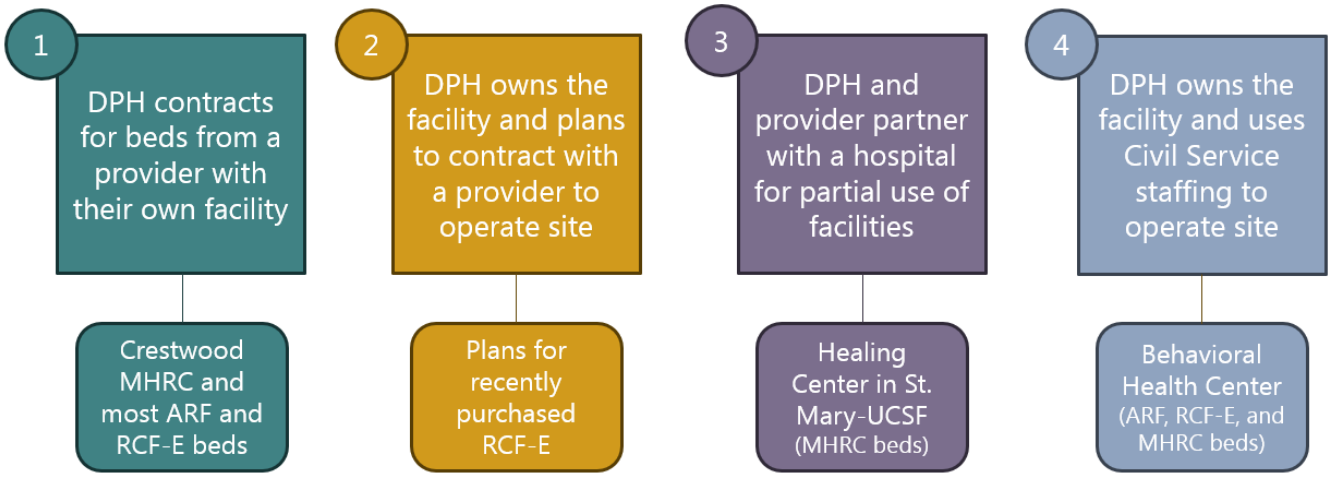
According to interviews, cost drivers across ARF, RCF-E and MHRC programs include increased staffing costs, rising patient acuity requiring enhanced levels of care, as well facility capital and operating costs. Expanding programs would require one-time acquisition costs, ongoing operating costs, insurance fees, maintenance and planned improvements (see Appendix 6 for San Francisco-specific cost estimates), a majority of which must be covered by local sources.

In March 2024, California passed a two-part initiative to re-structure Mental Health Services Act and create a $6.48 billion bond to fund certain, mostly Medi-Cal eligible behavioral health programs and supportive housing. State funding would be accessed through the existing Behavioral Health Continuum Infrastructure Program ("Bond BHCIP"). The Workgroup convened in part to consider how the City could leverage Bond BHCIP and found that while this one-time facility acquisition funding is significant and may be used to acquire or renovate MHRC facilities, it does not support acquisition for ARF or RCF-E facilities which are considered non-medical facilities.

The State established a $448 million Bay Area cap in Bond BHCIP Round 1 and Round 2 funding for 2024-2025. As noted above, only MHRCs are eligible, not ARF and RCF-E programs. Additionally, Bond BHCIP applicants must match funding awards by 10%, must cover operating costs through local sources, and are expected to have site-control of launch-ready properties when applying for funding. As examples of costs for MHRC facilities, Bond BHCIP Round 3 and 5 grant awards for various counties that applied for MHRC facilities ranged widely, from $4.6 million to $76 million, and these grants may account for acquisition and/or renovation (see Appendix 6).

5. Facility procurement is administratively burdensome, and the City often struggles to expand programs with the necessary expediency.

San Francisco uses a variety of strategies to achieve its bed expansion goals, though the most common strategy, historically, is to contract for dedicated or as-needed beds with private operators (see model #1 in the figure below). More recently, DPH has used new capital funding to purchase facilities directly or through no-interest loans with nonprofit service providers and then contract for services at the site (see model #2 in the figure below).[7] DPH currently partners with the Mayor's Office of Housing and Community Development to administer no-interest loans to nonprofit providers, although there is a limited number of providers skilled in property ownership to be scaled up and have a bigger impact.



A recent Controller's Office report provides details about the operational challenges with these various approaches to bed expansion. The report states that contracting with providers that can deliver services within their own facilities (model #1) may be the fastest option for expansion, though this may not adequately address the market barriers described above. Models #2 or #3 may be most viable for MHRC programs that require hospital-grade buildings; however, such facilities are rarely available for purchase.

The City could collaborate with private hospitals that have appropriate settings and meet building standards for partial use of their facilities (model #3). While this opportunity is rare, the Crestwood San Francisco

[7]The no-interest loan program is limited to nonprofit providers and, currently, many ARF, RCF-E and MHRC operators are for-profit businesses.

Healing Center at St Mary's, UCSF is an example of a successful MHRC program collaboration with between DPH, a private operator, and a hospital.

According to the Controller's Office March 2024 report, the following constraints, among others, impact the City's ability to rapidly bring on and sustain new programs:

- The City must follow **slow administrative processes and regulated steps** for formal approvals that can limit the City's ability to competitively engage in the real estate market.
- Departments often lack specialists in functions outside of their typical scope, including asset management, real estate acquisition, facility licensing issues, and other essential tasks associated with acquiring and managing real property. **Gaps in staffing and expertise** can slow the expansion process.
- For all new projects, the City must work closely with the local community to ensure the site meets the neighborhood's needs. The **community input process can add to the timeline** and may result in changes to decisions about program location.
- Departments can slow the process when they conduct **extensive reviews of a potential property** to assess its fit for the program or delay internal decision-making about site viability.
- The due diligence process on a potential facility includes thorough site assessments to ensure that the property meets all City requirements. Similarly, given complex licensing requirements, most buildings will need renovation to ensure they are compatible with the intended use and to meet standards. **San Francisco Public Works is required to perform this work for City acquisitions**, but departments cite these stages as common points of delay or bottleneck in the process.
    - Departments may seek a contractor to expedite due diligence, which requires a solicitation process and clear rationale for Civil Service Commission approval.
    - Additionally, departments may seek a waiver of the requirement to use San Francisco Public Works for renovations, in which case there must be clear rationale for the Board of Supervisors to approve the waiver.
- Facility expansion is a complex initiative, and the department may need to solicit for both program delivery and property management of a new facility (e.g., when the department has purchased the site). There may be a **limited number of behavioral health service providers with skill and expertise in property management**, and departments may need to spend time facilitating partnerships between operators or engaging in capacity building to ensure they identify a qualified team of contractors.
- The City operates a low-interest loan program to support nonprofit ownership of small sites (such as those used for ARFs or RCF-Es). To date, this program has only awarded loans for new Cooperative Living sites to providers with existing service contracts. **New legislation and/or new policies may be needed to expand this program** beyond co-ops, and to expand it to new providers or operators. For example, DPH and the Mayor's Office of Housing and Community Development (which manages the low-interest loan program) would need to establish a process for issuing joint solicitations for services paired with site acquisition.

The City has explored different methods to improve the facility acquisition process, including a recent ordinance that waives the lengthy Request for Proposal process for five years. DPH and the Workgroup affirmed that even with current legislative efforts to streamline the procurement process, more needs to be done to accomplish a timely residential treatment program expansion that is urgently needed. The Controller's Office report also emphasizes that all acquisition options need sustained funding for ongoing operational and reserve funding.

6. Mirroring nationwide and statewide trends, the City and its service providers face persistent challenges with recruiting, hiring, and maintaining skilled staff.

Programs delivering behavioral health services struggle to recruit and retain staff, especially staff with specialized experience like serving clients with dual diagnoses. Across the sector, staff report high levels of burnout, burdensome and lengthy hiring processes, and low compensation. According to interviews, these staffing challenges contribute to delays in intake processes, client care concerns, and denials of patients from specific facilities that do not have appropriate staff to treat them.

Staffing behavioral health positions is a challenge across the sector, especially in the community behavioral health setting. In a survey of public behavioral health systems across California, 70% of agencies reported difficulty recruiting licensed mental health and substance use professionals.

Program operators report being unable to provide competitive salaries compared to health plans, nursing homes, and hospitals. Some ARF operators and interviewed clinicians affirmed that retention is a challenge. Clinicians mentioned that while staff are passionate about the work, the environment can often result in burnout and other employers have more competitive salaries. **Across California counties, staffing shortages are common because of the relatively low wages ARFs, RCF-Es, and MHRCs offer**. This leads to staff leaving for higher wages offered by health plans, nursing homes, hospitals, and other healthcare providers. A local ARF operator mentioned limitations to recruiting experienced staff from home health agencies, which provide more comprehensive medical benefits packages (medical, dental, vision benefits). For more on healthcare staffing challenges and opportunities in San Francisco, see the Mental Health SF Staffing Analysis.

ARF and RCF-E operators most often employ direct care workers such as personal care aides, home health aides and nursing assistants. Recent data shows that direct care workers have low wages (below the national average living wage for adults with no children), limited access to benefits, and are disproportionally women and people of color. One small ARF operator that contracts exclusively with the City mentioned that while they have the staff necessary for less behaviorally complex clients, they reported that they do not receive sufficient funding to hire staff with specialized experience such medical staff trained in addiction.

One larger ARF operator stated they have full staffing capacity and employ nursing and mental health counselors, which enables them to provide specialized treatment on site. This is likely an exceptional situation given that this ARF is supported by a large, nonprofit mental health organization, unlike many other ARFs and RCF-Es.

The City and its contracted service providers are actively hiring new staff to serve clients with challenging behavioral health needs, but the Workgroup confirmed that wage and pipeline issues are present across the sector, particularly for staff with specialized experience. A Workgroup member highlighted new workforce development grants to support career pipeline for mental health workers that the City should continue to leverage, though the program's funding is limited.

The Workgroup affirmed that if hiring continues to be a challenge, changes to workflows and policies won't be able impactful without the staff to implement them.

7. Existing systems and regulations are not responsive to and may prevent appropriate service delivery to complex clients.

As emphasized above, the City serves a high-need population, with clients often having co-occurring mental health and substance use issues, which may also be paired with medical complexities. Many interviewed ARF and RCF-E operators mentioned risks to their operating licenses by state regulatory agencies such as the Department of Social Services – Community Care Licensing Division and the California Department of Health Care Services, as barriers to accepting complex clients. They cited that fines and penalties might be significant if a client is violent against others or makes claims against the facility.

This presents additional challenges considering that the City is obligated to find care for LPS conservatees but there is no legal requirement for a MHRC to admit an LPS conservatee, according to current CA Department of Health Care Services regulations. Licensing rules provide ARF, RFC-E, and MHRCs discretion on who they can admit as patients. Additionally, licensing prohibits MHRCs from admitting patients who are non-ambulatory. While ARFs and RCF-Es can admit non-ambulatory clients if they meet building requirements and pass permitting inspections, this is a level of medical care not offered by many operators.

Interviewed clinical providers speculated that San Francisco and other counties may not yet offer the **right model of care** that appropriately serves the most complex clients in the system. For example, some referring providers must currently choose whether to refer their clients with multiple needs either to a medical setting that does not offer substance use and/or mental health treatment or to a mental health and/or substance use treatment program that lacks the ability to care for that individual's medical needs.

There are very few programs that offer comprehensive treatments due to historically **siloed funding, regulatory, and licensing systems**. One provider said that they see the result of this lack of complex, combined treatment when some of the same clients continue to cycle in and out of local 90-day residential treatment programs for years.

In addition to expanding programs that offer multiple treatment types, providers emphasized the need to improve housing as settings for care. This may include adding services that help complex clients remain stable in housing (i.e., instead of decompensating and needing to be referred to an ARF, RCF-E or MHRC) as well as improving the connection between residential treatment and housing settings.

8. Changes in the State Hospital referral process create gaps in capacity for San Francisco clients who would be best served in this setting.

Workgroup members affirmed the need for an expansion of MHRC capacity. However, some members also stated that some of these capacity gaps may be impacted by **placing clients in MHRCs who would be better served at a State Hospital**. State Hospitals[8] are locked facilities that provide mental health treatment to individuals who are mandated for treatment by a criminal or civil court judge. These facilities take on

[8] There are five: Department of State Hospitals (DSH)-Atascadero, DSH-Coalinga, DSH-Metropolitan, DSH-Napa, and DSH-Patton.

some of the most behaviorally complex clients, including individuals who are incompetent to stand trial, under conservatorship, justice involved individuals with mental health issues, and registered sex offenders.[9]

Though comprehensive historical data about the State Hospital system is difficult to access, some reports cite that in the 1950s, the California State Hospital census was 37,000 patients.[10] As of June 2024, the California Department of State Hospitals (DSH) reported a census of 5,724 patients within State Hospital facilities.[11] This exponential decrease reflects the impact of deinstitutionalization, the movement to close State Hospitals and other community hospitals providing psychiatric care and shift care to counties. This was done primary through the 1965 law implementing the Medicaid IMD exclusion described in Finding 4.

More recently, DSH made changes to the county referral process to State Hospitals which have resulted in fewer beds allocated to San Francisco. According to data DPH requested from the State, the average number of San Francisco County patients at State Hospitals was 42.1 five years ago and as of 2024, the average is 22 patients (see chart below for average State Hospital census of San Francisco clients by fiscal year).

San Francisco State Hospital Clients from Fiscal Year 2020 to Fiscal Year 2024[12]

Fiscal Year (FY)	Average Annual Total of San Francisco County Patients	# of San Francisco County Patient Admissions	# of San Francisco County Patient Discharges	Estimated Overall State Hospital Census[13]
FY19-20	42.1	2	2	6,317
FY20-21	38.6	2	7	6,270
FY21-22	28.1	3	16	5,913
FY22-23	22.4	4	6	5,740
FY23-24	22.0	1	4	5,724

It is difficult to understand county-by-county trends in utilization at State Hospitals since there is not a publicly-available real-time inventory reflecting State Hospital utilization. DSH produces budget summaries that include documentation of patient counts by type of facility. Among the five State Hospitals, the census fell from 6,317 patients in June 2020 to 5,724 patients in June 2024.[14] However, the census fluctuates each year, and the State does not report the total number of beds available. According to a 2021 report on Adult

[9] "Who We Treat," California Dept. of State Hospitals, https://www.dsh.ca.gov/About_Us/index_en.html, Accessed Dec. 5, 2024.
[10] Lyons, Richard D. "How Release of Mental Patients Began." The new York Times, October 30, 1984, Section C, Page 1. Retrieved January 2, 2025 from https://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html
[11] Estimated State Hospital census data as of June of that fiscal year; https://www.dsh.ca.gov/About_Us/DSH_Budget_Information.html, retrieved December 5, 2024.
[12] City and County of San Francisco State Hospital Bed Utilization Data, provided by San Francisco Dept. of Public Health, received by the Controller's Office Nov. 25, 2024. "San Francisco County Patients" represents clients DPH admitted directly as well as clients admitted to a State Hospital through processes such as court orders where San Francisco subsequently became the payor.
[13] Estimated State Hospital census data as of June of that fiscal year; https://www.dsh.ca.gov/About_Us/DSH_Budget_Information.html, retrieved December 5, 2024.
[14] Ibid.

Psychiatric Bed Capacity Need and Shortage Estimates, the San Francisco Bay Area had the largest shortfall of acute psychiatric beds, inclusive of State Hospitals, of any California county.[15]

Workgroup Recommendations

The findings of the workgroup identify complex and interrelated challenges that will require an array of strategies to address. In some cases, the City can take actions itself to fulfill its bed expansion and placement goals. However, the City must also collaborate with local, regional and statewide partners, and must advocate for greater support from the state and federal governments to sustain its bed expansion. The following recommendations outline the options and opportunities San Francisco can pursue to create lasting change in the system of care.

LOCAL SOLUTIONS

The City should continue its work to expand residential treatment programs, using options designed to gain more control over placement options and more directly counter market pressures. The City should also develop improved analytical tools to gain a deeper understanding of clients' complexities and to determine how the expansion has impacted client needs and the system overall.

1. To address capacity gaps, the City should complete a net expansion of its ARF, RCF-E and LSAT treatment programs.

New program slots should be specifically designed for and should have an explicit commitment to serve highly complex clients. The expansion should include:

A. A **net of 20 to 40 ARF and RCF-E beds** operating within the system by December 2027.
B. A **net of 55 to 95 MHRC beds** operating within the system by December 2027.

The 2023 DPH Bed Optimization Study assessed that the City needs 20 to 40 additional ARF and RCF-E program slots. In order to see an impact, these beds must be reserved for the hardest to serve clients requiring increased levels of therapeutic care, including clients with medical complexities in addition to behavioral health needs. While the City can design programs and contract for enhanced staffing, to fully achieve an expansion for this complex population specifically, the City may also need to implement subsequent recommendations in this report focused on countering market pressures.

The 2023 DPH Bed Optimization Study also estimated that the City needs an additional 55 to 95 MHRC beds to support reduced wait times across the system of care. Workgroup members affirmed that adding 55 MHRC beds would positively impact the overall system of care, including decreasing wait times for clients across other settings. It is possible that adding 55 MHRC beds to the City's portfolio would allow for a much larger impact across the system by opening placements in lower levels of care and supporting additional

[15] https://dhs.saccounty.gov/PUB/Documents/Public-Health-Advisory-Board/PHAB-Meeting-Documents/2022/Presentations/Adult%20Psychiatric%20Bed%20Capacity%20Need%20and%20Shortage%20Estimates%20in%20California%202021.pdf (pg. 20, Table 6).

individuals to move more quickly to appropriate levels of care. Workgroup members stated that **adding the top range of program slots would have even greater impact on behavioral health system**, as it could allow space for individuals previously unable to access care to be more quickly diverted (e.g., from jail) into the level of treatment they require.

Estimating costs for expanding the City's ARF, RCF-E, and MHRC program depend on the bed type and number of beds. To implement this recommendation, the City may anticipate new annual patch costs ranging from $12.1 million to $23.5 million.

ARF & RCF-E			
20 Beds		40 Beds	
Low Patch: $200/Day **$1.5 Million**	High Patch: $250/Day **$1.8 Million**	Low Patch: $200/Day **$2.9 Million**	High Patch: $250/Day **$3.7 Million**

For ARF and RCF-E placements, DPH estimates that the patch costs to provide higher levels of care for complex clients may range from $200 - $250 per client per day (an increase from the current $150 average noted above), depending on the level of care needed. Total annual ARF and RCF-E patch costs could range from $1.5 million to $3.7 million, depending on the number of beds and the patch rate used. These rates do not account for costs associated with models where DPH may purchase a facility. These costs vary widely and depend on the condition of the site. DPH recently purchased a 54-bed facility which did not need rehabilitation for $13.8 million.

MHRC			
55 Beds		95 Beds	
Low Patch: $527/Day[16] **$10.6 Million**	High Patch: $570/Day **$11.4 Million**	Low Patch: $527/Day **$18.3 Million**	High Patch: $570/Day **$19.8 Million**

DPH estimates that patch costs for MHRC programs range between $313 to per day to $570 per day, depending on the level of care needed. However, for the most complex clients, DPH estimates a range of $527 per day to $570 per day. Total annual MHRC patch costs could range from $10.6 million to $19.8 million, depending on the number of beds and patch rate used.

MHRC facilities must meet facility standards that are similar to hospitals. San Francisco has a limited number of suitable buildings to renovate into MHRC facilities, and these could require major renovations beyond acquisition. Due to high real estate costs in San Francisco and the unknown condition of a potential site, estimates for acquiring a MHRC facility are in the tens of millions of dollars. As a point of comparison, Sacramento County won a Bond BHCIP grant of $23.5 million for a 64-bed MHRC facility; however, it is unknown whether the grant covers costs to acquire a building, renovate an existing building, or purchase and renovate a building.

To achieve this recommendation for a net expansion of ARF, RCF-E and MHRC programs, the City will need to prioritize ongoing operating funding to sustain these services over time; as noted above, the average length

[16] The low daily patch rate used in the model accounts for the care needs of a highly complex client. DPH may apply a smaller daily patch rate (e.g., as low as $313 per day) for this setting when clients are less complex.

of stay at these levels of care range from two to seven years. Assuming the expansion of ARF, RCF-E, and MHRC beds come online over two years, the City may anticipate General Fund costs of:

- FY25-26: **$13.2 million** General Fund patch costs to support 20 ARF and RCF-E beds, and 55 MHRC beds at the highest patch rate.
- FY26-27: **$23.5 million** General Fund patch costs to support 40 ARF and RCF-E beds, and 95 MHRC beds at the highest patch rate.

The Mayor and the Board of Supervisors should prioritize these services and **sustain their associated costs within the City's budget**.

2. To counter market pressures, the City should implement strategies to achieve a net expansion of these programs that provide the City with more control over client placement.

In working toward these program expansion goals, the City should prioritize acquisition and contracting strategies that provide the City with more control in placement of clients into programs and which are designed to counter the market forces that have resulted in difficulty placing complex clients.

In particular, the City should:

A. Review all existing City-owned facilities and, with labor partners and facility licensing experts, consider whether and how to **reprogram these existing facilities to serve San Francisco's most complex clients**. This would allow the City to retain market-constrained (i.e., fully contracted) programs for less complex clients.
B. With guidance from legal experts, implement **new contract terms** to ensure providers accept placements, such as incentives for accepting more complex clients and/or contract penalties for denial of complex clients. As feasible, the City may implement these terms when:
    i. Partnering with private operators to expand facilities and secure dedicated beds for San Francisco via contracts.
    ii. Actively seeking out new facilities for City acquisition with contracted services.

Strengthening the City's ability to place clients in care is paramount in its bed expansion plans. Under current market conditions, the City may contract with providers to deliver residential treatment services for its clients but may be unable to place the hardest to serve individuals in those placements due to operator discretion in accepting a new client in their facility. These strategies recognize and confront the City's capacity *and* placement barriers by securing more placements and reducing provider discretion.

However, the City will need to consult with its legal teams to determine what types of contract terms can be applied and what penalties may be possible that do not disadvantage clients actively being served by a particular provider. Additionally, penalties may disincentivize private operators from doing business with the City, and so likely need to be paired with financial incentives.

3. To address capacity gaps, local and regional hospitals should leverage underutilized spaces to develop MHRC programming for placement by the City or hospital partners.

By December 2025, the City should initiate conversations with leaders at local and regional private hospitals to **explore options for utilizing hospital space for a MHRC expansion**. Due to regulatory requirements, MHRCs must meet similar facility standards as hospitals. The City has limited options to provide MHRC beds within San Francisco, though clinical providers noted that in-county placements can improve care coordination. Regional hospital partnerships with the City would enable San Francisco clients to receive care in, or close to, their home county. An example of this approach is the Crestwood San Francisco Healing Center at the St. Mary-UCSF campus which provides 54 beds within the City's existing MHRC portfolio. The City should create plans to actively engage local and regional hospitals on opportunities to expand the number of beds available.

4. To better understand the system's capacity gaps, DPH should refine its existing analysis and tracking tools.

By December 2025, DPH should improve its tools to ensure its projections for program expansion needs are accurate, nuanced, and show the impact of changes to the system of care and client needs over time. DPH has produced two iterations of its Bed Optimization study since 2020. However, given data limitations, these analyses could not show the more specific needs of DPH's complex population, such as how many clients may need a different level of care. DPH is actively working to update its Bed Optimization analysis to create a more "operational" tool that allows a timely assessment of the needs across the system (rather than every three years). With these updates, the Workgroup members recommend two new analytical approaches:

A. By July 2025, DPH should develop a process to track and annually report on current trends in bed availability, including documenting the number of beds in each level of care available for use, the number of beds actually utilized, and the procurement mechanism for beds in the system (e.g., contracted, City-owned, etc.).

DPH should develop a process to **track the progress of bed expansion efforts**, including the process used to expand (e.g., acquisition, contracting), target populations to be served, and the change in total beds in the system over time.

It is difficult to trace historical patterns of bed availability and utilization over time: pilot projects ramp up or ramp down; contractors adjust between fixed and as needed beds; capacity at a site changes when renovation or repair is needed; new funds are added to a program mid-year to augment staffing, changing the model of service; the contractor receives differential payments for a specific client due to needing enhanced staffing for complex behaviors; and other variations.

Because of these challenges in tracking, it is not feasible to look back at historical trends to determine how total capacity has changed over time and the impacts of past expansion efforts. However, DPH should begin creating tracking tools that account for the variables and changes in the bed inventory to allow ongoing tracking of these factors.

B. By December 2025, DPH should update its Bed Optimization analysis to more accurately project the number of program slots needed to serve specific populations, including based on the type of challenges given clients may face (e.g., justice involvement, medical complexities, cognitive impairments, etc.).

DPH should enhance its bed optimization analysis to collect additional data about clients in need of care. Data limitations meant that DPH could not stratify the 2023 bed optimization modeling by client characteristics or reasons for long wait-time for placement. This requires deeper and targeted work and may be enhanced by a new data system rolled out for behavioral health programs in 2024.

DPH should expand upon its 2024 bed optimization modeling to **determine which categories of complexity result in difficulty in placement for clients**. With a greater understanding of the number of clients with specific barriers to care and placement gaps, the City can add capacity targeted to these vulnerable individuals.

Paired together, these two analyses may show the success of treatment program expansion plans, viable strategies for expansion, and the impact the expansion has on clients requiring and using each level of care over time.

The City should use these analyses to regularly update bed expansion goals, clarify potential tradeoffs, such as budgeting challenges, and improve system planning. As one example, in many cases, clients step down from MHRC programs into other, less restrictive residential treatment settings. **Should the City achieve its goal of expanding MHRC bed availability by 55 to 95 beds by 2027, this may subsequently result in an increased need for new step-down levels of care, such as ARFs and RCF-Es beds.** As such, the City should use these tools to plan for and implement new or updated program expansion plans over time.

5. To address the time-consuming nature of expansion efforts, the City should develop a plan to address known barriers and delays in acquisition and/or contracting for new treatment facilities.

Currently, acquiring and launching a new program can take 18-24 months, assuming a smooth process. However, DPH's Bed Optimization modeling demonstrates an immediate need for programs to care for vulnerable clients across several levels of care. The City must act with urgency to ensure clients receive the care they need, including for clients under conservatorship who are in the care of the City due to a grave disability.

To achieve the goal of opening new treatment programs by December 2027, within the coming year, the Mayor should direct relevant departments to convene, discuss barriers, and produce and action plan summarizing potential solutions by December 2025. The plan should address the barriers that delay the expansion of behavioral health treatment, including specific policy or legislative approaches that address the challenges outlined in the February 2024 Controller's Office report. In particular, the plan should identify options that may solve the following constraints:

- Slow administrative processes and regulated steps for formal approvals.
- Lack of staffing for specialized functions, including asset management, real estate acquisition, facility licensing issues, etc.
- Long community acceptance processes for new programs.

- Backlog and delays in due diligence and renovation timelines.
- Lack of capacity among service providers to own facilities, manage the asset, and/or manage property.
- Current limit in the City's low-interest loan program.

The City can often contract for new programming more rapidly than it can acquire sites for City or nonprofit operation, and the City should **leverage existing legislation that waives solicitation requirements** for behavioral health service expansion. If there are specific roadblocks that are unresolved by current legislation, these should be incorporated into the action plan described above.

Similarly, if City teams identify new barriers or challenges while working to expand program capacity, these issues should be incorporated into the action plan, and departments should consider whether new legislative options could resolve those issue areas.

6. To address staffing challenges, the City should accelerate its work to implement the recommendations made in the 2024 Mental Health SF Staffing Analysis.

The strategies in the Mental Health SF Staffing Analysis report address hiring and retention challenges for civil service programs and nonprofit behavioral health providers in the City. The report identified options and strategies to consider, noting that addressing staffing gaps will require multiple coordinated strategies. Examples include:

- Exploring opportunities to adjust staffing models to leverage non-licensed paraprofessionals.
- Exploring where service providers can implement wage increases for hard-to-fill positions per their unique operational needs.
- Supporting service providers in their efforts to address wage pressures by reviewing existing contracts and assessing where contract or budget modifications may be appropriate and feasible for the overall system of care.

DPH provides ARF and RCF-E operators patch rates that are tiered to provide enhanced levels of care for clients in based on additional services they may require. To address the needs of the client population with greater complexity of needs, DPH may need to review its patch rate structure to ensure that the rates offered adequately supports the more intensive base levels of care needed to address the needs of a client population with greater complexity of needs.

Given the challenges of recruiting and retaining staff, the City should work with the State to understand what may be proposed or funded through the Proposition 1 (2024) Behavioral Health Workforce Initiative Program. The proposition outlined a three percent allocation of State funds for this purpose, and the City should ensure it is prepared to access this funding when it becomes available to address local pipeline constraints in staffing of behavioral health and related positions.

SOLUTIONS REQUIRING PARTNERSHIPS AND ADVOCACY

The challenge to place complex clients in care is not unique to San Francisco. Jurisdictions across California face similar placement and capacity challenges. Clients could benefit from collaboration between jurisdictions and hospital systems to expand placement options. However, San Francisco and other counties cannot achieve a sustainable expansion of residential treatment programs for highly complex clients without increased support from the state and federal governments. The federal and California state governments have an essential role in supporting local jurisdictions to achieve the best outcomes for their behavioral health clients, but there are key gaps in the system that may require legislation, new regulations, or new programming to address.

The recommendations in this section speak to the joint and coordinated advocacy approaches the City and its statewide partners should pursue over the coming year to push for state or federal policy solutions to key Workgroup findings related to funding, capacity, and placement challenges.

7. To address local funding constraints for these services, the State and federal governments should provide enhanced funding to supplement the cost of currently unreimbursed local programs.

A. The federal government should expand Institution for Mental Disease (IMD) Waiver programs for 60 days and beyond.

The City and statewide partners should advocate for federal government approval of the IMD Waiver to enable counties to bill Medicaid for up to 60 days of a patient's stay at a MHRC facility. Further, the City and statewide partners should advocate for an extension of this waiver beyond 60 days. On average, San Francisco clients remain in a MHRC facility for two years; even **a 60-day IMD Waiver would account for less than 10% of a typical stay**, and the typical county costs. These are highly skilled settings, providing intense treatment to complex clients, and the City and its partners should advocate for changes to federal rules that prohibit these services from being considered eligible for Medicaid reimbursement.

B. The State should make key changes to the Assisted Living Waiver (ALW) to allow a higher level of participation, revise participation policies, increase reimbursement rates by region, and improve data transparency.

The ALW program is a significant funding opportunity for the clients in need of ARF and RCF-E care. The ALW acts like DPH's patch in that it covers basic care and supportive living services for Medi-Cal eligible people aged 21 and older. The City and its statewide partners should advocate to the State to enact key changes to the ALW program to improve participation and data transparency.

There are several challenges that inhibit ALW program participation. Firstly, facilities need to enroll to become certified to receive the waiver. Secondly, there is a cap on the number of individuals that may enroll at certified facilities. In order to become a certified facility, operators must undergo a cumbersome certification process. Restrictive program policies, such as building structure requirements, prohibit some smaller San Francisco operators from becoming certified ALW facilities, limiting opportunities for clients to be placed in a local ALW certified facility. Clients must enter a centralized waitlist to be placed in a facility with ALW beds. The waitlist is currently not accepting any new referrals. In May 2024, the federal Centers for

Medicare & Medicaid Services expanded the state ALW program capacity by an additional 1,800 slots for Years 2-5 of the 2024-2029 program.

The City should advocate to the State to **increase the ALW program's capacity, fund additional placements,** and review and **revise restrictive program policies** that impede greater facility participation. These steps will enable more of San Francisco's clients to be placed in care in and out of county by opening the waitlist and increasing the number of facilities certified to participate in the program.

Additionally, the State should **create regional reimbursement rates** rather than statewide tiers to make the ALW rates more competitive in San Francisco and incentivize operators to participate. While the average ALW reimbursement rate across its five tiers is slightly higher than DPH's average ARF and RCF-E patch rates, the ALW rate may not be enough to incentivize operators to secure the waiver given the other barriers.

The State should also **improve data transparency** about ALW participation. The exact number of San Francisco's clients participating in the program is difficult to ascertain since the State manages the program, not the City. The State should provide more data at the county level to help jurisdictions understand and manage their client placements and leverage ALW more effectively to serve clients with varying levels of complexity.

8. To address local capacity gaps, the State should expand capacity across the State Hospital system and restructure how counties are allocated beds to account for county-specific levels of need.

With statewide partners, the City should advocate to the State to fund an **increase in the overall portfolio of available State Hospital beds to match statewide needs**. The State has proposed allocation plans that prioritize counties based on population; this would likely result in fewer total beds allocated to San Francisco, further limiting access for San Francisco's most complex clients. Rather than allocating based on population, the State should **establish an allocation process based on each county's level of need**. San Francisco can leverage enhanced internal tracking of client complexities per Recommendation #4 above to demonstrate local need to the State as part of its advocacy approach.

9. The State should play a larger role in supporting county partnerships to increase capacity across the state.

The Workgroup recommends that the State play a larger role in helping counties to partner on treatment program expansion. This could include incentivizing collaboration through the planning and roll-out of Proposition 1 funding. The City engaged a consultant to conduct research with other peer jurisdictions, in part to identify whether and how San Francisco might partner with one or more of them on expansion efforts. However, the response from county health officials was lukewarm. While some officials expressed interest in collaboration, they also cited "money and politics" as possible barriers, and one indicated it would need to be financially advantageous. There are legal disincentives, as most counties would need to bring any collaboration through a legislative process and complicated agreements. State direction, and potential regulatory shifts, may be needed to assist jurisdictions to implement partnerships.

To further promote these efforts, by July 2025, the City should agendize discussions with the California Association of Behavioral Health Directors to **determine whether cross-county partnerships on treatment program expansion is feasible and/or appropriate**. The City should lead work with Statewide

organizations to discover what would be needed for regional partnerships to expand residential care and treatment facilities. As part of this dialogue, San Francisco officials should explore how jurisdictions that have received State funding via BHCIP Rounds 3 and 5 and Proposition 1 Bond BHCIP plan to use these funds, and whether there may be opportunity for partnership within that use.

Through conversations, jurisdictions may learn what challenges may impede collaborative expansion, strategize options to resolve those issues, and highlight opportunities for mutual success. The City may leverage new legislation streamlining government-to-government contracting to support potential partnership negotiations.

10. To address placement challenges, the State should lead efforts to reform placement practices and create more transparency and oversight for the system.

By July 2025, the City should **take a lead role to engage various statewide trade and advocacy associations to develop joint policy platforms specific to the residential treatment needs of complex clients.** The City should initiate this work with organizations including the California Association of Behavioral Health Directors, the California Mental Health Services Authority, the California Association of Public Administrators, Public Guardians, and Public Conservators, and can raise the advocacy agenda at forums such as the California Health and Human services' Behavioral Health Task Force.

The City and its statewide partners should advocate for the State to take on a more directive role in ensuring highly-complex clients receive the care they need. This may require the State to establish new forums for oversight, such as an Office of Conservatorship or new public hearings. It may also require the State to adopt new regulations to counter market pressures and push private operators to accept county placements.

A. The State should lead efforts to **improve access to MHRC facilities**.

For example, the California Department of Health Care Services establishes regulations for Mental Health Rehabilitation Centers. Most of these sites are operated by private businesses, and the State has a role in ensuring they are adhering to licensing requirements. Current regulations allow these facilities to set program guidelines that may restrict access for patients with certain histories (e.g., justice involvement), behaviors (e.g., aggressive behaviors) or care needs. The California Department of Health Care Services can establish new regulations that limit this level of discretion by facilities, and play a greater role in ensuring vulnerable individuals, such as people who have been conserved due to a grave disability, are not denied care at a setting that might be best suited to their needs.

B. The State should establish a statewide **Office of Mental Health Conservatorships**.

The City should continue to work with partners, including the California State Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPGPC) to create a state office specifically to provide support and oversight to counties and their partners. This office should be responsible for providing technical assistance to county Public Conservator programs tasked with administering mental health conservatorships at the local level. This office should additionally gather relevant data on conservatorships and disseminate regular reports and information about best practices to local programs and stakeholders. Additionally, this office should track systems and resource gaps across the state, with the goal of informing policy makers and behavioral health partners.

C. The State should **enhance the Statewide bed inventory** to include information about cost, utilization, waitlist and other factors.

The State should enhance statewide bed inventory data, such as the California Department of Social Services' Licensed Capacity Year of Year Change by County and Program data,[17] to help jurisdictions more clearly understand the impacts of market pressures and capacity gaps. Currently, the State shares limited information on bed utilization and other details that may assist jurisdictions in monitoring their residential care and treatment portfolio wholistically and in contrast to peer jurisdictions. In order to produce this kind of information, jurisdictions may be required to report additional data about their own inventories and utilization. Improved transparency may reduce competitive market pressures among jurisdictions by illuminating differences between jurisdictions in service patch rates, volume of beds acquired versus utilized, and types of beds acquired and still needed. Greater information transparency could help jurisdictions better negotiate acquisition of bed capacity and bed placements with providers and may help jurisdictions notice potential collaboration opportunities to acquire or share facilities. While multiple recent legislative efforts to enhance transparency about bed inventories statewide have been introduced, none of passed.[18] The City should advocate its representatives to review the reasons those bills did not succeed and draft new legislation with these learnings.

D. The California Health and Human Services' Behavioral Health Task Force should use at least one of their monthly meetings to **hold a hearing** with an agenda focused on complex patient placement.

As part of a coordinated advocacy platform, by March 2025, the City should formally request that the California Health and Human Services' Behavioral Health Task Force hold a special hearing focused on complex patient placement to uplift the challenges local governments face in providing residential care and treatment to these clients. The City may highlight the recommendations of the Workgroup at that setting and leverage that body to explore Statewide policy approaches that support counties to address capacity, funding, staffing and other gaps that limit essential client services.

[17] "Community Care Licensing Division Data Hub," California Department of Social Services, https://www.cdss.ca.gov/inforesources/cdss-programs/community-care-licensing/ccld-data, Accessed, Dec. 5, 2024.
[18] California state legislators introduced AB 512, SB 1017, and SB 363 in the 2023-24 Regular Session but did not pass any bill.

Conclusion

San Francisco's residential care and treatment system faces capacity, placement, and funding challenges. While there is a need for general expansion of the system of care, the needs of complex clients are particularly acute. The Workgroup recommendations outline how the City, local and regional hospital partners, neighboring counties, and the State and federal governments can work towards resolving these systemic challenges.

The City has already taken key steps to achieve its expansion goals. in December 2024, the City submitted applications for Proposition 1 Bond BHCIP funding for one-time capital funds for several new projects. If awarded, these grants would result in an increase of 100 new MHRC treatment beds added to the system of care. One of these applications included a partnership between the City and UCSF Health to renovate existing hospital space for this purpose. These partnerships are essential to our City's ability to address the needs of the most vulnerable and complex patients in our community. Workgroup members remarked that with every additional MHRC bed, more individuals could enter and be treated in the City's entire system of care at any level of need. However, should the City not be awarded Bond BHCIP funding for any of the proposed initiatives, then City leaders will need to use alternative funding sources, such as the General Fund or other local sources, to accomplish the proposed, and necessary, projects.

While this application for new State funding, if approved, could significantly impact San Francisco's system of care across all levels, it does not address all the challenges raised by the Workgroup. The City also requires additional support from the State beyond awarding these one-time capital grants, including supporting ongoing operating funds for services at these sites.

The Workgroup process allowed experts to weigh in and design a set of robust recommendations that, if implemented, will expedite the expansion of essential treatment services, sustain that treatment ongoing, and address the placement barriers faced by complex patients. Though several recommendations require action by the State or federal governments, there is much that San Francisco can do on its own, and City leadership should prioritize these local actions while advocating for State and federal policy changes and funding. When acted on, the Workgroup's recommendations will help San Francisco better care for some of the most vulnerable individuals in our City.

Appendix 1: Workgroup Membership

Member Name	City Department/ Organization	Position	Notes
Supervisor Rafael Mandelman	Board of Supervisors	District 8 Supervisor	Workgroup Co-Chair
Dr. Grant Colfax	Department of Public Health	Executive Director	Workgroup Co-Chair
Kelly Dearman	Department of Disability and Aging Services	Executive Director	
Greg Wagner	Controller's Office	Controller	
Shalini Rana	Mayor's Office	Health Policy Advisor	
Dr. Hillary Kunins	Department of Public Health	Director of Behavioral Health and Mental Health SF	
Sneha Patil	Department of Public Health	Director of Policy and Planning	
Kelly Kirkpatrick	Department of Public Health	Mental Health SF Director of Finance and Administration	
Yoonjung Kim	Department of Public Health	Director of Residential System of Care, Behavioral Health Services; Co-lead Mental Health SF New Beds & Facilities Project	
Rose Johns	Human Services Agency	Planning Director	
Jill Nielsen	Department of Disability and Aging Services	Deputy Director of Programs, Public Conservator	
Chief Cristel Tullock	Adult Probation Department	Chief Probation Officer	
Monifa Willis	District Attorney's Office	Chief of Staff to DA Jenkins; Psychiatric Nurse Practitioner	
Simin Shamji	Public Defender's Office	Managing Attorney of the Advocacy Team Units	
Dr. William Isenberg	California Pacific Medical Center (CPMC) / Sutter Health	Chief Medical & Quality Officer, Sutter Health	
Dr. Mark Leary	University of California, San Francisco (UCSF)	Vice Chair of Psychiatry, Director of Psychiatric Emergency Services at Zuckerberg San Francisco General Hospital (ZSFG)	

Member Name	City Department/ Organization	Position	Notes
Dr. Carrie Cunningham	UCSF	Interim Division Director, UCSF/ZSFG Division of Citywide Case Management	
Dr. Matt State	UCSF	Chair of Psychiatry	
Dr. Murtuza Ghadiali	Kaiser Permanente	Director of the Department of Addiction Medicine and Recovery Services in San Francisco	Member for Sessions 1-3
Parnika Kodali	Kaiser Permanente	Chief Operating Officer, San Francisco Medical Center	Member for Sessions 4-5
Alex Wong	Kaiser Permanente	Government Affairs Lead	Member for Sessions 4-5
Matija Cale	SF Health Plan	Director of Clinical Operations	
Nato Green	SEIU 1021	Collective Bargaining Coordinator	
Supreet Pabla	California Nurses Association	Labor Representative Lead	Member for Sessions 4-5

Appendix 2: Interview Summaries

SUBJECT MATTER EXPERT INTERVIEW SUMMARIES

The Controller's Office interviewed residential treatment program subject matter experts who intersect with San Francisco's behavioral health system of care and used findings from these interviews to inform workgroup materials. The interviews covered questions related to client complexity, ideas on what the City could do to address placement and capacity challenges, and impacts of new conservatorship laws, among other topics. Depending on their roles, the Controller's Office asked interviewees what challenges they had in either accepting or referring complex clients into ARF, RCF-E, or MHRC facilities as well as recommendations for improving service delivery.

The Controller's Office interviewed the following stakeholders.

Clinical Providers. These comprised representatives from local behavioral health providers that deliver services to behaviorally complex clients but do not offer ARF, RCFE, or LSAT programs. Staff from the following organizations participated in interviews:

- Conard House
- HealthRight360
- PRC/Baker Places
- Progress Foundation
- UCSF Citywide (12 staff members from across Supportive Housing Case Management, Care Courts, Forensics, Emergency Department Case Management, and other divisions)

ARF and RCF-E Operators. The Controller's Office interviewed operators from small facilities (ten beds or less) to larger facilities (fifty or more) and located both within and outside of San Francisco. Staff from the following operators participated in interviews:

- United Family Care Home
- Broderick Street Adult Residential
- Mae Bea Andrews Home #1 and #2
- Colonial Acres
- Portola Gardens

Hospital Executives. The Controller's Office interviewed executives from Sutter Health and UCSF Health (St. Mary's and St. Francis Hospitals). Their hospitals have multiple campuses serving an array of clients that may occasionally treat the population of focus in this report for acute medical episodes.

Given the different roles of the subject matter experts, interview questions varied and not all stakeholders weighed in on all of the topic categories in this section. This appendix summarizes interview input according to the stakeholder group and key topics, where applicable.

INTERVIEW SUMMARY: CLINICAL PROVIDERS

Client Complexity

Providers stated that a majority of clients they serve have one or more of the types of complexities mentioned in the report, e.g.:

- acute mental or cognitive disorders
- active or previous substance use
- histories of aggressive behaviors
- registered sex offenders
- justice involvement
- medication non-adherence, etc.
- People who self-harm
- history of arson
- history of violence against staff
- methadone treatment
- psychiatric disorders and not stable on their medications, have active delusions and/or refuse to take medication
- medical complexities
- Language barriers

Several providers identified that medical complexities and physical impairments are especially challenging in behavioral health-focused settings, because many behavioral health treatment programs are not licensed to provide medical care or care for non-ambulatory clients. This creates challenges in finding the right treatment setting for clients, according to multiple providers, e.g., prioritizing a clients medical treatment over their substance use or mental health treatment. This can also be a common reason for placement denial at some settings.

One provider mentioned most of their clients are unhoused and this causes challenges in placement, while another mentioned that having housing (e.g., supportive housing) can be a challenge since clients with housing may be perceived as being served already but may not be getting adequate care.

Capacity, Placement, or Level of Care Challenges

Several of the interview participants were unaware of recent bed modeling results; however most clinical providers affirmed that there is both a capacity challenge and placement challenge. Several stated specifically that there are not enough MHRC or LSAT beds in the system and this is a clear capacity challenge. One participant noted a need for more State Hospital beds.

Some participants commented that other types of settings may be good alternatives to MHRC programs, such as intensive community-based services that are voluntary. There are limited spots in these types of settings as well, and not all clients may be appropriate for a voluntary setting, according to other participants. Other providers mentioned wanting to see added capacity across all levels of care, including more inpatient beds with longer lengths of stay and more State Hospital beds.

Moreso than placement or capacity, some providers stated that the main issue with finding care for behaviorally complex clients is that very few programs align to the array of client challenges. Referring providers must often choose between settings that offer medical, mental health, or substance use treatments and have very limited options that offer services with all of these treatment types. According to one provider, different skills and types of providers are needed in each setting, and so it is difficult to create a single program that serves all types of client needs. According to some, the system may not have the level or type of treatment approach that is needed for the complexities of the client population.

One provider noted that it is important to see the system as a continuum, rather than focusing on individual levels of care, and also highlighted the need to enhance prevention elements: addressing client needs early and sufficiently to prevent decompensation. Some posited that getting clients placed timely into the right level of care could help keep clients from decompensating and needing more intensive interventions like conservatorship down the line.

However, where possible, providers suggested supporting existing ARF, RCF-E, and MHRC providers and helping them enhance programming rather than creating new programs.

Several providers also commented on the time allotted for treatment programs. Numerous interviewees noted that a 90-day substance use treatment program is insufficient particularly given the rate of co-occurring mental illness that can complicate care. When treatment programs are too short, according to providers, this leads to the cycling in and out of systems, and possible decompensation leading to the need for conservatorship and locked settings.

Referral Process

Several clinical providers stated that the referral process to place clients into ARFs and RCF-Es is difficult and not transparent. They speculated that there is no data on real-time bed utilization, which would be helpful at the facility level to identify open spots.[19] While some acknowledged that referral into LSAT, ARF and RCF-E settings occur via DPH Utilization Management, some were not aware of this process and others expressed that they still need to support the referral in order for it to be successful. Several clinical providers stated that private ARF and RCF-E operators have too much discretion in which clients they accept and those operators may deny their clients for reasons they do not always understand or agree with.

Staffing

Most clinical providers agreed that there need to be appropriate staff levels and skills to support at any program serving behaviorally complex clients. This includes hiring mental health professionals, doctors, nurses, psychologists and other medically trained providers. Providers noted they do not have to be on staff every day so facilities can arrange for alternative staffing structures like utilizing part-time or external staff.

Interviewees noted the following perceived or observed impacts of pervasive staffing gaps:

- Many facilities do not have enough or the right type of staff and this leads to challenges in placing clients in those settings.

[19] DPH has a website with real-time facility capacity data: https://www.findtreatment-sf.org/. However, information is limited to shorter-term residential treatment, i.e., 90-day programs, in the City.

- Programs have insufficient staff with the right level of experience; participants noted that often people with the least clinical experience are placed in more challenging settings.
- Gaps in staffing can lead to lengthy intake process, and one participant noted that clients can stay in custody longer than necessary because there are too few intake staff at care settings to do intake assessment and processing timely.
- Gaps in language capacity across many facilities.
- Participants noted that it can be hard to connect with staff at facilities, complicating care coordination for their clients.
- Participants indicate that salaries are not sufficient for the work, and shared anecdotes about colleagues talking about how meaningful work is but they left the field or the area because the salary was not enough to make them stay.

They noted that gaps in service can occur when: staff do not have the language competency to communicate to non-English speaking clients, staffing shortages lead to a lengthier intake process, and when residential treatment facility staff are hard to reach for care coordination.

Conservatorship

During interviews, all clinical providers stated that, anecdotally, they have not experienced changes to their client population because of Senate Bill 43 (SB 43), which expands conservatorship eligibility. One provider identified that conserved clients generally have higher levels of acuity than what some treatment programs could support and add to client complexity. Some participants expressed that, even with SB 43, it can be difficult to get clients conserved. Some participants noted that they have experienced difficulties in getting placement for conserved clients.

Recommendations and Ideas

While not in scope of this report, several providers mentioned a need for more permanent housing with integrated substance use and mental health supports. They also recommended treatment programs incentivize participation by offering housing and enhancing the connection between treatment and housing in both directions.

Several providers noted the need for more on-site medical support within behavioral health treatment programs. According to these providers, this is not a regulatory issue, but rather a funding issue. Others proposed building out facilities that are flexible in their programming. Flexibility may mean being staffed to take clients with varying complexities and needs, and it may mean approaching certain client risk factors as "acceptable."

Some providers highlighted in-county care as preferable to out of county placement as it can make care coordination easier.

INTERVIEW SUMMARY: ARF AND RCF-E OPERATORS

Client Complexity

Operators reiterated some of the same complexities mentioned by clinical providers. One operator noted that referred clients should be mentally and medically stable for facilities to accept them for placement, which can be a challenge for behaviorally complex clients.

All the interviewed operators noted that they consider potential increased risk of complex patients to their existing client populations, staff, and to their operations. One operator perceived that the State departments that manage ARF and RCF-E licensing may penalize a facility (e.g., issue fines, revoke license) if clients present a safety risk, such as becoming violent against others in the facility. The facility is mandated to report these events to the licensing agency, which may lead to an investigation.

Adding to the element of risk, one operator noted that it can be challenging to transfer a client because of persistent misconduct. According to the operator, this is administratively burdensome, with the facility having to issue a 30-day eviction notice, hire a lawyer, and facilitate an alternative placement. It is also hard on the client, whose behaviors might change when being transferred from a familiar environment.

Capacity, Placement, or Level of Care Challenge

While not specifically weighing in on the question of whether the City has a capacity or placement issue, all the interviewed operators reported having bed vacancies at the time of the interview, and most noted that they regularly deny placement of clients due to licensing issues. For example, one stated that they may be referred a client who has ambulatory impairments and the facility does not have an elevator. They would not be allowed to accept a client with ambulatory issues and maintain their license. However, they also noted that they have denied clients due to "fit" with other residents at the facility.

Staffing

Most of the operators interviewed reported not having the skilled medical staff to adequately care for complex clients. Only one interviewed ARF facility employs on-site clinical and mental health staff, allowing them to take on complex clients. This may be a reason they allowed clients on Medication Assisted Treatment (MAT), a commonly cited reason that providers say facilities might deny placement.

Several operators without clinical staff mentioned the benefits of bringing in external healthcare providers. One operator mentioned that they coordinate periodic visits from a primary care physician for general check-ups; another operator mentioned previously utilizing Westside Crisis Center's roving crisis services for emergency psychiatric episodes; one operator reiterated that they don't have the need to employ skilled staff or the budget and suggested promoting more partnerships and coordination with external triage teams. This would reduce the burden on ARF and RCF-E facilities to manage complex care, which they state are not equipped for, and tap into the existing network of care.

Nearly all of the interviewed operators reported some level of staffing challenges, from difficulties recruiting staff during the COVID-19 pandemic to retention challenges given lower salaries and more comprehensive benefits in other related settings like home health care.

Conservatorship

Operators generally also noted that they are not getting more conserved clients than normal; however, operators stated that they have seen an increase in behavioral complexity among referred clients, including more individuals with substance use disorder, histories of violence, and/or experiencing homelessness. One operator noted that keeping conserved clients medicated is their biggest challenge in managing their care. However, another operator noted it is harder to provide services to non-conserved clients who do not want to participate in treatment. Nearly all the operators interviewed reported having some conserved clients.

Other Recommendations

All operators cited budget as a key operational barrier. Across interviews, there was consensus that additional funding would be useful to hire and retain skilled staff and/or to renovate or maintain facilities.

INTERVIEW SUMMARY: HOSPITAL EXECUTIVES

Client Complexity

Hospital executives noted that behaviorally complex clients are treated in their emergency rooms at varying degrees, depending on campus locations. One executive noted that about half of all patients that come to one of the emergency rooms has some form of complexity that makes their case challenging. These clients may come in specifically because of behavioral health crises, but often arrive with medical concerns that are complicated by behavioral health complexities.

One hospital executive mentioned that nearly all patients who come in on a 5150 involuntary psychiatric hospitalization are complex clients with mental health issues and dual diagnosis is prevalent. Patients who come to the emergency room five or more times almost always have dual diagnoses.

According to one participant, patients with medical needs related to substance use can be the most complex to treat. In particular, individuals who come to the hospital after an overdose often have damage resulting from that overdose, and may be in a coma, a medically induced coma or brain dead. In these cases, even finding a person's identity or their next of kin can be very challenging.

Like other interviewees, hospital executives noted that clients with histories of disruptive behaviors, violent tendencies, developmental disabilities, and/or substance use often present with additional complexities that may make them harder to serve in traditional medical setting. Sometimes patients who need to stay in hospital choose to leave and deny treatment.

Referral Process

Hospital executives noted a that placing behavioral health patients into lower levels of care is particularly challenging, especially if individuals are not from San Francisco and have out of county insurance plans or are experiencing homelessness. When these patients have additional complexities, such as cognitive impairments or aggressive behaviors, this can exacerbate these issues. This can lead to delays that result in the patient staying at the hospital longer than patients without complex behavioral health concerns.

One executive noted that the hospital's role focuses on stabilization and getting patients into the right next level of care. That hospital has a limited number of psychiatric beds (less than 20) so must work to find

placements in other settings for psychiatric patients needing longer care. Hospital social workers conduct care coordination to find alternative placements, preferably in county but sometimes out of county. These social workers may work with DPH for placement options within the City's network, but also other private networks.

Capacity, Placement, or Level of Care Challenge

Hospital executives generally agreed that there seems to be both a capacity and placement issue. One executive mentioned similar issues with skilled nursing facilities (SNFs), which provide a higher level of care than residential treatment facilities but also may provide long-term housing. While SNFs are reimbursed by insurance there are limited beds and if SNF operators feel they are not adequately reimbursed, they might be inclined to take more private paying clients and not accept complex clients.

One hospital executive mentioned that, across multiple emergency rooms, they have a daily average of 22 psychiatric patients, which is enough to back up their system. They also mentioned that the hospital might privately pay for a patient to go to a residential treatment facility to step down their care.

One hospital executive mentioned their interest in expanding hospital service offerings to better meet the needs of behaviorally complex clients. They mentioned the benefits of more partial hospitalization programs, primarily mental health and group programming, but cited cost as a barrier. One new mental health program cost the hospital $40 million for 18 new beds.

Conservatorship

Both hospital executives stated that they have not observed an increase in conserved patients with SB 43. One noted that there does not seem to be a process for implementing SB 43. Both identified that it can be difficult advocating for and getting conserved patients placed into residential care, even with in-house case managers. These patients might stay longer in the hospital than needed while waiting for placement, which impacts bed flow and increases the cost of care for emergency room stays. One would like to see an increase in the speed with which patients could be involuntarily taken into care.

Other Recommendations

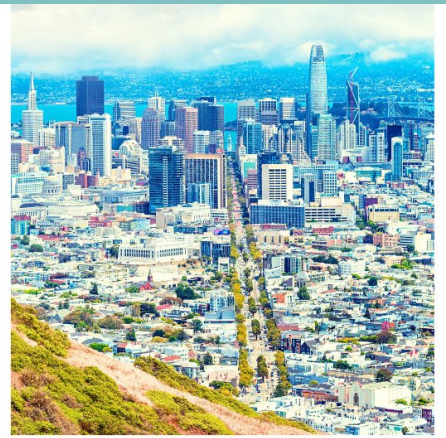
One hospital executive recommended the City seek partnerships, where possible. This could include leveraging community benefit dollars. This could also include streamlining MHRC facility expansion through partnerships with existing hospitals that have spare beds and operators willing to run the treatment program, e.g., the Crestwood San Francisco Healing Center.

Another executive identified a need for a facility that would accept patients with mental health and substance use disorders. Psychiatric settings at hospitals are primarily geared toward mental health disorders, but often patients enter the hospital with a primary substance use episode. They noted that hospital staff are not specifically skilled in substance use disorders and even psychiatry students are often more focused on mental health. It could be helpful to have more experts in substance use disorders placed in emergency department and among care coordinators working on patient placements.

One hospital is exploring expanding partial hospitalization programs. This is a program with primarily mental health programming and group therapy for half-day or full-day sessions. These are expensive programs at a

hospital, and the executive noted that cost barriers are the primary challenge. For example, that hospital added new mental health space for under 20 beds and it cost $40 million to upgrade the facility.

One executive noted that they have been asked by the hospital system to make the emergency department more “psych friendly,” e.g., better equipped to take on complex psychiatric cases with emergency medical needs, but this is expensive and difficult to build out given location constraints.



Appendix 3

Residential Care and Treatment Workgroup

Session: Workgroup Formation

Office of the Controller

Laura Marshall, Hannah Kohanzadeh, Oksana Shcherba

May 29, 2024

Agenda

1 Workgroup Purpose

2 Sponsorship & Membership

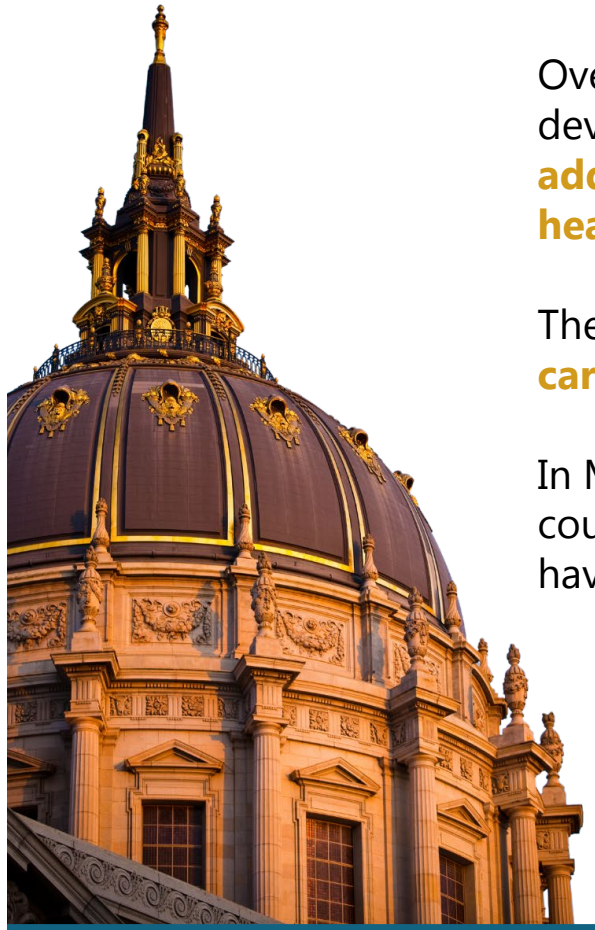
3 Topics and Considerations

4 Process for Findings and Recommendations

5 Discussion

Residential Care and Treatment Workgroup

Workgroup Purpose



Over a six-month process, the Workgroup will convene local and regional leaders to develop a recommended approach the City and County of San Francisco can use to **address its most pressing gaps in care for clients with the complex mental health needs**.

The Workgroup will focus on **locked sub-acute treatment** (LSATs) and **residential care facilities for adults and the elderly** (RCF/Es).

In March 2024, the state passed **Proposition 1**, which reallocates funding to counties for acquisition and expansion of facilities (such as LSATs). The City should have a plan in place to leverage this funding.

Residential Care and Treatment Workgroup

Sponsorship

Representative	Department
Supervisor Rafael Mandelman	Board of Supervisors
Andres Powers, Chief of Policy	Office of Mayor London Breed
Dr. Grant Colfax, Director of Health	Department of Public Health
Kelly Dearman, Executive Director	Department of Disability and Aging Services
Controller Greg Wagner	Controller's Office

Residential Care and Treatment Workgroup

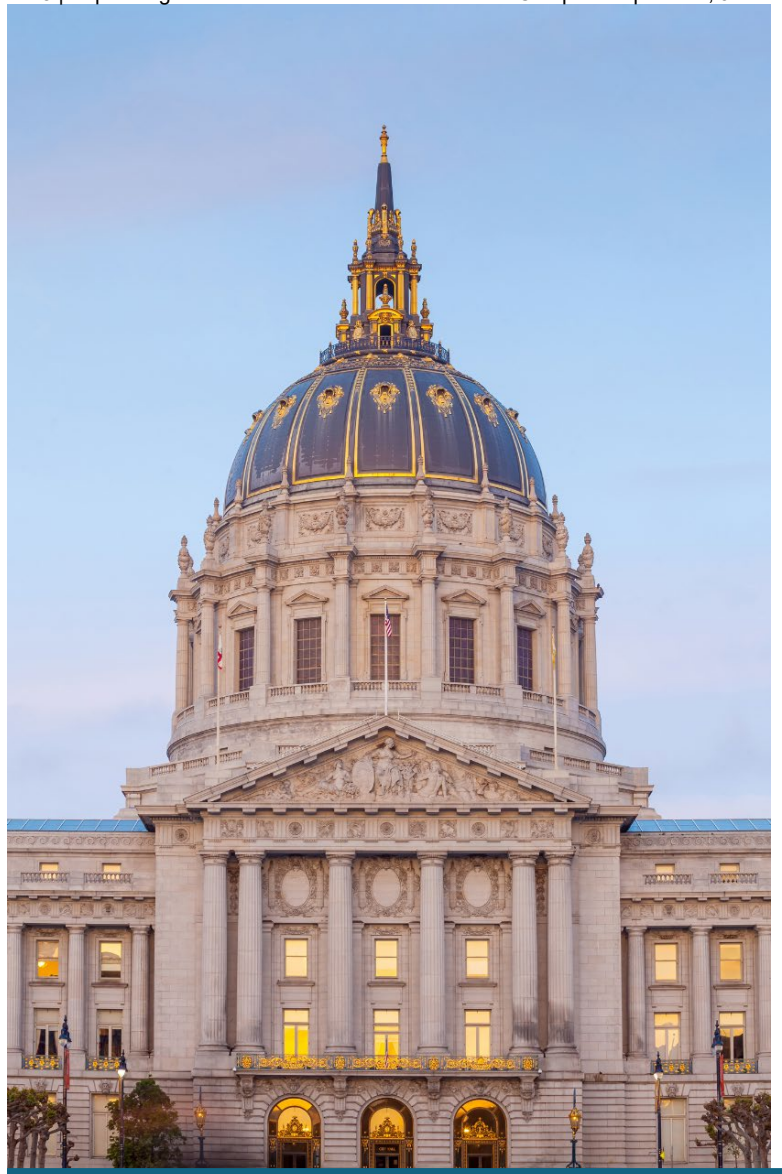
Membership

Department	Representatives
Office of Mayor London Breed	Shalini Rana, Health Policy Advisor
Department of Public Health (DPH)	Dr. Hillary Kunins, Director of Mental Health SF and Behavioral Health Services
	Kelly Kirkpatrick, MHSF Director of Administration and Operations
	Sneha Patil, Director of Policy and Planning
	Yoonjung Kim, Director of Residential System of Care, Behavioral Health Services and Co-lead New Beds & Facilities (Bed Expansion) Project - Mental Health SF
Department of Disability and Aging Services (DAS)	Jill Nielsen, Deputy Director
Human Services Agency	Rose Johns, Planning Director
District Attorney's Office	Monifa Willis, Chief of Staff to DA Jenkins, Psychiatric Nurse Practitioner
Public Defender's Office	Simin Shamji, Managing Attorney of the Advocacy Team Units
University of California San Francisco (UCSF)	Dr. Matt State, Chair of the Department of Psychiatry and Behavioral Sciences
	Dr. Mark Leary, Vice Chair of Psychiatry, Director of Psychiatric Emergency Services
Sutter Health	Dr. William Isenberg, Chief Medical & Quality Officer
Kaiser Permanente	Dr. Stuart Buttlaire, Regional Director of Behavioral Health and Addiction
	Dr. Murtuza Ghadiali, Director of Department of Addiction Medicine and Recovery Services in San Francisco
San Francisco Health Plan	Matija Cale, Director of Clinical Operations
SEIU 1021	Nato Green, Collective Bargaining Coordinator

Residential Care and Treatment Workgroup

Topics and Considerations

- **Program gaps analysis**, including patient flow and wait times
- **Federal and state policy**, including current operational barriers departments face in this work that a legislative approach could support, and how current law may impact this work
- **Regional market research**, including general analysis across the region to identify market drivers that may impact approach
- **Expansion scenarios**, including analysis of operational and acquisition costs and feasibility considerations
- **Review of final deliverables**, including establishing priorities and possible recommendations to include in the report



Residential Treatment and Care Workgroup

Process for Findings and Recommendations

As a result of this six-month process, the Controller's Office will develop a **final report** documenting recommendations for how the City and County of San Francisco intends to **procure more beds for the hardest to place individuals, seek out opportunities for regional partnerships, and access new funding to expand bed capacity**.

- The report will contextualize findings and discussions from the workgroup process.
- The final workgroup session will be dedicated to reviewing and affirming the recommendations in the report.
- The Controller's Office and workgroup sponsors will finalize and publish the report.

Residential Care and Treatment Workgroup

Discussion

- From your perspective, how does the gap in RCF/E and LSAT beds impact your work?
- What initiatives are currently underway at your organization that may inform this body?
- Are the topics outlined in the work plan relevant and appropriate to our goals?
- Are there specific experts or analyses we should include in a particular Workgroup session?

Questions?

Please reach out to:
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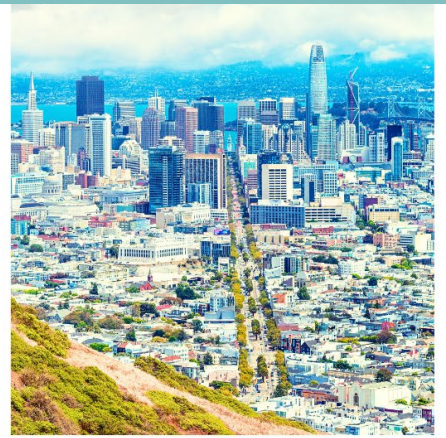
Hannah Kohanzadeh, Hannah.Kohanzadeh@sfgov.org
Oksana Shcherba, Oksana.Shcherba@sfgov.org



Appendix 4

Residential Care and Treatment Workgroup

Session: Program Gaps

Office of the Controller

Laura Marshall | Hannah Kohanzadeh | Oksana Shcherba

July 15, 2024

Agenda

1. Welcome and Introductions
2. Session Overview
3. Current Program Capacity
4. Program Gaps and Needs
5. Discussion and Recommendations

Session Overview

- Our goal today is to consider program gaps in the context of:
  - Currently available capacity
  - DPH's Bed Optimization Analysis which offers preliminary recommendations for bed expansion
  - Placement challenges for clients with complex needs
  - Impact of conservatorship on bed needs
  - Needs associated with conserved individuals in jail
- With this context, we will begin to develop recommendations for addressing program gaps

Current Program Capacity

The City has identified key gaps within the following program types, which are the focus of this workgroup:

- **Adult Residential Facilities** (ARFs)
- **Residential Care Facilities for the Elderly** (RCF-E)

Aka, Residential Care Facilities (RCFs)
Aka, Board and Care
Aka, Assisted Living

- **Locked Sub-Acute Treatment** programs (LSATs)

Aka, Mental Health Rehabilitation Centers (MHRC)

The following slides outline current available capacity in these settings, either within San Francisco, or among programs contracted in- and out-of-county by DPH.

ARFs and RCF-Es in San Francisco

DAS summarizes the Adult Residential Facility (ARF) and Residential Care Facility for the Elderly (RCF-E) capacity in San Francisco with data from the CA Department of Social Services. San Francisco currently has 3,104 beds across 88 facilities for both facility types. This captures all licensed facilities in San Francisco, including operators that are not contracted with DPH or DAS.

Residential Care Facilities for the Elderly (RCFE)*

Size (# Beds)	Facilities	Beds
1-6	14	82
7-15	15	193
16-49	8	279
50-99	4	263
100+	11	1,870
Total	52	2,687

Adult Residential Facilities (ARF)

Size (# Beds)	Facilities	Beds
1-6	24	139
7-15	6	65
16-49	5	158
50-99	1	55
100+	0	0
Total	36	417

While San Francisco saw a **net increase** of 227 ARF and RCF-E beds since 2021, the net number of **facilities decreased** by 6 in that time.

The 7 facilities that closed had fewer than 50 beds. The 1 new facility that opened had 100+ beds.

70% of RCF-E beds are now offered in facilities with >100 beds.

* Does not include Continuing Care Retirement Communities

Source: "Assisted Living in San Francisco" BOS Hearing Presentation. Feb. 21, 2024. SFHSA-DAS, which cited CA Department of Social Services, February 2024.

Current Mental Health Residential Treatment Types and Capacity

DPH currently offers approximately 1,861 beds across the residential continuum of care, including a total of **140 LSAT beds at MHRC facilities and 640 ARF and RCF-E beds** that serve clients with behavioral health needs.

DPH contracts for these bed types at facilities both in San Francisco and out of county.

Category	Type	Number of Beds
Residential Care Facilities	Residential Care Facility (RCF) *(fixed bed count)*	142
	Residential Care Facility (RCF) *(as needed)*	166*
	Residential Care Facility for the Elderly (RCFE) *(fixed bed count)*	59
	Residential Care Facility for the Elderly (RCFE) *(as needed)*	273*

Category	Type	Number of Beds
Locked Residential Treatment	Mental Health Rehabilitation Centers / Locked Subacute Treatment (MHRC / LSAT) *(fixed bed count)*	101
	Mental Health Rehabilitation Centers *(as needed)*	39*
	Psychiatric Skilled Nursing Facilities *(as needed)*	160*

As-needed bed counts are estimates and fluctuate based on needs and availability. Most as-needed beds are subject to competition with other counties.

*Estimate, including as-needed beds

Source: "Behavioral Health Residential Care and Treatment" BOS Hearing Presentation. Feb. 21, 2024. SFDPH.

DPH Bed Optimization Overview

In 2023, DPH updated its 2020 behavioral health bed modeling to develop preliminary recommendations for the number of beds needed for 95% of clients to experience zero wait time.

- The system needs the **right number of beds at all levels** to work best for clients and minimize wait times.
- Preliminary results show that DPH may need **150-225 beds** across long-term and short-term term care to achieve wait time goals.
- Bed optimization is an estimate based on utilization data and does not address all **client placement** needs.

Residential Expansion: Preliminary Recommendations

Residential Type	Additional Beds Needed	Considerations
Mental Health Rehabilitation Centers (MHRC) / LSAT	Estimated 55-95	• Given current wait times • Potential for increase in demand under SB 43
Behaviorally Complex Therapeutic (Enhanced Residential Care / Residential Care for the Elderly	Estimated 20-40	• Highly specialized level of care for complex, high-need clients difficult to place in care.

DPH currently recommends adding 55-95 LSAT beds and 20-40 Behaviorally Complex Therapeutic beds. Depending on the program model, Behaviorally Complex Therapeutic beds could be licensed as an ARF or an RCF-E.

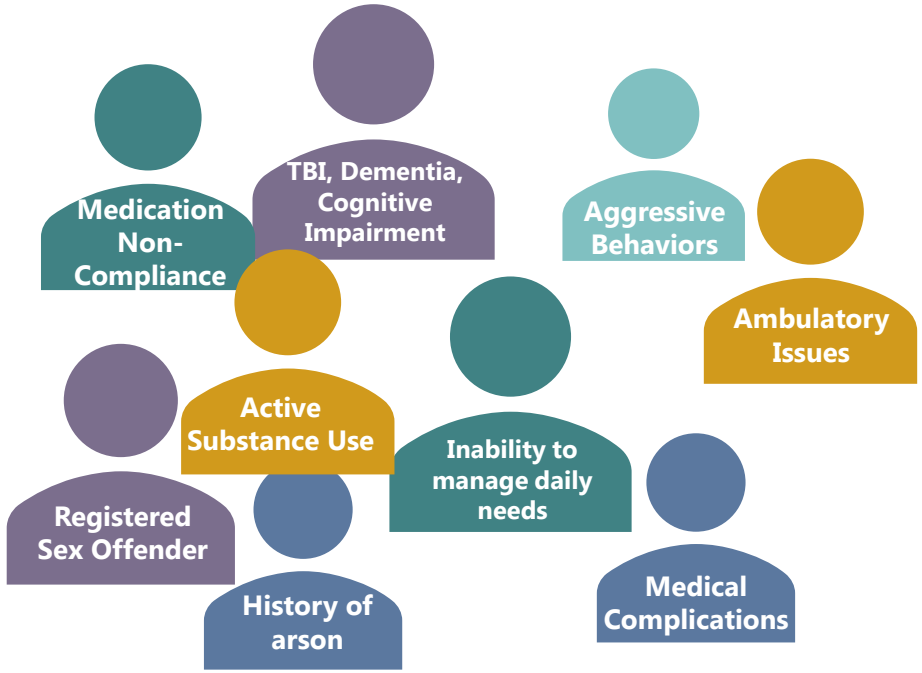
While the modeling did not recommend an increase in the *total* ARF and RCF-E bed count, there are challenges around the limited availability of ARF and RCF-E beds for clients with complex needs.

Source: "Behavioral Health Residential Care and Treatment" BOS Hearing Presentation. Feb. 21, 2024. SFDPH.

Placing Clients with Complex Needs

Defining Complexity

It is challenging to find appropriate placements for high-needs clients with the following characteristics:



Impact of Complexity

While there may be available capacity in ARFs, RCF-Es, and LSATs at a given time, highly complex patients are **most difficult to place** in the right level of care.

Residential facilities, especially ARFs and RCF-Es, vary in their ability to accept clients with complex needs.

A facility's level of care depends on both physical constraints (e.g., building accessibility and egress) and staffing level and training.

Challenges with Modeling of Program Gaps

- DPH did not include **State Hospital** bed needs because DPH does not have control over this level of care. There are conserved patients in jail awaiting a State Hospital placement.
- Current DPH modeling for ARFs and RCF-Es does not account for nuance regarding **wait times for complex patients**. Future modeling will require more detailed analysis of the level of care provided at different ARF and RCF-E facilities.
- DPH bed modeling focused on where to add beds based on placement data, **not on the location of client at time of referral**. This is why clients in jail are not specifically called out in the modeling.
- The model estimates demand based on historic utilization data. DPH offers **ranges for certain bed types** based on clinical assessment that demand estimates for certain levels of care were too low. More comprehensive wait time and referral data would allow for more accurate modeling.

Current Mental Health Residential Treatment Types and Capacity

Additions:
DPH has opened nearly 400 new residential behavioral health beds planned under Mental Health SF, a nearly 20% increase since 2020.

Losses:
Residential losses among SFDPH-contracted providers have primarily been among ARF and RCF-E programs.

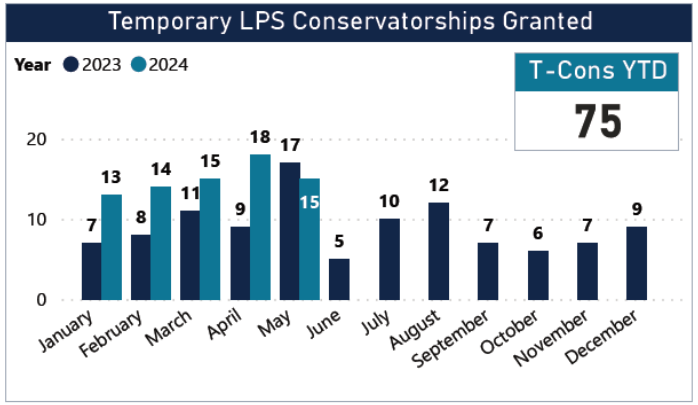
- In most cases, SFDPH was able to successfully transfer clients to continue care. In some cases, the facility continued to operate after the end of a contract and the clients remained, with payment covered by SSI. In a small number of cases, clients transferred to another level of care, or decided to discontinue service.

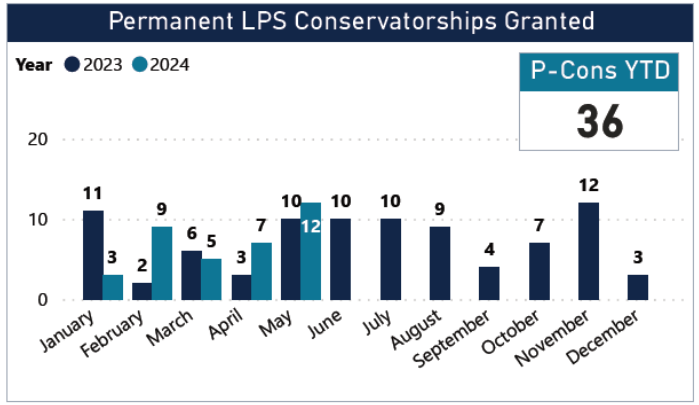
Conservatorship and Need for Beds

SB 43 (implemented January 1, 2024) expanded eligibility requirements to help more people struggling with substance use disorder get the care and support they need through conservatorship.

DAS (Public Conservator) data shows a marked increase in Temporary Conservatorships (T-Cons) since January.

Total active caseloads rose above 700 beginning in March 2024.





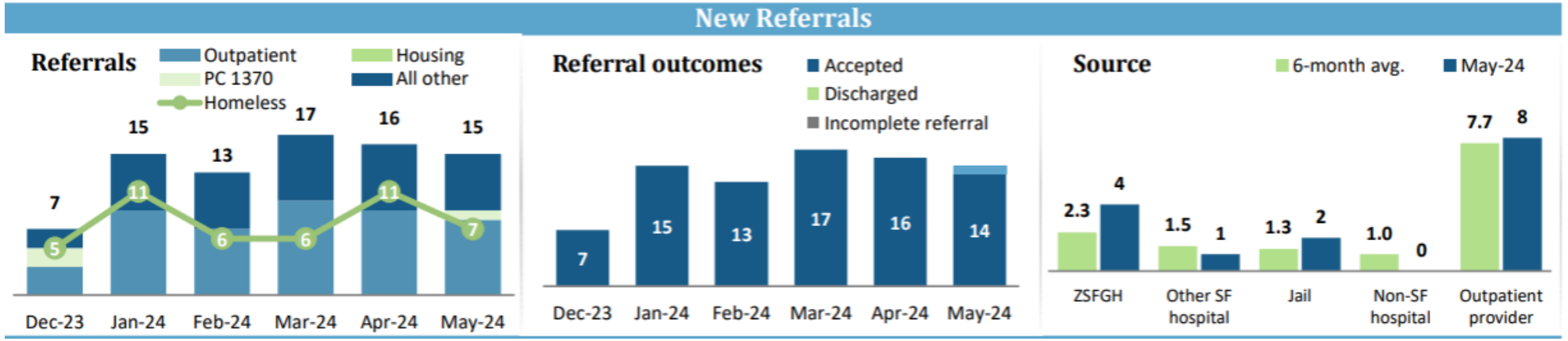
Active LPS Conservatorships

Year	Month	T-Cons	P-Cons	Total
2023	May	35	635	670
2023	June	31	637	668
2023	July	26	645	671
2023	August	30	648	678
2023	September	31	647	678
2023	October	31	651	682
2023	November	23	662	685
2023	December	28	657	685
2024	January	35	651	686
2024	February	35	654	689
2024	March	46	655	701
2024	April	56	653	709
2024	May	59	656	715

Note: Most conservatorships begin with a Temporary Conservatorship (T-Con), filed by the Public Conservator to ensure the client continues to receive care during the judicial process. T-Cons are generally effective for 30 days and may be extended. Should ongoing conservatorship be necessary, the PC recommends a Permanent Conservatorship (P-Con), which are effective for one year. To renew the conservatorship, the PC must file a new petition annually. All conservatorships must be granted by the Superior Court.

Conservatorship and Need for Beds

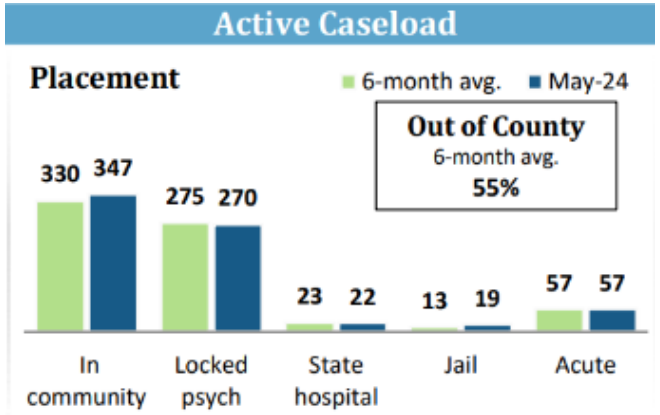
As of May 2024, DAS reports show outpatient providers as the leading source of conservatorship referrals (8), with ZSFG referrals as the second most frequent source (4).

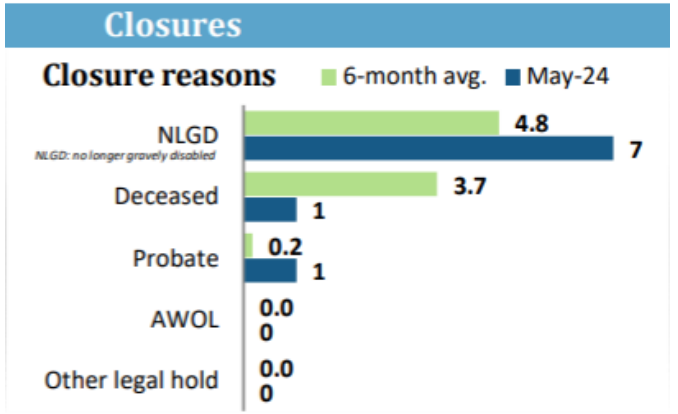


Conservatorship and Need for Beds

DAS (Public Conservator) also tracks data about where conserved clients have been placed.

- As of May 2024, San Francisco had an **active caseload of 715** conserved individuals.
  - 49% are in a community setting (including ARFs, RCF-Es, as well as in private homes or other community settings)
  - 38% are in a locked psychiatric facility (LSAT)
- San Francisco's commitment to placing in the least restrictive setting, as well as the outpatient referral pathways, contribute to a higher proportion of conserved clients in community compared to other counties (per DAS).
- Clients needs and condition may change over time, which may result in a changed placement or closure of conservatorship.





Placement Challenges with Conservatorship

LSAT Placement Barriers:

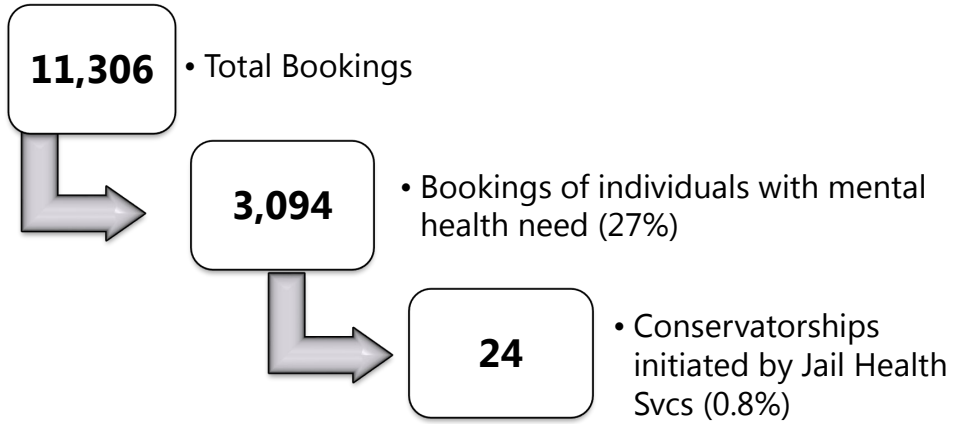
- 38% of current conserved clients are placed at a locked psychiatric facility, and DAS reports that almost half of outpatient referrals recommend LSAT placement.
- LSATs typically require a two-week hospital record showing patient needs, but outpatient referrals often cannot produce these records and so LSATs may decline placement.
- There is an overall system shortage for LSAT beds due to competition from other counties, making placements of conserved individuals needing this level of care challenging.

Lack of Appropriate ARF and RCF-E Facilities:

- Conserved clients at the ARF and RCF-E level of care typically need higher staffing support. DPH pays a "differential" rate for enhanced behavioral health staffing levels at certain ARF and RCF-E sites.
- There are few ARF and RCF-E facilities that offer this level of care, and those that do often struggle with staffing gaps that mean they cannot offer the staffing ratios a client may require.

Justice Involved Clients and Need for Beds

FY23-24 Jail Population
(non-unique)



As of July 2024, there are **17 conserved individuals** in jail.

Approximately one quarter of the population booked into jail have a mental health condition.

In total, **less than 1%** of individuals booked into jail have a conservatorship initiated by Jail Health Services.

In FY23-24, Jail Health initiated 24 conservatorships.

Patient Placement Process from Jail Health into Care Facility

~75% of individuals booked into jail are discharged from jail in 7 days or less.

Jail Health Placement Process

- Generally, the DPH utilization management and placement process for incarcerated individuals is the same as the process for clients in other settings.
- Differences include:
  - Requires consideration of the individual's criminal case / legal proceedings
  - Serious criminal charges / possible state prison sentence
  - Unanticipated release (these patients are sent to PES upon discharge)
- Jail discharge planning involves close collaboration with criminal justice and community partners, including Sheriff, Probation, Pre-Trial Diversion, Public Defender, District Attorney, and others. The time to placement in treatment depends upon many steps that must be executed by these stakeholders.

Discussion

- Do these program needs resonate?
- What additional program gaps or needs do you see in the system?
- Are there other factors that contribute to challenges placing complex clients from your own settings?
- What recommendations does the workgroup have?

Questions?

Please reach out to:
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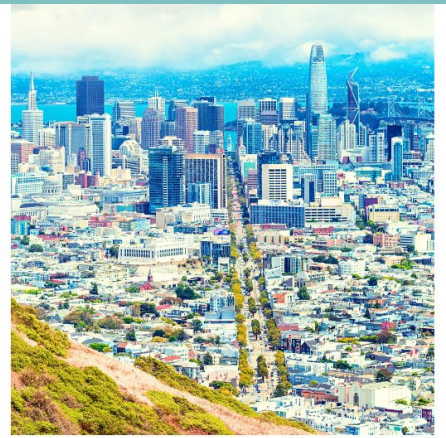
Hannah Kohanzadeh, Hannah.Kohanzadeh@sfgov.org
Oksana Shcherba, Oksana.Shcherba@sfgov.org



Appendix 5

Residential Care and Treatment Workgroup

Session:
LOCAL AND REGIONAL MARKET ANALYSIS

Office of the Controller

Laura Marshall | Hannah Kohanzadeh | Oksana Shcherba

September 27, 2024

Agenda

1. Welcome and Introductions
2. Session Overview
3. Regional and Market Analysis – Health Management Associates (HMA)
4. Local Provider Input on Barriers and Options
5. Breakout Groups: Priorities and Opportunities

Session Overview

Consider **regional and market analysis** presented by HMA, including how regional market pressures impact bed availability, as well as how other county health officials are addressing similar concerns.

Consider **input from San Francisco service providers**, including operational barriers they face in delivering services, and ideas and opportunities for how to address these constraints.

In breakout groups, begin to **prioritize** the key challenges or concerns that San Francisco should focus on solving (i.e., which may have the greatest impact) and **brainstorm policy, legislative or operational options** to address these.

Regional and Market Analysis

Health Management Associates (HMA)

HMA

Residential Care and Treatment: Regional and Market Research

September 27, 2024

PRESENTED BY:

Mary Adèr, MPP, MPH – Senior Consultant
Laura Collins, MSW, LICSW – Managing Principal
Anthony Federico, MA, MPA – Senior Consultant

PRESENTATION OUTLINE

1. Project Background
2. Methods
3. Themes and Findings
   A. General Landscape
   B. Program and Population Characteristics
   C. Strategies for Difficult-to-Place Individuals
   D. Costs
   E. Demand and Utilization
   F. Planning and Partnerships
4. Discussion

PROJECT BACKGROUND

- Adequacy of behavioral health (BH) beds is a top priority across California communities.
- The San Francisco Department of Public Health (SFDPH) engaged Health Management Associates (HMA) to conduct interviews and market research on Adult Resident Facilities (ARFs), Residential Care Facilities for the Elderly (RCFEs), and Mental Health Rehabilitation Centers (MHRCs) to inform local and regional strategies and planning efforts.

PROGRAM DEFINITIONS

- **Adult Residential Facilities (ARFs):** non–medical facilities that serve adults ages 18-59: Provide care and supervision for people who are unable to live by themselves, but who do not need 24-hour nursing care. The residents may have a mental, physical, or developmental disability. ARFs provide room, meals, housekeeping, supervision, storage, distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing, and transferring.
- **Residential Care Facilities for the Elderly (RCFEs):** Same as ARFs but serve people age 60+.

ARFs and RCFE are often referred to together as "Board and Care" (e.g., 4 to 6 beds) or "Assisted Living" (e.g., 16+ beds)

- **Mental Health Rehabilitation Centers (MHRCs):** Designed to provide long-term psychiatric care for individuals who no longer meet the criteria for acute care but are not yet ready for independent living or placement in Board and Care facilities. They operate in a locked setting and offer 24/7 psychiatric and nursing care, along with psychosocial rehabilitation services, tailored to the needs of individuals with severe mental illness who are placed under conservatorship. MHRCs are one type of Locked Subacute Treatment facility (LSAT) in some counties, including San Francisco.

Sources: California Department of Health Care Services (DHCS), California Advocates for Nursing Home Reform, Los Angeles County Department of Mental Health

METHODS

COUNTY INTERVIEWS

- Over August 5−28, HMA interviewed seven counties identified for input: Alameda, Los Angeles, Napa, Sacramento, San Diego, San Mateo, and Santa Clara.
- Interviews focused on program and population characteristics, strategies for difficult-to-place individuals, costs, demand and utilization, planning and partnerships.
- Interviewees consisted of county behavioral health leaders, managers, and analysts.
- Interviews were conducted virtually and lasted approximately 60 minutes each.
- County partners shared a wealth of valuable information. In a couple of instances, county partners withheld information due to concerns related to authorization or competitiveness (e.g., rate information).
- HMA made follow-up requests of the counties interviews, to obtain more detailed info about funding, patch rates, forecasting models, bed inventory, and more. Much of this was obtained, but it was not provided consistently by all counties.

METHODS

Market Research

- Reviewed regulations to examine the landscape, inventory, and populations served and excluded.
- Worked with the state Community Care Licensing Division (CCLD) datasets to isolate the total number of licensed and pending facilities (and bed count) statewide and in the counties identified for study.
- Data on operator costs and county spending is unavailable through market research. Detailed cost and spending was not available in the public domain.
- Little existing, published research, much of which was out-of-date or inapplicable.
- Recent, relevant, and valuable research included *Behavioral Health Treatment Beds: An Explainer (2024), California Healthcare Foundation; Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California (2021), RAND;* and *Continuum of Care Report (2022), DHCS.*
- Interviewed Heather Harrison, Senior Vice President of Public Policy & Public Affairs of the California Assisted Living Association (CALA), a trade group in Sacramento representing 600 RCFEs.
- Corresponded with Patricia Blum, PhD, Executive Vice President of Crestwood. Crestwood is one of California's leading residential treatment and care providers, with more than 29 campuses serving adults, including contracts with CCSF.

THEMES AND FINDINGS

GENERAL LANDSCAPE

- Each county contracts with a small subset of the licensed residential care and treatment programs in its county. BH leaders in the respective counties have a limited understanding of those licensed programs that are not contracted with the county (how they are funded and how referrals are made). Some interviewees assumed that most are private-pay.
- Each county establishes a different bed-type tier structure based on the client acuity level and intensity/type of care. Tiers are used to determine types of care, staff-to-client ratios, and rates.
- **All county interviewees reported struggling with the interrelated issues of overall costs, program closures, and bed and staffing shortages.** Counties are addressing this using a range of strategies, including state grants intended to invest in facilities and maintain supply.

GENERAL LANDSCAPE

Counties reported the number of beds they contract for across each program type. These numbers are dramatically lower than the overall portfolio of licensed programs/beds reflected in the Community Care Licensing Division database. See Appendix A.

Number of County-Contracted Beds, With Adjustment for County Population, Across Each Program Type as Reported by Each County

County	# ARF Beds	# ARF Beds per 100,000 age 18-59	# RCFE Beds	# RCFE Beds per 100,000 age 60+	# MHRC Beds	# MHRC Beds per 100,000 age 18+
Alameda	32	3.3	Referred HMA to state CCLD	-	240	18.3
Napa	1	1.4	1	2.6	32	29.4
Los Angeles	677*	12	678*	32.7	-**	-**
Sacramento	450	50.6	32	9.5	-**	-**
San Diego	172	9.1	62	8.9	299	11.5
Santa Clara	298	27.1	350	88.5	-***	-***
San Francisco	**308**	**61.1**	**332**	**171.2**	**140**	**20.1**
San Mateo	85	20.9	50	27.4	100	17

**LA reported a combined # beds for ARF and RCFE; this assumes a 50-50 split*

*** MHRC bed counts not provided in response to requests*

****has MHRC partnerships but not access to a fixed inventory*

PROGRAM AND POPULATION CHARACTERISTICS

Overview:

RCFEs, ARFs, and MHRCs serve individuals with a wide range of levels of independence and behavioral health needs.

Some individual counties and facilities impose additional eligibility or exclusion criteria, including: Medi-Cal membership (LA County DMH), Full-Service Partnership (FSP) enrollment (Sacramento), and conservatorship (Sacramento and San Mateo's MHRCs).

The only consistent population characteristic across RCFEs, ARFs, and MHRCs contracted by the counties interviewed was serious mental illness (SMI).

PROGRAM AND POPULATION CHARACTERISTICS

- Tiered Levels of Care: Counties operate residential treatment and care systems based on acuity tiers and the services and care provided. This ranges from non-clinical programs for lower-acuity individuals to augmented care programs offering clinical mental health supports and intensive care in secured MHRCs.
- Tiered systems are not standardized across counties.

PROGRAM AND POPULATION CHARACTERISTICS

- Co-occurring disorders: Although the primary reason for placement is a mental health diagnosis, many individuals served have co-occurring conditions, including substance use disorder, physical health needs, developmental disabilities, and neurological/cognitive impairments.
- Many programs either (1) serve individuals with co-occurring conditions, (2) offer enhanced licenses/staffing to provide specialized care for certain co-occurring conditions, or (3) exclude individuals based on their diagnoses to ensure the safety and well-being of the individuals and other residents.
- Exclusions: State regulations exclude active communicable tuberculosis, naso-gastric tubes, a need for 24/7 nursing care, ongoing behaviors that endanger the welfare of other residents, administration of oxygen, catheter care, and need for ongoing medication injections.

STRATEGIES FOR DIFFICULT-TO-PLACE INDIVIDUALS

- **Like San Francisco, all counties employ strategies to serve 'difficult-to-place' individuals, but still struggle with individual cases and limited system capacity.**
- Counties reported that clients with certain histories, diagnoses, functional limitations, or other needs can be difficult to place.
- Examples include: Co-occurring dementia and intellectual and developmental disabilities, being a registered sex offender (RSO), a history of arson, those with violent behavior, certain types of substance use, and specific disorders (polydipsia and pica were mentioned by Sacramento).
- Counties strategies to place these individuals include:
  - Leveraging County-provider relationships: Counties have developed trusting relationships with specific operators and can engage in persuasion and creative problem-solving to safely get individuals placed with those providers who may initially resist.
  - Incentives: Most counties offer financial incentives, including enhanced patch payments (county payments to operators) or other negotiated incentives, to facilitate placement.

STRATEGIES FOR DIFFICULT-TO-PLACE INDIVIDUALS

- Ongoing Support and Coordination: Counties provide ongoing support to clients once placed to support transitions and enable continuity of care, decreasing the likelihood of adverse outcomes. These supports consist of FSP and other case management teams. San Mateo's Collaborative Care Team and Sacramento's Intensive Placement Team are examples of such teams. As another example, Napa aims to place individuals near family, friends, and providers to better connect individuals with existing supports. (San Francisco has similar supports and goals.)
- Education with operators: The Los Angeles Department of Mental Health (LA DMH) provides education to operators, including a recent informational webinar, with more than 200 current and prospective operators, about the target population. Education initiatives create transparency regarding the populations served, their histories and their needs.
- Example: LA DMH uses Skilled Nursing Facility (SNF) placements for patients who have DME needs and can't navigate into an MHRC or who need help with ADLs to a point where they quality for skilled nursing, but their primary need for placement is still BH. LA DMH partners with the Medi-Cal Managed Care Plans on these placements: SNF services are reimbursed by MCP, but LA DMH pays for the BH services.
  - *Note: San Francisco contracts for approximately 165 beds in this level of care.*

FUNDING, PAYMENT, AND COSTS

Funding Overview*:* Counties use a variety of funding sources to support their ARF, RCFE, and MHRC needs. This funding is used to invest in facilities, keep operators in business, expand programming, and incentivize operators to place individuals with diverse BH needs. Funding programs include:

- County general funds, State grants, MHSA, Medi-Cal

- Methods for accessing this funding vary:
  - Counties securing funds to deliver to operators in some cases
  - Operators directly accessing funding in other cases

FUNDING, PAYMENT, AND COSTS

Payment Overview: Patches

- Patches are supplemental payments given to ARF, RCFE, or MHRC operators to incentivize placement of individuals with high levels of acuity or specialized needs. Patches are intended to pay for enhanced services and care to meet those needs.
- Patches were a key area of focus for county interviewees.
- These rates and rate structures vary widely: most counties use a base rate and escalating tiers, and the counties interviewed vary in the use of daily and monthly rates.
- These factors limit direct comparisons among counties.

FUNDING, PAYMENT, AND COSTS

Daily Payments Per Program Type as Reported by Counties

	Alameda	Napa	Sacramento	San Diego	San Francisco	San Mateo	Santa Clara
ARF/RCFE patches	$33-$230 (four tiers)	$173-$241 Avg. $201	$65	$45 regular $60 enhanced	$46-$280 Avg. $130	$40.56 Avg. enhanced $184	$104 base rate
MHRC rates	$510-$575	$261-$504 Avg. $363	$350	$345-$485 (three tiers)	$313-$577 Avg. $506	$280-$460	$350 base rate

FUNDING, PAYMENT, AND COSTS

- Los Angeles was unwilling to disclose rates for reasons of competitiveness but offered to provide the payment information that was publicly available.
- Santa Clara disclosed only its base rates (not additional tiers), as the county is in the process of studying and updating patch rates with county executives.

FUNDING, PAYMENT, AND COSTS

Cost Overview

- Of all the issues identified by the counties, costs were the greatest concern. **Rising costs cause operators to go out of business, diminishing the supply of residential care of all types.**
- **County interviewees identified significant cost drivers anecdotally, including staffing, rising patient acuity, and facility capital and operating costs,** including the acquisition of property, mortgages/rent, operating licenses, inflation, and recent legislative efforts in this area (discussed below).
- Staffing shortages are common in all the counties because of the relatively low wages ARFs, RCFEs, and MHRCs offer. This leads to staff leaving for higher wages offered by health plans, nursing homes, hospitals, and other healthcare providers.
- Counties generally contract with independently operated ARF, RCFE, and MHRC programs as opposed to owning/operating them, **allowing very little visibility into detailed costs**.
- Examples of variation in county approaches:
  - Sacramento reported their ARF/RCFE programs are 80% contracted out and 20% county-operated. They are also developing a MHRC facility with a BHCIP grant.
  - San Francisco offers a mix of county-operated and contracted beds for all bed types.

FUNDING, PAYMENT, AND COSTS

Cost Related to Legislation

- Legislative requirements are driving demand—which drives costs—especially recent laws and programs that are increasing demand for ARFs, RCFEs, and MHRCs. These include:
  - SB 43 (Chapter 637, Statutes of 2023), which expands the definition of “gravely disabled” and is expected to result in more conservatorships and programs that house conserved individuals.
  - CARE Act, which includes "prioritization" of housing for individuals in the CARE court process.

Additional legislation directly increases operational costs, namely the requirement to pay healthcare workers $25 per hour (delayed by a significant state budget crisis and depends on federal approval).

DEMAND AND UTILIZATION

- Demand for all three program types consistently outpaces the supply of available beds.
- Los Angeles County reported growth in their number of facilities (did not provide detail on the types of timeframe).
- Few counties revealed how long the wait list is for placement.
- Alameda County indicated that the wait time for RCFEs and ARFs was five to 10 days. For MHRCs, Alameda indicated, “It could take anywhere from a week to a month or months depending on factors including bed availability, legal status, acuity, and appropriateness for step down.”
- All counties reported occupancy at or near 100%. Los Angeles indicated that occasional levels below 100% are due to referral pauses for quality improvements, corrective actions, or staffing shortages.

DEMAND AND UTILIZATION

- Few counties provided detailed information on their demand and utilization measurement.
- Summary of average length-of-stay (LoS) data points obtained:

County	ARF LoS	RCFE LoS	MHRC LoS
Los Angeles	Not obtained	Not obtained	Nine months average
Sacramento	Range: six months to three years		Range: Six to 24 months
San Francisco	**6.8 years**	**4.4 years**	**2.2 years**
San Mateo	Six years (in-county) / three years (out of county)	Four years (in county) / three years (out-of-county)	Two years average

DEMAND AND UTILIZATION

- Demand Forecasting and Utilization Management
- Like San Francisco, some counties utilize sophisticated tools to project demand and manage their ARF, RCFE, and MHRC systems.
- San Diego model: The county developed the Behavioral Health Continuum of Care Optimal Care Pathways (OCP) model focuses on the Medi-Cal eligible population.
  - Based on Crisis Resource Need Calculator developed by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Los Angeles: In addition to a utilization-based model like San Diego's, Los Angeles also uses a prevalence/population data model.
- Utilize outputs for regular reporting to local leaders and improved system management and planning.
- RAND's *Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California* (2021) used three methods to estimate the psychiatric bed needs of California: (1) interviews with administrators across levels of care, (2) epidemiological/pop health data, and (3) a Technical Expert Panel

- Tools enable robust, data-informed management and planning
- Some projections do not align; these tools haven't been perfected

PLANNING AND PARTNERSHIPS

- Interviewees expressed interest in collaborative planning with San Francisco
- Some cited “money and politics” as possible barriers to partnership. One county indicated it would have to be financially advantageous to collaborate.
- Several counties indicated they would have to bring the issue of collaboration to county executives for consideration.

HMA

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APPENDIX A

Inventory of Beds by Program and County Per the Community Care Licensing Division (CCLD) With Adjustment for Population

County	# ARF Licensed Beds	# ARF Beds per 100,000 age 18-59	# RCFE Licensed Beds	# RCFE Beds per 100,000 age 60+	# MHRC Licensed Beds	# MHRC Beds per 100,000 age 18+
Alameda	1,484	154.6	3,115	885.9	154	11.7
Napa	46	65.2	842	2,207.4	54	49.7
Los Angeles	11,417	201.5	37,544	1,811.9	286	3.7
Sacramento	1,905	214.3	9,746	2,898.6	54	4.4
San Diego	3,282	173	17,114	2,447.7	409	15.8
Santa Clara	1,931	175.9	6,159	1,557.1	100	6.7
San Francisco	**473**	**93.8**	**2,897**	**1,494.2**	**101**	**14.5**
San Mateo	698	171.1	4,234	2,323.9	68	11.6

Data published by CCLD (7/21/24) and DHCS (published 1/24). Counts are inclusive of all licensed beds across the state, not limited to those beds contracted by County BH departments. The ARF figures exclude closed programs, Social Rehabilitation Facilities, and Adult Day Programs. The RCFE data excludes closed facilities and Continuing Care Retirement Communities. The MHRC data are presented as published by DHCS.

Local Provider Input on Barriers and Options

Controller's Office

Session Overview: Operator and System of Care Interviews

ARF and RCF-E Operators

United Family Home Care

In-county ARF
32 Bed Capacity (10 vacancies)

Broderick Street Adult Residential

In-county ARF
33 Bed Capacity (4 vacancies)

Mae Bea Andrews Home #1 & 2

In-county ARF
12 Bed Capacity (1 vacancy)

Colonial Acres

Out of county RCF-E
20 Bed Capacity (7 vacancies)

Portola Gardens

In-county RCF-E
130 Bed Capacity (36 vacancies)

NOTE: These providers do not deliver LSAT, ARF or RCF-E care, but do offer services to many of the same client populations.

System of Care Providers

UCSF Citywide

12 attendees representing: Supportive Housing Case Management, Care Courts, Forensics, CASC, Emergency Department Case Management, and other divisions.

Conard House

HealthRight360

PRC / Baker Places

Progress Foundation

Session Overview:
Summary of Key Operational Barriers and Pain Points

1

System Barriers

- Licensing Constraints and Disconnect between Multiple Systems
- Challenge of Referral Process and Facility Discretion
- Challenges with Placing Conserved Clients

2

Market Pressures

- Patch Rate Needed for Enhancing Support for Complex Clients

3

Staffing Constraints

- High Vacancy Rates in Key Behavioral Health Positions
- Low Wages Resulting in Difficulty Filling Positions

4

Facility and Capacity Constraints

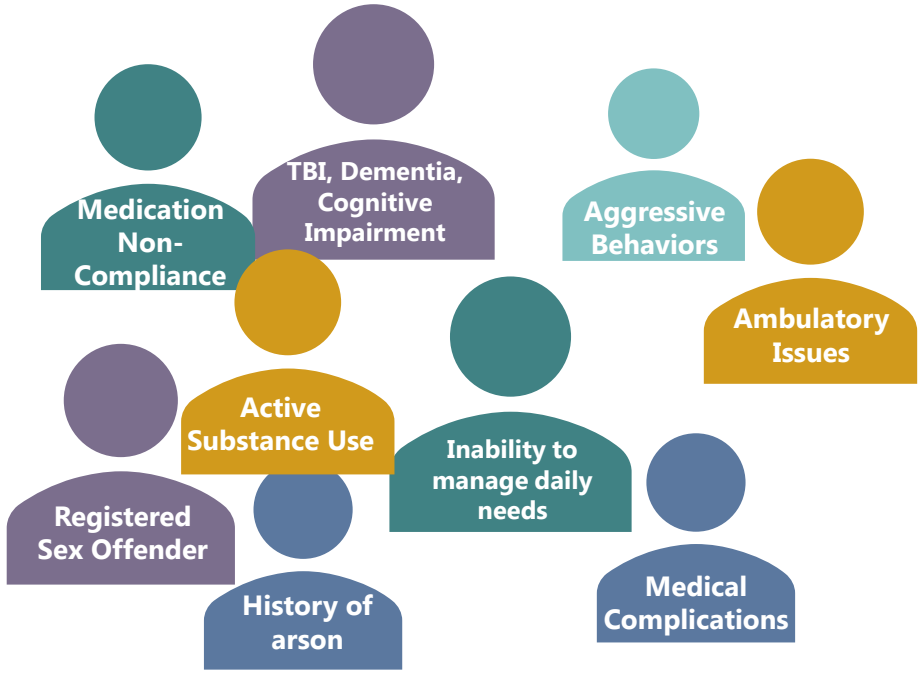
- Needing the Right Array of Beds Across Levels of Care
- Difficulty Acquiring Appropriate Treatment Facilities

Placing Clients with Complex Needs

From July session…

Defining Complexity

It is challenging to find appropriate placements for high-needs clients with the following characteristics:



Impact of Complexity

While there may be available capacity in ARFs, RCF-Es, and LSATs at a given time, highly complex patients are **most difficult to place** in the right level of care.

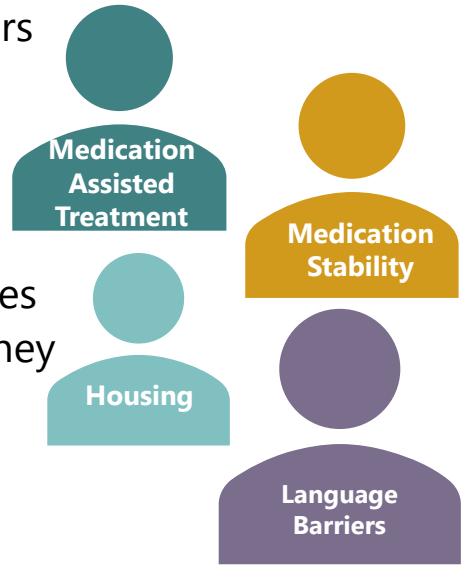
Residential facilities, especially ARFs and RCF-Es, vary in their ability to accept clients with complex needs.

A facility's level of care depends on both physical constraints (e.g., building accessibility and egress) and staffing level and training.

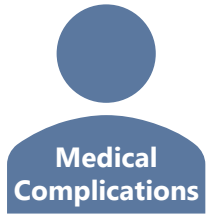
Clinical Providers Affirm Complexity Factors

Clinical providers indicate a **vast majority** of their clients have one or more of these barriers to care, and noted a few **additional** factors:

- Clients on methadone
- Clients who are not stable on psychiatric medications
- Clients who are housed – the system makes it hard to step up or down in care when they are housed
- Clients with language barriers (and insufficient staff to support in a variety of languages)



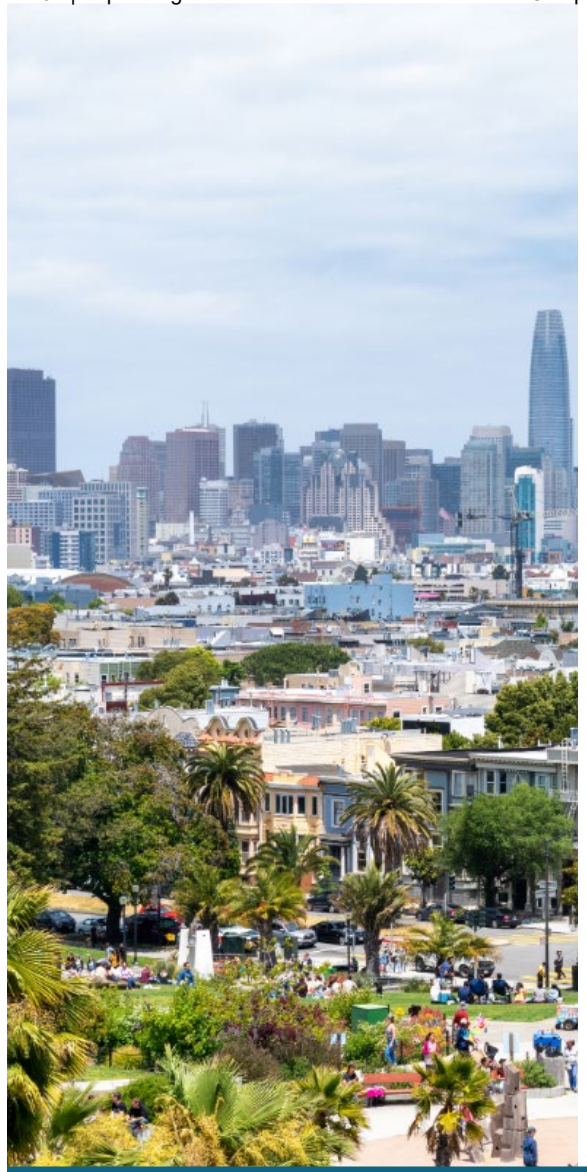
Several clinical providers highlighted that clients with **Medical Complications** are often the most challenging as there are few settings that can offer both behavioral health and medical supports across various levels of care.



ARF and RCF-E Operators Weigh Risks of Accepting Complex Clients

Interviewed operators all mentioned weighing risk level of new clients and **prioritizing stability and safety of current residents** to determine whether to accept a placement.

- **Risk of license citations or revocation** if complex clients harm themselves or other clients or cause service disruptions.
  - Operators cited litigation, fines and other challenges when serving clients they are not equipped for, and this can lead them to make conservative decisions when determining which clients to accept into a facility.
- **Caring for aging and long-standing residents** while balancing the needs and demands of younger, potentially volatile new residents.
- Clients' medication use may be more complex than providers can support with existing staffing.
  - Some RCF operators were willing to accept clients on Medication Assisted Treatment **(MAT) only if they had the clinical staff and/or proximity to a methadone clinic**.
- Operators noted legal or licensing barriers, such as:
  - Unable to accept a client who is a sex offender if located near a school.
  - Unable to accept non-ambulatory clients if site does not have an elevator.



Clinical Providers Identified System Barriers to Getting Clients into Right Level of Care

Clinical Providers shared input on **general system issues** and challenges placing their complex clients. Not all feedback relates specifically to LSATs or ARFs and RCF-Es.

Structural Disconnect between SUD and Mental Health Care for LSATs

- According to clinical providers, many substance use disorder (SUD) treatment facilities **will not take individuals with a mental health condition**, even as clinicians stated that clients almost always have co-occurring disorders.
- This can go both ways for dually-diagnosed clients, as many with a primary SUD disorder may not be appropriately served in Mental Health settings.
- For LSATs and some other treatment settings, this is a **State licensing challenge**: siloed funding, regulatory and licensing systems have led to facilities not aligning to the complex needs of clients.

Clinical Providers Identified System Barriers to Getting Clients into Right Level of Care

Disconnect between Behavioral Health and Medical Care

- Clinical providers noted that the most complex clients have multiple types of needs, including both behavioral and physical health needs, and the right level/type of care to serve both may not exist.

- According to clinical providers, decisions about placement weigh whether medical or behavioral issues are primary, though **both may be factors in the client's success** in the program.

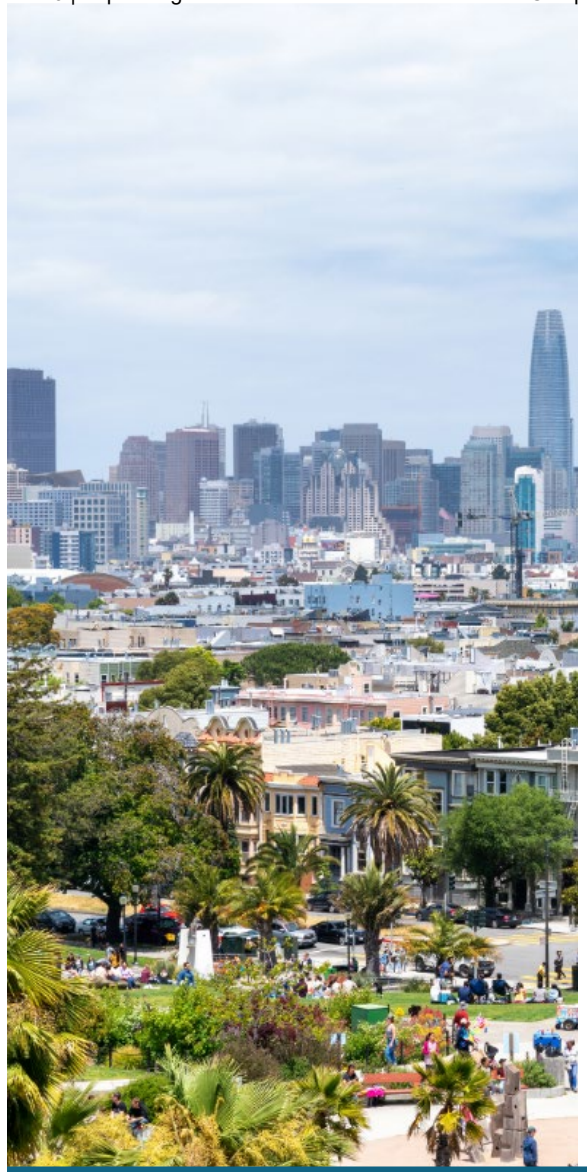
For example, a client in a 90-day treatment program may **decompensate medically** and need support with activities of daily living (ADLs) that a provider is unable to offer due to licensing.

However, an ARF or RCF-E would **not have the behavioral health staffing** to support that client through a 90-day treatment model.

Clinical Providers Identified System Barriers to Getting Clients into Right Level of Care

Conservatorship and Barriers to Care

- Clinical providers spoke generally about conservatorship-related challenges, though comments did not distinguish between types of conservatorship.
- Providers confirmed the challenge related to getting patients placed into LSAT beds without an **inpatient hospital stay** and believe **longer stays** would support clients to stabilize.
- Providers and ARF/RCF-E operators shared concerns about getting services for conserved clients: they struggle to enforce Affidavit Bs (involuntary medication order), access placements and/or receive police support or ambulance transport.



Clinical Providers Identified System Barriers to Getting Clients into Right Level of Care

Facility Discretion in Accepting Placements

- Clinical providers expressed that they often struggle to find and secure placement for complex clients, with each placement requiring multiple referrals due to operator denials of care.
  - Note: DPH manages a centralized **referral system** for ARF and RCF-E levels of care. Once DPH authorizes for client for ARF or RCF-E placement, DPH presents referrals to operators. However, several interviewed providers noted they still do a lot of this "legwork" themselves.
- Providers expressed that individual **facilities have too much discretion** in which clients they will accept, though RCF operators commented on **licensing and safety risks** associated with some denials.

System Levers to Consider

Levers Proposed by Providers and Operators

ARF and RCF-E Operators and Clinical Providers proposed several system-related "levers" that could address some of the challenges associated with placing complex clients, e.g.:

- Streamline referral processes, including clarifying which operators can accept complex clients, and where feasible **limiting operator discretion** in accepting these clients.
- Support operators to be **more flexible**, e.g., offer small capital investments for enhancements that allow a site to take complex clients.
- Develop **new behavioral health treatment models** that pair physical and behavioral health services at sites with longer timelines: providers estimated that this type of care could reduce demand for higher or lower levels.
- Enhance **supportive housing** with higher levels of service (e.g., part of the "continuum") and improve connections to housing for behavioral health clients.

Key Question: What other ways can we consider how to address denials of complex patients?

E.g., Address Market Failures
Use incentives and market levers to pressure the private market to accept complex clients?

System Levers to Consider

Do we need legislation to **change licensing rules** to make existing facilities more flexible in taking clients?

For example…

SB 1238: Health Facilities
Status: Passed the Assembly and Senate, awaiting Governor's action
Bill Author: Susan Talamantes Eggman

- This bill would expand the definition of psychiatric health facilities (PHFs) and MHRCs in the LPS Act to also include care for people with severe substance use disorders, or co-occurring mental health and substance use disorders, making it easier to **admit clients with primary SUD diagnoses.**

Key Question: Which legislative approach may best address our local system barriers to placing complex clients?

Or do we need legislation to **create a new type of facility** that doesn't exist yet?

For example…

SB 1082: Augmented Residential Care Facility Licensing
Status: not passed
Bill Author: Susan Talamantes Eggman

- This bill would have created a new residential model called an Augmented Residential Care Facility to provide nonmedical care to clients with **SMI** who require augmented supports beyond what is typically available in ARFs and RCF-Es.

Other options? E.g., Adapt model of ARF for Persons with Special Health Care Needs (supporting people with developmental delays) to instead serve clients with complex behavioral needs?

*Mental Health Rehabilitation Center (MHRC), a type of LSAT

System Levers to Consider

The City has an obligation to find care for LPS conservatees despite operator discretion.

What regulatory protections ensure that LPS conservatees can access placement in a MHRC to receive the treatment needed to recover from their grave disability and terminate conservatorship?

Key Question: Could new regulatory changes help?

According to CA Department of Health Care Services (DHCS) regulations:

- There is **no legal requirement** for a MHRC to admit LPS conservatees.
- Licensing rules provide a MHRC **discretion** to determine the population of patients it will admit via its plan of operation, which documents the level of impairment and diagnoses it will admit.
- Plans are **subject to approval** of the local mental health director.
- Licensing prohibits a MHRC from admitting patients who are **non-ambulatory**, require a level of medical care not provided by the operator, or who would be more appropriately served by an acute psychiatric hospital.

Could legislation change how much **discretion** operators have in accepting placements? E.g.:

- Requiring facilities that receive Medi-Cal to accept Medi-Cal clients with specific needs or conditions?
- Requiring that conserved patients do not need to voluntarily engage in treatment to be accepted?

System Levers to Consider

SB 992 (2018) states that residential treatment facilities are not allowed to deny admission to potential clients because they have a valid prescription from a licensed health care professional for an FDA-approved medication for Medication Assisted Treatment (MAT).

Clinical providers continue to report **barriers to care and denials from programs for clients on MAT.**

Key Question: If there is existing legislation to compel facilities to accept clients on MAT, what is the continued barrier to placement?

Market and Funding Constraints on Placing Complex Clients

All interview participants commented on funding, particularly the "**patch rate**" for ARF and RCF-E operators, as a key barrier.

Several operators stated that the City's **patch program is insufficient** to cover resident needs or to maintain necessary skilled staff and may be a reason why they turn down more complex clients.

According to interviewed ARF and RCF-E operators, if the City contracts for a high proportion of their beds, this limits the operator from taking private paying clients to supplement gaps in funding.

San Francisco's Approach:

Like other counties, DPH offers a **differential daily bed rate** ("patch") for a certain client if they need a special type of care.

On top of SSI from clients, daily patches range from **$40/day** (small facility) to **$250/day** (advanced facility that offers all services on site, including nursing and MD services).

Of note, two operators that take more private-paying clients did not mention cost as a barrier to operations.

Market and Funding Levers to Consider

Levers Proposed by Providers and Operators

ARF and RCF-E Operators and Clinical Providers proposed several funding and market-related "levers" that could address some of the challenges associated with placing complex clients, including:

- **Increase the ARF and RCF-E patch rate,** including for more complex clients.
- Consider contracting with **nonprofits** to deliver ARF and RCF-E services.
- **Prioritize funding for in-county operators** and service providers to ensure strong care coordination, or fund enhancements to care coordination for out-of-county placements.

Current DPH Strategies

- DPH supports **640 RCF beds**, the majority (65%) contracted with **in-county** operators. They provide a range of services, from support with ADLs to higher levels of medical and behavioral health support.
- DPH's bed optimization analysis indicates that the current 640 ARF and RCF-E beds are likely sufficient for the system overall, but among these, **too few can provide enhanced staffing levels for specialized populations** (e.g., memory care).
- Typically, larger operations can support higher levels of care due to operational cost-effectiveness. **Many enhanced ARF and RCF-E operators are located out-of-county**.

Staffing Constraints are Primary Barrier

All interview participants commented on staffing as a key barrier across the system.

- Lack of staffing causes **delays with intake processes** to get clients into an available bed.
- Facilities are struggling with **burnout and overwork**, so it can benefit them to accept less-complex clients.
- Large caseloads and capacity issues lead to challenges with **connecting with staff across settings**, making care coordination difficult.
- Clinical Providers experience backlogs and delays of up to 9 months for **State-level clearances** for staff to work in licensed facilities: they have a candidate ready to start but delays in getting them into the job.
- Salary levels may be a driver of staffing gaps across the system. ARF and RCF-E operators struggle to fill **minimum wage home care positions** given the challenge of the role when serving complex clients.
- ARF and RCF-E operators mentioned care models being more successful when they have **clinical staff on site** for enhanced mental health needs.

Staffing Levers to Consider

The Controller's Office released its **Mental Health SF Staffing Analysis** in August 2024. This report documents the primary drivers of vacancy rates among licensed and non-licensed behavioral health staff, as well as wage and vacancy data for both civil service programs and nonprofit service providers.

The report identified **options and strategies to consider**, noting that addressing staffing gaps will require multiple coordinated strategies. Examples include:

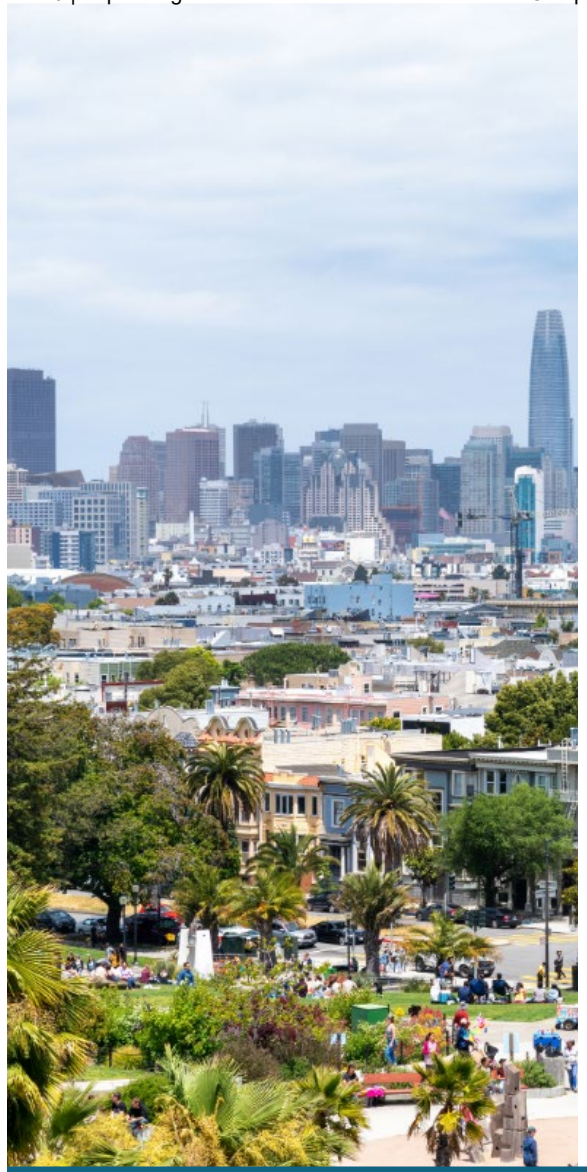
- Explore opportunities to **adjust staffing models** to leverage non-licensed paraprofessionals.
- Explore where nonprofit service providers can implement **wage increases for hard-to-fill positions** per their unique operational needs.
- Support nonprofit service providers in their efforts to address wage pressures by working together to review existing contracts and **assess where contract or budget modifications may be appropriate** and feasible for the overall system of care.
- Expand technical assistance for nonprofit service providers to understand their **costs of doing business**, which can inform new City solicitation responses or budget discussions with funding departments.

Report linked here.

Clinical Providers Identified Capacity Gaps

Having the Right Array of Beds Across Levels of Care

- Clinical providers stated that they experience gaps in bed capacity in other settings in addition to the ARF, RCF-E or LSAT levels of care, and expressed the perspective that there is a need for **more inpatient bed capacity**.
- With more timely inpatient or residential care, these providers said that **fewer clients may decompensate** to the degree that they require conservatorship and/or locked settings.
- Providers also identified a gap in the **duration of inpatient beds,** sharing that clients often need longer to stabilize than Medi-Cal may pay for or than the hospital can offer.



Clinical Providers Identified Capacity Gaps

Having the Right Array of Beds Across Levels of Care

- Clinical providers noted the **decline in State Hospital beds** as a key gap. One noted that Napa provides excellent care and rarely rejects the most complex clients, but there is limited opportunity to place in this setting.
- Several clinical providers stated that there is a **specific shortage of LSAT beds**, though one provider noted that possibly expanding voluntary programs that are similar to LSAT may be appropriate for some clients currently waiting for LSAT placements.

Capacity Levers to Consider

Levers Proposed by Providers and Operators

Clinical Providers proposed several capacity-related "levers" that could address some of the challenges associated with placing complex clients *(Note: providers were not aware of the 2024 bed modeling results when offering these ideas):*

- Add **more inpatient capacity** with longer stays to support clients to stabilize.
- Add **more residential capacity** as step-down after inpatient stabilization.
- Add **more LSAT capacity** and/or voluntary beds at a similar level of care
- Create **more "flexible" options** within the system, such as programs able to take dually-diagnosed clients, or programs that are staffed to take clients with varying complexities or needs and/or adjust operations when needed to take on these cases.

Additional Levers

- DPH bed modeling analysis describes **capacity needed throughout the system**.
- DPH has initiated advocacy to receive an increase in **State Hospital beds**.
- The Controller's Office published a memo in March 2024 that identified certain operational considerations for **expanding DPH's treatment bed portfolio**.

Capacity Levers to Consider

In 2023, DPH updated its behavioral health bed modeling, which recommends that DPH should add **153-225** behavioral health residential care and treatment beds across the continuum.

The analysis **does not recommend adding more inpatient beds**.

Instead, the model emphasizes **adding beds in lower-levels of care** because:

- Many patients in inpatient levels of care should be in a lower-level setting.
- The addition of beds in downstream categories would avoid the need to expand higher levels of care.

Residential Type	Additional Beds Needed	Considerations
Mental Health Residential Treatment	~50	• Includes different lengths of stay • Includes need for clients with specific needs (e.g., both severe mental health and substance use diagnoses; seniors; and perinatal clients)
Mental Health Rehabilitation Centers (MHRC) / LSAT	Estimated 55-95	• Given current wait times • Potential for increase in demand under SB 43
Behaviorally Complex Therapeutic (Enhanced Residential Care / Residential Care for the Elderly	Estimated 20-40	• Highly specialized level of care for complex, high-need clients difficult to place in care.
SUD Residential Withdrawal Management	~8-10	• Includes high-complexity withdrawal management for people with both severe withdrawal medical needs and other health needs
SUD Residential Step-Down	~20-30	• The number of clients served in RSD has increased as SFDPH has added capacity.
State Hospital Beds	Admission data needed to make a recommendation.	• These beds are managed by the State. • 2022 RAND analysis showed that access to these beds significantly contributes to the supply other beds types

Capacity Levers to Consider

State Hospitals

A 2022 RAND analysis indicated that access to State Hospital beds significantly contributes to the supply of other bed types. DPH did not have access to State Hospital admission data as part of the 2024 bed optimization analysis.

Historically, the State Hospital system allocated **45 beds** to San Francisco.

→

Several years ago, the State changed its bed allocation process, creating a **single waitlist for all counties**, with no dedicated beds for San Francisco.

Under this model, San Francisco is currently using 22 beds.

→

The State has proposed a new allocation plan that **prioritizes counties based on population**. The new plan would likely result in fewer total beds allocated to San Francisco.

DPH has advocated to the State to demonstrate greater need and to request a dedicated bed allocation.

Key Question: What additional State-level work may support this effort?

Capacity Levers to Consider

MHSA accounts for one-third of state funding for county behavioral health services

Proposition 1

Prop 1 (SB 326 and AB 531):

- Amends California's Mental Health Services Act (MHSA) – now renamed Behavioral Health Services Act (BHSA).
- Creates a $6.38 billion general obligation bond funding **behavioral health treatment and residential facilities** (including for drug and alcohol treatment) as well as **supportive housing** for veterans and individuals at risk of or experiencing homelessness with behavioral health challenges.
- At least 3% of funding will go to the Department of Health Care Access and Information (HCAI) to implement a **statewide Behavioral Health workforce development initiative**.

Prop 1 does not include an increase in operating funding for behavioral health and **ARFs and RCF-Es are not eligible** for Behavioral Health Continuum Infrastructure Program (BHCIP) bond funding.

Proposition 1 –BCHIP Eligible Facility Types

Bond funds include **$4.4 billion** in capital funding grants for counties, cities, and tribal entities for voluntary and involuntary behavioral health treatment and residential facilities through BCHIP.

Funding allocations	Bond BHCIP Round 1	Bond BHCIP Round 2
Bay Area regional allocation (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma)	$278 million	$170 million
Other regional allocations	$1.2 billion	$721 million
Statewide discretionary	$342 million	$209 million
Dedicated City/County/Tribal funding	$1.5 billion	N/A
Total bond funding	**$3.3 billion**	**$1.1 billion**

See the list for eligible facility types, which generally must provide Medi-Cal billable services.

Hospital-based Outpatient Treatment (outpatient detoxification/withdrawal management)
Mental Health Rehabilitation Center (MHRC)
Narcotic Treatment Program (NTP)
NTP Medication Unit
Office-based Opioid Treatment
Outpatient Treatment for SUD
Partial Hospitalization Program
Peer Respite
Perinatal Residential SUD Facilities
Psychiatric Health Facility (PHF)
Psychiatric Residential Treatment Facility (PRTF)
Short-term Residential Therapeutic Program (STRTP)
Skilled Nursing Facility with Special Treatment Program (SNF/STP)
Sobering Center (funded under the Drug Medi-Cal Organized Delivery System [DMC-ODS] and/or Community Supports)
Social Rehabilitation Facilities (SRFs)
Acute Psychiatric Hospital
Adolescent Residential SUD Treatment Facility
Adult Residential SUD Treatment Facility
Behavioral Health Urgent Care (BHUC)/Mental Health Urgent Care (MHUC)
Chemical Dependency Recovery Hospital
Children's Crisis Residential Program (CCRP)
Community Mental Health Clinic (outpatient)
Community Residential Treatment System (CRTS)/Social Rehabilitation Program (SRP)
Community Treatment Facility (CTF)
Community Wellness/Prevention Center (Tribal entities only)
Crisis Stabilization Unit (CSU)
General Acute Care Hospital (GACH) for behavioral health services only

Behavioral Health Facility Acquisition Options Analysis

The Controller's Office conducted a qualitative review of the processes and options for acquiring new facilities using research and interviews. The memo includes process considerations and challenges, as well as policy considerations and options to address DPH's and the City's goals to expand behavioral health treatment.

DPH may achieve expansion goals more quickly using no-interest loans for provider ownership.

Regardless of the acquisition option, DPH must ensure it allocates sufficient funding for ongoing operations and may need to moderate its acquisition or loan programs to ensure it has adequate ongoing and reserve funding.

Find Memo here.

Acquiring complex treatment facilities is time consuming, and DPH may be most successful through contracting or acquisition for City ownership.

If DPH prioritizes facility acquisition for City ownership, it will need to expand its own internal capacity to manage these assets.

While DPH may provide a nonprofit with grant funding to purchase a property, the inherent risks far outweigh the operational benefits of this approach.

Summary of Key Operational Barriers

1

System Barriers

- Licensing Constraints and Disconnect between Multiple Systems
- Challenge of Referral Process and Facility Discretion
- Challenges with Placing Conserved Clients

2

Market Pressures

- Patch Rate Needed for Enhancing Support for Complex Clients

3

Staffing Constraints

- High Vacancy Rates in Key Behavioral Health Positions
- Low Wages Resulting in Difficulty Filling Positions

4

Facility and Capacity Constraints

- Needing the Right Array of Beds Across Levels of Care
- Difficulty Acquiring Appropriate Treatment Facilities

Is the solution…?

- New Funding
- New Legislation
- Staffing Patterns
- Operational Changes
- Licensing Changes

Discussion

- What operational barriers should the City prioritize solving? What, if solved, will have the most impact on client care and system operations?
- Which levers or opportunities may be most effective at solving the challenges you prioritize?
- Are we missing any options, opportunities, or levers?

Questions?

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Appendix

Includes:

- **MHSF Staffing Analysis Findings**
- **Facility Acquisition Options Analysis Findings**
- **Additional Ideas offered during Interviews**

Mental Health SF Staffing Analysis Findings

The Controller's Office released a report on the primary drivers of vacancy rates among licensed clinicians and non-licensed behavioral health staff. The report included wage and vacancy data for both civil service programs and nine local nonprofit service providers funded by DPH's Behavioral Health Services (BHS).

Key findings include:

Civil Service Programs

- In FY22-23, **civil service programs** had a point-in-time vacancy rate of **17.5%** among Behavioral Health Clinicians and **29.0%** among Health Worker III staff.
- BHS also experienced **high turnover (9%)** among Behavioral Health Clinicians as compared to its civil service workforce overall.

Nonprofit Programs

- During FY22-23, **nine surveyed service providers** reported a point-in-time vacancy rate of **20.9%** among licensed behavioral health workers and **10.3%** among non-licensed behavioral health workers.
- Based on interviews, **residential treatment programs**, Full-Service Partnerships, and **intensive case management** programs serve the highest acuity patients are hardest to staff.

Mental Health SF Staffing Analysis Findings

Staffing challenges here in San Francisco are part of a **national sector wide staffing gap** caused by:

- Burnout
- Low compensation
- Extensive documentation requirements
- Difficulty recruiting licensed professionals, especially staff who have experience working with specific populations (e.g., dual diagnoses)

Based on qualitative interviews, drivers of staffing challenges among **both civil service programs and CBO providers in San Francisco** include:

- Competition for limited pipeline
- Non-traditional treatment models
- Increase in telehealth
- COVID-19 pandemic

Staffing challenges for San Francisco contracted **service providers** included:

- Lower wages and less competitive benefits for both licensed and non-licensed clinicals as primary drivers of staffing challenge.
- CBOs mentioned the following other factors contributing to staffing challenges:
  - Difficulty hiring bilingual staff
  - Board of Behavioral Sciences (BBS) number requirement to be able to apply for Behavioral Health Clinician (2930) positions
  - Required substance use counselor certification

Behavioral Health Facility Acquisition Options Analysis

The Controller's Office conducted a qualitative review of the processes and options for acquiring new facilities using research and interviews. The memo includes process considerations and challenges, as well as policy considerations and options to address DPH's and the City's policy goals related to behavioral health treatment expansion.

Option	Description	Tradeoffs
City ownership	City purchases and retains the legal title for a property; can manage with City staff or contract out to provider	Requires an up-front use of one-time funding and ongoing operating funds. The City performs asset management, including investments to sustain the property's value.
Loans for provider ownership	City supports a nonprofit's building ownership through a no-interest or low-interest loan	Can reduce the management burden on the City, may take less time to negotiate and process than City acquisition. However, doesn't have benefit of long-term property purchase.
Leased property	City leases a building from a private landlord and engages a nonprofit to provide services	Does not provide a long-term investment, though this approach can reduce the management burden on the City.
Contracting with funds for renovation	City provides a grant or contract to fund renovations in parallel with a contract for use of the expanded beds	While this option may help expand current providers' operations, many legal and programmatic challenges exist, including ensuring compliance the Admin Code.

Bed Capacity Levers to Consider: Behavioral Health Facility Acquisition Options Analysis

DPH may achieve expansion goals more quickly using no-interest loans for provider ownership.

DPH already partners with MOHCD in its no-interest loan program.

While new staffing would be necessary for an expansion, the administrative capacity to operate no-interest loans could be more easily scaled up than the staffing needed to support acquisition for City ownership.

Acquiring complex treatment facilities is time consuming, and DPH may be most successful through contracting or acquisition for City ownership.

Programs like LSATs require hospital-grade buildings that can be difficult to find within existing buildings available for sale.

These may be more easily acquired through contracting with existing operators and/or providing start-up costs within a contract to support expansion.

In a rare case where an appropriate facility is available for purchase, it is likely that DPH should purchase and manage the building itself rather than establishing a no-interest loan for a nonprofit provider to purchase the site.

Bed Capacity Levers to Consider: Behavioral Health Facility Acquisition Options Analysis

Regardless of the acquisition option, DPH must ensure it allocates sufficient funding for ongoing operations.

One-time funds should have one-time uses, such as acquisition options.

Ownership requires the City to budget for and fund ongoing operating costs, and whether staffed by the City or a nonprofit, the building will require asset and building management staffing.

Nonprofit operators will rely heavily on the City's ongoing funding for asset and property management functions.

DPH may need to moderate its acquisition or loan programs to ensure one-time acquisition costs are adequately paired with ongoing and reserve funding.

If DPH prioritizes facility acquisition for City ownership, it will need to expand its own internal capacity to manage these assets.

DPH could either expand its own asset management skills, currently housed under the Capital Planning team, or may explore using a contractor for certain specialty functions.

These functions should not be managed by a different City department.

Bed Capacity Levers to Consider: Behavioral Health Facility Acquisition Options Analysis

While DPH may provide a nonprofit with grant funding to purchase a property, the inherent risks far outweigh the operational benefits of this approach.

DPH could provide a grant to a nonprofit to purchase a building or make capital improvements for a public purpose, such as a behavioral health treatment facility.

While this option may reduce the City's management burden, it comes with significant risks. DPH is likely to have more success with lower risk using other approaches for its expansion of behavioral health services.

The City's Administrative Code and Charter create legal and bureaucratic barriers to providing small grants to support "flexibility" at existing care settings, as was proposed by clinical providers.

There are also staffing barriers, as it is not the typical scope of DPH staff to validate capital improvement needs of providers.

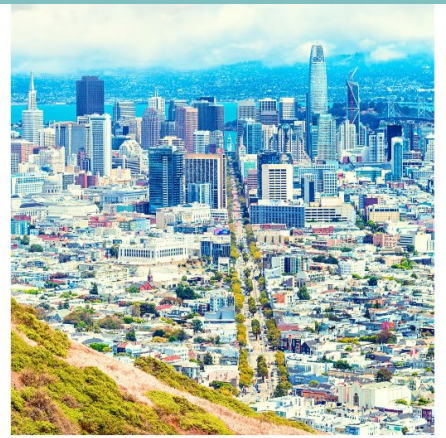
Code changes and/or staffing enhancements may be needed to make this approach viable.

Miscellaneous Ideas Proposed by ARF and RCF-E Operators and/or Clinical Providers

- Incentivize participation in treatment by offering a clear pathway to housing.
  - Providers noted that once a client improves clinically, they may no longer be a priority for housing.

- Develop appropriate staffing levels for residential facilities, using a highly-staffed model.
  - Providers believe that churn through the system can be caused by insufficient staffing at key levels of care (i.e., 90-day treatment in addition to RCF-E and ARF).

- Ensure gaps in insurance coverage (e.g., Medi-Cal in another county or lapsed) are not used as a reason for denial to a facility.
  - Providers propose a policy where clients are placed first and then have coverage issues addressed.



Appendix 6

Residential Care and Treatment Workgroup

Session: Costing Scenarios

Office of the Controller

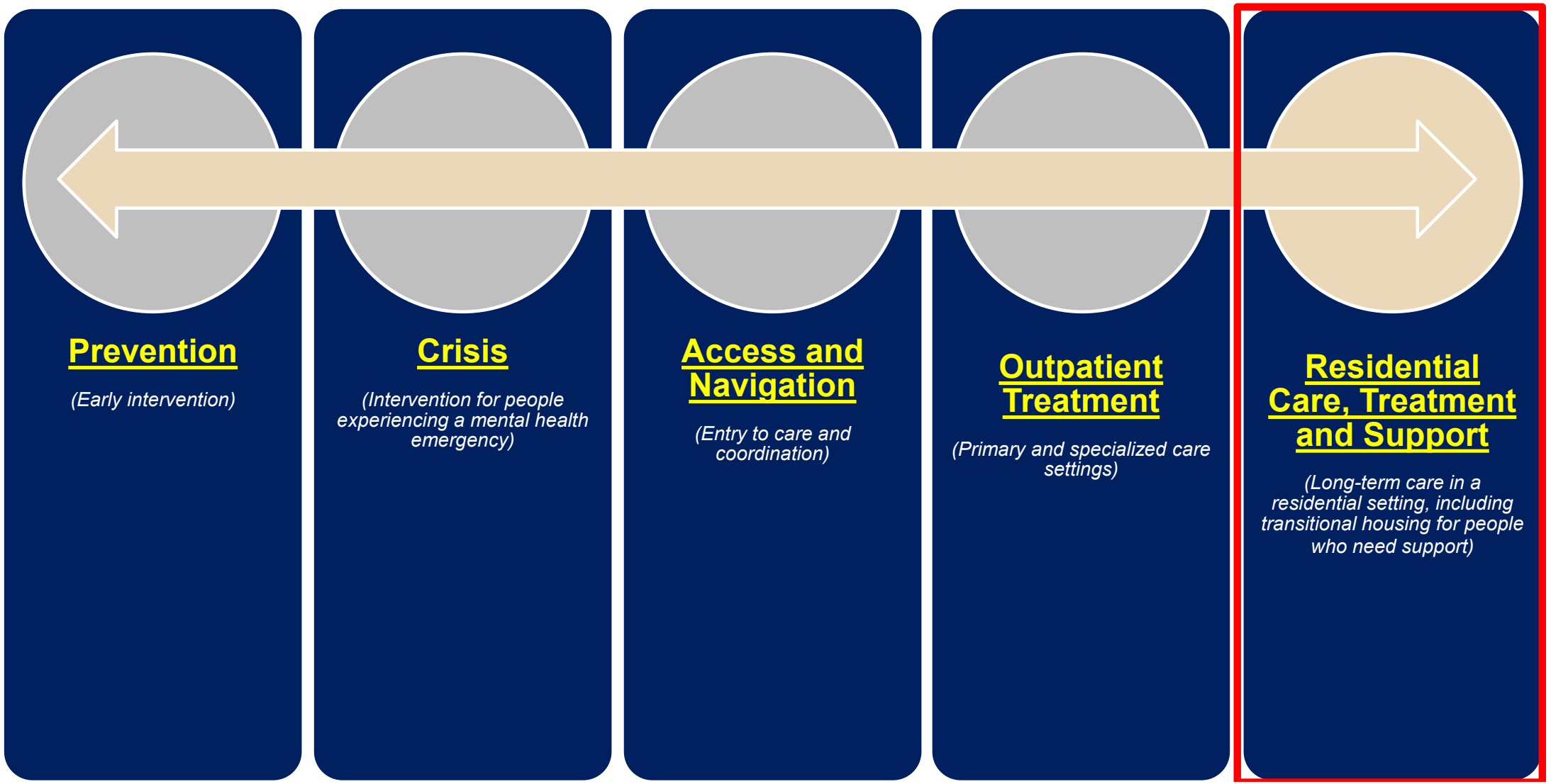
Laura Marshall | Hannah Kohanzadeh | Oksana Shcherba

October 23, 2024

Agenda

1. Welcome and Introductions
2. Level Setting on the System
3. Bed Capacity Status and Costing Scenarios
4. Operating Challenges
5. Federal & State Financing Resources
6. Options Analysis
7. Discussion

Range of Behavioral Health Care Services



SFDPH Behavioral Health Residential Growth

Since 2020, SFDPH has opened nearly 400 new residential behavioral health beds planned under Mental Health SF.

- Represents a nearly 20% increase over baseline bed count of ~2,200 beds.

Current residential behavioral health bed inventory is estimated at ~2,551 beds, including:

- Mental Health Residential programs (~ 1,861 beds as of FY 23-24):
  - Emergency and Acute Care; Locked Residential Treatment; Voluntary Residential Treatment; Low-Threshold MH Care; Therapeutic Residences; Residential Care Facilities; Mental Health Housing
- Substance Use Residential programs (~ 690 beds as of FY 23-24):
  - SUD Residential Treatment; Low-Barrier SUD Residential; Therapeutic Residences; Co-Ops

Current Mental Health Residential Treatment Types and Capacity

DPH currently offers approximately 1,861 beds across the residential continuum of care, including **140 beds at MHRC facilities and 640 ARF and RCF-E beds** that serve clients with behavioral health needs.

DPH contracts for these bed types at facilities both in San Francisco and out of county.

Category	Type	Number of Beds
Residential Care Facilities	Residential Care Facility (RCF) *(fixed bed count)*	142
	Residential Care Facility (RCF) *(as needed)*	166*
	Residential Care Facility for the Elderly (RCFE) *(fixed bed count)*	59
	Residential Care Facility for the Elderly (RCFE) *(as needed)*	273*

Category	Type	Number of Beds
Locked Residential Treatment	Mental Health Rehabilitation Centers / Locked Subacute Treatment (MHRC / LSAT) *(fixed bed count)*	101
	Mental Health Rehabilitation Centers *(as needed)*	39*
	Psychiatric Skilled Nursing Facilities *(as needed)*	160*

As-needed bed counts are estimates and fluctuate based on needs and availability. Most as-needed beds are subject to competition with other counties.

*Estimate, including as-needed beds

Source: "Behavioral Health Residential Care and Treatment" BOS Hearing Presentation. Feb. 21, 2024. SFDPH.

Projected Mental Health Residential Treatment Capacity Needs

In 2023, DPH updated its behavioral health bed modeling, which recommends that DPH should add **153-225** behavioral health residential care and treatment beds across the continuum.

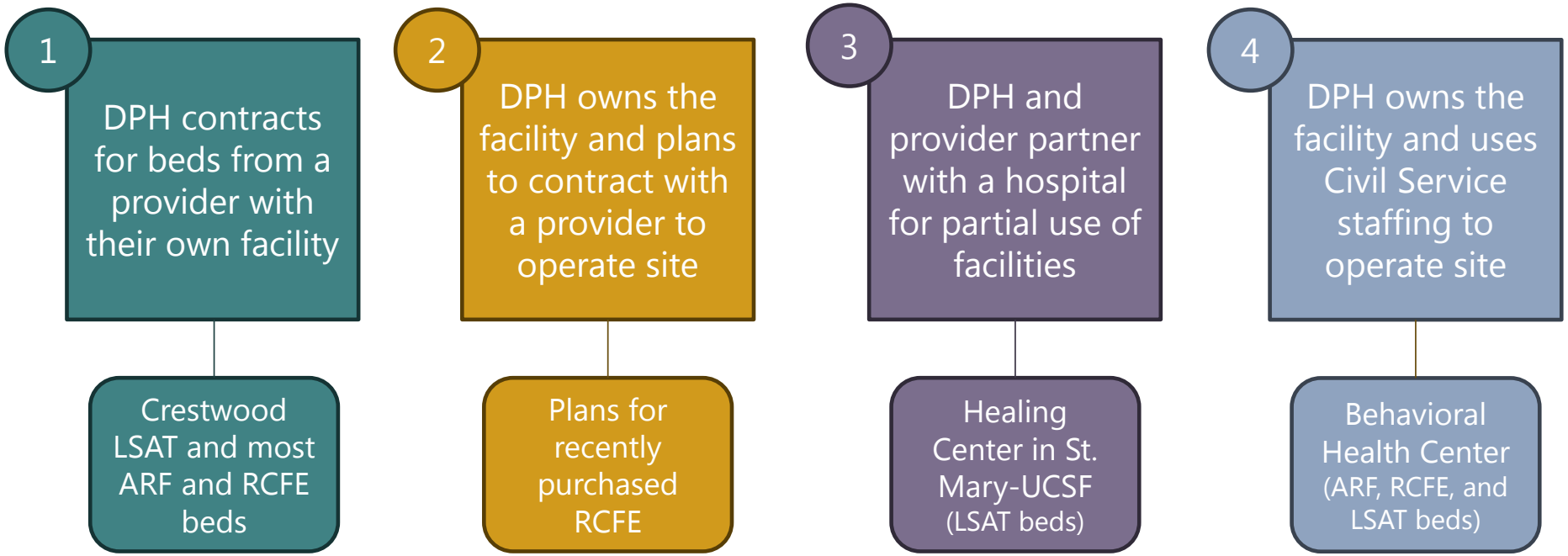
The model recommends adding **20-40** new ARF and RCFE beds for behaviorally complex clients and **55-95** new LSAT beds.

Residential Type	Additional Beds Needed	Considerations
Mental Health Residential Treatment	~50	• Includes different lengths of stay • Includes need for clients with specific needs (e.g., both severe mental health and substance use diagnoses; seniors; and perinatal clients)
Mental Health Rehabilitation Centers (MHRC) / LSAT	Estimated 55-95	• Given current wait times • Potential for increase in demand under SB 43
Behaviorally Complex Therapeutic (Enhanced Residential Care / Residential Care for the Elderly	Estimated 20-40	• Highly specialized level of care for complex, high-need clients difficult to place in care.

Residential Type	Additional Beds Needed	Considerations
SUD Residential Withdrawal Management	~8-10	• Includes high-complexity withdrawal management for people with both severe withdrawal medical needs and other health needs
SUD Residential Step-Down	~20-30	• The number of clients served in RSD has increased as SFDPH has added capacity.
State Hospital Beds	Admission data needed to make a recommendation.	• These beds are managed by the State. • 2022 RAND analysis showed that access to these beds significantly contributes to the supply other beds types

San Francisco's Current Facility Options

There are several current models for operating ARF, RCFE and/or LSAT beds, though the first model below **(#1)** is the most common option.



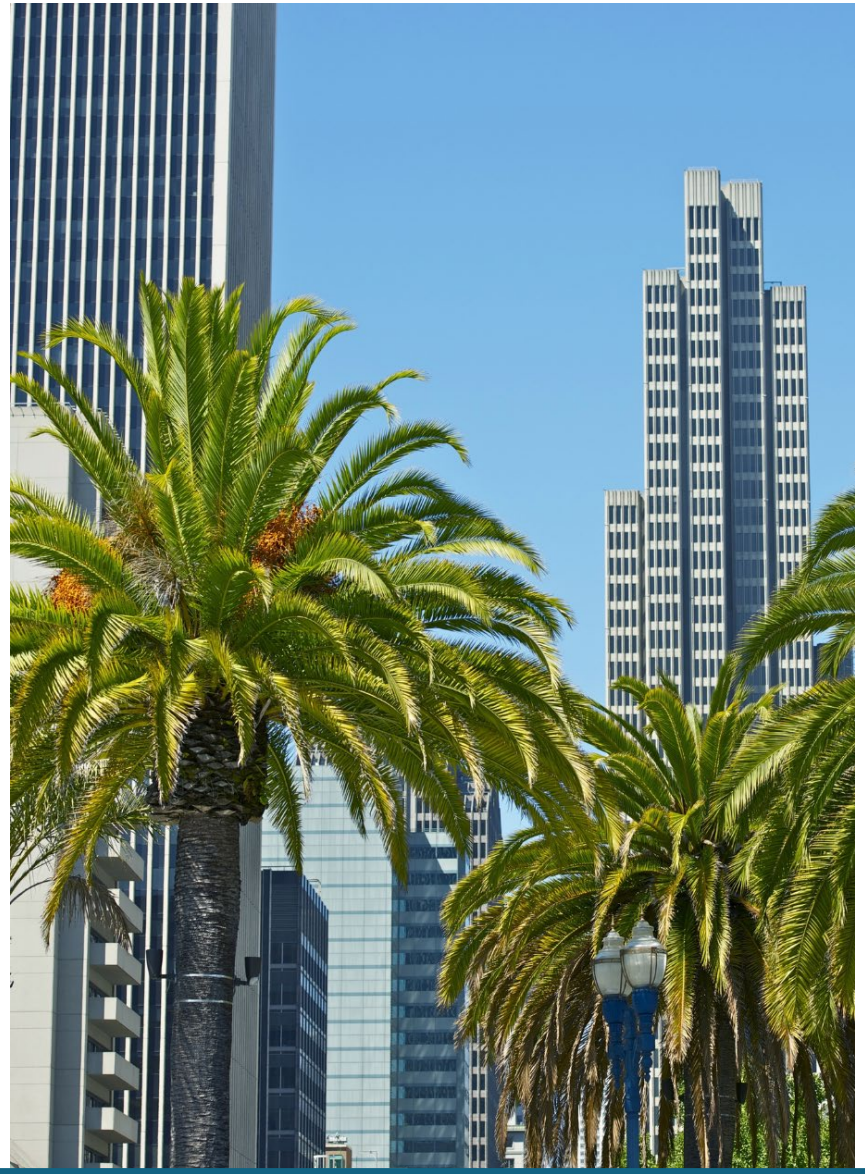
The following slides consider costs associated with alternative models, including DPH ownership with contracted operations **(#2)** and partnership with hospitals and providers on space and operations **(#3)**.

Costing Scenarios: Rate Assumptions

The Controller's Office developed costing scenarios using a per-bed patch rate inclusive of all costs associated with operating the site.

- The **"High" Patch Rate** assumes the provider uses higher staffing models appropriate for complex client needs, including nursing and medical staff.
- The **"Low" Patch Rate** assumes the provider may staff the facility with moderately increased staffing levels and may have lower operating costs.

Typically, providers receive the patch rate in addition to the SSI allocation for each client ($1,398 per month for ARFs & RCFEs and $1,050 for MHRCs). The SSI allocation pays for room, board and supervision, while the county patch covers enhanced services for complex clients.



Costing Scenario: ARF & RCFE Example

Scenario

- DPH purchases and owns a facility in San Francisco
- DPH contracts for services

Estimated One-Time Purchase Costs

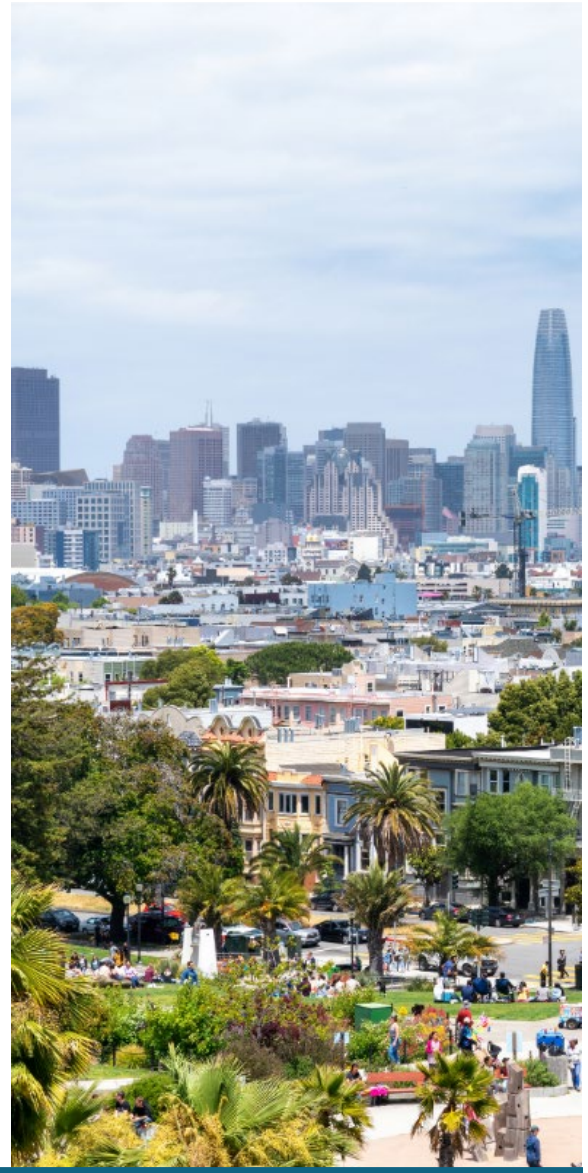
Example: DPH recently purchased a facility for **$13.8 million** which will serve as a **54-bed RCFE**. (No rehabilitation needed.)

Estimated Annual Patch Costs

DPH estimates that it needs 20 to 40 additional ARF and RCFE beds with higher levels of care for complex clients. Annual costs could range from **$1.5 million** to **$3.7 million** each year, depending on the number of beds and the patch rate used.

20 Beds	
Low Patch $1.5M	High Patch $1.8M

40 Beds	
Low Patch $2.9M	High Patch $3.7M



Costing Scenario: MHRC Example

To help determine MHRC facility acquisition costs, we looked at recent grant awards for the same purpose.

Behavioral Health Continuum Infrastructure Program (BCHIP) Grant Awards

Proposition 1 (2024) bond funds include **$4.4 billion in capital funding grants** for voluntary and involuntary behavioral health treatment and residential facilities through Bond BHCIP. **Jurisdictions must match 10% of award.**

BHCIP Round 3 and 5 Awards for MHRC Facilities Ranked by Largest Award Amount per Bed

County	Name of Grantee	Number of Beds	Estimated Award Amount	Award Amount per Bed
Riverside	County of Riverside	50	$75,900,000	$1,518,000
Humboldt	Mad River Community Hospital	9	$12,300,000	$1,366,667
Alameda	Bay Area Community Services Housing Corporation	34	$18,000,000	$529,412
Contra Costa	Contra Costa Behavioral Health Services	45	$18,600,000	$413,333
Sacramento	County of Sacramento - Behavioral Health Services	64	$23,500,000	$367,188
Mendocino	Redwood Quality Mangement Company, Inc.	16	$4,600,000	$287,500
Monterey	County of Monterey	100	$20,000,000	$200,000

Note the wide range of dollar per bed.

The number of beds range from 9 to 100.

It is not known whether these costs are for acquisition of a building, renovation of an existing site, or acquisition and renovation.

Costing Scenario: MHRC Example

Scenario 1
- DPH purchases and owns the facility
- DPH contracts for services

Estimated One-Time Purchase Costs

Example: **$25M facility*** with 64 beds purchased using BHCIP grant, plus **required local match of $2.5M**.

* Sacramento BHCIP award as benchmark. The award does not include the match amount.

Scenario 2
- Provider leases hospital space
- DPH contracts for services

Estimated One-Time Renovation Costs

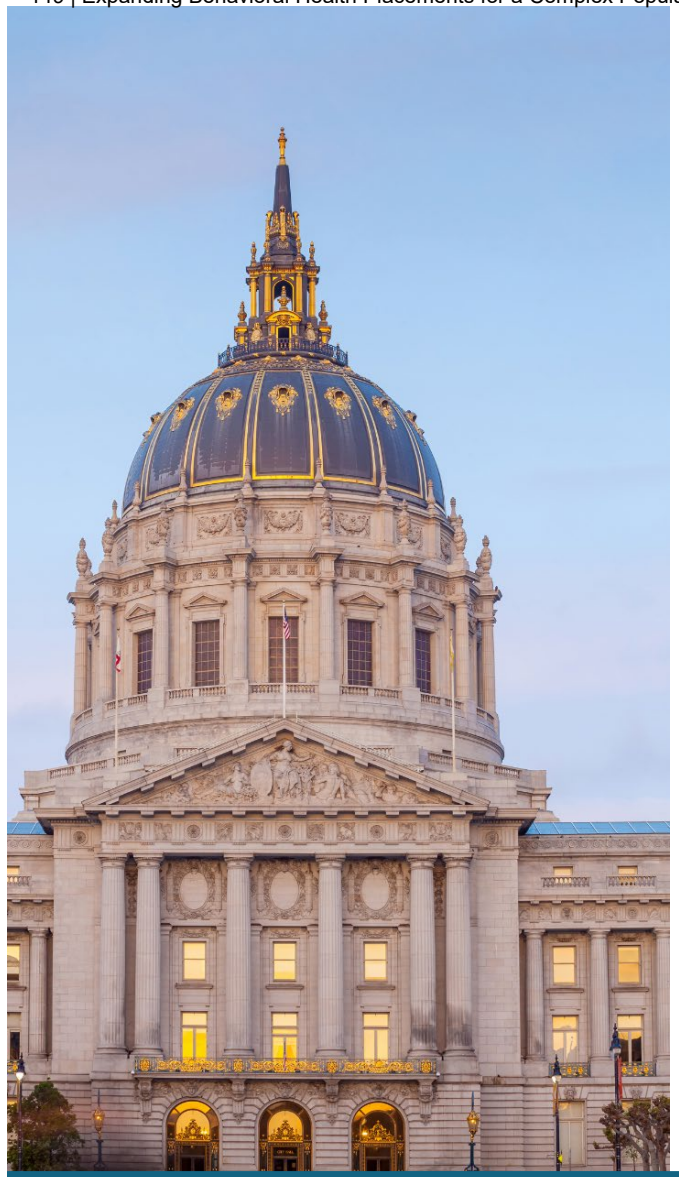
Example: DPH partnered with St. Mary's-UCSF to lease space for the Healing Center for 54 beds. The site required renovations, but not a full change of use which greatly minimized costs. Adjusted for inflation, the **minor renovations cost $4.3M**.

Estimated Annual Patch Costs for Either Scenario

DPH estimates that it needs 55 to 95 beds additional MHRC beds. Annual costs could range from **$10.6 million** to **$19.8 million** each year, depending on the number of beds and the patch rate used.

55 Beds	
Low Patch $10.6M	High Patch $11.4M

95 Beds	
Low Patch $18.2M	High Patch $19.8M



Building Maintenance and Management Costs

These models assume DPH ownership of a building, which comes with additional ongoing costs, including **annual allocations** for:

- **Maintenance**, including unexpected costs (client damages room)
- **Reserves** for planned improvements (new roof, new paint, elevator)
- **Insurance** to operate site (impacted by exponential spikes in market)

DPH may contract with an operator to perform some or all these functions (see Facility Acquisition Barriers Assessment for details), but the **patch rates listed do not account for all these costs** in addition to enhanced staffing for behaviorally complex clients.

Depending on funding, properties may be required to maintain reserve accounts (e.g., $250 per unit for tax credit funding), and many must also hold a percentage of the operating budget on hand depending on loan terms.

MOHCD compared costs across 15 current nonprofit operators managing buildings similar to the ARF / RCEF example provided earlier and estimates that, on average, a provider may need to account for typical operating costs of $31,000 annually.

Operating Challenges

- ARF and RCFE operators commented on funding constraints as a key barrier, particularly the **patch rate**.
  - Patch rates are impacted by **inflation**: DPH must continually adjust operating budgets to account for operators' inflationary pressures, such as rising insurance costs, rising wages, and other inflationary costs.
  - While nonprofits may be allocated a Cost of Doing Business adjustment in the budget process, this does not apply to most ARF, RCFE and MHRC operators.

- Hospital-grade facilities that are appropriate for MHRCs are scarce in San Francisco. There are fewer than 10 hospitals in San Francisco; it would take partnership and analysis to determine if any have space appropriate to convert for MHRC use.

Government Financing Options: Assisted Living Waiver

Assisted Living Waiver (ALW): Federal

The ALW is a federal 1915(c) Medicaid Home and Community-Based Services waiver in place in California since 2009 to offer an alternative to long-term nursing facility placement. The ALW acts like the county patch in that it covers basic care and supportive living services for Medi-Cal eligible people aged 21 and older.

- An operator can apply to certify beds for ALW placement and reimbursement. **Counties cannot layer patch rates or other funding on top of the ALW reimbursement for one of these beds.**
  - Three facilities with **180** total beds in San Francisco have been certified for the ALW program.
  - Other counties have significantly more ALW facilities certified for the program. For example, Sacramento County has 77 facilities with **1,867** total beds participating in the ALW program.
  - ALW **utilization** by county is not publicly available, though DAS requested this information in 2019 and found that fewer than 20 San Francisco residents were enrolled.
  - These figures may be meaningful to our comparison of how many government-subsidized beds are available in San Francisco compared to other counties.
- CA Department of Health Care Services is seeking federal approval to increase the enrollee cap beyond its current 14,544 slots since demand for the waiver significantly exceeds available capacity.

Government Financing Options: Assisted Living Waiver

Assisted Living Waiver (ALW): Federal

The City could work to expand the number of facilities using the ALW to support its expansion goals. However, there are challenges that may limit the benefits of this approach.

Facilities need to enroll to receive the waiver which is a cumbersome process. There is a cap on the number of individuals that may enroll at certified facilities. There is a centralized waitlist for clients to be placed in a facility with ALW beds. The waitlist is currently not accepting any new referrals.

While the average ALW patch rate ($153) is slightly higher than DPH's average patch rate, this may not be enough to incentivize operators to secure the waiver given other barriers.

DPH's average patch rate is $111 for RCFEs and $130 for ARFs.

2024 ALW Reimbursement Rates

Tier 1	$91.13 per participant per day
Tier 2	$108.89 per participant per day
Tier 3	$126.64 per participant per day
Tier 4	$171.02 per participant per day
Tier 5	$257.25 per participant per day

The average patch rate across the 5 ALW tiers is $153.

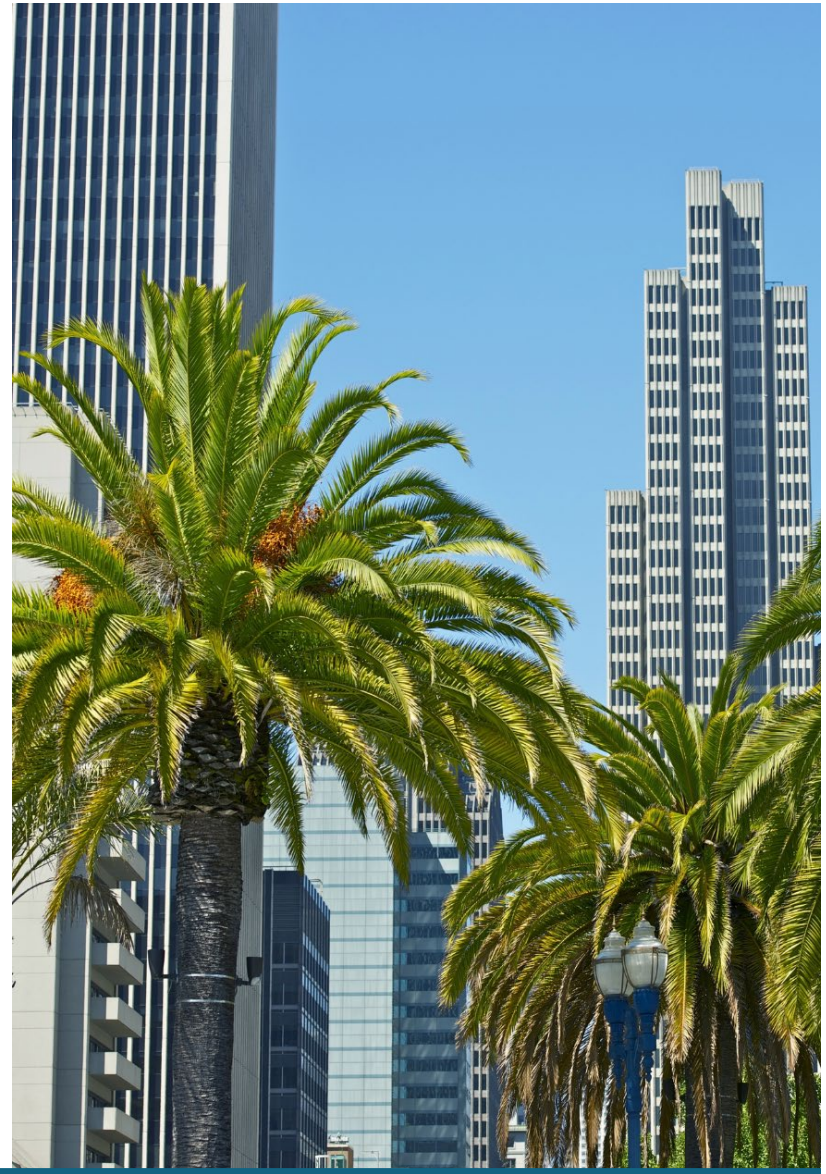
Government Financing Options: Medi-Cal

BHCIP: State

- While **MHRCs are eligible** for bond funding, ARF and RCFE facilities are not "Medi-Cal eligible."
- Grants are for capital costs only; **local jurisdictions must cover operating costs**, including the full cost for some services and the local match (often 50%) for services covered by Medi-Cal.
- Bond BHCIP Round 1 applications are due in December 2024 with a Bay Area regional cap of **$278M** in awards. Bond BHCIP Round 2 is scheduled for Spring 2025 with a Bay Area regional cap of **$170M** of total grant funds available.
- Jurisdictions must have site control of launch-ready properties.

Government Financing Options: Medicaid

- IMDs are facilities that have 16+ beds to treat mental illness and receive medical and nursing care services.
- In California, these can be psychiatric hospitals, psychiatric health facilities, skilled nursing facilities with some special treatment programs, mental health rehabilitation centers, or state hospitals.
- Medicaid's longstanding **IMD exclusion limits federal funding for inpatient behavioral health care, including mental health or substance use disorder care**, for Medicaid-eligible IMD patients.
  - For DPH placements, LSATs typically receive $1,050 per month in SSI from the client, and **DPH covers the full cost of the daily rate using unreimbursed local funding**.
  - DPH may spend approximately $25M to $28M annually for 140 LSAT placements without Medicaid reimbursement (e.g., 140 beds x $550 avg daily rate x 365 days).



Summary of Financial Challenges to Bed Expansion

DPH is actively pursuing multiple strategies to achieve its bed expansion goals, including site acquisition and contracting for beds.

Regardless of approach, **costs are likely difficult to cover in the current budget environment**. It may require up to $10M to $30M one-time and $2M to 20M annually to fund San Francisco's proposed bed expansion goals for behaviorally complex clients needing ARF, RCFE or LSAT care. Operational costs are likely to increase year over year with inflation.

While there is an option for bond funding for potential MHRC sites, federal and state funding for ongoing operations and client services is limited, putting pressure on the local General Fund.

Using existing contracting practices has its own drawbacks. For example, market pressures put San Francisco in competition with other counties for placements. Without control over facilities, San Francisco will continue to struggle to place its most behaviorally and medically complex clients.

What strategies should the City pursue to fulfill its expansion goals?

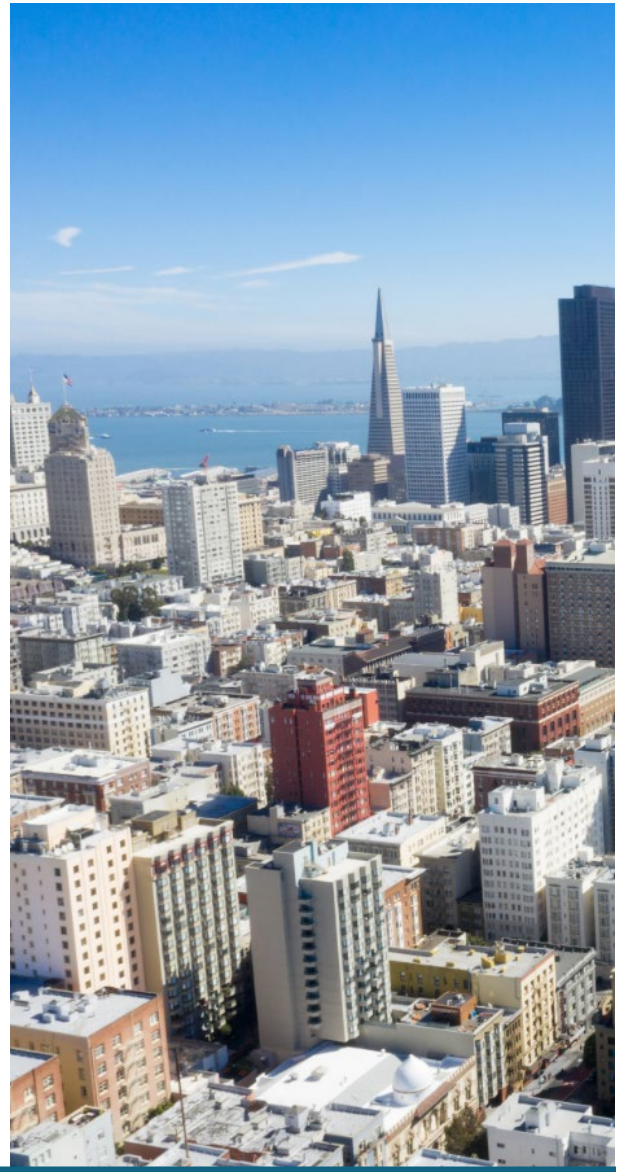
What Options are Available to San Francisco?

Advocate for State and Local funding for these levels of care

- The City can encourage the **state** to pair BHCIP capital grants with ongoing operating funds to make facility expansion more feasible for all counties.
- The City can lobby the **federal** government to:
  - Remove Medicaid's IMD exclusion
  - Allow residential care and treatment facilities to bill medical staff visits to Medicaid.

Tradeoffs:

- It is unclear where additional operating funds would come from given the financial outlook. The reform of the Mental Health Services Act to the Behavioral Health Services Act under Proposition 1 (2024) did not increase the amount of ongoing funding available for behavioral health services.
- IMD changes have been a subject of national advocacy for years. This is likely a long-term strategy that will not resolve immediate funding needs.



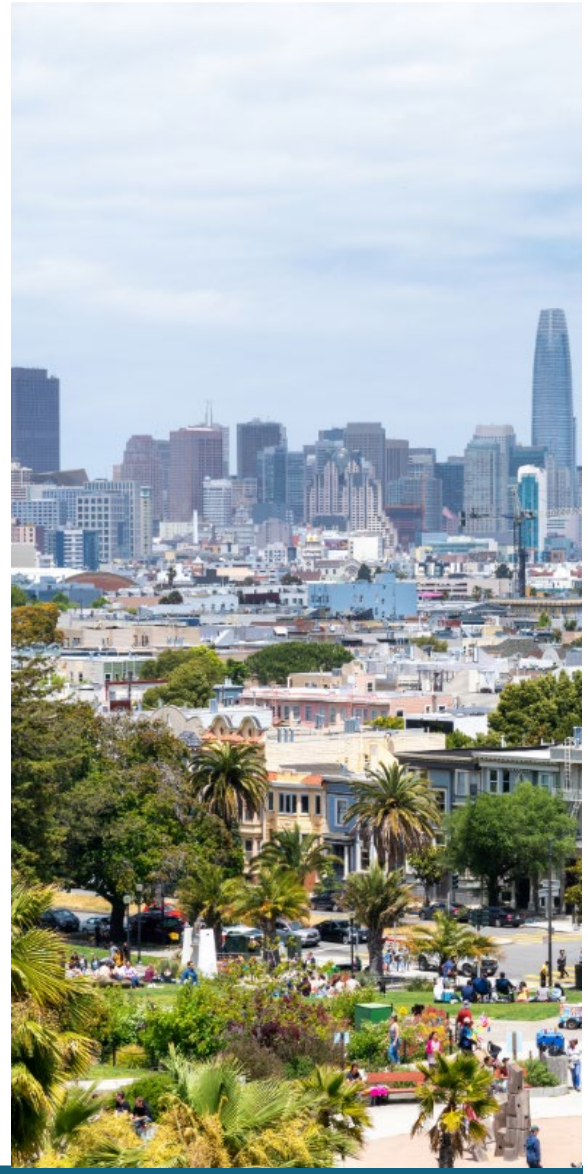
What Options are Available to San Francisco?

Prioritize acquisition and ownership to achieve expansion goals

- The City can seek out opportunities to purchase facilities to create capacity for the complex client population.
  - Facility ownership lessens the impact of contractor discretion on placing clients and on the use of "as needed" beds.
  - Facility ownership allows the City to control the use of the facility as future needs shift.
  - This option may include seeking out partnerships with local or regional hospitals to leverage available space for MHRC facilities.

Tradeoffs:

- If there are budget shortfalls, the City may need to reallocate contract funding to sustain owned assets – potentially resulting in net neutral bed numbers rather than bed expansion.
- Acquisition, rehab and contracting has a longer timeline than contracting for existing beds.



What Options are Available to San Francisco?

Encourage private operators to expand facilities and partner on dedicated beds

- Private operators may apply for Proposition 1 Bond BHCIP grants to acquire new facilities. The City can establish partnerships with operators to commit to filling beds.
  - Private operators can bring new beds online faster than the City.
  - Private operators may purchase facilities out of county which may be less expensive than facilities in San Francisco.
  - A partnership can allay the market related placement barriers.

Tradeoffs:
- The timeline to find the best partner and most appropriate facility is uncertain.
- Negotiating dedicated beds may lead to higher ongoing bed rates.

Discussion

- Which options are feasible? Which should the City prioritize?
- Are there other options or opportunities that the City should explore?
- How can the City collaborate with partners – neighboring counties, hospitals in San Francisco, etc. – to launch work on these options?

Questions?

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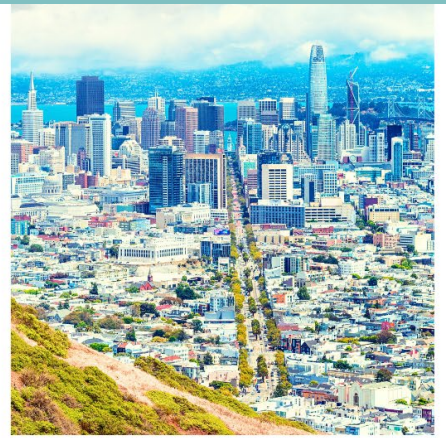


Appendix 7

Residential Care and Treatment Workgroup

Final Session: Potential Recommendations

Office of the Controller

Laura Marshall | Hannah Kohanzadeh | Oksana Shcherba

November 18, 2024

Agenda

1. Workgroup Findings
2. What Can San Francisco Do?
3. What Requires Regional Partnerships?
4. What Requires State or Federal Engagement?
5. Discussion

Workgroup Findings

The City has added over 400 residential care and treatment beds since 2020 and now offers nearly 2,600 beds across a spectrum of service levels, including nearly 700 Substance Use Residential programs and approximately 1,900 Mental Health Residential programs.

- However, DPH projects that **the City needs additional ARF, RCF-E and LSAT beds** based on updated modeling.

The City is experiencing both a **capacity** challenge and a **placement** challenge.

- The City must add capacity at the ARF, RCF-E and LSAT levels of care, but the City must also address the difficulty with placing its most complex clients.
- Expanded beds must be **targeted to a behaviorally complex population** that DPH has the most difficulty placing in facilities, even when facilities have capacity.
- Client complexities include medical complications, ambulatory issues, aggressive behaviors, justice system involvement, and more.

Workgroup Findings

1

The market fails to encourage placement of complex clients

Operators continue to decline the most complex clients, despite supplemental state and county funding

2

High local costs may impede bed expansion efforts

The City must fund acquisition and operating of most ARF, RCF-E, and LSAT beds using local sources

3

Procurement in San Francisco is time-consuming, even as the expansion need is urgent

Facility acquisition and/or procurement is lengthy, administratively burdensome and can take years

4

Staffing challenges are persistent and impact service delivery

Mirroring national trends, San Francisco faces persistent challenges with recruiting, hiring, and maintaining skilled staff

5

Licensing regulations cause service limitations for complex clients

Existing system design and state licensing regulations are not responsive to and often prevent appropriate service delivery to complex clients

Potential Recommendations

Potential Recommendations

What can San Francisco do?

1. DPH should refine existing analysis and develop new tracking tools to ensure its projections for bed expansion needs are accurate and can be tracked over time
2. The City should work to achieve a net expansion of ARF, RCFE, and LSAT beds by 2027
3. The City should consider various strategies to achieve net expansion that provide the City with more bed placement control
4. The City should develop local legislation to expedite acquisition and/or contracting for new treatment facilities
5. The City should continue to address staffing challenges

Recommendation Options: What can San Francisco do?

1. DPH should refine existing analysis and develop new tracking tools to ensure its projections for bed expansion needs are accurate and can be tracked over time

- By December 2025, DPH should **develop a process to track and annually report on current bed availability**, including documenting the number of beds in each level of care in use and the remaining available
  - Tracking should disaggregate contracted beds, as needed beds, and City-operated beds
  - DPH should begin collecting data to enable the department to review historical trends in bed availability and document how bed availability and use has changed over time
- DPH should refine its Bed Optimization analysis to develop a **deeper understanding of client complexities and specific treatment needs** for this group
  - By fall 2026, DPH should update its model to more accurately project the number of beds needed to serve specific populations

These two analyses can show the success of bed expansion plans, viable strategies for expansion, and the impact the expansion has on clients requiring and using each level of care over time.

Recommendation Options: What can San Francisco do?

2. The City should work to achieve a net expansion of ARF, RCFE, and LSAT beds by 2027

A net of **at least 25 ARF and RCFE beds** specifically designed for and with explicit commitment to serve highly complex clients

The City may anticipate one-time costs of $14M to acquire a new facility and annual patch costs ranging from $1.8M to $2.3M depending on the acuity of clients served

A net of **at least 50 LSAT beds** with explicit commitment to serve highly complex clients

The City may anticipate one-time costs ranging from $4.6M - $75.9M to acquire a new facility and annual patch costs ranging from $9.6M to $10.4M depending on the acuity of clients served

Recommendation Options: What can San Francisco do?

3. The City should consider various strategies to achieve net expansion that provide the City with more bed placement control to counter market forces that result in difficulty placing complex clients

1. In collaboration with City labor partners, **reprogram existing City-owned facilities** to serve San Francisco's most complex clients
   - Retain market-constrained settings for less complex clients
2. Partner with **private operators** to expand facilities and **dedicate beds** to San Francisco via contracts
3. Actively seek out new facilities for **City acquisition** or nonprofit acquisition via no-interest loan
4. As feasible, the City may need to implement **new legal terms** to ensure providers accept placements, such as **incentives** for accepting more complex clients and/or **contract penalties** for denial of complex clients

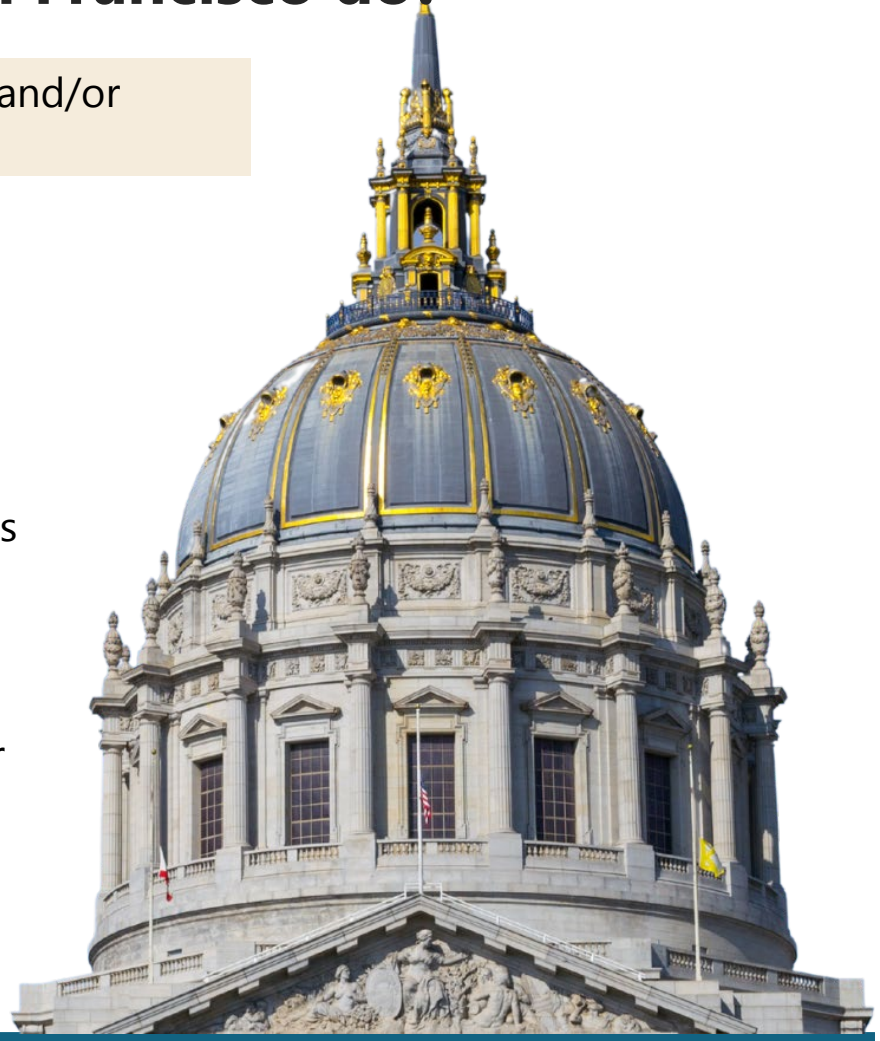
Recommendation Options: What can San Francisco do?

4. The City should develop local legislation to expedite acquisition and/or contracting for new treatment facilities

Acquiring and launching a new program can take 18-24 months, if all goes well.

To support the City to achieve its bed expansion timelines, the City should:

- Leverage existing legislation that waives solicitation requirements for behavioral health service expansion
- Identify **new legislative options to streamline contracting and/or acquisition**, such as expanding the no-interest loan program and/or granting waivers of certain contracting steps for acquisition or new services



Recommendation Options: What can San Francisco do?

5. The City should continue to address staffing challenges and implement recommendations made in the Mental Health SF 2024 report

The strategies in the report address hiring and retention challenges for civil service programs and nonprofit behavioral health providers in the City.

See the Mental Health SF Staffing Analysis here

Potential Recommendations

What requires regional partnerships?

6. The City should initiate conversations to develop one or more partnerships with another county to expand facilities
7. Regional hospitals should use underutilized spaces to provide dedicated LSAT beds for the City
8. The City should work with a state advocacy organization to establish a regional collaboration with other local Bay Area counties

Recommendation Options: What requires regional partnerships?

6. In 2025, the City should initiate conversations to develop one or more partnerships with another county to expand facilities

- The City may leverage new legislation streamlining government to government contracting to support negotiations.
- The City should engage with counties that have applied for round 3 and 5 BHCIP bond funding to create new facilities to determine if there is an opportunity to partner.

Recommendation Options: What requires regional partnerships?

7. Regional hospitals should use underutilized spaces to provide dedicated LSAT beds for the City

- Due to regulatory requirements, **hospital grade facilities more easily meet the building standards required for LSAT beds**
- The City has limited options to provide LSAT beds in the San Francisco
- Regional hospital partnerships with the City could enable San Francisco clients to receive care in, or close to, their home county

Recommendation Options: What requires regional partnerships?

8. By winter 2025, the City should work with a state advocacy organization to establish a regional collaboration with other local Bay Area counties

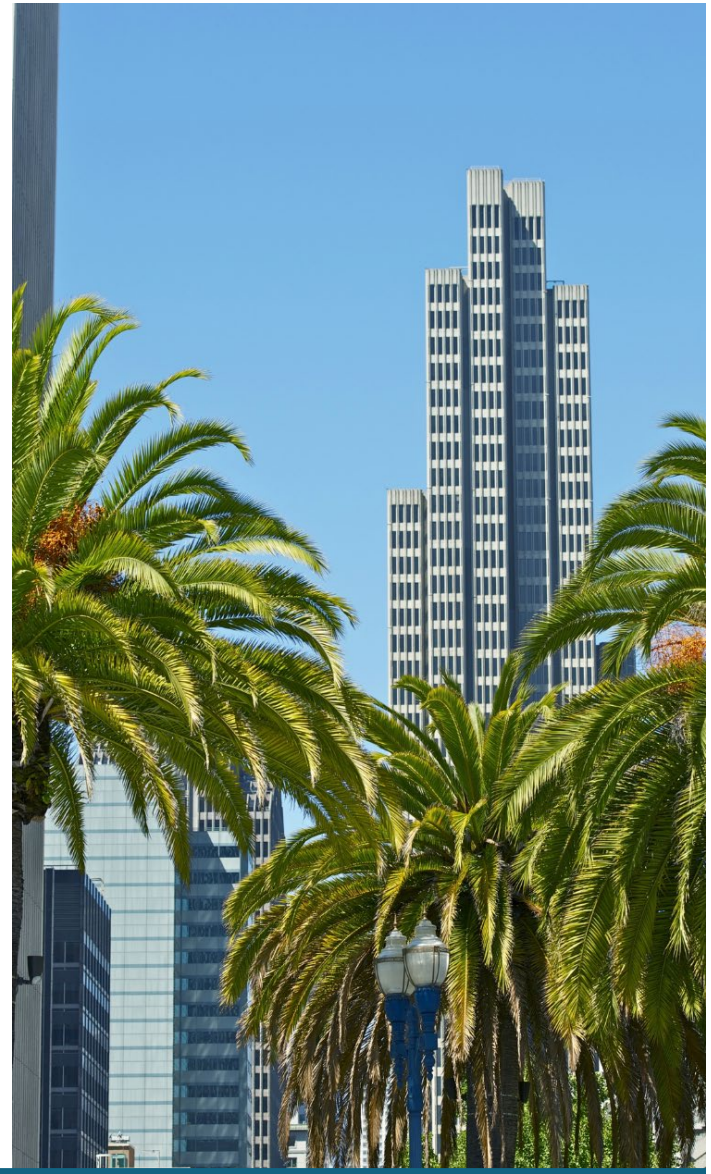
A core goal of this collaboration should be to develop a **joint policy and advocacy platform** for State level advocacy specific to the residential treatment needs of complex clients

Potential Recommendations:

What requires State or Federal engagement?

With regional partners and locally, the City should develop an advocacy platform to include the following policy objectives.

9. The state and federal governments should enhance funding to supplement the cost of currently unreimbursed local programs
10. The State should expand the number of State Hospital facilities and beds and to restructure how counties are allocated beds
11. The State should enhance the Statewide bed inventory to include information about cost, utilization, waitlists and other factors
12. The State should lead efforts to improve access to Mental Health Rehabilitation Center facilities



Recommendation Options: What requires State or Federal engagement?

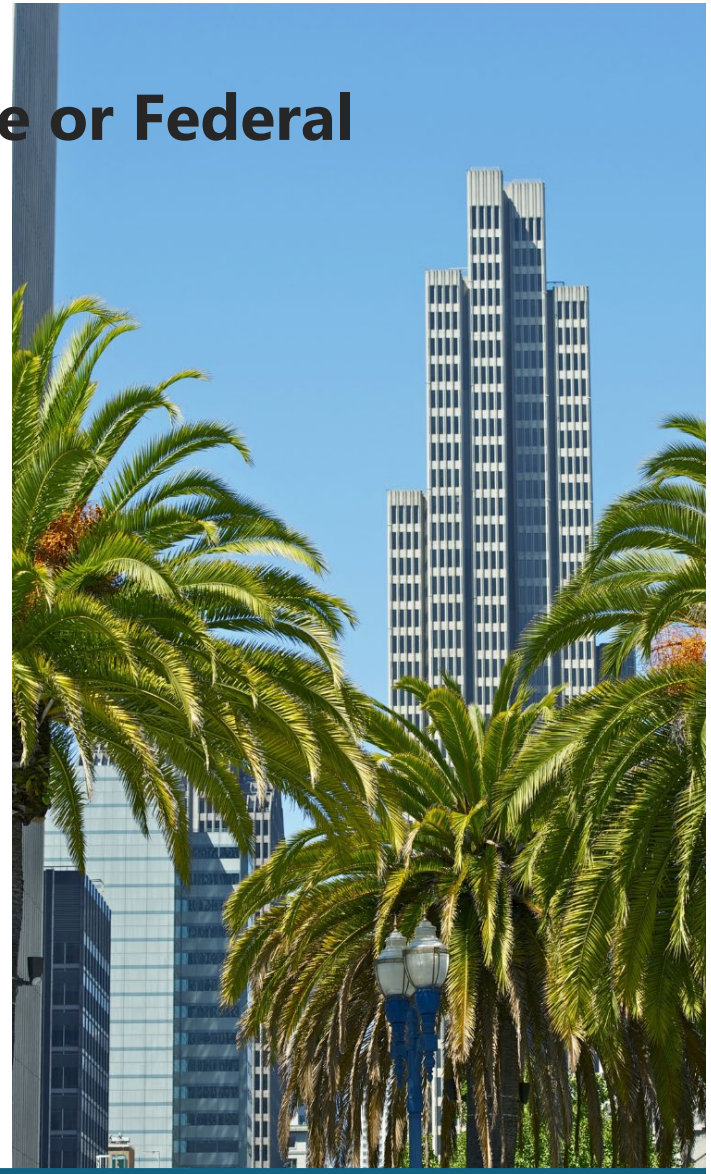
9. With regional partners and locally, the City should advocate to the state and federal governments for enhanced funding to supplement the cost of currently unreimbursed local programs

- The federal government should expand the **IMD Waiver programs** to fund MHRC stays for 60 days and beyond
- The State should make key changes to the **Assisted Living Waiver (ALW) program**, including:
  - To allow a higher level of participation in the ALW program
  - To create regional reimbursement rates, rather than statewide tiers, to make the ALW rates more competitive in San Francisco and incentivize operators to participate
  - To reconsider restrictive program policies, such as building structure requirements, that may prohibit smaller facilities from getting certified
  - To make participation data more transparent to jurisdictions

Recommendation Options: What requires State or Federal engagement?

10. With regional partners and locally, the City should advocate to the State to expand the number of State Hospital facilities and beds and to restructure how counties are allocated beds to account for county-specific levels of need

- The State should **increase the overall portfolio** of available State Hospital beds to match statewide needs
- The State should establish a bed allocation process that **dedicates beds based on level of need**, not just county or city size which leaves San Francisco at a disadvantage



Recommendation Options: What requires State or Federal engagement?

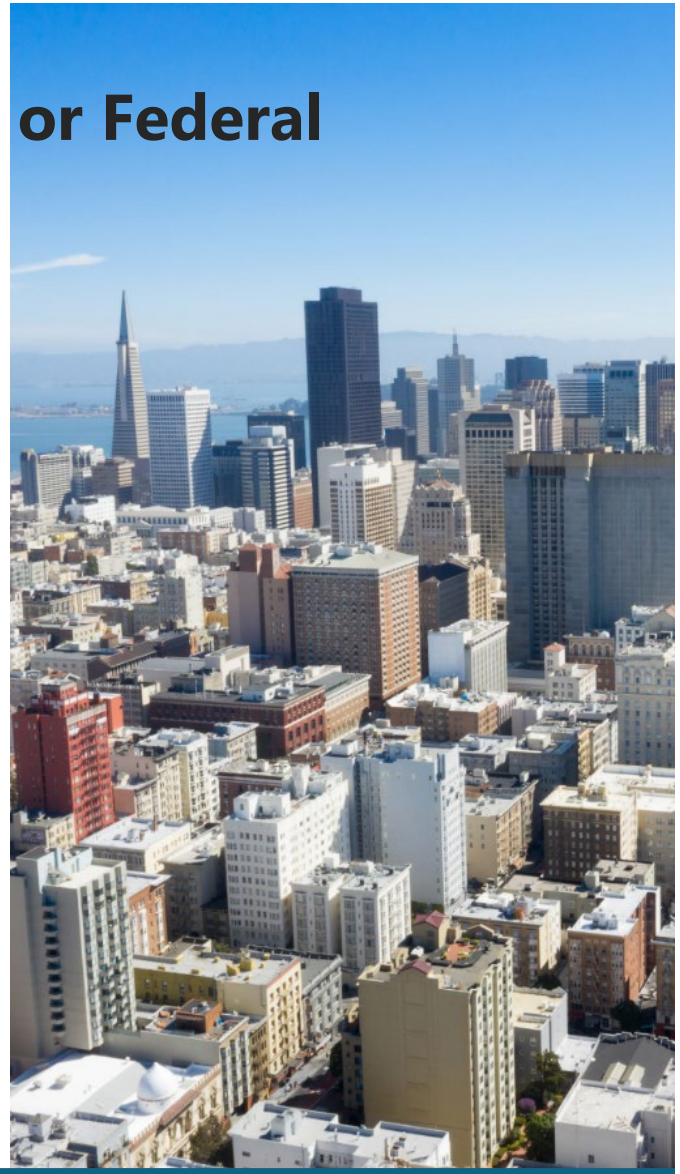
11. With regional partners and locally, the City should advocate to the State to enhance the Statewide bed inventory to include information about cost, utilization, waitlists and other factors

- This type of report may reduce competitive **market pressures** among jurisdictions by enhancing transparency in the marketplace
- There have been multiple **recent legislative efforts** to enhance transparency about bed inventories statewide, including SB363, AB512 and SB1017, all of which failed in the legislature
- Additional advocacy should consider strengths and drawbacks of these prior approaches to craft measures that may be more likely to pass

Recommendation Options: What requires State or Federal engagement?

12. With regional partners and locally, the City should advocate for the State to lead efforts to improve access to Mental Health Rehabilitation Center facilities

There are a limited number of these facilities and limited access for patients with certain histories or care needs, and State-level leadership could support access for more clients to this level of care



Discussion

- Which options seem most feasible to accomplish?
- Are we missing any options or opportunities?
- Any changes needed?

Questions?

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