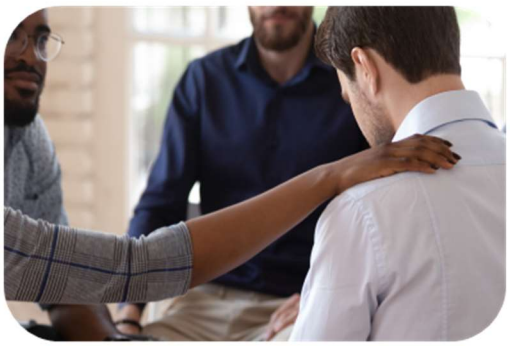
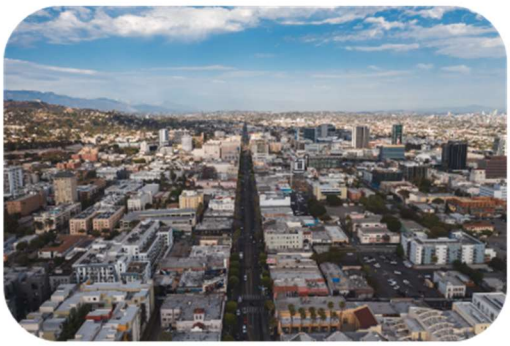









Research Study

Serving Our Vulnerable Populations:

Los Angeles County Adult Residential Facilities and Residential Care Facilities for the Elderly

August 2023

THE future ORGANIZATION

Acknowledgements

Initiative Partners

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The Future Organization Research Team

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ARF & RCFE Owners and Operators

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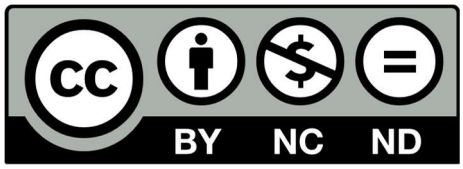

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Introduction

Los Angeles County-based Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) serve a diverse range of the most vulnerable populations, with an equally wide range of individuated needs. Multiple systems of care seek to navigate and place residents within these facilities to provide housing, assistance, supervision, access to services, and fulfillment of their most basic human wants and needs. As this study will descriptively and analytically identify, the popular but generic term of "board and care" is an unfortunate, imprecise, and somewhat misleading disambiguation of multiple variants of privately-owned businesses across two, California State-licensed classes of congregate facilities, which vary significantly in size, settings, resident compositions, amenities, access to services provided, funding streams, and willingness to serve vulnerable populations, such as:

- people reliant on public benefits, or without other means
- people with experience of homelessness;
- people living with mental illness;
- people living with physical disability;
- people living with developmental disabilities;
- people who cannot provide care for themselves;
- people who have reached a life-stage or age which requires external support;
- people who have been justice-involved (with experience of incarceration); and,
- people living with substance addiction (substance use disorder).

This study has a directed focus on licensed ARFs and RCFEs in Los Angeles County that are already serving, or express willingness to serve, people reliant on public benefits, people with experience of homelessness, and people living with mental illness.

Adult Residential Facilities, or ARFs, are instrumental in specifically serving the needs of the above, identified, vulnerable populations between the ages of 18 and 59. Nearly all ARFs rely almost entirely on public benefits to serve their populations, and rely heavily on interface with Los Angeles County agencies and nonprofits to connect their residents to the care and wraparound services that they need. A significant proportion of ARFs are specialized through contract and service-level agreements to particular segments of systems of care, most notably, the high proportion of Los Angeles County ARFs in exclusive service to Regional Centers, with accountability and responsibility to provide room, board, and care to individuals living with developmental disabilities, which are not included in the focus of this study.

Residential Care Facilities for the Elderly, or RCFEs, are essential to serving individuals aged 60 and up who may have reduced capability in providing care for themselves, may have reduced access to family and/or friends to assist them with their needs, and who may require increased levels of supervision, medical care, and access to amenity that they would not otherwise have by continuing to live in other housing situations. RCFEs are more complicated than ARFs to define, due to the significant proportion of facilities that exclusively host residents who are privately funded or self-funded in settings providing enhanced levels of luxury and amenity. However, many RCFEs serve an important role in providing housing, care, and comfort to aged individuals from the diverse communities of Los Angeles County that rely on public benefits. This study does not feature RCFEs that exclusively serve residents who access to private-funding or have substantive personal means to fund accommodation, care, and services with enhanced levels of personal amenity or luxury.

This study was designed to explore the dimensions of services, needs, and capabilities of a specific Market within the complex landscape of ARFs and RCFEs in Los Angeles County, with emphasis on understanding how this valuable resource can be preserved, enhanced, and improved to serve individuals from many of the most vulnerable groups in Los Angeles County communities, with an stated objective to explore how facilities are, and will continue to serve, people with experiences of homelessness. This research was conducted and delivered without implicit bias or any preconception of outcomes or intentions: it seeks to provide evidence for owners and/or operators of facilities, decision makers and staff of government agencies and nonprofit entities, funders, advocates, families, residents, and members of the community to understand the opportunities, capabilities, and gaps in services across this Market.

The intention of the recommended actions presented within this study is to foster greater levels of sustainability and survivability for ARFs and RCFEs, inspire quality and continuous improvement, deliver enhancement of the quality of life and outcomes for the residents of these facilities, engage stakeholders that can contribute to the public discourse or make decisions about prospective change, and identify how the continued funding, participation and expansion of these facilities can address the crisis of people experiencing homelessness across Los Angeles County communities and beyond. This study does not make unsubstantiated judgements about any person, group, agency, policies, or actions: rather, it seeks to encourage critical dialogue, consideration, directed improvements, and spark innovation that will lead to beneficial change in services and housing for vulnerable populations in Los Angeles County, especially for people with experience of homelessness.

Our team at The Future Organization hopes that you find the product of our year of research into Los Angeles County ARFs and RCFEs to be both useful and informative in the advancement of the interests of both facilities and the vulnerable populations they serve, house, and care for, as well as advancing efficiency, effectiveness, and quality in the delivery of programs, services, and funding in service to the public interest.

Aimery Thomas, M.P.A., M.A.I.R., LSSBB
Managing Director
The Future Organization LLC
August 2023

Study Objectives

1. To conduct primary, original market and social research with:

    a) Los Angeles County-based Adult Residential Facility (ARF) and Residential Care Facility for the Elderly (RCFE) owners and operators that serve people living with mental illness and/or people reliant on public benefit, and,

    b) Residents within aforementioned facility types, and community stakeholders responsible for leading delivery of services across the homelessness Continuum of Care (CoC) at governmental and nonprofit agencies, to explore the following directed research questions:

        - How many people experiencing homelessness (PEH) are moving from street encampments / permanent supportive housing / shelters to ARFs / RCFEs?
        - How effective are ARFs / RCFEs at keeping PEH housed long-term?
        - What are the costs to taxpayers of using ARFs / RCFEs instead of services provided on the street?
        - Do ARF / RCFE residents move to lower or higher levels of care and how often?
        - What is the utilization rate of the ARF / RCFE system, and how close to being fully utilized are the beds?
        - What appear to be the unmet needs of the unhoused population as well as those in other institutions, for ARF / RCFE beds?
        - What leads people to need ARF / RCFE services?

2. To collaboratively explore, enhance, and improve upon existing research questions in consultation with the Client, partners, sponsors, and community stakeholders to maximize the outputs and impact from the unprecedented opportunity to conduct high-validity, large-scale, sample-based research across Los Angeles County ARF and RCFE facilities and their respective resident populations.

Executive Summary: Part A
The Market and Capacity to Serve

- The "Market" is defined as Los Angeles County-based, licensed Adult Residential Facilities (ARFs) and licensed Residential Care Facilities for the Elderly (RCFEs) currently serving or willing to serve people reliant on public benefits for their room, board, and care, people living with mental illness, and people with experience of homelessness (referred to herein as the "identified, vulnerable population").

- From July 2022 through November 2022, N=353 interviews were conducted with the owners and operators of Market ARFs and RCFEs. N=40 qualitative, executive interviews were conducted with senior leaders of public agencies, nonprofits, and other stakeholders, or "Market Users", from other systems and continuums of care between January 2023 and March 2023, to provide insights across Los Angeles County systems of care and service that have interface with the identified, vulnerable population served by the Market.

- The Market does not include facilities under exclusive contract ("vendorization") with Los Angeles County's Regional Centers, in service to people living with developmental disabilities, supported by a different set of public funding mechanisms and service reimbursement rates.

- The Market consists of both small and large business owners, either as individuals or managing groups of facilities, that have a commonality in their identified need for greater levels of public, financial, and policy support from government, nonprofits, and elected officials, to continue to deliver consistent levels of housing, service, and care to members of identified, vulnerable populations.

- Based on incidence rates from outreach performed across 3,065 licensed ARFs and RCFEs in Los Angeles County for the study, the total number of ARFs and RCFEs serving the Market is estimated to be 750 facilities, with an estimated, total licensed bed capacity of 25,000 beds.

- During the study period (July 2022 through November 2022), owners and operators of Market ARFs and RCFEs identified that 25.9% of their resident bed capacity was vacant or underutilized (approximately 6,400 beds), with the majority of underutilized beds located at RCFEs. Additional actions are required by government and nonprofits to fund and activate many potential placements.

- The mean duration of continuous ownership and operations for Market ARFs and RCFEs is 14.54 years, which bears significant impact on the issues of asset conditioning, deferred maintenance, and quality. Additional funding is needed to assure quality in asset condition to preserve access to the Market into the future. 59.2% of Market facilities are owned in a group with other ARFs and RCFEs.

- Market ARFs and RCFEs are not universally regarded by all of the Market's Users as being an integral component of systems delivering health or mental health services to vulnerable individuals, despite providing medication management, supervision, activities of daily living (ADLs), and enabling a stable platform for delivery of health care-related and mental health-related services.

- The mean staff-to-resident service ratio across all Market facilities is 0.86 staff per 1.0 resident, at full capacity. Mean duration between medical health visits by residents at Market facilities is once every 6.6 weeks; the mean duration for mental health service visits by residents is once every 5.9 weeks.

- Opportunities exist for government agencies and nonprofits to deliver wraparound services to greater numbers of facilities in the Market, as well as ensure more equitable balance in the geographic distribution of services to facilities across the entirety of Los Angeles County and its Service Planning Areas (SPAs). Improving access to and distribution of government and nonprofit wraparound services to Market facilities in all County localities will provide enhanced care outcomes, enhance rates of graduation to lower levels of care, and assure more consistent quality of life for residents from the identified, vulnerable population.

Executive Summary: Part B
Key Market Issues

- The Market of ARFs and RCFEs serving the identified, vulnerable populations in Los Angeles County is not optimally utilized, due to a lack of centralized coordination and significant differences in access to real-time information amongst the Market's Users. Public agencies, nonprofit entities, and other entities utilizing the Market largely compete to reserve and access bed space to serve specific segments of vulnerable populations, maintain semi-exclusive or contractual relationships with facilities utilizing their own navigation processes, and utilize a wide range of relatively complex public funding streams, especially in transitioning people experiencing homelessness to ARFs and RCFEs.

- There is identified, unmet need from Market Users for a single government agency or entity to provide consistent information about the service capabilities and utilization rates of every ARF and RCFE for all Market Users, ensuring maximal use of capacity, equitable distribution of resources, and improved service outcomes for the identified, vulnerable population. As vulnerable residents are frequently placed in to the first available facility, rather a facility that best matches individual care needs, there are a large number of transfers between facilities amongst Market ARFs and RCFEs that could be prevented if more detailed information about facility capability and suitability for prospective residents was made available to Market Users prior to navigation and/or placement.

- Without a greater, commercial marketplace that supports large numbers of privately-funded beds at their facilities, Market ARFs receive resident referrals from a very different mix of channels than RCFEs, although hospitals, medical, and mental health facilities (such as skilled nursing (SNFs), recuperative care, and institutions for mental disease (IMDs) are significant sources of resident referrals for Market ARFs and RCFEs, with RCFEs making near-exclusive use of paid referral services.

- Low proportions of residents graduate from Market facilities to lower levels of care (12.9%), such as permanent supportive housing or affordable housing, indicating potential gaps in government and nonprofit wraparound training and education services that could enable more resident movements. Reduced rates of graduation to lower levels of care for existing residents capable of doing so is a key structural impediment preventing more efficent and effective use of the Market's limited ARF capacity.

- 89.8% of Market ARFs and RCFEs indicated no intention to sell or transfer facility ownership for a period of 12 months after interview, with only 4.2% expressing intention to sell or transfer facility ownership. 23.5% of facilities identified inflation and rising costs as a primary factor for potential closure or sale, with 19.0% indicating that a lack of residents (leading to financial stress) as a factor, and 13.9% indicating (potential or relative) reduction in public funding as a primary factor.

- Despite Adult Residential Facilities (ARFs) delivering the greatest net amount of public utility in largely dedicated service to identified, vulnerable populations, the future outlook for sustaining the Market's ARFs can be regarded as critically-challenged. Owners and operators, along with Market Users, have identified low levels of growth and expansion in this license class of facilities, disproportionately low levels of public funding to sustain provision of resident room, board, and care in comparison to other housing and channels of care serving other vulnerable populations, and few, easy-to-access incentives from government to support the construction or expansion of ARFs to serve vulnerable populations. Local government planning and zoning policies and processes serve to significantly inhibit ARF growth.

- Given local and national trends indicating substantive growth in the numbers of people over the age of 62 who currently experience (or who may yet experience) homelessness, Residential Care Facilities for the Elderly (RCFEs) will play an increasingly important role in serving the specialized needs of seniors with experience of homelessness, providing access to appropriate health care, mental health care, and in delivering activities of daily living (ADLs) for those without sufficient capabilities to be placed within permanent supportive housing, affordable housing, or other housing situations that enable greater levels of independence. Public funding levels supporting individuals at RCFEs need to increase to meet the customary rate levels of low-to-mid cost RCFEs in Los Angeles County.

Executive Summary: Part C
Resident Experience and Perceptions

- N=625 in-person interviews were conducted with residents of Market ARFs and RCFEs between July 2022 and November 2022. 47.8% of residents interviewed had experienced homelessness at some point in their adult lives, 61.4% were living with a diagnosed mental illness, 51.8% were living with physical disability, 33.9% had experience of substance addiction (substance use disorder), and 29.4% had experience of incarceration for a period of 30 or more days.

- Overall, Market residents experience very high mean levels of overall satisfaction (8.55 out of 10.00), trust in staff (8.47 out of 10.00), and willingness to suggest similar housing to others with comparable needs (8.47 out of 10.00). Residents with experiences of homelessness, mental illness, disability, incarceration, and addiction experience generally high levels of mean satisfaction, trust, and suggestibility scores as other residents, with some minor variation. These findings indicates that the Market is very successful in serving the needs of residents from across multiple segments of the identified, vulnerable population, inclusive of those with co-occurrence of needs.

- Owners and operators of Market facilities provided relatively accurate estimations of mean resident satisfaction and trust scores. Utilizing linear regression analysis, the experience factors that most significantly correlated to overall resident satisfaction were access to medical care, quality of meals and snacks, and responsiveness of staff to resident complaints.

- 88.3% of residents indicated that their Market ARF or RCFE made them feel like they were part of a community, with 77.6% indicating that their Market ARF or RCFE feels like a home. 64.6% of residents interviewed indicated that they felt safer in their Market ARF or RCFE than in their most prior housing of choice, with 52.0% indicating that their current housing made them feel less lonely.

- 50.1% of residents expressed belief that they would experience homelessness without housing at their facility. Residents provided a mean score of 6.11 out of 10.00 in assessing their reduced level of confidence in the permanence of their Market ARF or RCFE housing situation, far lower than any other perceptual factor recorded.

- 89.1% of residents surveyed indicated that they have no unmet needs from their residence at a Market ARF or RCFE, with food quality and variety as the principal unmet need expressed by the remainder of residents. Only 20.4% of residents did not acknowledge any benefit from their housing and care at a Market ARF or RCFE.

- Nearly 1 in 4 residents interviewed indicated that seeking long term medical care and being unable to care for oneself are the primary reasons for residents leaving their most recent housing of choice, with similar proportions indicating that the need for others to provide care for them and having nowhere else to go were the primary reasons for their current residence in a Market ARF or RCFE.

- 45.0% of residents interviewed would prefer to graduate to another housing type or situation from a Market facility. Owners and operators of the same Market facilities believed that only 9.5% of their current residents had any desire for another type of housing, a key gap in perceptions.

- More than 2 out of 3 residents (68.7%) indicating preference to graduate to another housing type would like another opportunity to try to live on their own. 38.5% of Market residents with preference to seek another housing type identified a need for financial support to enable their move (or graduate) to their preferred housing type in the future.

- 60.3% of residents interviewed indicated being willing to engage in conditional paid work that aligned with their skills, capabilities, and interests if it didn't interfere with their public benefits. A few residents interviewed indicated that they already engaged in paid work on an informal basis.

Executive Summary: Part D
The Needs of Market Owners and Operators

- Market ARFs and RCFEs owners and operators expressed very high levels of mean satisfaction with their roles and work in the industry, providing a mean satisfaction score of 8.87 out of 10.00. However, owners and operators reported only moderately high levels of willingness to suggest facility ownership to other potential entrants at a mean score of 7.39 out of 10.00.

- Many owners and operators of facilities expressed that they feel unheard and unseen across the greater Los Angeles County communities that they serve, and feel unrecognized for the critical community housing, service, and care elements that their facilities provide to vulnerable residents.

- Owners and operators of Los Angeles County ARFs and RCFEs in the Market experience administrative burdens and bear some increased labor costs from direct participation in government benefit programs serving the identified, vulnerable population, partly from reporting and documentation processes. Participants in the Market report inconsistent levels of awareness and participation, with some expressing general confusion regarding the extensive range of government benefit programs, services, and funding streams that can be utilized to support residents.

- Wait times for vulnerable individuals (and Market facilities) seeking participation in public benefit programs to fund residence at Market ARFs and RCFEs, especially those administered by the State of California, can be lengthy, often preventing timely placement of individuals in immediate need of support, or requiring facilities to go into arrears to stabilize a resident's public funding sources.

- Only 19.4% of Market facilities indicated intention to increase bed count / resident capacity within the year after the survey, with 39.4% expressing intention to increase staff headcount.

- 22.3% of facilities, principally RCFEs, indicated not currently receiving any form of government benefits or payments to pay for resident room, board, or care, despite willingness to serve members of the identified, vulnerable population, as expressed in pre-qualification to participate in the study.

- 56.3% of Market owners and operators indicated that their main priority for government is to increase resident care funding. A significant proportion of Market ARF & RCFE owners and operators receiving Social Security Supplemental Income (SSI) benefits to reimburse room, board, and care for residents express very high levels of dissatisfaction with the current reimbursement rates, providing a mean satisfaction score of 4.07 out of 10.00.

- The COVID-19 pandemic disproportionately interfered with the ability of many facilities to take steps to address deferred maintenance and service quality improvement priorities. Enabling residents to regain amenities and services lost during the pandemic, namely activities and excursions, was a central focus for service improvement of Market ARF and RCFE owners and operators, followed by increasing staff levels to better serve residents. However, deferred maintenance is a longitudinal issue in the Market, largely relating to asset age and the non-purpose-built nature of many facilities.

- Interviews with Market ARF and RCFE owners and operators identified a need for more consistency and use of formal quality assurance processes and practices across resident services, cleaning, and maintenance for facilities. Many facilities identified a need for external funding and expert support with issues relating to facility maintenance and pest control.

- Although Market owners and operators provided generally high mean satisfaction scores regarding their experiences with government agencies at all levels (cities/municipalities, Los Angeles County agencies, and the Community Care Licensing Division), they identified a number of specific opportunities for improvement by government agencies (with detail provided in a later section of this study, further described via **Recommended Actions**).

Executive Summary: Part E
Utilizing the Market to Address Homelessness

- 10.6% of the N=625 Residents interviewed reported moving into their ARF or RCFE directly from experiencing homelessness. Based on further discussion and exploration with Market Users, an estimated 25% of all Market ARF and RCFE residents could have originated from experiencing homelessness, inclusive of indirect movements through other systems of care and custody. 47.8% of all residents of Market ARFs and RCFEs interviewed indicated experiences of homelessness at some point during their adult lives.

- Many Market facility owners and operators are likely unaware they already serve residents with experiences of homelessness. Even though all Market respondents indicate a willingness to serve people from the identified, vulnerable population, more than half (52.4%) believed they possessed no "direct experience" with people who had experienced homelessness, despite nearly half of residents from the same facilities (47.8%) reported having experience with homelessness as an adult. This finding may indicate potential gaps in owner and operator knowledge and perceptions about many residents' detailed histories and life circumstances.

- Market facility owners and operators and Market Users alike generally expressed that the general public, elected officials, and some stakeholders across systems of care have low levels of awareness regarding the critical role that ARFs and RCFEs have in serving people with experience of homelessness, amongst other segments of the identified, vulnerable population.

- Funding for Market ARFs and RCFEs to address the issue of homelessness is not seen by Market Users or owners and operators to have been prioritized in public policy discussions or in media coverage, nor has it been consistently viewed by decision makers as either permanent housing or as a critical tool to address the issue of homelessness. These policy positions, as established by key players in the Los Angeles County homelessness Continuum of Care and across the State of California, are largely believed to be originated from federal government definitions of housing, based on tenancy rights, as established by the U.S. Department of Housing and Urban Development (HUD).

- 58.7% of ARFs and RCFEs have no contact at all with any homelessness services providers in LAHSA's Coordinated Entry System (CES) serving Los Angeles County Continuum of Care. Lack of integration prevents efficient navigation, referral, and placement of more people experiencing homelessness into facilities that are already built, willing, and able, with underutilized capacity to immediately house them, if provided with commensurate funding and wraparound services to do so.

- Greater utilization of RCFEs within homelessness services policy, planning, and funding to house seniors experiencing homelessness with significant care needs is an essential component to successfully addressing this segment of the homelessness crisis, especially for those with complex, co-occurring care needs or with a lack of capability to live alone. Funding to bridge the gap between relatively-low public benefit funding levels and low- to mid- level market rates at RCFEs is needed to maximize capacity for the identified, vulnerable population with a significant supply of existing, vacant beds at Los Angeles County RCFEs.

- Mean confidence to remain in the industry as an owner or operator of a Market ARF or RCFE drops considerably over a 10-year time frame, identifying the potential for a future shortage of experienced professionals to serve as owners and operators of Market facilities in Los Angeles County, with some implications for successful integration as both an existing and expanded resource to serve people experiencing homelessness into the future.

- Funding public-private partnerships to construct new, purpose-built ARFs and RCFEs to specifically serve people experiencing homelessness was an alternative shared by many Market Users, alongside facility owners and operators, to address the continuing crisis of homelessness in Los Angeles County.

Executive Summary: Part F
Taxpayer Costs for Homeless Services vs. Market Housing

- It is estimated that the provision of services and care to people experiencing homelessness in Los Angeles County came at a direct cost to local taxpayers of more than $2.05 billion for calendar year 2022. This estimated cost to taxpayers is inclusive of expenditures by County of Los Angeles Departments, all 88 cities and municipalities located within Los Angeles County, the Los Angeles Homeless Services Authority, and the California Department of Transportation.

- The study utilized a full-time homeless individual, or "FTHI" basis to estimate per-individual costs of in-situ services and care. FTHI estimates the equivalent costs of supporting a person experiencing a period of "uninterrupted" homelessness (or in-situ, on the street, in a vehicle, in temporary / crisis / bridge accommodation, and/or without other permanent address or abode) for the duration of a calendar year (365 days). FTHI accounts for in-situ service delivery to people that experienced homelessness for only a portion of the calendar year.

- The estimated cost to Los Angeles County taxpayers of providing services and care to people experiencing homelessness during the 2022 year was $34,194, per FTHI.

- Based on estimated utilization levels of government funding across resident populations, the comparative weighted mean cost per resident, per year across all Market ARF and RCFE beds in Los Angeles County receiving any direct source of public funding in 2022 was $20,713.

- The difference between provision of in-situ homelessness services and provision of Market ARF and RCFE services, housing, and care equates to a 39.4% reduction in costs to taxpayers, per individual, over the 2022 calendar year. At an estimated mean savings of $13,481 per individual served, per year, there is significant prospective cost savings to Los Angeles County taxpayers in serving vulnerable individuals through significant enhancement of public funding to congregate, Market ARFs and RCFEs versus provision of in-situ services and care to people experiencing homelessness from a range of governmental, contracted, and nonprofit entities in Los Angeles County.

- If all 65,111 people experiencing homelessness recorded by LAHSA's January 2022 point-in-time count were housed and funded by a hypothetical, mass-scale expansion of new and existing Market ARFs and RCFEs (more than 250% of the total, current number of congregate facilities and beds in the Market), the taxpayers, government agencies, and systems of Los Angeles County could save a projected $810 million dollars per year in costs from in-situ homeless services costs (exclusive of all one-time costs to acquire and develop the congregate and program resources, and exclusive of other, methodologies to further reduce or defray individual service and program costs).

Recommended Actions are provided in detail on Page 220.

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Study Background

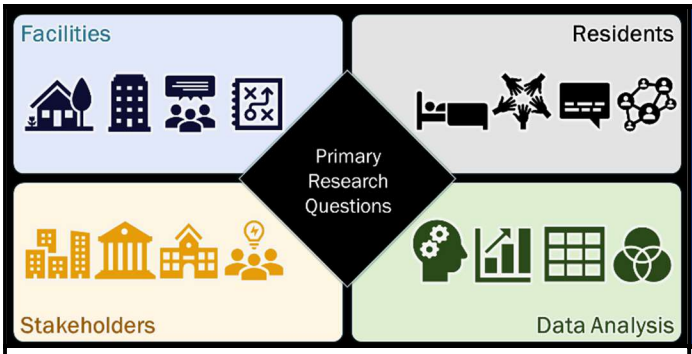
This section identifies the research study's objectives, examines the methodologies utilized, and details the multiple research samples that were drawn across Los Angeles County ARFs and RCFEs, resident populations, and Market Users to produce the research study.

Methodology

The study was designed and executed utilizing a staged, mixed-methods approach for the conduct of directed market and social research, inclusive of quantitative, qualitative, and econometric research methods across multiple research populations and sources. The identified "Market", defined by research scope, was inclusive of all Los Angeles County-based Adult Residential Facilities (ARFs) and Residential Facilities for the Elderly (RCFEs) that were willing to serve those living with mental illness, willing to serve residents 100% reliant on any form of public benefits, and did not exclusively provide services to privately-funded resident populations.

With additional research and in consultation with project sponsors and partners, it was determined that the study should exclude facilities that exclusively served residents living with developmental disabilities, as these facilities have contractual and operational obligations to the Regional Center system that would likely restrict their capabilities in serving other vulnerable populations, and these facilities were identified to have access to enhanced funding sources that differed significantly from facilities primarily focused on serving the identified, vulnerable populations that objective to this study.

Additional outreach was made with community stakeholders, thought leaders, and organizations to identify additional research questions, to maximize opportunity as a de facto, pre-funded omnibus project to further public knowledge of the Market in greater detail than prior studies. The research design process classified the primary research questions forming the objectives into specific activities, based on the identification of sources and stakeholders that were expected to provide the most valid, accurate, and relevant information:

	(Primary Research) Facility Owners & Operators	(Primary Research) Residents	(Primary Research) Stakeholders	(Secondary Research) Public Data Analysis
How many people experiencing homelessness (PEH) are moving from street encampments / permanent supportive housing / shelters to ARFs / RCFEs?	YES	YES	NO	NO
How effective are ARFs / RCFEs at keeping PEH housed long-term?	YES	YES	NO	NO
What are the costs to taxpayers of using ARFs / RCFEs instead of services provided on the street?	NO	NO	YES	YES
Do ARF / RCFE residents move to lower or higher levels of care and how often?	YES	YES	YES	NO
What is the utilization rate of the ARF / RCFE system, and how close to being fully utilized are the beds?	YES	NO	NO	YES
What appear to be the unmet needs of the unhoused population as well as those in other institutions, for ARF / RCFE beds?	NO	NO	YES	YES
What leads people to need ARF / RCFE services?	YES	YES	YES	NO

The identified research components form the basis of the design and strategy to achieve the primary research objectives:

Research Components	Methodology
Facilities Survey Interviews	Site-based survey and data collection activities across a half-census of facilities owners and operators, from a distributed sample of facilities across Los Angels County, inclusive of Service Planning Areas, facility size (bed count), and license category (ARF / RCFE)
Resident Survey Interviews (Parts A and B)	Face-to-face surveys with a demographically-representative sample of ARF & RCFE residents, inclusive of gender, racial & ethnic self-identity, age group, and health & disability factors (substance use disorder, serious mental illness, and physical disability).
	In-depth qualitative research interviews with a subsample of ARF/RCFE residents who have transitioned from homelessness to communicate their stories regarding their lived experiences to validate and further inform research insights.
Stakeholder Qualitative Interviews	Executive interviews with key decision makers at agencies from across Los Angeles County supportive housing providers, the homelessness services continuum of care, and other agencies with direct interface in addressing the service needs of the Los Angeles County unhoused population.
Data Analysis	Collection, analysis, and evaluation of regulatory, public, and nonprofit data sources pertaining to facilities, resident populations, movements between housing types, public costs pertaining to care provision, and performance in serving the population, as identified and available.

The following deviations from the original research design were executed based on constraints encountered during the conduct of fieldwork for the study:

1) **Reduction in Facilities Sample Size**
The original sample size sought for the Facilities (owner/operator) segment was reduced from N=500 to N=353, due to the size of the universe of facilities serving the identified, vulnerable populations being smaller than originally hypothesized (at N=750, not N=1,000). The adjusted sample is believed to deliver an effective half-census of the Market in service to the identified, vulnerable populations.

2) **Study Timeframe**
Originally designed as a 7- to 8-month research endeavor, due to the re-emergence of pandemic safety conditions during field research and other operational factors, the research and study production timeline extended to slightly more than 12 months.

3) **Merger of Resident Part A and Part B Research**
Due to budgetary and time constraints driven by operational difficulties experienced during an extended, COVID-19 pandemic-modified timeline for fieldwork, the Residents (Part B) segment of fieldwork activities was merged with Residents (Part A), with additional qualitative feedback elicited from all resident respondents during field research survey interviews.

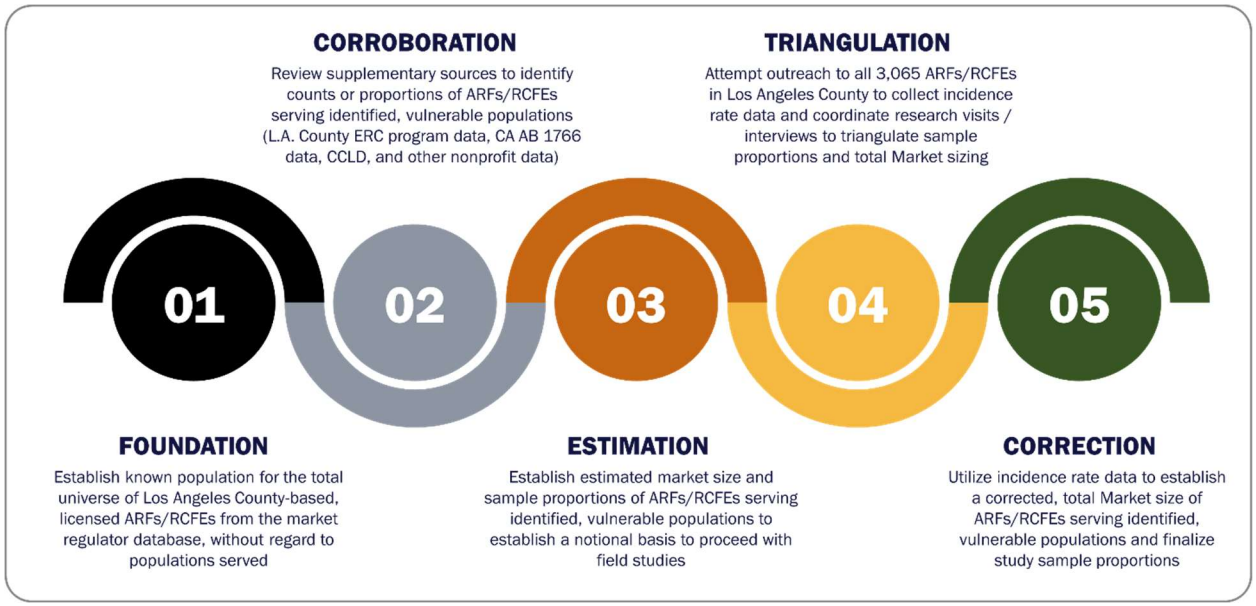
Sample Design Process

The facilities that serve as the population for the research study were licensed, Los Angeles County-based Adult Residential Facilities (ARFs) and Residential Facilities for the Elderly (RCFEs) that expressed willingness to serve those living with mental illness, residents reliant on public benefits, such as SSI, SSDI, the Los Angeles County Enhanced Residential Care program funding, and other public benefits, and/or serving residents at risk of homelessness who need greater levels of daily support and protective supervision.

As one of the first research studies to attempt to draw a balanced sample across both facilities and the residents of Los Angeles County ARFs and RCFEs serving vulnerable populations, the research team had envisaged that more precise demographic data regarding the exact composition of the ARF and RCFE populations could be obtained prior to field studies, namely with cooperation of the market regulator, the California Department of Health Care Services (DHCS) Community Care Licensing Division (CCLD), and/or other public agencies. In practice, the majority of market and social research studies have the benefit of existing census or demographic data from which to draw reasonably, well-informed sample size guidelines for the purposes of pre-establishing sample validity and proportions for survey collection. Unfortunately, baseline information about the specific service characteristics of facilities or the demography of the populations they serve was not available for use by the study. The study presents consolidated demographic and service information about these facilities in a public context, possibly for the first time.

Delivering the Facilities and Resident work of the research study with a valid and reliable research sample size was an implicit objective for the study, with intent to serve and inform governmental, nonprofit, and community stakeholders as to how substantial funding could potentially be directed to ARFs and RCFEs serving the identified, vulnerable population, better integrate these facilities into the homelessness CoC (amongst other systems of care), as well as inform decision makers with evidence to evaluate policies to better preserve and sustain this Market of facilities. The original target of the facilities research sample design was to deliver an effective, half-census of ARFs and RCFEs serving the identified, vulnerable populations. TFO engaged a range of agencies and nonprofits, collected and analyzed multiple datasets, and consulted subject matter experts to gain access to any data or insights regarding any means of identifying facilities that served specific populations within research scope.

As no census data for the demographic compositions of ARFs and RCFE resident populations or the specific services delivered existed for Los Angeles County or California facilities, notional sample estimates were prepared prior to fieldwork, based on limited data, to enable the commencement of field studies. Notional samples for both Facility and Resident surveys were further modified during research, triangulated, and corrected utilizing incidence rate data from outreach activities across the entire pre-qualified population of 3,065 licensed, Los Angeles County-based ARFs and RCFEs, as shown in the following process diagram:



The facility sample size was modified with respect to the following factors that were encountered in the conduct of facility coordination and outreach activities to support field studies:

1) Greater than anticipated levels of ARFs in exclusive and non-exclusive service to the Regional Center system serving individuals living with developmental disabilities;

2) Greater than anticipated levels of RCFEs in exclusive service to privately funded or self-funded residents;

3) Congregate facility and resident access issues related to the continuance of the COVID-19 pandemic during field studies, with the additional, unexpected emergence of the epidemic of MPOX;

4) Lower than anticipated levels of participation from facilities owners and operators, with many expressing hesitance due to previous research experiences, or having general distrust of any research-based activities, reducing levels of participation.

Research Sample Sizes

Field research interviews with owners, operators, and residents of Los Angeles County ARFs and RCFEs willing to serve the identified, vulnerable population (referred to herein as the "Market") were carried out between July 2022 and November 2022. Executive interviews with stakeholders at public agencies and nonprofits were carried out from December 2022 through March 2023.

Facility Owners & Operators (N=353)

- ARF & RCFE Owners & Operators currently serving, or willing to serve, identified, vulnerable populations
- In-person and telephone interviews
- Computer-assisted interviews
- 40 to 60 minutes each
- Margin of error: +/- 3.83% at the 95% confidence level

Residents (N=625)

- Individuals housed at ARFs & RCFEs currently serving or willing to serve, identified, vulnerable populations
- In-person interviews only, as per Research Standards
- Computer-assisted interviews
- 25 to 35 minutes each
- Margin of error: +/- 3.80% at the 95% confidence level

Stakeholders (N=40)

- Public agency leaders, nonprofit leaders, and other Market Users across systems of service and care
- Telephone interviews only
- Executive interviews with qualitative discussion guides
- 30 to 60 minutes each
- Margin of error: NaN

Images: RODNAE Productions on Pexels and: www.dreamstime.com

Facilities Sample Summary

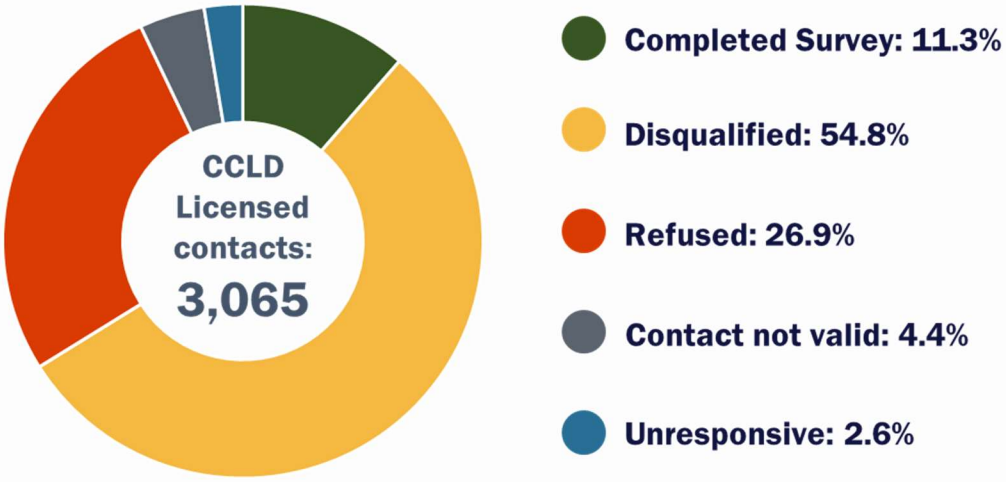
Surveys were conducted in-person and by telephone with N=353 owners and/or operators of licensed ARFs and RCFEs across Los Angeles County who identified their facilities as currently serving, or willing to serve the identified, vulnerable population (the "Market").

Table 1.1: Facility Sample Summary (N=353)			
Facility License Class	ARF	RCFE	ALL
Count Achieved	136	217	353
Proportions Achieved	*38.5%*	*61.5%*	*100.0%*
Facility Size (Bedcount)	ARF	RCFE	ALL
Count Achieved (<6 BEDS)	55	149	204
Proportions Achieved (<6 BEDS)	*15.6%*	*42.2%*	*57.8%*
Count Achieved (7-60 BEDS)	49	26	75
Proportions Achieved (7-60 BEDS)	*13.9%*	*7.4%*	*21.2%*
Count Achieved (>61 BEDS)	32	42	74
Proportions Achieved (>61 BEDS)	*9.1%*	*11.9%*	*21.0%*
Service Planning Area (SPA)	ARF	RCFE	ALL
Count Achieved (SPA 1 - Antelope Valley)	3	23	26
Proportions Achieved (SPA 1 - Antelope Valley)	*2.2%*	*10.6%*	*7.4%*
Count Achieved (SPA 2 - San Fernando Valley)	13	64	77
Proportions Achieved (SPA 2 - San Fernando Valley)	*9.6%*	*29.5%*	*21.8%*
Count Achieved (SPA 3 - San Gabriel Valley)	21	62	83
Proportions Achieved (SPA 3 - San Gabriel Valley)	*15.4%*	*28.6%*	*23.5%*
Count Achieved (SPA 4 - Metro Los Angeles and Center Cities)	28	7	35
Proportions Achieved (SPA 4 - Metro Los Angeles and Center Cities)	*20.6%*	*3.2%*	*9.9%*
Count Achieved (SPA 5 - West Los Angeles and West Cities)	6	8	14
Proportions Achieved (SPA 5 - West Los Angeles and West Cities)	*4.4%*	*3.7%*	*4.0%*
Count Achieved (SPA 6 - South Los Angeles and South Cities)	25	5	30
Proportions Achieved (SPA 6 - South Los Angeles and South Cities)	*18.4%*	*2.3%*	*8.5%*
Count Achieved (SPA 7 - East Los Angeles and Southeast Cities)	11	10	21
Proportions Achieved (SPA 7 - East Los Angeles and Southeast Cities)	*8.1%*	*4.6%*	*5.9%*
Count Achieved (SPA 8 - South Bay and Coastal Cities)	29	38	67
Proportions Achieved (SPA 8 - South Bay and Coastal Cities)	*21.3%*	*17.5%*	*19.0%*
Facility Respondent Role	ARF	RCFE	ALL
Count Achieved (Operator only)	79	114	193
Proportions Achieved (Operator only)	*40.4%*	*45.2%*	*43.3%*
Count Achieved (Owner and Operator)	55	98	153
Proportions Achieved (Owner and Operator)	*58.1%*	*52.5%*	*54.7%*
Count Achieved (Owner only)	2	5	7
Proportions Achieved (Owner only)	*1.5%*	*2.3%*	*2.0%*

The proposed sample of ARFs to take part in the study was initially anticipated to be between 56.0% and 60.0%, greater than the proportion or count of RCFEs expected to participate. During early coordination of research works with ARF owners and operators, the research team encountered significant proportions of ARFs that were exclusively contracted to the Regional Center System serving the developmentally disabled community, which required significant modification to sample proportions. This information was later corroborated by a special information request kindly furnished by the market regulator, the Community Care Licensing Division (CCLD) of the California Department of Social Services (CDSS). Data furnished by CCLD indicated that across select Service Planning Areas within Los Angeles County, more than 90% of licensed ARFs were contracted to provide exclusive service to the Regional Centers and their consumers.

The original, notional distribution of proportions for the sample based on facility license class was based on a computation of the combined means of the total estimated population of residents (total licensed beds) and the total number of facilities projected to be in the Market, based on confidential data furnished as a result of prior research directed by California Health and Safety Code Section 1507.4 relating to residential facilities (formerly and colloquially, AB 1766 – Bloom)[2]. During field studies, it was determined that incidence rates for Market participation for ARFs and RCFEs in service to identified, vulnerable population as the study focus were vastly different from the CA HSC-directed dataset[3], so the facilities sample was modified based on what was encountered via outreach and supplemental research into all 3,065 Los Angeles County licensed facilities.

The research study utilizes analysis and projections from **incidence rate data** from attempted outreach to all 3,065 facilities in Los Angeles County along with Facilities survey data to determine metrics such as total "Market" size, bed capacity, and utilization rates. The incidence rates encountered are shown below:



Proportions for segmentation based on the size, or licensed bed count, of facilities were originally proposed based on splits of facilities serving 5 or fewer beds, 6 to 20 beds, and 21 beds or more, based on analysis of the distribution of facility size across the entire population of more than 3,065 licensed facilities serving Los Angeles County. However, during the pilot of the survey instrument and through initial data analysis, it was found that the original segments planned did not adequately describe enough differences between facilities of different size segments as originally intended. These proportions were also skewed by the presence of many Regional Center-contracted ARFs serving resident populations of fewer than 6 beds. The facility size variable was re-segmented to current ranges which better described observable differences amongst the population of ARF/RCFE facilities willing to serve the identified, vulnerable population.

[2] https://legiscan.com/CA/text/AB1766/id/2210273/California-2019-AB1766-Chaptered.html
[3] Prior data analysis conducted by The Future Organization into the AB1766 dataset in 2021 produced for ARFs and RCFEs in Los Angeles County had identified that the dataset could serve as a valid "half-census" of all County-based facilities, but without additional segmentation and qualification to account for service to the identified, vulnerable population, it was found to be unsuitable for use as a baseline for the study.

Proportions for the distribution of the facility sample by Los Angeles County Service Planning Area (SPA) remained largely unchanged from notional levels as originally cross-referenced with CCLD databases, with exception for minor change in distribution based on lower or greater than anticipated numbers of facilities serving the identified, vulnerable population on a localized basis. As there is no extant dataset or available census by which to perform confirmatory analysis of this sample distribution to further validate it, the distribution achieved from field studies is reasonable and nominal for the purposes of demonstrating any significant differences between populations of facilities based on SPA distribution.

Resident Sample Summary

N=625 resident surveys were conducted in-person, on-site at licensed facilities across Los Angeles County at ARFs and RCFEs identifying as currently serving or willing to serve the identified, vulnerable population (the "Market").

Table 1.2: Resident Sample Summary (N=625)			
Resident Facility License Class	ARF	RCFE	ALL
Count Achieved	337	288	625
Proportions Achieved	53.9%	46.1%	100.0%
Resident Facility Size (Bedcount)	ARF	RCFE	ALL
Count Achieved (<6 BEDS)	45	96	141
Proportions Achieved (<6 BEDS)	*13.3%*	*33.3%*	*22.6%*
Count Achieved (7-60 BEDS)	99	58	157
Proportions Achieved (7-60 BEDS)	*29.4%*	*20.1%*	*25.1%*
Count Achieved (>61 BEDS)	193	134	327
Proportions Achieved (>61 BEDS)	*57.3%*	*46.6%*	*52.3%*
Resident Age Range	ARF	RCFE	ALL
Count Achieved (18 to 54 years of age)	215	33	248
Proportions Achieved (18 to 54 years of age)	*63.8%*	*11.5%*	*39.7%*
Count Achieved (18 to 54 years of age)	68	26	94
Proportions Achieved (18 to 54 years of age)	*20.2%*	*9.0%*	*15.0%*
Count Achieved (18 to 54 years of age)	53	227	280
Proportions Achieved (18 to 54 years of age)	*15.7%*	*78.8%*	*44.8%*
Count Achieved (Declined to state)	1	2	3
Proportions Achieved (Declined to state)	*0.3%*	*0.7%*	*0.5%*
Resident Gender Identity	ARF	RCFE	ALL
Count Achieved (Female)	116	140	256
Proportions Achieved (Female)	*34.4%*	*48.7%*	*40.9%*
Count Achieved (Male)	220	147	367
Proportions Achieved (Male)	*65.3%*	*51.0%*	*58.7%*
Count Achieved (Transgendered)	0	1	1
Proportions Achieved (Transgendered)	*0.0%*	*0.3%*	*0.2%*
Count Achieved (Declined to state)	1	0	1
Proportions Achieved (Declined to state)	*0.3%*	*0.0%*	*0.2%*

Table 1.3: Resident Sample Summary, continued (N=625)			
Resident Racial Identity (MR)	ARF	RCFE	ALL
Count Achieved (White/Caucasian)	133	161	294
Proportions Achieved (Female)	*39.5%*	*55.9%*	*47.0%*
Count Achieved (Black/African American)	110	52	162
Proportions Achieved (Male)	*32.6%*	*18.1%*	*25.9%*
Count Achieved (Hispanic/Latino/Latinx)	68	37	105
Proportions Achieved (Transgendered)	*20.2%*	*12.8%*	*16.8%*
Count Achieved (Asian/Asian American)	32	35	67
Proportions Achieved (Declined to state)	*9.5%*	*12.2%*	*10.7%*
Count Achieved (Native American/Alaska Native)	11	9	20
Proportions Achieved (Female)	*3.3%*	*3.1%*	*3.2%*
Count Achieved (Middle Eastern)	2	1	3
Proportions Achieved (Male)	*0.6%*	*0.3%*	*0.5%*
Count Achieved (Declined to state)	2	4	6
Proportions Achieved (Declined to state)	*0.6%*	*1.4%*	*1.0%*
Key Study Factors	ARF	RCFE	ALL
Count Achieved (Living with a diagnosed mental illness)	287	97	384
Proportions Achieved (Living with a diagnosed mental illness)	*74.7%*	*25.3%*	*61.4%*
Count Achieved (Experience of homelessness as an adult)	204	95	299
Proportions Achieved (Experience of homelessness as an adult)	*68.2%*	*31.8%*	*47.8%*
Count Achieved (Living with a physical disability)	135	189	324
Proportions Achieved (Living with a physical disability)	*41.7%*	*58.3%*	*51.8%*
Count Achieved (Experience of incarceration over 30 days)	140	44	184
Proportions Achieved (Experience of incarceration over 30 days)	*76.1%*	*23.9%*	*29.4%*
Count Achieved (Experience with substance addiction)	142	70	212
Proportions Achieved (Experience with substance addiction)	*67.0%*	*33.0%*	*33.9%*

Comparable proportions of ARF and RCFE residents were intended for notional quotas established based on facility license class, but the research team encountered lower proportions of residents at RCFEs that were capable of participating in the research due to age-related health factors, such as communication impairments and memory care needs, and the proportion of ARF residents was increased. The notional quota for residents based on facility size ranges was intended to be proportional to the maximum resident capacity housed by each size category of facility within the Market's composition across both ARFs and RCFEs.

Notional quotas for residents identifying as having Male or Female gender identity were derived from calculations of means taken from the LAHSA 2020 Homeless Count and US Census Bureau 2020 Decennial Census, with weight added to the LAHSA figures due to the increased incidence rates of Male-gendered individuals reported with experience of homelessness. There was a low incidence rate of respondents with Other Gender Identities (Transgendered, but not identifying as Male or Female, and Non-Binary Gendered) respondents in the LAHSA 2020 Homeless Count, with no coverage from the US Census Bureau 2020 Decennial Census data. The field study attempted to establish accurate gender identity representation within facility populations, and respectfully captured all gender identity information provided, verbatim, provided by respondents. However, this data could not be used for study segmentation purposes due to a low sample size that could potentially be used to identify individual respondents across sensitive questions.

The segmentation of age groups was originally envisaged to be comparable to that of the LAHSA Greater Los Angeles Homeless Count to ensure portability and comparability of segmentation. However, as no ARF or RCFE is licensed to serve individuals under the age of 18, this population was removed from sample consideration. Further, a very low number of residents were encountered from the 18 to 24 age group within facilities, so this group was merged with the 25 to 54 age group. The 55 to 61 age group was retained, as preliminary analysis demonstrated key differences in perceptions and experiences from this population in comparison to younger or older cohorts, also effectively serving as a "transitional age" between ARF and RCFE populations. Another effect of facility sample change, greater numbers of research interviews with RCFEs in the Market increased proportions for the 62+ age group within resident age sampling, coupled with residents in this age group that continue to be housed within ARFs under specific exemptions.

The field study team observationally established that the population of facilities serving identified, vulnerable populations did not have similar compositions of racial identity among its residents in comparison to the LAHSA 2020 Homeless Count or the 2020 Decennial Census for Los Angeles County. Greater than anticipated proportions of residents identifying as White / Caucasian were generally observed at RCFEs, and significantly lower than expected proportions of residents identifying as Latino/Latinx were observed across both ARFs and RCFEs. However, the observed proportions of residents identifying as Black / African American largely matched the expected means of estimates established from LAHSA and U.S. Census Bureau datasets.

Although no minimum sample criteria were established for residents identifying as Native American / Alaskan Native, Pacific Islander / Native Hawaiian, and Middle Eastern were established, racial identity data for individuals of these groups was collected, and is presented alongside segmentation wherever possible. A reference note is provided to indicate where this data is valid for consideration of statistical significance. To provide more accurate levels of representation for individuals who identify as possessing more than one racial identity, residents were enabled to provide multiple answers corresponding to their self-identified racial identity, which was treated as a multiple response (MR) variable for segmentation and analytics purposes.

A series of notional, minimum quotas (at 15% of total, minimum sample) were established based on the experiential characteristics of residents in the sample, pertaining to key study factors. These were established in consultation with subject matter experts serving the vulnerable, identified population, and in consideration of the need for the research to understand the specific experiences of these groups in relation to other residents:

- Experience of living with a diagnosed mental illness
- Experience of homelessness as an adult
- Experience of living with a physical disability
- Experience of incarceration for a period of greater than 30 days'
- Experience with addiction to drugs and/or alcohol (substance use disorder)

As the incidence rate for all categories of key study factors far exceeded notional sample requirements, the total resident research sample of N=625 was deemed to be valid and sufficient for consideration of how the perceptions of residents with these experiences differ from those of other residents.

Additional Resident Sample Reference

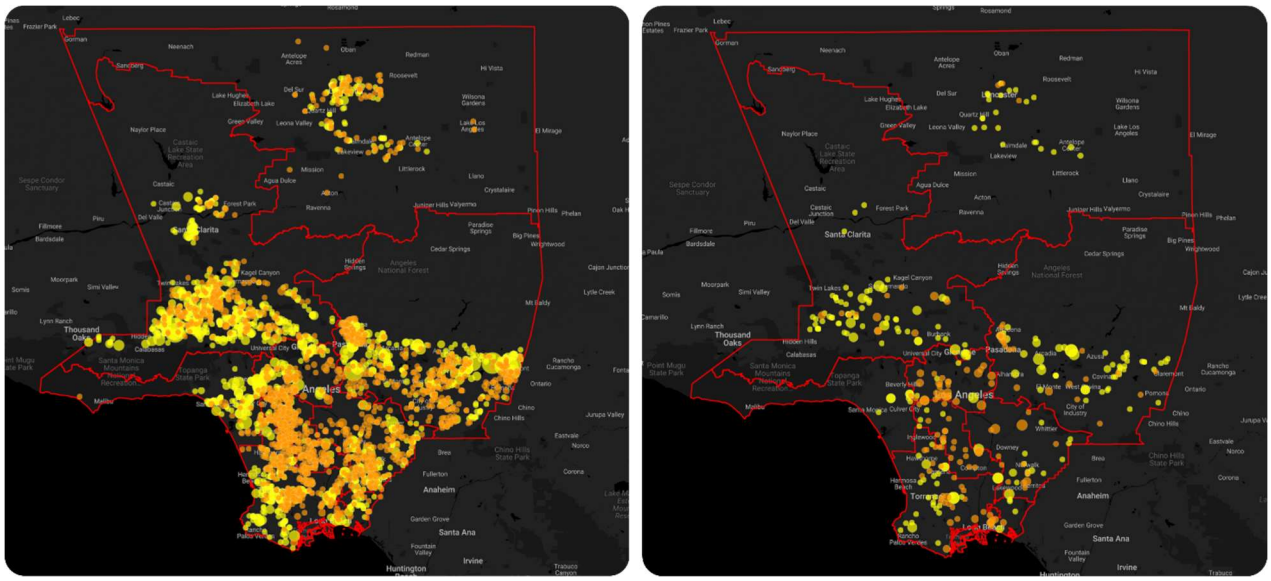
The following recorded Resident survey factors have not been utilized for segmentation or analysis in the study, as the following factors yielded comparable results, inconclusive utility, or provided insufficient quality of sample for analytics purposes in comparison to other factors:

Table 1.4: Additional Resident Sample Characteristics (N=625)			
Prior Service in U.S. Armed Forces	ARF	RCFE	ALL
Count Achieved (Prior Service in U.S. Armed Forces)	41	52	93
Proportions Achieved (Prior Service in U.S. Armed Forces)	*12.2%*	*18.1%*	*14.9%*
Spanish or Hispanic Ethnic Identity	ARF	RCFE	ALL
Count Achieved (Spanish or Hispanic Ethnic Identity)	85	42	127
Proportions Achieved (Spanish or Hispanic Ethnic Identity)	*25.2%*	*14.6%*	*20.3%*
Preference of Daily Language Other than English	ARF	RCFE	ALL
Count Achieved (Preference of Daily Language Other than English)	20	17	37
Proportions Achieved (Preference of Daily Language Other than English)	*5.9%*	*5.9%*	*5.9%*
Highest Level of Educational Attainment	ARF	RCFE	ALL
Count Achieved (Less than 8th grade or equivalent)	11	4	15
Proportions Achieved (Less than 8th grade or equivalent)	*3.3%*	*1.4%*	*2.4%*
Count Achieved (Some high school, not completed)	83	40	123
Proportions Achieved (Some high school, not completed)	*24.6%*	*13.9%*	*19.7%*
Count Achieved (High school diploma / graduate / G.E.D.)	150	96	246
Proportions Achieved (High school diploma / graduate / G.E.D.)	*44.5%*	*33.3%*	*39.4%*
Count Achieved (2-year college degree or diploma)	47	59	106
Proportions Achieved (2-year college degree or diploma)	*13.9%*	*20.5%*	*17.0%*
Count Achieved (4-year college or university degree)	35	75	110
Proportions Achieved (4-year college or university degree)	*10.4%*	*26.0%*	*17.6%*
Count Achieved (Graduate degree (M.A., M.S., J.D., Ph.D., or equiv.)	11	12	23
Proportions Achieved Graduate degree (M.A., M.S., J.D., Ph.D., or equiv.)	*3.3%*	*4.2%*	*3.7%*
Count Achieved (Declined to state)	0	2	2
Proportions Achieved (Declined to state)	*0.0%*	*0.7%*	*0.3%*
Service Planning Area (SPA)	ARF	RCFE	ALL
Count Achieved (SPA 1 - Antelope Valley)	1	14	15
Proportions Achieved (SPA 1 - Antelope Valley)	*0.3%*	*4.9%*	*2.4%*
Count Achieved (SPA 2 - San Fernando Valley)	59	75	134
Proportions Achieved (SPA 2 - San Fernando Valley)	*17.5%*	*26.0%*	*21.4%*
Count Achieved (SPA 3 - San Gabriel Valley)	44	118	162
Proportions Achieved (SPA 3 - San Gabriel Valley)	*13.1%*	*41.0%*	*25.9%*
Count Achieved (SPA 4 - Metro Los Angeles and Center Cities)	89	10	99
Proportions Achieved (SPA 4 - Metro Los Angeles and Center Cities)	*26.4%*	*3.5%*	*15.8%*
Count Achieved (SPA 5 - West Los Angeles and West Cities)	12	15	27
Proportions Achieved (SPA 5 - West Los Angeles and West Cities)	*3.6%*	*5.2%*	*4.3%*
Count Achieved (SPA 6 - South Los Angeles and South Cities)	34	4	38
Proportions Achieved (SPA 6 - South Los Angeles and South Cities)	*10.1%*	*1.4%*	*6.1%*
Count Achieved (SPA 7 - East Los Angeles and Southeast Cities)	27	15	42
Proportions Achieved (SPA 7 - East Los Angeles and Southeast Cities)	*8.0%*	*5.2%*	*6.7%*
Count Achieved (SPA 8 - South Bay and Coastal Cities)	71	37	108
Proportions Achieved (SPA 8 - South Bay and Coastal Cities)	*21.1%*	*12.8%*	*17.3%*

Licensed Facility, Sample, and Capacity Visualizations

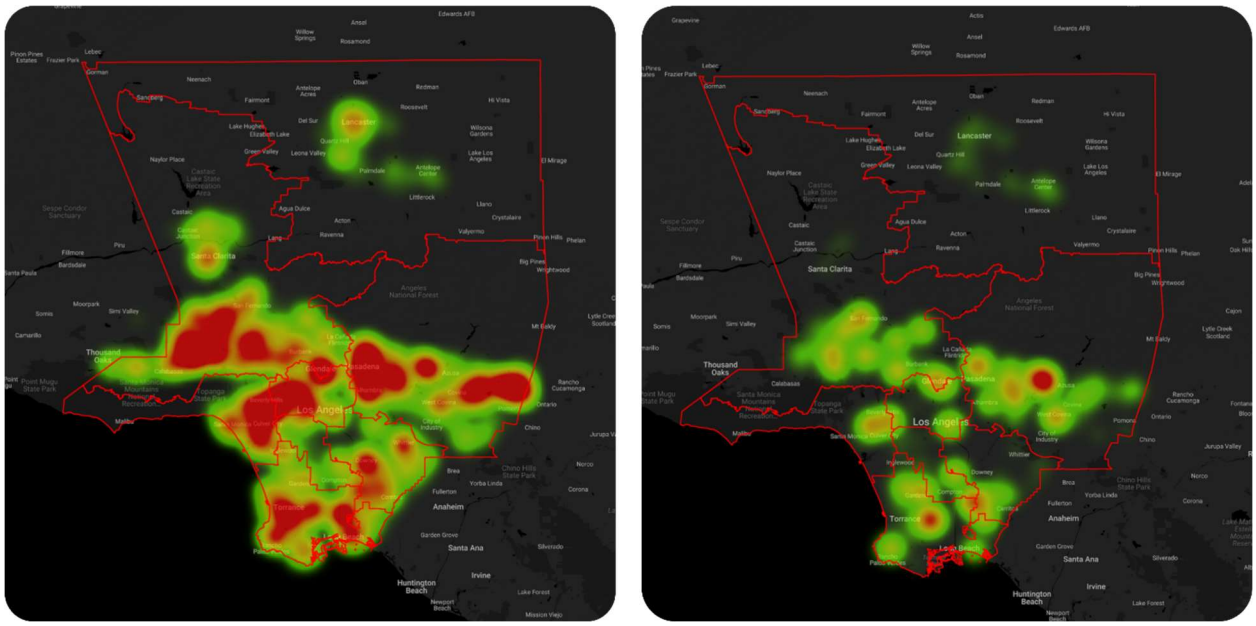
The following visualizations show the geographic distribution and capacity of the 3,065 ARFs and RCFEs in Los Angeles County identified from CCLD databases at the time of the study, alongside the sample engaged for this study. Red outlines indicate Los Angeles County jurisdictional boundaries and Service Planning Areas (SPAs).

Los Angeles County Facility Geomapping *(licensed ARFs in orange, and licensed RCFEs in yellow)*
(left) Approximate locations for all, 3,065 CCLD-licensed facilities in Los Angeles County in during the study; (right) Approximate locations of facilities serving the identified, vulnerable populations engaged by the study.

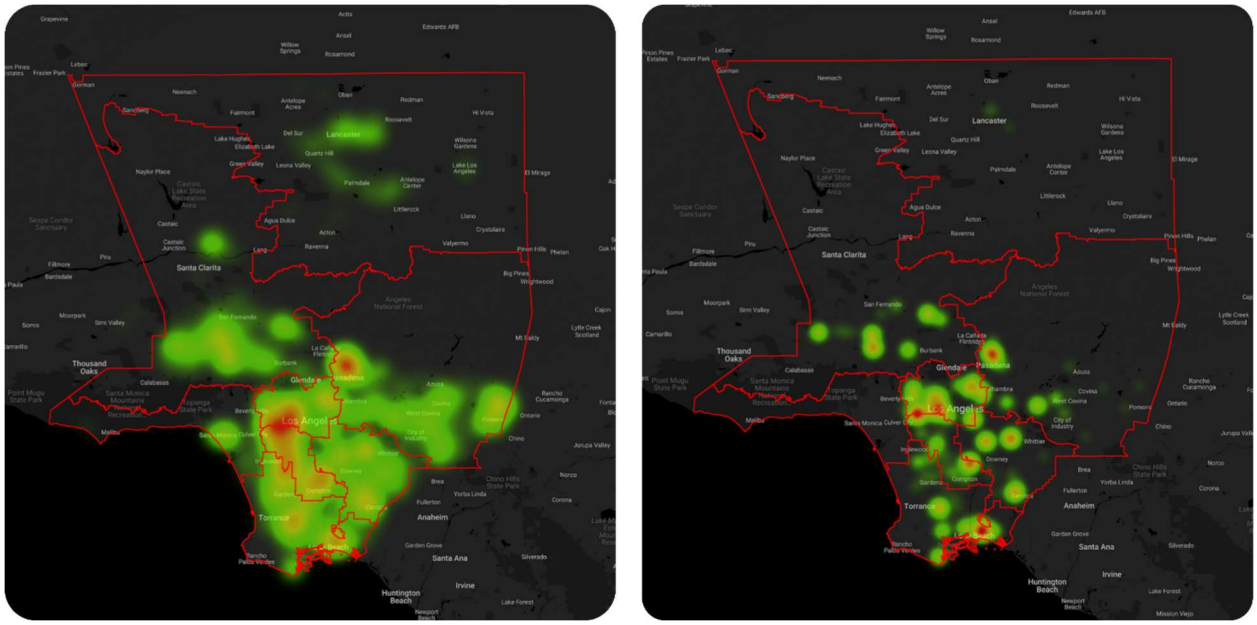


The following visualizations illustrate the distribution of total resident capacity in Los Angeles County by all licensed ARFs/RCFEs in service to any population, in comparison to the distribution of total resident capacity in Los Angeles County delivered by facilities participating that serve the identified, vulnerable populations at focus in this study, referred to herein as "the Market":

ARF Capacity Heatmaps:*(left) All CCLD-licensed, Los Angeles County ARFs, weighted by total bedcount; (right) ARFs serving the identified, vulnerable population engaged by this study, weighted by total bedcount.*



RCFE Capacity Heatmaps:*(left) All CCLD-licensed Los Angeles County RCFEs, weighted by total bedcount; (right) RCFEs serving the identified, vulnerable population engaged by this study, weighted by total bedcount.*



2.0

Image: www.dreamstime.com

Market Sizing. Capacity, and Utilization

A critical path task for the study was to develop highly-detailed estimations of the number of facilities, their capacity, and use by the identified, vulnerable population: assuring study sample validity and aiding governmental, nonprofit, and other Market Users of Los Angeles County ARFs and RCFEs in developing a more detailed understanding of Market composition and capabilities.

Defining the Market Serving the Identified, Vulnerable Population

N=750
THE MARKET

The total number of facilities in Los Angeles County that are willing to serve or are already serving the identified, vulnerable population, based on surveys, analysis, and incidence rate data from direct outreach.

MARKET SIZING PROCESS STEPS	ARF	RCFE	ALL
ALL LICENSED ARF & RCFE FACILITIES IN LOS ANGELES COUNTY during the study period (from July 2022 through October 2022)	1,544 (100.0%)	1,521 (100.0%)	3,065 (100.0%)
Facilities in Los Angeles County, identified by outreach, analysis, and incidence rate estimation, that are **NOT SERVING OR WILLING TO SERVE** the identified, vulnerable population	1,260 (81.6%)	1,055 (69.4%)	2,315 (75.5%)
Facilities identified by survey participation that indicated they are **WILLING TO SERVE OR ARE ALREADY SERVING** the identified, vulnerable population	136 (8.8%)	217 (14.3%)	353 (11.5%)
✚	✚	✚	✚
Projected remainder of Los Angeles County facilities, established from analysis of incidence rates, estimated to be **WILLING TO SERVE OR ARE ALREADY SERVING** the identified, vulnerable population, but **NOT SURVEYED**	148 (9.6%)	249 (16.3%)	397 (13.0%)
⬇	⬇	⬇	⬇
THE MARKET Projected total number of Los Angeles County facilities that are estimated to be **WILLING TO SERVE OR ARE ALREADY SERVING** the identified, vulnerable population	n=284 (18.4%)	n=466 (30.6%)	N=750 (24.5%)

- Based on public data sourced from CCLD, the ARF and RCFE market regulator, there were 3,065 qualified and actively-licensed facilities present within the CCLD database for Los Angeles County ARFs and RCFEs during the field study period (July 2022 through November 2022), providing a total capacity of 56,660 licensed beds in Los Angeles County.[4]

- The N=353 ARFs and RCFEs serving the identified, vulnerable populations that were interviewed and participated in the study have a licensed capacity of 11,783 beds.

- Based on the qualified survey participation of N=353 ARFs and RCFEs, coupled with incidence rate data collected from outreach calls and desk research conducted for coordination of the study across the total population of 3,065 CCLD-licensed facilities, there is an estimated population of N=750 facilities in Los Angeles County that serve the identified, vulnerable populations of residents, with an estimated licensed capacity of 25,035 beds, within a +/- 3.80% margin of error.

- For brevity, the aforementioned estimate of N=750 licensed, Adult Residential Facilities and Residential Facilities for the Elderly serving the identified, vulnerable populations will be referenced within this study as the “Market”.

[4] This number is inclusive of facilities that held probationary and provisional licenses that had not been fully resolved during this period,

Market Underutilization (Vacancy) Rates

Calculations of vacancy rates were derived from a facility's current population of residents as reported by owners and/or operators of ARFs and RCFEs, divided by a facility's total, licensed bed count (also confirmed from the CCLD licensing database).

FQ6. "To confirm, what is your total licensed bed count?"
FQ7. "How many residents do you currently have living here?"

FACILITY OWNERS & OPERATORS (N=353)

Table 2.1: Underutilization, by License Class	ARF	RCFE	ALL
	16.5%	31.4%	25.6%

ARFs that serve the identified, vulnerable populations reported mean vacancy / underutilization rates of 16.5%, significantly lower than their RCFEs counterparts, which reported mean vacancy / underutilization rates of 31.4%.

RCFEs possess generally greater proportions of vacancies and underutilized bed capacity in their facilities in comparison to ARFs, without examination of factors such as facility size, location, and specific populations served, among others. Anecdotally, RCFE owners and/or operators serving individuals from identified, vulnerable populations may opt to reserve capacity to serve privately- or self-funded individuals, which aids these facilities in maintaining business sustainability, stability, and profitability.

Table 2.2: Underutilization, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	20.0%	21.1%	27.4%

Facilities licensed to serve populations of 61 or more beds have significantly greater proportions of vacancies, in comparison to smaller facility sizes.

Table 2.3: Underutilization, by License Class and Facility Size	ARF	RCFE
≤ 6 BEDS	25.8%	18.2%
7–60 BEDS	13.6%	33.4%
≥ 61 BEDS	16.9%	33.1%

ARFs licensed to serve 6 beds or less have significantly greater proportions of vacancies and underutilization in comparison to larger ARFs. Larger RCFEs serving either 7 to 60 licensed beds or 61 or more licensed beds have the greatest proportions of vacancy / underutilization rates in comparison to all other facilities.

Table 2.4: Underutilization, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	36.8%	22.8%	19.5%	14.4%	25.8%	27.4%	15.5%	18.4%

Licensed ARFs and RCFEs in SPAs 1 (Antelope Valley), SPA 5 (West Los Angeles and West Cities), and SPA 6 (South Los Angeles and South Cities) report greater proportions of vacancies and underutilization of licensed beds than facilities serving other Los Angeles County Service Planning Areas. Facilities serving SPA 4 (Metro Los Angeles and Center Cities) and SPA 7 (East Los Angeles and South East Cities) report significantly lower vacancy / underutilization rates than those located in other SPAs.

Table 2.5: Underutilization, by SPA & License Class	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
ARF	47.2%	16.5%	10.8%	16.1%	23.7%	27.9%	13.4%	17.8%
RCFE	35.5%	24.0%	22.5%	7.5%	27.4%	24.8%	17.8%	18.9%

Further segmenting vacancy/underutilization rates by SPA and license class, ARFs and RCFEs in SPA 1 (Antelope Valley) display significantly greater proportions of availability than facilities of either class in other SPAs. One potential explanation for this difference is the large, relative distance of SPA 1 and its facilities from other communities within Los Angeles County. ARFs serving SPA 3, SPA 4, and SPA 7 reported significantly lower vacancy/underutilization rates compared to other SPAs, with a similar finding for RCFEs located in SPA 4.

Table 2.6: Underutilization, by SPA and Facility Size	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
≤ 6 BEDS	35.2%	20.8%	11.6%	12.8%	17.9%	36.5%	12.5%	15.5%
7–60 BEDS	56.2%	21.5%	23.5%	13.5%	25.0%	15.3%	16.0%	20.8%
≥ 61 BEDS	NaN*	33.0%	30.5%	17.6%	35.3%	19.2%	35.0%	23.0%

*No facilities with 61 or more licensed beds were qualified or agreed to take part in the research from SPA 1

After correlating that the previous finding SPA 1 affects facilities of all sizes present within the service catchment, facilities in SPA 6 (South Los Angeles) licensed to serve 6 beds or less were reported significantly greater vacancy rates than other 6 bed facilities located in other SPAs. 61 or more licensed bed facilities in SPA 2 (San Fernando Valley), SPA 5 (West Los Angeles and West Cities), and SPA 7 (East Los Angeles and South East Cities) also reported significantly greater rates of vacancy/underutilization than most comparably-sized facilities located in other SPAs. Significantly lower proportions of vacancies and underutilization were detected amongst 6 or fewer bed licensed facilities located in SPA 3 (San Gabriel Valley), SPA 4 (Metro Los Angeles and Center Cities), and SPA 7 (East Los Angeles and South East Cities), and SPA 8 (South Bay and Coastal Cities), as well as for 7 to 60 licensed bed facilities serving SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities).

Approximately 6,400 beds were estimated to be vacant in the estimated Market of N=750 Los Angeles County ARFs and RCFEs willing to serve or already serving individuals from the identified, vulnerable populations during the study period. Specific actions are needed from Market Users and government entities to activate these underutilized beds in Los Angeles County for future resident use:

- Additional funding is required to activate the majority of the underutilized beds (mostly at RCFEs), to bridge the gap at facilities with lower-range private rates to house older residents from identified, vulnerable populations
- Owners and operators require assurances that consideration will be given by System Users regarding the acuity of needs of individuals placed and the specific suitability of facilities to meet their needs, to minimize disruption to existing resident populations and minimize the possibility of future transfer resident activity
- Market Users need to enhance the ease of doing business for facilities receiving public benefit for resident care, streamlining administrative burdens that generate higher labor costs at facilities, ensuring greater integration of wraparound services to match resident needs, and promoting graduation, wherever practicable
- Facilities need reliable and consistent navigation of residents from Market Users into facilities to avoid disruption to their businesses by minimizing vacancies
- A whole-of-government effort is required to simplify the identification of a vast range of resident programs and benefit sources, providing technical assistance to facilities to maximize participation in serving identified, vulnerable populations

Market User Views on Capacity and Demand

A common view amongst nearly all Market Users is that utilization rates and capacity across the Market are universally high: a common perception which runs contrary to the data collected by this study. Primary Market Users and referral sources include the Los Angeles County Department of Health Services (DHS) and Department of Mental Health (DMH) programs (including Full Service Partnership, HOME, and PH2), the Public Guardian, acute psychiatric hospitals, public and private hospitals (both in- patient and emergency room flows), law enforcement, case management and housing navigators working within the Coordinated Entry System (bridge, interim housing, street teams, and permanent supportive housing), recuperative care facilities, community clinics (FQHCs), the Los Angeles County Jail, and the DHS Office of Diversion and Re-entry. These Market Users span the universe of health, mental health, and justice systems alongside the homelessness and housing Continuum(s) of Care in Los Angeles County, with unrelenting demand for client placements at Market ARFs and RCFEs.

Systemic congestion is believed to exist across most management and coordination of Market ARF and RCFE bed capacity, affecting the flow of clients at all levels, and across all systems of care. The consistency of opinion about the lack of available beds is attributed in part to significant variance among Market Users on the very definition of ARFs/RCFEs, with most familiar with generic housing capabilities and referring to them as "board and cares": some even mistaking them with skilled nursing facilities (SNFs). Most Market Users believe that the primary manner to access ARF or RCFE beds was through the DMH / DHS Enriched Residential Care or Enriched Residential Services Programs, which were frequently reported to be "at capacity", with a waitlist, or "out of funding". For other Market Users, there was lack of understanding about how to identify, refer individuals to, and fund placements within Market facilities. Service quality, continuity of care, and the appropriateness of services available to individuals placed within facilities were also of significant concern to many stakeholders.

Several Intensive Case Management Services (ICMS) providers connecting individuals to housing within the homelessness Continuum of Care, overseen by DHS, acknowledged that their primary focus has traditionally been to simply "move unhoused individuals indoors" or to "advance them to another setting", largely correlated with a "housing first" policy approach utilized across many homelessness services programs. When ICMS and Coordinated Entry System (CES) stakeholders place people experiencing homelessness into ARFs or RCFEs, internal pressures to deliver a higher quantity of placements for LAHSA has historically led to a significant mismatching of clients to the most appropriate housing options to match their individual care needs. Contributing to this problem is a persistent lack of access to real-time bed availability information from Market ARFs/RCFEs, and no capability to document Market facility placements at ARFs or RCFEs in LAHSA's homelessness management information systems (HMIS). One CES stakeholder reported a practice of steering clients with acute mental health or physical capability issues to hospital emergency rooms, hoping that client would eventually land in the appropriate setting, such as an ARF. This same CES stakeholder was unaware of any potential for direct placements of individuals at ARFs or RCFEs.

A stakeholder representing a private hospital in the City of Los Angeles indicated that their emergency room does not have any direct connections to services for unhoused individuals living with substance use addiction, chronic health, and/or mental health conditions. The stakeholder estimated that only 15% connected of unhoused individuals presenting are connected to case management or housing navigation through CES, further indicating that approximately 25% of all of repeat, emergency room patients are unhoused seniors (over the age of 60) in urgent need of continuing support and care in a housed situation, such as an RCFE.

Market Users across mental health services also report persistent pressures to simply move their clients "along in the system", from Acute Psychiatric Hospitals to lower levels of care, such as Outpatient Treatment Programs and Enriched Residential Services Programs (previously known as "IMD step-downs"). This phenomenon is largely attributed to be the result of high levels of demand for placements and settings, and was reported to occur whether or not clients "are ready for less supervision and/or treatment".

Public hospital stakeholders observe that patients awaiting a conservatorship process can experience delays between three to six months while they recover, with the service experience largely characterized as being as "disjointed". These pre-conserved individuals are on a prioritization list for placement with institutions for mental disease (IMDs), Enriched Residential Services, sub-acute care, and other programs, indicating a heavy reliance on mental health placements within services that other vulnerable individuals compete for. This demand contributes to a shortage of appropriate placements across all levels of care within this channel of

service. Stakeholders from UCLA-Olive View Hospital did not indicate awareness of the complete range of County programs and resources available, indicating an opportunity to reduce reliance on the hospital system through more community-based interim housing placements at ARFs and RCFEs.

The DMH Full-Service Partnership (FSP) was reported to have limited capacity to absorb the heavy in-flows of individuals referred by County hospitals. Both Los Angeles General Medical Center and UCLA-Olive View hospitals reported requiring greater access to expedited benefits enrollment to place their patients in FSP more efficiently. Other Market Users indicated a need for greater FSP capacity to appropriately serve their clients on an ongoing basis, and support stabilization of their mental health. Many seek FSP to provide a more robust service offering for individuals to enable their stable placements in ARFs and RCFEs.

Los Angeles General Medical Center (formerly L.A. County-USC Hospital) stakeholders indicated persistently poor coordination with the Los Angeles County Sheriff's Department in serving the needs of justice-involved individuals, indicating that people departing jail custody were "frequently dropped at the hospital door, without coordination or notice to personnel". It was also reported that people leaving Sheriff's custody had received limited access to mental health treatment while incarcerated or detained, commencing delivery of comprehensive mental health treatment only when admitted at their hospitals. Market Users largely agree that better coordination of ARF/RCFE placement from hospitals across Los Angeles County is a critical unmet need, as hospitals are naturally serving the highest need individuals and present some of the greatest opportunity to efficiently and directly connect patients with the longer-term settings offered within the Market of ARFs and RCFEs.

The imminent introduction of Care Courts[5] in Los Angeles County before the end of 2023 is of deep concern to several Market Users, who expect that the already high demand for Market ARF and RCFEs will significantly increase as a result of implementation. Concerns were also expressed regarding the impacts of the renewal of conservatorship for clients who require ongoing care and supervision after the one-year term, as well as the availability of beds or the capacity of the Market to continue provide the resources and wraparound services that conserved individuals require to find stability.

Law enforcement stakeholders indicated that some ARFs and RCFEs can misuse emergency calls to police services to mental health-related ("5150") holds, with aim to evict their residents when they could be hospitalized for having an episode, rather than calling the Department of Mental Health (DMH) Psychiatric Mobile Response Team (PMRT). The California Long-Term Care Ombudsman, with regulatory accountability to protect dependent adults, corroborated reports of inappropriate evictions from facilities through inappropriate use of law enforcement resources, or when clients are hospitalized for medical care needs.

These observations from Market Users across many systems of care clearly identify a need for more centralized navigation, planning, and demand management across all flows and channels of vulnerable individuals originating from Market Users, or ARFs and RCFEs will continue to experience underutilization and inefficiency from these many sources of placements.

[5] https://www.gov.ca.gov/2023/01/13/los-angeles-county-accelerates-care-court-implementation-to-support-californians-with-untreated-severe-mental-illness/

Probable Underutilization Outside of the Market

As this study was limited to a focus on a Market of facilities willing to serve the identified, vulnerable populations, there are some important opportunities for governmental and nonprofit funders of housing and care for vulnerable residents to consider with regard to the more than 2,250 remaining, non-aligned ARFs and RCFEs in Los Angeles County that do not indicate willingness to serve or currently serve to the identified, vulnerable population. There will be a proportion of RCFE owners and operators that will never join the Market, largely due to the service design of their businesses to deliver customizable luxury to self-funded and privately funded users of elder care. However, based on informal feedback, there are opportunities to persuade this segment of RCFEs to accept a highly-limited number of vulnerable individuals with lower acuity of needs if placements were funded at "reasonable" levels, or if other incentives were provided to these facilities. This is a significant consideration for prospective philanthropic funders willing to engage these RCFEs in a limited fashion, as the unit cost for service of this channel has high probability of being less than the cost of building new facilities, and could be ready to house appropriate individuals in a significantly lesser amount of time.

If vacancy/utilization rates for ARFs[6] and RCFEs across "non-Market" facilities are similar to that within the Market, there could be as many as 8,100, additional vacant beds, (in excess of the 6,400 within the Market) which are underutilized across the total population of Los Angeles County ARFs and RCFEs. Based on limited feedback from facility owners and operators not presently willing to serve the identified, vulnerable, population, governmental and community stakeholders need to consider taking the following steps to activate more of this potentially underutilized bed space outside of the Market to enhance the capability of Los Angeles County ARF and RCFE resources to deliver greater levels of community benefit:

1) Increase engagement to owners and operators of facilities not serving the identified, vulnerable populations, holding frank conversations to clearly identify the community need and assure them that they will be supported in a transition to serve at least some residents with lower acuity needs from vulnerable populations. A similar approach was taken with hotel owners serving Project Roomkey and hospitality industry programs across the homelessness Continuum of Care for crisis and bridge housing for those experiencing homelessness, extended well beyond the COVID-19 pandemic[7].

2) Attempt to close or bridge gaps in per-capita resident funding, increasing levels to ensure that the value proposition to business owners and operators of facilities not currently serving the identified, vulnerable population is enhanced and their business sustainability concerns are met, nearly identically to the needs expressed by Market owners and operators already serving or willing to serve this population. Market Users will also need to find ways to reduce some of the excess time, bureaucratic, and labor cost burdens of participation and service for all facilities.

3) Enhance connection to wraparound services, resources, and training to enable facilities not currently serving the identified, vulnerable populations to overcome preconceptions, prospective challenges, and fears. Additionally, facilities not currently serving identified, vulnerable populations would need time to become operationally ready to deliver services to different populations with distinctive needs.

4) Ensure consistency of navigation and placement services to assure facility owners and operators that bed space allocated to service identified, vulnerable populations will not be vacant, and that residents who need to be advanced to higher levels of care will be moved in a responsive manner. This is another need of the existing Market that has not been fully satisfied.

5) Increase public support and awareness of the importance of facilities that serve the identified, vulnerable populations, to create a stable and sustainable business environment for facility owners and operators that may encounter resistance from their local community members to serving new populations. Reducing stigma and resistance from communities to support even more owners joining the Market with their facilities

[6] The study identified, but was unable to quantify, reports of underutilization of bed space at 6-bed ARFs exclusively contracted to serve the Regional Center consumers, attributed to changes in Regional Center preferred service models over recent years.

[7] https://covid19.lacounty.gov/project-roomkey/

3.0

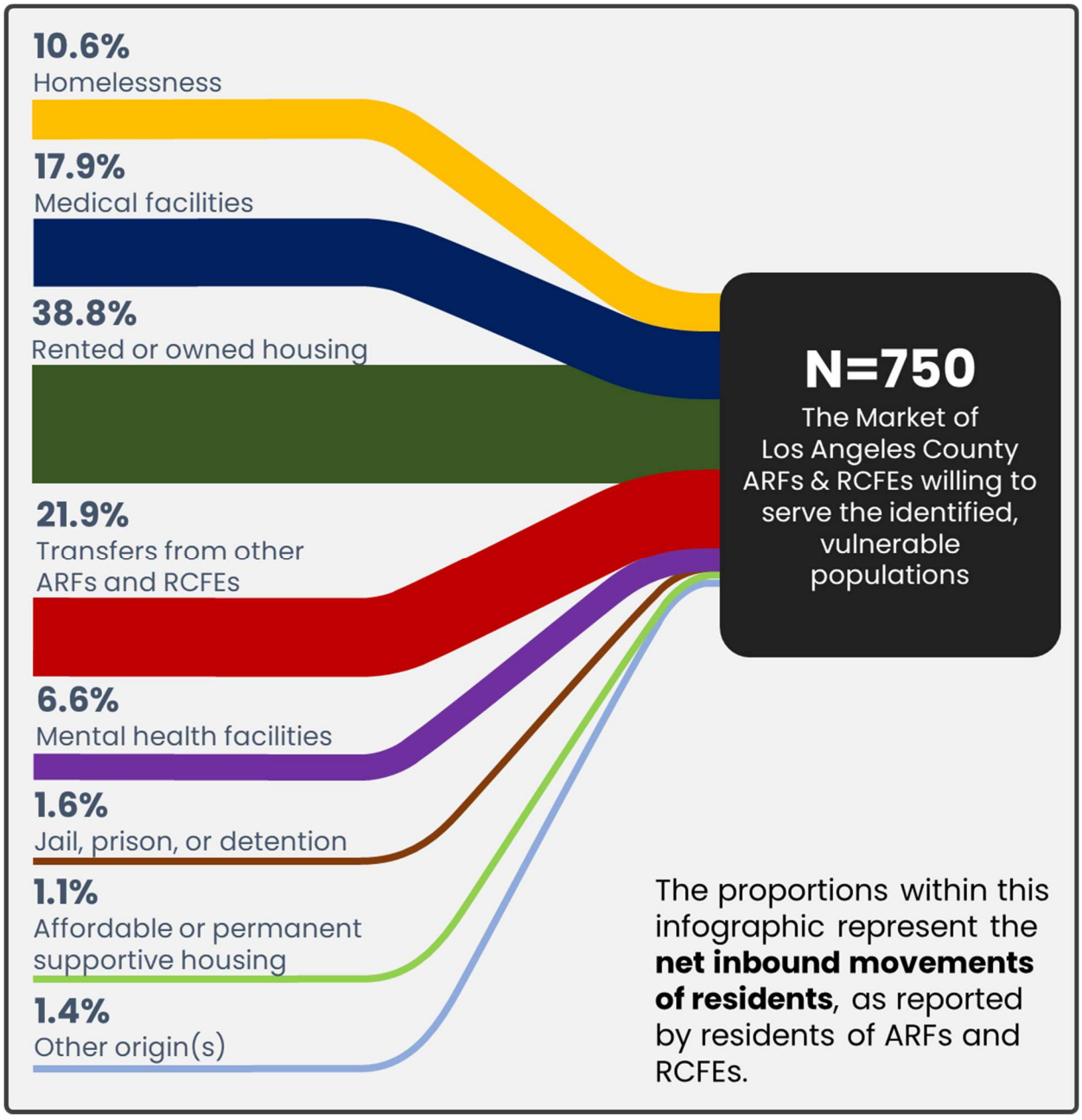
Image: www.dreamstime.com

Market Inputs and Resident Placement

Understanding insights into total system use, presentation of a visualization identifying the sources and origins for facility residents, and the mechanisms by which residents of ARFs and RCFEs are placed within Los Angeles County facilities will aid market users, owners, and operators of ARFs and RCFEs to identity future opportunities to optimize navigation and maximize use of available beds for residents, hopefully leading to greater Market efficiency and sustainability for all participants.

Visualizing Market Resident Inputs

One of the key gaps in general knowledge learned from qualitative research from this study was insufficient levels of understanding from Market Users serving identified, vulnerable populations as to where the total population of residents living in facilities come from, and how they move from various systems of care into facilities. Residents of ARFs and RCFEs come from a variety of sources, represented by different groups of Market Users attempting to provide housing, health, and care solutions to a range of vulnerable populations. The following visualization depicts overall, resident-reported points of origin, prior to living at a Market facility:

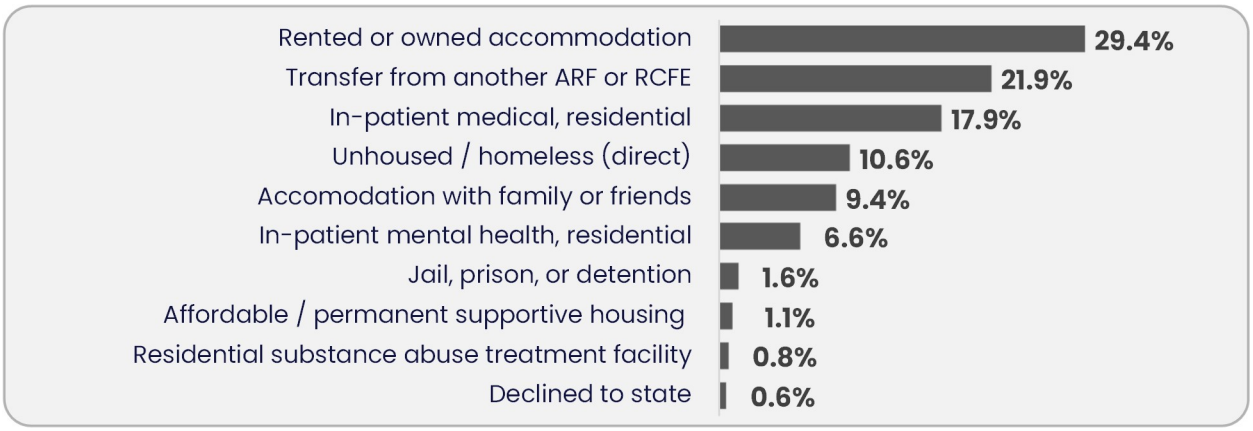


Resident Origins (Self-Reported)

Residents were asked to identify their immediate housing situation prior to their arrival at their current ARF or RCFE. This could include situations where the resident was unhoused, permanently housed, temporarily housed, receiving medical health, mental health, and/or substance abuse treatment at a hospital or other specialized facility, or other situations, including transfers from other ARFs or RCFEs.

RQ16. "What type of housing did you have before you moved in here?" (PROMPTED)

RESIDENTS (N=625)



A key finding for this study, 10.6% of residents indicated that they came to their current facility directly from experiencing homelessness, inclusive of residents who were living directly on the streets, living out of a vehicle, temporary residence in a shelter, or otherwise without a regular home. Resident-reported proportions for origination of experiencing homelessness are nearly 3% greater than as estimated by facility owners and/or operators. Given qualitative feedback from residents regarding their indirect steps in moving from experiencing homelessness to facilities, this figure does not represent the total proportion of previously unhoused individuals served, due to their initial, indirect movements through in-patient medical, mental health, incarceration, and other systems prior to their housing at a facility. This issue is explored in greater detail in a later section of this study. A further 6.6% of residents reported moving directly from residential, mental health treatment settings, such as institutions for mental disease (IMDs).

38.8% of ARF and RCFE resident respondents reported moving into their facility from rented or owned housing controlled by themselves, family, or friends, with another 17.9% moving directly to their facility immediately after receiving treatment at a hospital, skilled nursing facility (SNF), or physical rehabilitation facility.

Nearly 21.9% of resident respondents identified that they had come to their current facility from other ARFs and RCFEs, indicating a high level of transfer activity between licensed facility populations, identifying potential issues with the optimality of resident placements, which will also be explored later in the study.

Table 3.1: Resident Origins, by License Class	ARF	RCFE	ALL
Rented or owned accommodation	16.3%	44.8%	29.4%
Transfer from another ARF or RCFE	26.4%	16.7%	21.9%
In-patient medical, residential	16.0%	20.1%	17.9%
Unhoused / homelessness (direct)	14.2%	6.3%	10.6%
Rented or owned accommodation w/family or friends	11.3%	7.3%	9.4%
In-patient mental health, residential	10.4%	2.1%	6.6%
Jail, prison, or detention	2.4%	0.7%	1.6%
Affordable / permanent supportive housing	1.5%	0.7%	1.1%
Residential substance abuse treatment facility	0.9%	0.7%	0.8%

RCFEs were observed to have a significantly greater proportion of residents that originated from living alone or with others in a rented or owned accommodation than ARFs (44.8%), while ARFs were observed to possess significantly greater proportions of residents that reported originating directly from homelessness (14.2%), in-patient mental health facilities (10.4%), and incarceration (2.4%).

ARFs also possessed significantly greater proportions of residents who reported transferring from other ARFs than RCFEs (26.4%), triangulating greater need to resolve issues relating to the optimality of resident placements with ARFs that can best serve their needs.

Comparably low proportions of residents reported to have originated from residential substance abuse treatment facilities or affordable / permanent supportive housing situations prior to their housing at their current facility.

Table 3.2: Resident-Reported Origins, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Rented or owned accommodation	43.3%	21.0%	27.5%
Transfer from another ARF or RCFE	12.8%	24.8%	24.5%
In-patient medical, residential	17.7%	21.7%	16.2%
Unhoused / homelessness (direct)	6.4%	15.3%	10.1%
Rented or owned accommodation w/family or friends	12.8%	10.2%	7.6%
In-patient mental health, residential	3.5%	3.8%	9.2%
Jail, prison, or detention	1.4%	0.6%	2.1%
Affordable / permanent supportive housing	1.4%	1.9%	0.6%
Residential substance abuse treatment facility	0.7%	0.0%	1.2%

Facilities serving 6 licensed beds or fewer had the greatest proportion of residents that reported originating from living alone or with others in a rented or owned accommodation, in comparison to respondents at larger capacity facilities. This smallest size category of facility had the smallest proportion of residents who came to reside at the facility direct from homelessness, at only 6.4%. Interestingly, facilities with populations between 7 and 60 beds were observed to have significantly greater proportions of residents who reported coming from in-patient medical facilities or being unhoused / experiencing homelessness in comparison to larger or smaller facilities.

Greater proportions of residents (~25%) in the categories of facilities with 7 to 60 and 61 or more licensed beds reported originating from transfers from other ARFs and RCFEs than 6 bed or fewer licensed bed facilities. A significantly greater proportion of residents who reported originating from in-patient mental health was observed with 61 or more bed facilities.

Table 3.3: Resident Origins, by Age Range	18-54	55-61	62+
Rented or owned accommodation	16.9%	23.4%	42.9%
Transfer from another ARF or RCFE	25.4%	28.7%	16.4%
In-patient medical, residential	15.7%	17.0%	20.4%
Unhoused / homelessness (direct)	15.3%	9.6%	6.8%
Rented or owned accommodation w/family or friends	9.3%	10.6%	9.3%
In-patient mental health, residential	10.9%	6.4%	2.9%
Jail, prison, or detention	2.8%	2.1%	0.4%
Affordable / permanent supportive housing	1.6%	1.1%	0.7%
Residential substance abuse treatment facility	1.6%	1.1%	0.0%

A significantly greater proportion of residents aged 18-55 reported originating at their current ARF or RCFE from experiencing homelessness, in-patient mental health facilities, or carceral settings (jail, prison, or detention) than across older resident cohorts.

Residents aged between 55 and 61 years of age reported being transferred to their current facility from other ARFs and RCFEs in significantly greater proportions than residents of younger or older age groups. Residents

aged 62 or older reported originating in rented or owned housing in significantly greater proportions than other age groups.

Table 3.4: Resident Origins, by Gender Identity	FEMALE	MALE
Rented or owned accommodation	31.6%	28.1%
Transfer from another ARF or RCFE	20.7%	22.3%
In-patient medical, residential	18.0%	18.0%
Unhoused / homelessness (direct)	9.4%	11.4%
Rented or owned accommodation w/family or friends	10.9%	8.4%
In-patient mental health, residential	7.4%	6.0%
Jail, prison, or detention	1.2%	1.9%
Affordable / permanent supportive housing	0.4%	1.6%
Residential substance abuse treatment facility	0.4%	1.1%

There were no significant differences observed across the analysis of segmentation for resident origins based on gender identity.

Table 3.5: Resident Origins, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Rented or owned accommodation	31.6%	21.6%	28.8%	34.3%	17.6%	33.3%	33.3%
Transfer f/ another ARF / RCFE	22.1%	26.5%	21.2%	13.4%	29.4%	33.3%	0.0%
In-patient medical, residential	19.4%	17.9%	11.5%	19.4%	11.8%	0.0%	33.3%
Unhoused / homelessness (dir.)	9.2%	13.6%	11.5%	9.0%	17.6%	33.3%	0.0%
Rented or owned accom. w/ family	9.9%	9.3%	9.6%	13.4%	11.8%	0.0%	33.3%
In-patient mental health, res.	5.1%	9.3%	11.5%	4.5%	0.0%	0.0%	0.0%
Jail, prison, or detention	0.7%	2.5%	2.9%	1.5%	5.9%	0.0%	0.0%
Afford. / perm. support. housing	1.4%	0.0%	1.0%	4.5%	0.0%	0.0%	0.0%
Res. substance abuse facility	0.3%	1.9%	1.0%	0.0%	5.9%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid comparison with other groups

Black / African American and Native American / Alaska Native resident respondents reported originating from being unhoused / experiencing homelessness or being transferred to their current ARF or RCFE from another in significantly greater proportions than residents of other racial identity groups.

A significantly greater proportion of Asian / Asian American residents reported originating at their current facility directly from rented or owned housing, housing with family or friends, or affordable / permanent supportive housing than residents of other racial identity groups.

Hispanic / Latino / Latinx residents reported being transferred from in-patient mental health facilities in significantly greater proportions than residents of other racial identities.

Table 3.6: Resident Origins, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Rented or owned accommodation	17.4%	17.4%	29.9%	19.0%	17.9%
Transfer f/ another ARF / RCFE	25.0%	23.7%	22.2%	24.5%	25.0%
In-patient medical, residential	18.2%	18.1%	22.8%	14.7%	16.0%
Unhoused / homelessness (dir.)	13.3%	21.7%	11.4%	17.4%	17.9%
Rented or owned accom. w/ family	11.5%	7.4%	7.4%	8.2%	10.8%
In-patient mental health, res.	9.6%	7.7%	4.6%	7.6%	9.4%
Jail, prison, or detention	2.3%	1.7%	0.3%	5.4%	0.9%
Afford. / perm. support. housing	1.0%	1.0%	0.6%	1.1%	0.5%
Res. substance abuse facility	1.0%	0.7%	0.6%	2.2%	1.4%

Resident respondents from all 5 of the key experiential study factors reported being transferred to their current facilities from other ARFs and RCFEs in elevated proportions compared to other resident respondents interviewed.

Significantly greater proportions of residents who indicated that they had experienced homelessness as an adult reported originating directly from being unhoused prior to their current facility, along with residents who had experiences of incarceration for periods of 30 days or more, and residents who had the experience of addiction to drugs and/or alcohol.

Table 3.7: Resident Origins, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Rented or owned accommodation	46.7%	24.6%	50.6%	12.1%	14.8%	26.3%	28.6%	22.2%
Transfer f/ another ARF / RCFE	13.3%	17.9%	17.3%	35.4%	29.6%	15.8%	21.4%	23.2%
In-patient medical, residential	20.0%	25.4%	11.7%	13.1%	25.9%	23.7%	14.3%	19.4%
Unhoused / homelessness (dir.)	0.0%	9.7%	5.6%	12.1%	14.8%	21.1%	14.3%	13.0%
Rented or owned accom. w/ family	20.0%	9.7%	4.9%	13.1%	11.1%	7.9%	11.9%	10.2%
In-patient mental health, res.	0.0%	6.7%	4.9%	8.1%	3.7%	2.6%	7.1%	10.2%
Jail, prison, or detention	0.0%	2.2%	1.2%	4.0%	0.0%	0.0%	2.4%	0.0%
Afford. / perm. support. housing	0.0%	1.5%	1.9%	0.0%	0.0%	0.0%	0.0%	1.9%
Res. substance abuse facility	0.0%	1.5%	0.6%	1.0%	0.0%	2.6%	0.0%	0.0%

Residents at facilities located in SPA 6 (South Los Angeles and South Cities) reported that they had originated from being unhoused / experiencing homelessness in significantly greater proportions than residents housed at facilities in any other SPA.

Facilities located in SPA 2 (San Fernando Valley), SPA 5 (West Los Angeles and West Cities), and SPA 6 (South Los Angeles and South Cities) had the greatest proportions of residents who reported originating from in-patient, medical settings prior to arriving at their facility.

The greatest proportions of residents originating from in-patient, mental health settings were encountered in SPA 8 (South Bay and Coastal Cities) and SPA 4 (Metro Los Angeles and Center Cities), with SPA 4 also reporting significantly greater proportions of residents originating from jail, prison, or detention settings prior to facility arrival.

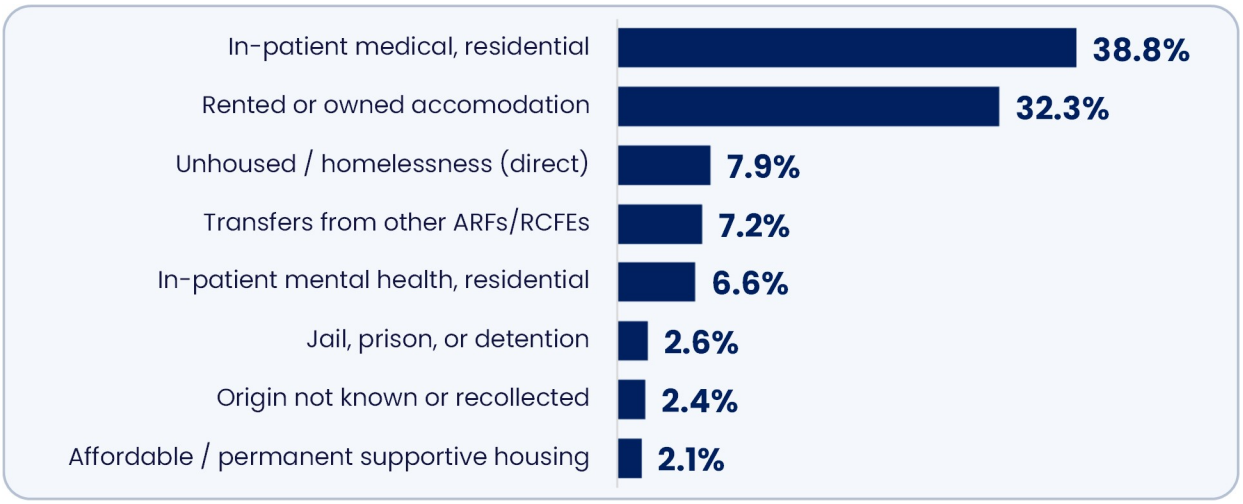
Facilities located in SPA 4 (Metro Los Angeles and Center Cities) and SPA 5 (West Los Angeles and West Cities) had significantly greater proportions of residents who reported being transferred from other ARFs and RCFEs in comparison to residents at facilities located in other SPAs.

Resident Origins (Facility-Reported)

Owners and operators of facilities serving the identified, vulnerable populations were also asked to provide estimates of where they believed that their population of residents originated from.

FQ15. "Thinking about your current population of residents, approximately what percentage have come to live at your facility from each of the following situations?" (PROMPTED TO 100%)

FACILITY OWNERS & OPERATORS (N=353)



There are substantive differences between resident-reported recollections and facility owner/operator estimated reports of resident origins. The majority of residents reported entering facilities by owners and/or operators of ARFs and RCFEs originate from situations of in-patient, medical residential settings (38.8%), such as hospitals, skilled nursing facilities (SNFs), and other residential recuperative care settings, followed by homes that were rented or owned (32.3%) by the resident, their family members, or friends of the resident. A further 6.6% of residents originated from locked door, in-patient mental health facilities, such as institutions for mental disease (IMDs). Residents originating from experiences of homelessness (unhoused on the streets, a shelter, a vehicle, or otherwise without a permanent home) account for 7.9% of residents currently present in the population of ARFs and RCFEs willing to serve the identified, vulnerable populations at focus for the study, again, lower than the proportions reported by the residents themselves and indicating a potential gap in knowledge regarding resident origins.

Another key difference in the information provided between the pool of residents and facility owners and/or operator respondents interviewed is a nearly 14% decrease in the proportions of residents reported to have been transferred from another ARF or RCFE by facilities, indicating that facility stakeholders may not have a clear understanding of this issue and how it can impact both the effectiveness of the care they deliver, and their business profitability, and sustainability in regard to clearly identifying their capabilities to serve members of identified, vulnerable populations more effectively, from their very first placement at a licensed facility.

Table 3.8: (Facility) Resident Origins, by License Class	ARF	RCFE	ALL
In-patient medical, residential	38.4%	39.1%	38.8%
Rented / owned accommodation	12.7%	44.7%	32.3%
Unhoused / homelessness (direct)	13.2%	4.6%	7.9%
Transfers From Other ARFs / RCFEs	10.4%	5.2%	7.2%
In-patient mental health, residential	13.6%	2.2%	6.6%
Jail, prison, or detention	6.4%	0.3%	2.6%
Origin not known or recollected	2.6%	2.2%	2.4%
Affordable / permanent supportive housing	2.9%	1.6%	2.1%

ARF owners and operators reported significantly greater proportions of residents originating directly from experiencing homelessness, from in-patient mental health treatment facilities, from jail, prison, or detention, and in transfers from other facilities, in comparison to RCFE owners and operators, reported significantly greater proportions of residents who originated from rented or owned property than their ARF counterparts.

Table 3.9: (Facility) Resident Origins, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
In-patient medical, residential	37.1%	40.8%	41.7%
Rented / owned accommodation	39.1%	21.6%	24.4%
Unhoused / homelessness (direct)	5.4%	14.0%	8.8%
Transfers From Other ARFs / RCFEs	8.6%	3.2%	7.5%
In-patient mental health, residential	3.3%	12.3%	10.0%
Jail, prison, or detention	2.1%	3.8%	2.9%
Origin not known or recollected	2.4%	2.3%	2.3%
Affordable / permanent supportive housing	2.0%	2.0%	2.6%

Owners and operators of larger facility sizes (from 7 to 60 beds, and 61 beds or more) reported greater proportions of residents originating from homelessness and in-patient mental health situations than facilities licensed for 6 or fewer beds. Facilities with 6 or fewer licensed beds reported the greatest proportion of individuals originating from living situations by themselves or alongside others in rented or owned accommodation. Facilities of all sizes reported low proportions of residents at their facilities who came from affordable or permanent supportive housing, or who came from unknown or unrecollected origins.

Table 3.10: (Facility) Resident Origins, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
In-patient medical, residential	33.6%	39.2%	29.8%	46.4%	24.6%	38.0%	47.2%	48.4%
Rented / owned accommodation	39.3%	38.9%	42.6%	16.1%	19.5%	18.8%	25.8%	28.6%
Unhoused / homelessness (direct)	5.5%	6.5%	4.3%	11.9%	14.3%	11.4%	6.7%	10.4%
Transfers From Other ARFs / RCFEs	13.9%	7.9%	8.7%	3.4%	17.6%	9.3%	0.5%	3.1%
In-patient mental health, residential	1.9%	2.8%	7.0%	10.9%	13.1%	7.3%	9.6%	7.6%
Jail, prison, or detention	0.0%	2.0%	2.1%	4.9%	9.0%	8.2%	0.1%	0.8%
Origin not known or recollected	3.8%	1.3%	2.4%	4.3%	1.8%	7.0%	2.6%	0.0%
Afford. / perm. supportive housing	1.9%	1.5%	3.3%	2.2%	0.0%	0.0%	7.6%	1.1%

Greater proportions of residents moving from experiencing homelessness into facilities were observed by facilities located in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities) and SPA 6 (South Los Angeles and South Cities). Facility owners and operators in SPA 4 (Metro Los Angeles and Center Cities), SPA 7 (East Los Angeles and South East Cities), and SPA 8 (South Bay and Coastal Cities) reported the significantly greater proportions of resident population that had originated from in-patient medical treatment settings in comparison to most other SPAs, whilst owners and operators of facilities in SPA 1 (Antelope Valley), SPA 2 (San Fernando Valley), and SPA 3 (San Gabriel Valley) reported greater proportions of residents who originated from rented or owned accommodation in relation to facilities located in other SPAs.

Resident Duration in Prior Scenarios

Residents that did not originate at their Market ARF or RCFE directly from any form of housing in the community were asked to identify (to the best of their recollection), how long they had been in their prior living scenario:

RQ20., RQ 21., AND RQ23. "For approximately how long (were you in your previous situation)?" **AND RQ24.** "What was the nature of the treatment that you were receiving?" (recoded into months)

RESIDENTS (n=159)

Residents who had direct experience of homelessness facilities spent an average of 47.6 months (almost 4 years) unhoused prior to their arrival at Market facilities. Comparable means for residents with direct experience of moving to Market ARFs and RCFEs from in-patient mental health residential settings, such as institutions for mental disease (IMDs), were observed, at 39.8 months (more than 3.3 years).

Relatively-lengthy mean durations of stays from residents moving from in-patient medical, residential facilities (including skilled nursing and recuperative care) were also observed, at 20.8 months (just over 1.5 years).

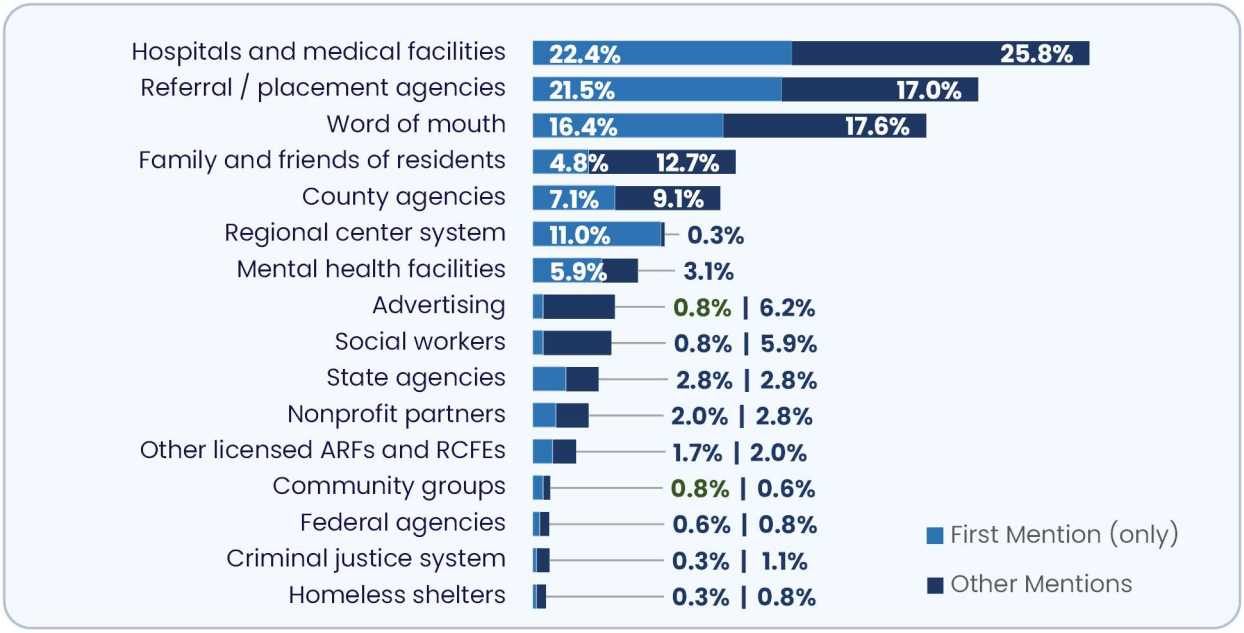
These findings support observations communicated by Market Users, who identified a lack of navigation, real-time information, and tools to support greater efficiency in placements for vulnerable individuals to ARFs and RCFEs in the Market.

Sources of Resident Referral

Facilities were asked to identify any sources of resident referrals and/or navigation into facilities that they utilized to maximize the service capacity at their facilities. The first-mentioned referral source from each respondent was documented separately to understand the differences in "top-of-mind" or primary referral sources, in comparison to all referral sources utilized.

FQ16. "What is your number one source for the referral or placement of residents at your facility? AND **FQ17.** "What are some of your facility's other sources for resident referrals and placements?" (UNPROMPTED)

FACILITY OWNERS & OPERATORS (N=353)



Nearly half of all Market facilities reported receiving referrals from hospitals and medical facilities, followed closely by referral / placement agencies, and word of mouth. Los Angeles County agencies were only reported to serve as a direct source of referral by 16.2% of respondents willing to serve the identified, vulnerable population, with only 7.1% of facility owners and/or operators noting County agencies (such as DHS and DMH) as their first-mentioned referral source, indicating opportunities for the expansion of the roster of facilities to serve with already-established County programs, such as the Enhanced Residential Care (ERC) program. The Regional Center system (11.3%), also contributes referrals to facilities not under exclusive contract and serving "mixed" populations, confirmed by qualitative research as delivering service to individuals with a lower acuity of developmental disability service needs. Nonprofit partners and homeless shelters represented low numbers of referrals to facilities, indicating that these providers of care have relatively low impact in directing members of identified, vulnerable populations to housing, service, and care from ARFs and RCFEs.

Table 3.11: First Mention Referral Source, by License Class	ARF	RCFE	ALL
Hospitals and Medical Facilities	33.8%	15.2%	22.4%
Referral and Placement Agencies	2.9%	33.2%	21.5%
Word of Mouth	0.7%	26.3%	16.4%
Regional Center System	25.0%	2.3%	11.0%
County Agencies	14.7%	2.3%	7.1%
Mental Health Facilities	12.5%	1.8%	5.9%
Family and Friends of Residents	1.5%	6.9%	4.8%
State Agencies	1.5%	3.7%	2.8%
Nonprofit Partners	2.2%	1.8%	2.0%
Other ARFs and RCFEs	0.7%	2.3%	1.7%

Without access to a greater marketplace that supports any large numbers of privately-funded beds at their facilities, ARFs have a different mix of channels by which they access referrals than RCFEs. Highlighting key differences in first-mentions for sources of resident referrals between ARFs and RCFEs, ARFs receive significantly greater proportions of referrals from hospitals and medical facilities, the Regional Center system (in a non-exclusive context), Los Angeles County Agencies, and mental health facilities, compared to RCFEs. RCFEs display significantly greater proportions of first-mentioned referrals from agencies (commercial placement entities and brokers), word of mouth, and the families and friends of residents than ARFs, largely reflective of the mixed compositions of private pay and publicly funded residents that RCFEs can serve.

Table 3.12: All Resident Referral Sources, by License Class (MR)	ARF	RCFE	ALL
Hospitals and Medical Facilities	55.9%	43.3%	48.2%
Referral and Placement Agencies	9.6%	56.7%	38.5%
Word of Mouth	14.7%	46.1%	34.0%
Family and Friends of Residents	9.6%	22.6%	17.6%
County Agencies	34.6%	4.6%	16.1%
Regional Center System	25.0%	2.8%	11.3%
Mental Health Facilities	19.1%	2.8%	9.1%
Advertising	0.7%	10.6%	7.1%
Social Workers	5.9%	7.4%	6.8%
State Agencies	2.9%	6.9%	5.4%
Nonprofit Partners	6.6%	3.7%	4.8%
Other ARFs and RCFEs	2.9%	4.1%	3.7%

The dominant sources of overall referrals mentioned for ARFs are hospitals and medical facilities, with 55.9% of facilities indicating that they receive residents from this channel, followed closely by Los Angeles County Agencies at 34.6% of facilities, and mental health facilities, at 19.1% of facilities. Direct referrals from homeless shelters and services were only mentioned by 2.9% of ARF respondents.

For RCFEs, referral and placement agencies and services were the dominant source of resident referrals at 56.7% of respondents, followed by word of mouth at 46.1%, and hospitals and medical facilities at 43.3%. Family and friends of residents were also referenced as a notable source of referrals for RCFEs, at 22.6%. RCFEs reported a considerably lower proportion of referrals from County Agencies than ARFs, at only 4.6%. No RCFE indicated receiving any resident referrals from homeless shelters or services across this Continuum of Care (CoC).

Table 3.13: First Mention Referral Source, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Hospitals and Medical Facilities	11.3%	40.0%	35.1%
Referral and Placement Agencies	27.0%	13.3%	14.9%
Word of Mouth	21.6%	5.3%	13.5%
Regional Center System	17.2%	5.3%	0.0%
County Agencies	4.9%	9.3%	10.8%
Mental Health Facilities	2.5%	12.0%	9.5%
Family and Friends of Residents	6.9%	4.0%	0.0%
State Agencies	1.0%	4.0%	6.8%
Nonprofit Partners	2.5%	1.3%	1.4%
Other ARFs and RCFEs	1.5%	0.0%	4.1%

Larger facilities with 7 to 60 licensed beds or 61 or more licensed beds displayed significantly greater proportions of first-mentioned sources of resident referral from hospitals and medical facilities (including skilled nursing facilities, or SNFs), than facilities licensed for 6 or fewer beds, reporting this as a first-mention in significantly lower proportions.

6 or fewer licensed bed facilities reported significantly greater proportions of referrals from referral and placement agencies (largely RCFEs), word of mouth (also correlating with RCFEs), and the Regional Center system, than larger facilities. The finding with the Regional Center system correlates with feedback from this community, reflective of the preferred housing service model in service to those living with developmental disability for facilities of limited, total capacity. Interestingly, facilities with licensed bed counts of between 7 and 60 first-mentioned referrals from higher-acuity mental health facilities in significantly greater proportions than larger or smaller facilities, also exclusively reporting all first-mentioned referrals from homeless shelters and services (not shown in table).

Table 3.14: All Resident Referral Sources, by License Class (MR)	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Hospitals and Medical Facilities	36.8%	61.3%	66.2%
Referral and Placement Agencies	48.0%	26.7%	24.3%
Word of Mouth	38.7%	24.0%	31.1%
Family and Friends of Residents	21.6%	14.7%	9.5%
County Agencies	9.3%	28.0%	23.0%
Regional Center System	17.2%	5.3%	1.4%
Mental Health Facilities	3.4%	22.7%	10.8%
Advertising	7.8%	1.3%	10.8%
Social Workers	5.4%	9.3%	8.1%
State Agencies	2.0%	6.7%	13.5%
Nonprofit Partners	3.9%	9.3%	2.7%
Other ARFs and RCFEs	3.9%	2.7%	4.1%

7 to 60 and 61 or more licensed bed facilities reported significantly greater proportions of referrals from hospitals and medical facilities, County agencies, state agencies, and social workers than their 6 or fewer licensed bed counterparts. Facilities serving between 7 and 60 licensed beds reported significantly greater proportions of referrals from mental health facilities than facilities licensed to serve smaller or larger populations. 7 to 60 licensed bed facilities also reported receiving referrals from nonprofit partners and the legal (criminal justice) system in significantly greater proportions than other facilities. Facilities with 6 or fewer licensed beds reported significantly greater proportions of overall referrals from placement agencies, work of mouth, resident family and friends, and the Regional Center system.

Table 3.15: First Mention Referral Source, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Hospitals and Medical Facilities	7.7%	20.8%	16.9%	40.0%	0.0%	33.3%	9.5%	31.3%
Referral and Placement Agencies	38.5%	32.5%	16.9%	2.9%	57.1%	3.3%	23.8%	17.9%
Word of Mouth	38.5%	11.7%	21.7%	5.7%	0.0%	13.3%	19.0%	16.4%
Regional Center System	7.7%	1.3%	9.6%	20.0%	14.3%	26.7%	28.6%	7.5%
County Agencies	0.0%	5.2%	2.4%	14.3%	14.3%	13.3%	4.8%	10.4%
Mental Health Facilities	3.8%	5.2%	9.6%	5.7%	0.0%	3.3%	4.8%	6.0%
Family and Friends of Residents	0.0%	7.8%	8.4%	0.0%	0.0%	0.0%	0.0%	6.0%
State Agencies	3.8%	1.3%	3.6%	2.9%	7.1%	0.0%	0.0%	4.5%
Nonprofit Partners	0.0%	3.9%	1.2%	5.7%	0.0%	3.3%	0.0%	0.0%
Other ARFs and RCFEs	0.0%	2.6%	3.6%	0.0%	7.1%	0.0%	0.0%	0.0%

Facilities in SPA 4 (Metro Los Angeles and Center Cities), SPA 6 (South Los Angeles), and SPA 8 (South Bay and Coastal Cities) first-mentioned greater proportions of resident referrals from hospitals and medical facilities than facilities located in other SPAs. Referral and placement agencies were reported as a first mention for facilities serving SPA 1 (Antelope Valley), SPA 2 (San Fernando Valley), and SPA 5 (West Los Angeles and West Cities) in greater proportions than other SPAs.

Referrals from the Regional Center system were reported as a first mentioned source in significantly greater proportions in SPA 4 (Metro Los Angeles and Center Cities), SPA 6 (South Los Angeles and South Cities), and SPA 7 (East Los Angeles and South East Cities) than other SPAs, with mental health facilities first mentioned in SPA 3 (San Gabriel Valley) in greater proportions than facilities in other locations.

Table 3.16: All Resident Referral Sources, by License Class (MR)	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Hospitals and Medical Facilities	34.6%	45.5%	38.6%	62.9%	21.4%	46.7%	42.9%	68.7%
Referral and Placement Agencies	50.0%	54.5%	34.9%	20.0%	64.3%	13.3%	38.1%	35.8%
Word of Mouth	57.7%	36.4%	37.3%	20.0%	21.4%	36.7%	23.8%	29.9%
Family and Friends of Residents	26.9%	22.1%	25.3%	2.9%	14.3%	6.7%	23.8%	10.4%
County Agencies	7.7%	13.0%	9.6%	37.1%	21.4%	30.0%	9.5%	14.9%
Regional Center System	7.7%	1.3%	10.8%	20.0%	14.3%	26.7%	28.6%	7.5%
Mental Health Facilities	3.8%	6.5%	12.0%	11.4%	0.0%	13.3%	4.8%	10.4%
Advertising	3.8%	6.5%	8.4%	2.9%	21.4%	6.7%	0.0%	9.0%
Social Workers	3.8%	5.2%	7.2%	5.7%	0.0%	3.3%	19.0%	9.0%
State Agencies	7.7%	5.2%	8.4%	2.9%	14.3%	0.0%	0.0%	4.5%
Nonprofit Partners	0.0%	6.5%	3.6%	14.3%	0.0%	6.7%	0.0%	3.0%
Other ARFs and RCFEs	3.8%	3.9%	4.8%	2.9%	7.1%	3.3%	0.0%	3.0%
Hospitals and Medical Facilities	0.0%	2.6%	3.6%	5.7%	7.1%	0.0%	4.8%	0.0%
Referral and Placement Agencies	0.0%	1.3%	3.6%	0.0%	0.0%	3.3%	0.0%	0.0%
Word of Mouth	0.0%	0.0%	0.0%	8.6%	0.0%	0.0%	4.8%	1.5%

Considering overall mentions of referral sources, facilities located in SPA 4 (Metro Los Angeles and Center Cities) and SPA 8 (South Bay and Coastal Cities) reported significantly greater proportions of referrals from hospitals and medical facilities than ARFs and RCFEs in other service planning areas. Referral and placement agencies were reported in significantly greater proportions across SPA 1 (Antelope Valley), SPA 2 (San Fernando Valley), and SPA 5 (West Los Angeles and West Cities), largely driven by RCFEs in those areas.

Los Angeles County agencies were identified as sources for referrals in significantly greater proportions in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities), and SPA 6 (South Los Angeles) than in other SPAs, potentially indicating greater distribution of service concentration and focus in these catchments than in other areas.

Homeless shelters and services were reported as a source of referral in significantly greater proportions in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities), and SPA 7 (East Los Angeles and South East Cities) than other SPAs, with nonprofit partners indicated in significantly greater proportions again in SPA 4 and SPA 6 (South Los Angeles and South Cities).

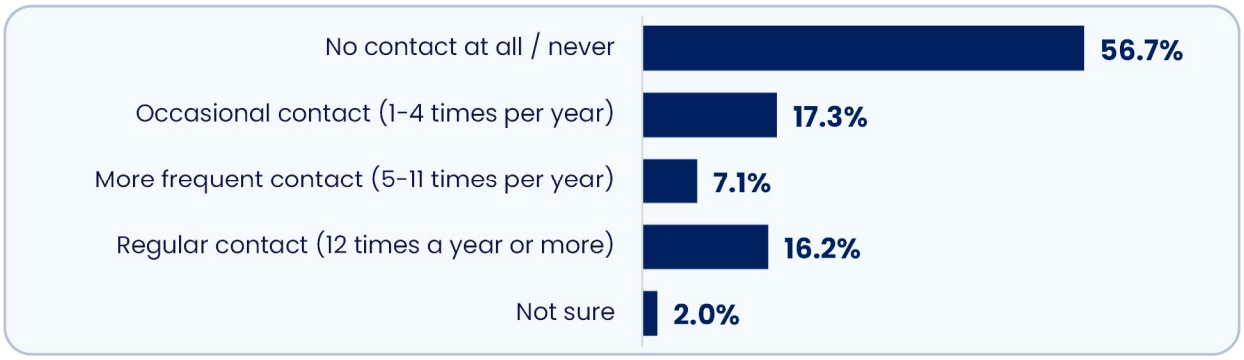
The Regional Center system was reported as a source of referral in significantly greater proportions across SPA 4 (Metro Los Angeles and Center Cities), SPA 6 (South Los Angeles and South Cities), and SPA 7 (East Los Angeles and South East Cities), despite general preference and policies against placements for their clients in mixed populations that could subject them to increased vulnerabilities, as expressed by Regional Center system stakeholders during qualitative research.

Market Interaction with Homelessness and Housing Services

Facility owners and operators were asked to identify how frequently they recalled having contact with government, nonprofit, and/or community groups and agencies within the Homelessness Continuum of Care (CoC) that specialized in delivering services to Los Angeles County populations experiencing homelessness.

FQ61. "How often does your facility communicate with government or nonprofit organizations who are working to serve people experiencing homelessness in our communities?"

FACILITY OWNERS & OPERATORS (N=353)



56.7% of respondents indicated that their facility had no contact at all over the 12 months prior to interview with organizations serving Los Angeles County homelessness Continuum of Care (CoC), inclusive of governmental agencies such as LAHSA, Coordinated Entry Service (CES) providers, nonprofits, and homeless shelters or bridge housing providers. This indicates a significant gap in capabilities and interface in serving the needs of people experiencing homelessness with any capability to be housed at ARFs and RCFEs.

The gap in contact and inclusion was partly explained during qualitative interviews with senior stakeholders at LAHSA and CES providers, indicating that the CoC model and requirement to follow the U.S. Department of Housing and Urban Development (HUD) definitions of "what housing is"[8], and that HUD-funded activities did not identify ARFs and RCFEs as a housing bona fide housing resource, and were not qualifiable in their direct service models. LAHSA stakeholders also identified definitional issues for ARFs and RCFEs in regard to their classification as non-medical facilities. However, LAHSA stakeholders indicated that the agency connected vulnerable individuals to the Market resources via Los Angeles County Agencies, such as DMH and DHS, based on individual needs.

With fewer than 1 in 5 (16.2%) of ARF and RCFE owners and/or operators reporting regular contact with organizations with a significant potential to supply residents in need of housing, a major priority for both licensed facilities and the homelessness CoC should be to remedy this gap in communications, policy, and service models. Exploration of increasing the efficiency of delivering benefit via more direct placement and benefit to individuals in need of housing within the Market is needed, regardless of external funding and policy guidelines, utilizing direct contact and alternative funding to better activate this underutilized service pathway.

Table 3.17: Interaction with CoC, by License Class	ARF	RCFE	ALL
No contact at all / never	36.0%	70.6%	56.7%
Occasional contact (1-4/year)	23.5%	13.6%	17.3%
More freq. contact (5-11/year)	14.0%	2.8%	7.2%
Regular contact (12+/year)	24.3%	11.2%	16.3%
Not sure	2.2%	1.9%	2.0%

[8] A key issue identified in discussions with LAHSA senior stakeholders was the lack of tenancy rights and privileges afforded to residents of ARFs and RCFEs in comparison to individuals with a housing rental or leasing agreement encountered across most other forms of "permanent" housing. This specific issue prevents definition of ARFs and RCFEs as permanent housing by HUD, despite some de facto acceptance of ARFs and RCFEs as permanent housing by other government agencies, communities, families of residents, residents, and members of the public. The need for redefinition is also supported by the experiences of residents with decades-long durations of residence at both ARFs and RCFEs.

RCFEs willing to serve the identified, vulnerable population are significantly less likely to have any interaction with organizations within serving across the homelessness Continuum of Care (CoC), including shelters, than ARFs, identifying a significant missed opportunity in outreach and coordination of placements for unhoused people over the age of 60, in particular people experiencing homelessness who possess challenges and needs relating to maintaining their activities of daily living (ADLs). Overall, ARFs have significantly greater frequencies of contact with homelessness services providers and systems than RCFEs.

Table 3.18: Interaction with CoC, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
No contact at all / never	67.8%	48.6%	36.5%
Occasional contact (1-4/year)	14.4%	16.2%	27.0%
More freq. contact (5-11/year)	5.9%	8.1%	9.5%
Regular contact (12+/year)	9.9%	25.7%	24.3%
Not sure	2.0%	1.4%	2.7%

ARFs and RCFEs with 6 or fewer licensed beds experienced significantly lower levels of contact with shelters and homelessness service providers, with more than two-thirds (67.8%) indicating that they had no direct contact with entities specifically serving this Continuum of Care (CoC). There appears to be a relationship between the size of a facility and its contact with homelessness providers and shelters, with approximately 1 out of 4 facilities that hosted more than 7 licensed beds indicated that they had at least monthly contact with these service providers, and far greater proportions of facilities with 61 licensed beds or more reporting any frequency of contact that smaller ARFs or RCFEs.

Table 3.19: Interaction with CoC, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
No contact at all / never	69.2%	59.2%	61.7%	22.9%	57.1%	40.0%	76.2%	64.2%
Occasional contact (1-4/year)	15.4%	17.1%	16.0%	31.4%	21.4%	23.3%	9.5%	11.9%
More freq. contact (5-11/year)	7.7%	6.6%	3.7%	14.3%	7.1%	10.0%	4.8%	7.5%
Regular contact (12+/year)	7.7%	13.2%	16.0%	28.6%	14.3%	26.7%	4.8%	16.4%
Not sure	0.0%	3.9%	2.5%	2.9%	0.0%	0.0%	4.8%	0.0%

Market facilities serving SPA 7 (East Los Angeles and South East Cities). SPA 1 (Antelope Valley), SPA 8 (South Bay and Coastal Cities), reported significantly lower proportions of contact with homelessness services providers and shelters in comparison to other Los Angeles County Service Planning Areas, indicating a key deficiency and barrier for utilization of ARFs and RCFEs to serve the homelessness CoC in these areas. More than a quarter of facilities serving SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities) reported having contact with such service providers on at least a monthly basis.

These patterns of missing interactions across Los Angeles County service geographies represent significant levels of missed opportunity in optimally moving individuals experiencing homelessness into facilities that could serve the needs of members of this vulnerable population: largely due to the formal definitions of “what permanent housing is” by agencies. It is further hypothesized that this issue likely extends across the entire State of California, reducing housing resources for vulnerable populations in ARFs and RCFEs across all 58 counties.

Circular Service Flows Within the Market

While this study has identified valid estimates of proportions across the channels of origin for Market residents and has identified many of the factors leading to placements in ARF/RCFEs, discussions with Market Users identified concerns about the frequency of transfers and "circular flows" of vulnerable individuals across and between a range of settings: from in-patient medical facilities such as hospitals, in-patient mental health facilities, incarceration, ARFs/RCFEs, and to again experiencing homelessness.

Nearly every Market User engaged in qualitative discussions reported significant proportions of churn in clients who fall out of the reach of systems of care, and are forced to again restart their journeys from hospitals, shelters, on the street, or elsewhere. The rates of lateral placement into other ARFs/RCFEs where wraparound services may or may not be delivered, and data about the "unknown" movements of residents, along with data regarding movements into acute health or mental health settings, lend support and credulity to many of the Market User observations regarding referral and placement churn.

One of the most successful approaches to the initial placement and utilization of Market ARFs and RCFEs in Los Angeles County has Los Angeles Department of Mental Health (DMH) and Department of Health Services (DHS) programs that integrate referrals and placements across a range of sources into Market ARFs and RCFEs, via their Enhanced Residential Care (ERC) programs and services. However, there are many potential Market Users not availing their clients of the support of these County agencies in serving vulnerable populations: contributing to circular service flows across systems of care. The consensus across multiple stakeholders from homelessness Coordinated Entry System (CES) providers is that a significant proportion of their clients are gravely disabled, of advanced age, and have co-occurring conditions that prevent them from accessing their services, or from having sufficient capability to live independently. CES providers indicated that many unhoused clients have difficulty finding their way into (or remaining in) interim housing until a more long-term placement can occur, but would like a more direct pathway to refer these individuals to more optimal care settings, like Market ARFs or RCFEs. CES providers also report that street-level teams frequently encounter significant numbers of vulnerable clients in unsafe situations, with many clients living with physical disabilities such as blindness, paralysis, or amputations. CES stakeholders concurred that persistent need exists for crisis and/or acute bridge settings to triage and address the medical needs of clients in order to prepare them for direct referral to an ARF or RCFE as effectively permanent housing.

CES providers acknowledged a lack of expertise and internal skills amongst their staff to appropriately serve aged- or severely-disabled clients they encounter, or even objectively assess them (and their acute needs) for appropriate placement and services. For most interim housing providers, stakeholders stated that they had limited ability to provide any of these same transitional services, and that accountability for this activity rests with the Los Angeles County ERC program(s). These providers observed that the longer people are unhoused, "the sicker and more vulnerable they are", and indicated that their services help them less effectively. One CES provider indicated that although they are contracted with DHS and DMH, they lacked awareness of the specific services or capabilities of any ERC programs or the Market's licensed facilities. To address the critical care needs of their specific clients, one CES provider had even established a specialized, acute bridge housing program, offering many of the wraparound services and linkages commonly found via County ERC programs that enable further navigation and placement to Market ARFs or RCFEs. This provider program has a substantial waitlist, and indicated that up to a third of their clients (33%) would benefit from this type of setting, even though this offering is not core to their organization's service focus. Despite establishing a service relationship with a primary care provider to get their clients connected to medical care, the program is not optimal because the care is delivered off-site, and transporting medically- frail clients is extremely challenging. Despite the extraordinary efforts of this provider, many clients have died in shelter without ongoing access to medical care to address their specific care needs.

Several CES providers reported that their housing navigators attempt to address the needs of clients with significant medical needs by utilizing housing vouchers, to surreptitiously move them into permanent supportive housing (PSH), a practice corroborated by PSH stakeholders interviewed. PSH stakeholders indicated that their capabilities leave them ill-equipped to appropriately serve these individuals within an independent living setting. These observations from CES and PSH stakeholders identify a clear gap in LAHSA, CES, and affiliated stakeholder knowledge regarding the capabilities of Market ARFs and RCFEs, the specific service offerings of County agencies like DMH and DHS, or how to access the Market of ARFs and RCFEs.

Some interim and PSH housing providers attempted to retain such clients, but many are alleged to reject such placements, forcing vulnerable individuals to "start over" in CES service processes. For vulnerable individuals that were placed in PSH without first addressing their mental health needs, many were referred on to the DMH Psychiatric Mobile Emergency Response Team (PMRT) because they would eventually decompensate, violate house rules, or were going to be evicted due to behaviors that risk the health or well-being of other residents. According to stakeholders interviewed, these are common examples of circular flows of vulnerable individuals across Los Angeles County systems of care, with many Market Users hoping that such movements might eventually lead individuals to placement within the DMH ERC program. However, the inefficiency of such indirect "referrals" results in elevated costs to taxpayers, longer timeframes, and produces reduced care outcomes.

Nearly all DMH, DHS, and County-operated hospital stakeholders indicated that they directly refer vulnerable individuals to ARFs and RCFEs, including those affiliated with the Full-Service Partnership (FSP) program. The Los Angeles County Public Guardian also refers conserved individuals to Market ARFs and RCFEs often, and has direct interactions with facilities that they are aware of, from existing relationships and referrals of other individuals who had been conserved at a Market facility. When the Public Guardian's clients are discharged from acute care settings, they need to be referred immediately based on their recommended level of care. If their access to public benefits has not already been established, this creates further delay, or puts pressure on Market ARFs and RCFEs awaiting payment, posing additional burden to facilities. Many Lanterman-Petris-Short Act (LPS)[9] conservatees are also placed within Market facilities, starting in an acute setting or IMD, then stepping down into a moderate setting such as Enriched Residential Services (ERS), then into a Market ARF or RCFE, with an intention that after an indeterminate period of residence at a Market facility, that they can be released from conservatorship. As at February 2023, there are approximately 2,000 LPS conservatees within Los Angeles County systems of care.

Market Users identified significant utilization of the HOME program (serving 100% formerly unhoused clients) through direct placement in Market facilities to stabilize clients and transition them to PSH. There is general agreement from stakeholders that people experience of homelessness have different needs than those in bridge or interim housing, and that the HOME program has significant contact with Market facilities. Some DMH programs referred clients internally into the ERC program, where there was more assurance that a viable transition and long-term client stability was more likely.

Recuperative care facility stakeholders reported that they tend to maintain clients who are not appropriate for other channels of independent living within their facilities, due to concerns that placements of individuals in Market ARFs and RCFEs may not be successful. No recuperative care stakeholders reported consistent referrals to the ERC program, and many reported that with Market ARF and RCFE referrals and placements they are unable to ascertain success "unless they are asked to look for a person on the street", or "if their previous client returns to them". Recuperative care facility stakeholders would prefer to have a more formalized transition of clients and their services, coordinating care with staff at Market facilities for better delivery of recovery services, increasing their likelihood of preference for Market ARF and RCFE referrals and placements.

The insights uncovered suggest that a single County agency should be designated and funded to administer complete navigation and real-time information services for all Market ARFs and RCFEs, for all Market Users, to reduce circular flows across systems of care, inform all Market Users of capabilities, enable expansion of Market capacity, ensure the continuity and appropriateness of care, and to promote universal visibility of access and awareness of the services offered by Market ARFs and RCFEs. Effectively, this agency would serve as a virtual traffic controller or demand manager for Market placements of all vulnerable individuals in Los Angeles County. It is not believed that such accountability would suit a non-governmental partner, due to the inherent complexity of establishing the endeavor, and the need to secure long-term funding for assurance of longitudinal service delivery.

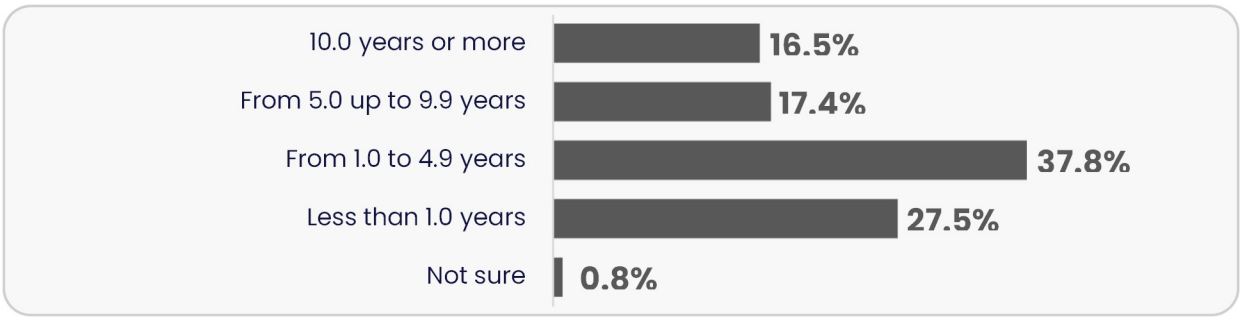
[9] https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=1.&article=

Duration of Residence at Facilities

Residents were asked to recall, to the best of their ability, how long they had been continuously housed at their current ARF or RCFE. Respondents were allowed to answer in any measure, with resident responses rounded and recoded into the nearest whole month of residence for comparison and analysis.

RQ15. "How long have you lived here?"

RESIDENTS (N=625)



Although the greatest proportions for mean duration of residence at ARFs and RCFEs serving the identified, vulnerable populations is from 1.0 to 4.9 years (37.8%), more than a third (33.9%) of residents have lived at their licensed facilities for a mean duration greater than 5.0 years.

Table 3.20: Duration of Residence (In Months), by License Class	ARF	RCFE	ALL
	72.2	40.9	57.9

Means for the duration of residence at ARF facilities are significantly greater than those observed for RCFEs, in part attributed to the greater typical age range (18-60) and younger mean entry age of the populations that ARFs serve.

Table 3.21: Duration of Residence (In Months), by License Class	ARF	RCFE
≤ 6 BEDS	67.9	27.5
7–60 BEDS	56.0	52.0
≥ 61 BEDS	81.6	45.6

Residents of ARFs with 6 or fewer licensed beds and 61 or more licensed beds report significantly greater mean durations of residence at their facility than residents in RCFEs within the respective licensed bed size ranges. Residents at 61 or more bed ARFs also report significantly greater mean durations of residence than those housed at comparably-sized ARFs or RCFEs.

TABLE 3.22: Duration of Residence (In Months), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	40.7	54.5	66.8

There was an observed increase in mean resident duration of stay that generally correlated with the size of the facility, as measured by licensed bed count.

TABLE 3.23: Duration of Residence (In Months), by Gender Identity	FEMALE	MALE
	50.5	62.5

Residents of female gender identity reported significantly lower mean durations of residence than their male-gendered counterparts.

TABLE 3.24: Duration of Residence (In Months), by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESSAS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	68.4	59.5	52.6	63.7	63.8

Across all key study factors, residents with experience of living with mental illness, those with experience of addiction to drugs and/or alcohol, and those with experience of incarceration for a period of greater than 30 days reported increased mean durations of facility residence in relation to others.

TABLE 3.25: Duration of Residence (In Months), by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER**	MIDDLE EASTERN**
	57.5	62.9	56.5	47.7	40.9	92.3	53.3

** Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups for this question

Black / African American residents reported elevated mean durations of residence in ARFs and RCFEs in comparison to residents from other racial identity groups, while Asian / Asian American and Native American / Alaskan Native residents reported significantly lower mean durations of residence.

TABLE 3.26: Duration of Residence (In Months), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	35.1	49.2	49.8	62.2	56.7	53.5	94.4	67.6

Mean durations of residence reported from SPA 7 (East Los Angeles and South East Cities) were significantly greater than those observed from most other SPAs, with elevated mean durations of residence observed from respondents in SPA 4 (Metro Los Angeles and Center Cities) and SPA 8 (South Bay and Coastal Cities). Residents from SPA 1 (Antelope Valley) reported significantly lower mean durations of facility residence.

Extended Durations of Residence at Market ARFs

Not all residents of Market ARFs or RCFEs are capable of moving from their facility to placements at lower levels of care across Los Angeles County communities, as many have significant co-occurring health, capability, and care needs that make their return to another housing type both challenging and resource-intensive, if not simply impossible. However, there are a range of reasons for the observed disparity in duration of resident stays between ARFs and RCFEs that are not attributable to individual resident needs.

One obvious consideration: many residents at ARFs are placed with facilities at significantly lower entry ages than their RCFE counterparts, enabling residence for extended periods of time before they meet ARF age limitations and might be identified for transfer to an RCFE (or are assigned an exemption to remain in place at an ARF). For Market Users such as government agencies and nonprofits, understanding that some ARF residents are significantly more likely to be at their facilities for substantively greater durations of time over residents at RCFEs should also be influential in encouraging more optimal placement of residents at the right facility to serve their individual needs.

A significant missed opportunity exists to return more Market ARF residents to lower levels of care and greater levels of personal independence. Wraparound programs and services to develop skills and capabilities required to produce these outcomes are not as prevalent for access by Market ARF residents as needed. Many ARF residents are unable to access all of the services that correspond with their specific needs, which corresponds with a gap that exists in the services that enable capable residents to “graduate” to lower levels of care and more independent housing. Not all wraparound services offered by government and nonprofit service providers are as accessible in all Service Planning Areas (SPAs) of Los Angeles County.

Promoting changes in Market User understanding as to where the accountability of enhancing graduation rates from ARF residents to lower levels of care is a key consideration, as owners and operators of facilities largely perceive the accountability to deliver wraparound services that enable residents to move on from facilities to be with Los Angeles County agencies and nonprofit service partners. However, some senior stakeholders from Los Angeles County agencies indicated their belief that the accountability for this activity largely rests with facility owners and operators, established from their conditions of licensing with CCLD.

Resolving the differences in perceptions for the accountability for assisting residents to access skills and services to graduate or move to lower levels of care (wherever practicable) is of critical importance for both Market Users, agencies, and facilities alike, as it will increase the capacity of the Market to serve even greater numbers of vulnerable individuals, ensuring that bed capacity within facilities remains utilized for the right reasons and the residents best served. Processes, greater levels of external support, and increased access to wraparound services to help facilities to address the needs of residents capable of making a transition are required to expand service capability in the Market’s ARFs.

4.0

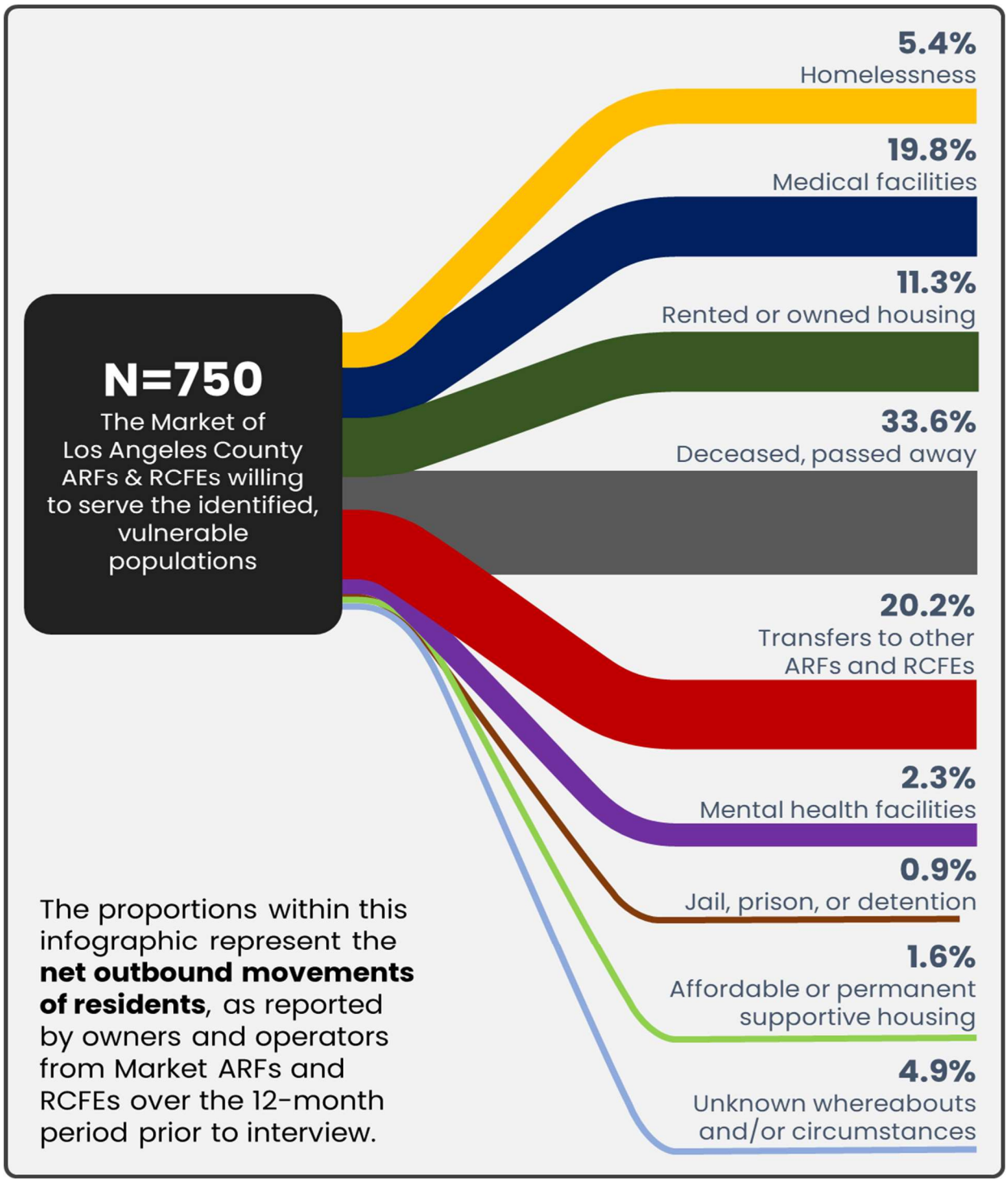
Image: www.dreamstime.com

Market Outputs and Resident Turnover

Understanding when and why residents leave ARFs and RCFEs is important to maximizing opportunities to optimize resident movements to greater or lesser levels of care, increasing the capacity of the Market to serve even more individuals from identified, vulnerable populations.

Visualizing Market Resident Outputs

Comparable to existing knowledge relating to resident inputs at ARFs and RCFEs, there are significant gaps in Market User knowledge relating to the outflows of residents. The following visualization represents the proportions of owner/operator-estimated resident outbound movements from their facilities for a period of 12 months prior to interview:



Market Turnover Rates for Residents

Facility owners and/or operators were asked to provide a total estimation of turnover, or outbound resident movements from their facility for any reason, over the 12 months prior to their date of interview.

FQ18. "Approximately how many residents permanently stopped living at your facility for any reason (in the previous 12 months)?"

FACILITY OWNERS & OPERATORS (N=353)

Table 4.1: Mean Turnover (Prior 12 Months), by License Class	ARF	RCFE	ALL
	5.15	4.80	4.93

ARFs experience slightly greater mean counts in resident turnover per year than their RCFE counterparts, but the study also identified ARFs to serve a generally more diverse population of residents with identified vulnerabilities and needs as a license class.

Table 4.2: Mean Turnover (Prior 12 Months), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	1.91	4.80	13.39

In relation to facility size, there is a natural correlation between resident population size and annual resident turnover, with larger facilities experiencing proportionately greater levels of resident outbound movements.

Table 4.3: Mean Turnover (Prior 12 Months), by License & Size	ARF	RCFE
≤ 6 BEDS	0.67	2.37
7–60 BEDS	4.92	4.58
≥ 61 BEDS	13.19	13.55

Small ARFs experience significantly lower mean levels of resident turnover than their RCFE counterparts, with an initial hypothesis suggesting that this would be related to median resident age and morbidity factor-based differences between license classes. However, this hypothesis does not hold for comparison of ARFs and RCFEs serving licensed bed counts of 7 to 60 and 61 or more beds. ARFs serving 6 or fewer licensed beds or less have an anomalously lower mean proportion of resident turnover in comparison to similarly-sized RCFEs, for reasons which cannot be effectively evaluated by the study.

Table 4.4: Mean Turnover (Prior 12 Months), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	2.96	4.12	5.81	9.74	4.50	2.93	2.10	4.91

In relation to Los Angeles County Service Planning Areas, facilities located in SPA 4 (Metro Los Angeles and Center Cities) report significantly greater mean numbers for annual resident turnover in comparison to other SPAs across County. One potential hypothesis for this is proximity to the greatest concentration of services (across health, mental health, justice, and other services) in Los Angeles County, as well as proximity to the greatest concentration(s) of unhoused individuals living in Los Angeles County.

Facilities serving SPA 1 (Antelope Valley), SPA 6 (South Los Angeles and South Cities), and SPA 7 (East Los Angeles and South East Cities) reported significantly lower counts of mean resident turnover than facilities located in other SPAs.

Table 4.5: Mean Turnover (Prior 12 Months), by SPA & License Class	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
ARF	0.67	4.92	4.81	10.50	5.67	2.88	2.09	3.79
RCFE	3.26	4.14	6.15	5.86	3.00	3.20	2.70	5.79

ARFs located in SPA 4 (Metro Los Angeles and Center Cities) reported significantly greater mean counts of resident turnover for a 12-month period than facilities located in any other SPA. RCFEs located in SPA 3 (San Gabriel Valley), SPA 4, and SPA 8 (South Bay and Coastal Cities) reported elevated mean counts of resident turnover in relation to other SPAs.

ARFs located in SPA 1 (Antelope Valley), SPA 6 (South Los Angeles and South Cities), and SPA 7 (East Los Angeles and South East Cities) reported significantly lower mean counts of resident turnover than ARFs in other SPAs, with RCFEs located in SPA 7 also reporting significantly lower mean counts of resident turnover than RCFEs in other SPAs.

Table 4.6: Mean Turnover (Prior 12 Months), by SPA and Facility Size	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
≤ 6 BEDS	2.96	2.11	2.07	1.30	2.14	0.94	2.00	1.51
7–60 BEDS	3.00	6.80	4.05	8.88	4.00	2.38	0.40	3.07
≥ 61 BEDS	NaN	12.08	13.91	20.00	6.50	9.00	10.00	14.44

*No facilities with 61 or more licensed beds were qualified and agreed to take part in the research from SPA 1

Facilities with 6 or fewer licensed beds located in SPA 6 (South Los Angeles and South Cities) reported significantly lower levels of mean counts of resident turnover than those of similar size located in other areas, with 7 to 60 licensed bed facilities in SPA 6 and SPA 7 (East Los Angeles and South East Cities) also reporting significantly lower mean counts of resident turnover than those located in other areas of similar size range. Facilities in SPA 5 (West Los Angeles and West Cities) with 61 or more licensed beds reported significantly lower levels of mean counts of resident turnover than those located in other SPAs.

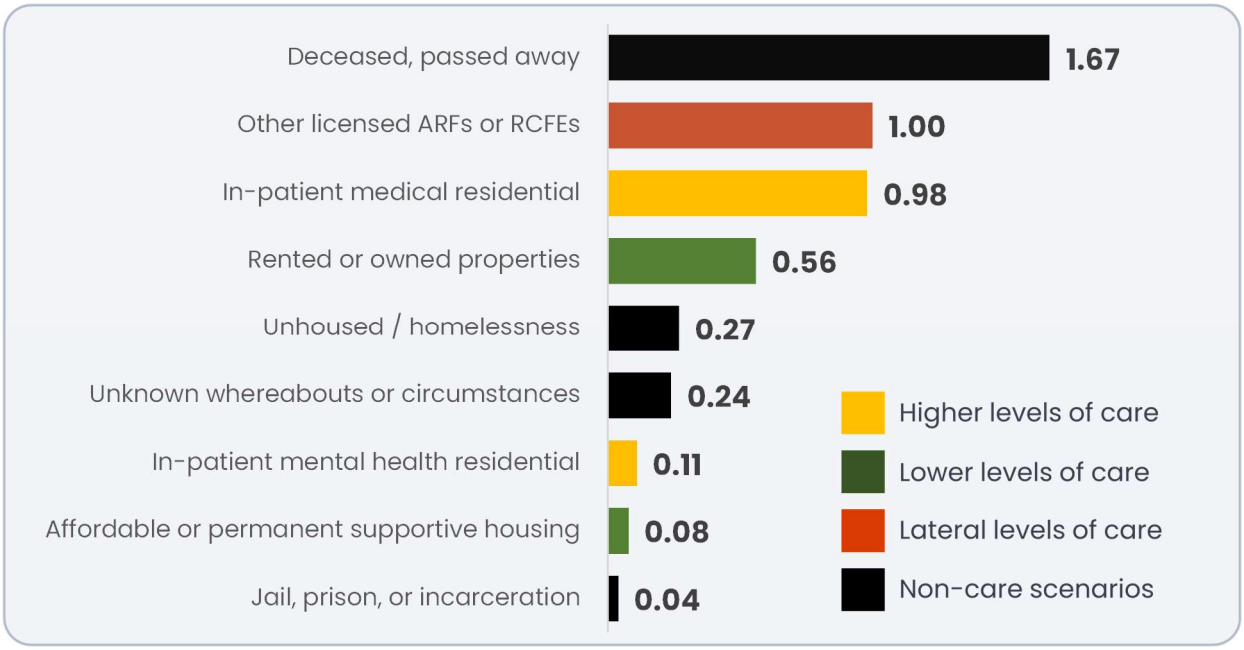
Licensed facilities with 7 to 60 beds located in SPA 2 and SPA 4 reported significantly greater mean counts of resident turnover in comparison to facilities located in other SPAs, with 61 or more licensed bed facilities in SPA 4 also reporting significantly greater mean counts of resident turnover over a 12-month period.

Resident Outcomes from Market Turnover

Facility owners and operators were specifically probed across a comprehensive list of outcomes to establish reasonable estimates for the total movements of former residents after ending their housing at facilities.

FQ19. "Thinking again about all of the residents who permanently stopped living at your facility (in the previous 12 months), approximately how many former residents moved directly from your facility into the following situations?" (PROMPTED TO EQUAL THE RESPONDENT TOTAL OF FQ18.)

FACILITY OWNERS & OPERATORS (N=353)



Overall, a typical facility within the Market of ARFs and RCFEs serving identified, vulnerable populations lose 1.67 mean residence to mortality every 12 months, a figure that is weighted heavily by RCFEs and the aged populations they serve. Approximately 1.0 residents per year move to other licensed ARFs and RCFEs or to an in-patient, medical facility, respectively.

Only 0.56 mean residents "graduate" to rented or owned properties from a typical Market ARF or RCFE each year, with only a further 0.08 moving to affordable or permanent supportive housing situations, reinforcing a study finding that very low proportions of residents graduate to lower levels of care or more independent living situations, attributable to a gap in connections with agencies and services supporting these options, and a gap in wraparound services that build skills and capabilities with residents able and ready to make future transitions.

Table 4.7: Mean Outbound Moves (Prior 12 Months), by License Class	ARF	RCFE	ALL
Deceased, passed away	0.38	2.47	1.67
Other licensed ARFs or RCFEs	1.57	0.64	1.00
In-patient medical residential	0.82	1.08	0.98
Rented or owned properties	0.71	0.47	0.56
Unhoused / homelessness	0.60	0.06	0.27
Unknown whereabouts or circumstances	0.53	0.06	0.24
In-patient mental health residential	0.27	0.01	0.11
Affordable or permanent supportive housing	0.15	0.03	0.08
Jail, prison, or incarceration	0.10	0.00	0.04

The largest mean counts of movements from former residents across nearly all categories occur at ARFs, with a mean of 5.15 residents of turnover per annum (keeping in mind that this figure is inclusive of facilities ranging in size from fewer than 6 beds up to facilities with more than 150 residents).

RCFEs, which have a mean turnover of 4.80 residents per annum, experience greater outflows of residents than ARFs from moves to residential medical facilities, inclusive of hospitals, skilled nursing, and hospice facilities, and significantly greater mean turnover from resident mortality, largely understood to be a function of the increased age and co-morbidities of the populations that facilities within the license class serve.

Table 4.8: Mean Outbound Moves (Prior 12 Months), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Deceased, passed away	1.22	1.03	3.54
Other licensed ARFs or RCFEs	0.25	1.61	2.43
In-patient medical residential	0.17	0.63	3.57
Rented or owned properties	0.14	0.88	1.39
Unhoused / homelessness	0.04	0.11	1.04
Unknown whereabouts or circumstances	0.05	0.39	0.62
In-patient mental health residential	0.01	0.05	0.46
Affordable or permanent supportive housing	0.03	0.09	0.19
Jail, prison, or incarceration	0.02	0.03	0.12

Facilities with 61 or more beds have significantly greater mean counts of resident movements in comparison to facilities with lower total resident populations across all categories, confirming a simple test hypothesis that rates of resident turnover are at least in part, a function of facility population size.

Table 4.9: Mean Outbound Moves (Prior 12 Months), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Deceased, passed away	1.73	1.61	2.51	0.69	1.64	0.37	1.33	1.87
Other licensed ARFs or RCFEs	0.69	0.44	0.92	4.03	0.57	0.40	0.14	0.91
In-patient medical residential	0.15	1.51	1.31	1.60	0.43	0.53	0.29	0.49
Rented or owned properties	0.08	0.51	0.52	0.89	0.29	0.40	0.33	0.90
Unhoused / homelessness	0.15	0.03	0.07	0.74	1.07	0.63	0.10	0.30
Unknown whereabouts or circumst.	0.00	0.08	0.22	1.11	0.00	0.43	0.05	0.13
In-patient mental health residential	0.08	0.01	0.07	0.29	0.14	0.10	0.00	0.24
Afford. or perm. supportive housing	0.04	0.09	0.14	0.11	0.00	0.00	0.10	0.03
Jail, prison, or incarceration	0.00	0.01	0.05	0.11	0.00	0.07	0.05	0.04

Facilities located in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities), and SPA 6 (South Los Angeles and South Cities) reported significantly greater mean counts of former residents who returned to experiencing homelessness, in comparison to facilities located in other Los Angeles County SPAs. SPA 4 facilities also reported significantly greater mean counts of residents who moved to unknown whereabouts or circumstances, with owners and operators reporting that they could not account for these former resident's movements after their disappearance from facilities. This finding suggests the presence of localized issues, social hazards in the environment for residents, or operational circumstances that facilities face in SPA 4 that owners and operators in other SPAs do not.

SPA 2 (San Fernando Valley), SPA 3 (San Gabriel Valley), and SPA 4 (Metro Los Angeles and Center Cities) reported the greatest mean counts of former residents who moved to higher levels of medical and mental health care compared to facilities in other SPAs, including movements to residence in hospitals, skilled nursing facilities (SNFs), and hospice facilities, and institutions for mental disease (IMDs).

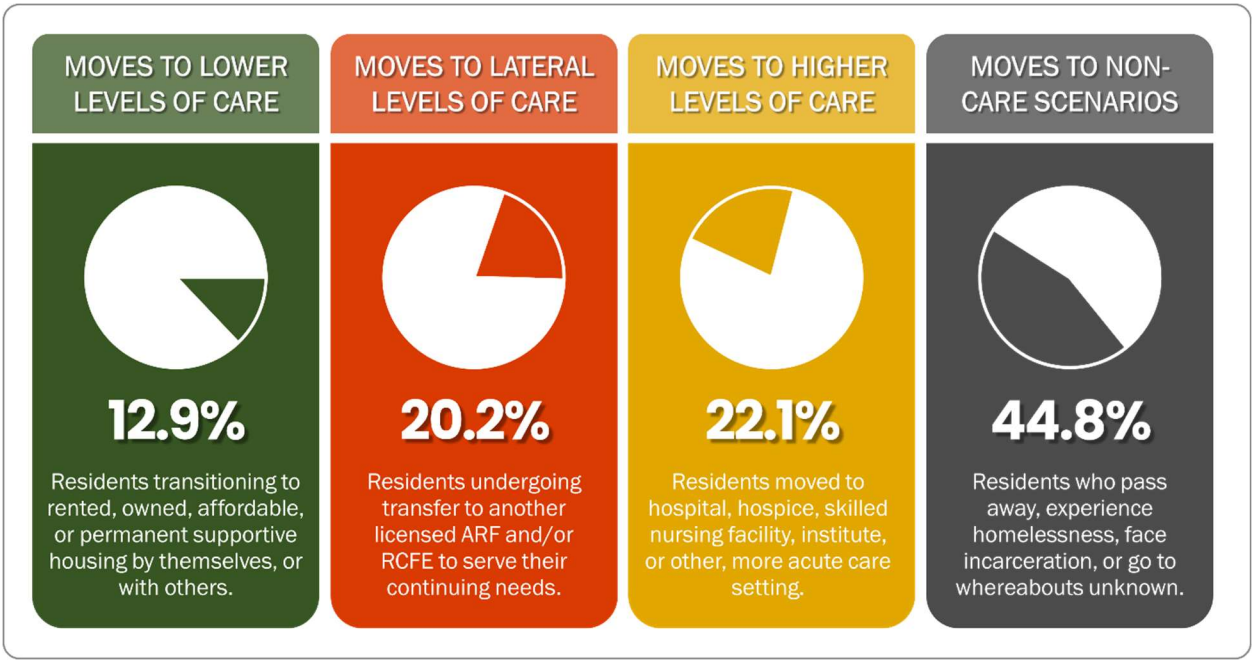
Significantly lower mean counts of residents moved on to in-patient, medical residential facilities from SPA 1 (Antelope Valley), SPA 5 (West Los Angeles and West Cities), SPA 6 (South Los Angeles and South Cities), SPA 7

(East Los Angeles and South East Cities), and SPA 8 (South Bay and Coastal Cities) than residents from the remaining SPAs. Facilities in SPAs 4 (Metro Los Angeles and Center Cities) and SPA 8 (South Bay and Coastal Cities) reported the greatest mean counts of former residents who "graduated" to lower levels of care, from movements to general market (rented or owned) housing, living with friends and relatives, or moving into affordable or permanent supportive housing.

Facilities in SPA 3 (San Gabriel Valley) also reported significantly greater mean counts of mortality for former residents than facilities in other SPAs, largely attributable to greater proportions of RCFEs in that area.

Resident Movements to Other Levels of Care

A key objective of the study was to identify the proportions of residents moving to higher or lower levels of care from ARFs and RCFEs serving identified, vulnerable populations.



Based on the study sample of N=353 facilities, 1,749 residents of ARFs and RCFEs left their facilities in the year prior to the study, for any reason. Extrapolating these proportions from the sample to the estimated N=750 facilities willing to provide service to the identified, vulnerable populations, the Los Angeles County Market generates an estimated 3,716 vacancies per year in turnover from resident populations, with a margin of error of +/- 3.80 percent.

Approximately 479 (12.9%) former residents from the Market are estimated to have moved to lower (less acute) levels of care, inclusive of residents who moved into independently rented or owned housing, by themselves with family and friends, or moved to affordable or permanent supportive housing programs. A further 751 (20.2%) former residents are estimated to have moved laterally into other Market ARFs and/or RCFEs.

Approximately 821 (22.1%) of former ARF and RCFE residents are estimated to have permanently moved from the Market to a higher (more acute) level of care, such as medical facilities, inclusive of hospitals, skilled nursing facilities (SNIFs), and hospice facilities, along with a smaller proportion of former residents who "stepped up" to residential mental health treatment facilities, namely institutions for mental disease (IMDs).

Accounting more specifically for the 44.8% of former residents in the Market moving to situations where no further care is known to be provided by any system (characterized as "non-care" scenarios) approximately 1,249, or 33.6% of the pool of 3,716 former residents, are estimated to pass away each year. Another 200 (or 5.4%) of former residents from the Market are estimated to have returned to experiencing homelessness, with

a slightly lower proportion of 182 (4.9%) of former residents are estimated to have circumstances of departure, and/or current whereabouts which are unknown to Market facility owners and operators.

The proportions reported from the survey sample (N=353) were recalculated utilizing incidence rate data to produce estimated counts of resident moves for the total, Los Angeles County Market of N=750 facilities willing to serve the identified, vulnerable population.

Overall, very low proportions of residents graduate from Market facilities to lower levels of care, such as permanent supportive housing or affordable housing, indicating potential gaps in government and nonprofit wraparound training and education services that could enable more resident movement and graduation.

Inefficiency of Resident Transfers within the Market

Approximately 751 residents are estimated to have moved from one licensed ARF or RCFE to another within the Market, accounting for more than 20.2% of all movements from Market facilities (of approximately 3,716 outbound moves from former residents, in total).

In discussions with Market Users across systems of care, the presence of such a high proportion of lateral movements within the Market was attributed to a few factors. For residents who were affiliated with the Los Angeles County Enriched Residential Care Program(s), DMH Outpatient Mental Health Programs, or DMH Enriched Residential Services Programs, residents can be "moved along" out of a more-resourced bed, to a lesser-resourced bed within the system. There is a shared perspective from some Market Users that residents are permanently moving along a one-way path via a service continuum, whereas others identify that they reach a "service cliff", indicated by Market Users expressing concern about movement out of resourced facilities and into placements at less-resourced facilities, with gaps in connections to wraparound services that may detract from long-term resident stability and success.

Market Users that did not have a service process of placing vulnerable individuals via County-resourced programs and channels reported making the best of non-optimal facility placements and retaining clients even though their organization's policies and contractual terms provided other direction. Many of these stakeholders align their clients with services such as outpatient mental health, unscheduled appointments that attempt to bridge care, with hopeful and eventual referral into FSP, among other DHS and DMH programs. A common factor mentioned was a "continuous sense of urgency" experienced by some Market Users, and desire to place vulnerable individuals at any facility available to try to address their needs while keeping them housed, in-line with an approach to house people in the first-available placement setting. In making rapid placements, Market Users frequently indicated that their clients expressed resistance at being placed in facilities that were not optimally located near familiar communities, resulting in further dissatisfaction and eventual need to relocate them to more familiar surroundings, resulting in at least a portion of the excess lateral placements observed amongst Market ARFs and RCFEs.

Many owners and operators of Market ARFs and RCFEs shared observations that residents who are arbitrarily placed in their facilities can prove to be "too disruptive" to the health and well-being of other residents in facility communities, which leads them to seek other ARFs or RCFEs which are better suited to address the behavioral, substance abuse, and/or social needs of the disruptive resident. In some circumstances, Market owners and operators are left with no choice but to transfer disruptive residents due to personal safety risks

posed to others from the escalation of incidents into physical conflict and/or violence. Market facilities generally experience unmet need from Market Users for the more optimal placement of the residents, and assurance that residents who are placed with them generally have the types of needs and requirements that they are most prepared and equipped to serve.

This correlates with unmet Market User needs to have access to standardized assessment criteria that facilitate the matching of vulnerable clients to facilities with capability to serve residents with such attributes. Market Users need more information to have in-depth understanding of the nominal range of behaviors and circumstances for all residents housed at a facility. However, there are unintended consequences and chilling effects from the release of such information: residents could be intentionally placed in a Market facility with the wrong level of care to simply move them along, or an unreasonable burden could be placed on specific facilities that were relegated to serve only the most "difficult" residents, in relation to other facilities. If applied to individual residents, it could lead to residents experiencing greater incidences of being forcefully evicted, or hospitalized and unable to retain their placements, continuing to result in excess movements to other facilities.

Stakeholders with the California Department of Aging's Long-Term Care Ombudsman observed that there was significant movement of people experiencing homelessness into RCFEs when facilities had an open bed, but indicated that when many RCFEs were able to replace the individual with a privately-funded or better-funded client, formerly unhoused residents are wrongfully evicted, another contributor to lateral movements. Although some movements between ARFs and RCFEs occur due to the "aging-out" of residents, many ARFs obtain waivers for residents that qualify for movement to an RCFE but opt not to transfer them.

Market User Views on Movements to Other Levels of Care

Some Market Users viewed the collective resource of Market ARFs and RCFEs as a homogenous, housing resource, with some further characterizing them as "a dead-end street", "human warehouses", or "a final destination" for residents. However, these simple characterizations conflict with the value that the same stakeholders expect from Market ARFs and RCFEs in delivering housing and care services for residents. These casual descriptives also identify a greater issue: that most Market Users have little conception of where residents move to when they leave a Market facility, or worse, that they have no expectations regarding the quality or extent of programs and services to enable capable residents to graduate, or de-escalate, to a lower level of care. This can be partly attributed to a "housing first" approach (and policy) that was identified across the Market, but without adequate follow-up or understanding from many Market Users about what can, or should, come next for residents in regard to servicing their individuated needs.

A key benefit in creating a pathway for capable individuals to leave a Market facility for another housing type is the generation of additional housing capacity for other vulnerable individuals who need to transition to facilities. Such residents need to be offered the potential of developing independent living skills and capabilities to further transition to other, less acute or managed housing types.

In interviews with the residents of facilities during the study, many expressed genuine desire and identified attainable and achievable supports that they could use to transition to another public housing type, such as affordable housing, permanent supportive housing, or independent living. Few residents were able to identify specific programs or support to enable such transitions to lower levels of care, nor could the study identify the consistent delivery of such programs across governmental and nonprofit agencies serving much of the Market. Coupled with the expressed desire of many ARF residents to engage in paid employment that matched their level of capability and skills, this is a clear indication of a service gap in County and nonprofit programs to enable greater resident movement from Market facilities to lower levels of care that should be remedied.

Similarly, there is no widespread knowledge from any stakeholders affiliated with the Market, with the exception of facility owners and operators, regarding the proportions of residents that move to higher levels of care (such as more acute medical and mental health settings), or the significant level of lateral movements of residents between Market facilities themselves. It is hypothesized that Market facility residents who remain permanently incapable of moving away from a cycle of transfers between ARFs and RCFEs to other housing types providing the basis for many of the aforementioned negative perceptions and sentiments expressed by Market Users.

Most Market Users only notionally understand the movements of vulnerable residents to higher levels of care based on a limited number of interactions with individuals, and not always with great depth. This operational myopia tends to prevent stakeholders from seeing a complete picture of need in individuals, including health care, acuity of mental health condition(s), substance misuse treatment, and other substantive human needs. Tools and processes used for assessment of individuals also varied significantly across systems of care managed by Market Users, and were reported to be formal or informal, depending on the nature of services delivered within a system of care's rules, standards, accountabilities, and funding.

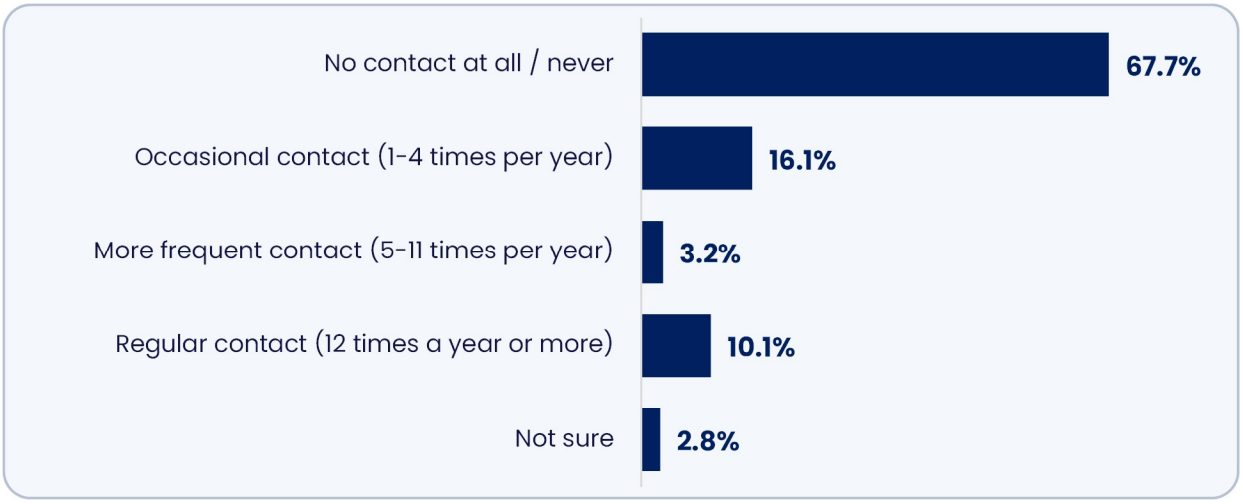
Market Users generally shared the belief that for some individuals with complex or co-occurring needs, ARFs and RCFEs can serve as permanent homes, with no genuine need to move residents along to another level of care without any newly-diagnosed needs. However, they also identified belief that there was an absence of robust transition protocols for Market ARFs and RCFEs or appropriate service levels required to quickly treat and stabilize residents after transitions from Market facilities into higher levels of care.

Market Interaction with Affordable and Permanent Supportive Housing Services

ARF and RCFE owners and/or operators were asked to identify approximately how many times a year that their staff has direct contact with representatives of nonprofit and governmental organizations delivering access to affordable and/or permanent supportive housing services across Los Angeles County communities.

F62. "How often does your facility communicate with government or nonprofit organizations working to provide affordable or permanent supportive housing to people in our communities?"

FACILITY OWNERS & OPERATORS (N=353)



More than two-thirds (67.7%) of owners and/operators of Market ARFs and RCFEs report that their facilities have no contact with organizations and stakeholders serving affordable and permanent supportive housing across Los Angeles County. This finding identifies a serious gap in the Market's capability to graduate or move residents with the desire and capability to seek settings that require lower levels of care, which leads the Market to a condition of decreased capacity from turnover to serve the identified, vulnerable population.

There may be a need to reinforce the concept of the imminent need to graduate residents, where possible and practicable, with Market owners and operators, ensuring that the maximum number of individuals who are capable of moving to lower levels of care and other housing is enabled through promotion of individual participation in skill and capability development programs, which generates valuable capacity on the Market for new residents from the identified, vulnerable population to take their vacated placements.

Table 4.10: Interaction with AH/PSH Services, by License Class	ARF	RCFE	ALL
No contact at all / never	47.1%	68.7%	60.3%
Occasional contact (1-4/year)	19.1%	16.4%	17.4%
More freq. contact (5-11/year)	11.8%	3.3%	6.6%
Regular contact (12+/year)	16.9%	10.3%	12.9%
Not sure	5.1%	1.4%	2.9%

Significantly lower proportions of ARFs report no contact with affordable or permanent supportive housing service providers than RCFE counterparts, with 16.9% of ARFs reporting to have roughly monthly contact with these organizations. Overall, ARFs reported significantly greater proportions of contact with these housing organizations than RCFEs, although fewer RCFE residents are surmised to have capabilities or abilities to engage meaningfully with such programs due to increased incidence of age-related, medical health, and care needs compared to ARF residents.

Table 4.11: Interaction with AH/PSH Services, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
No contact at all / never	70.3%	54.1%	39.2%
Occasional contact (1-4/year)	14.9%	16.2%	25.7%
More freq. contact (5-11/year)	5.0%	8.1%	9.5%
Regular contact (12+/year)	7.4%	17.6%	23.0%
Not sure	2.5%	4.1%	2.7%

Facilities licensed for populations of 6 beds or less report significantly greater proportions of having no contact with affordable or permanent supportive housing service providers than larger facilities, with the largest of facilities, those serving 61 or more licensed beds, reporting significantly greater proportions of contact overall. This finding suggests that facilities of larger capacity are either performing more outreach to integrate with this potential service channel to seek outbound resident placements, or are being prioritized for contact or connected by affordable or permanent supportive housing organizations seeking their participation with greater frequency.

Table 4.12: Interaction with AH/PSH Services, By SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
No contact at all / never	61.5%	60.5%	54.3%	48.6%	64.3%	60.0%	71.4%	68.7%
Occasional contact (1-4/year)	15.4%	17.1%	21.0%	14.3%	35.7%	20.0%	14.3%	11.9%
More freq. contact (5-11/year)	7.7%	3.9%	4.9%	11.4%	0.0%	3.3%	4.8%	11.9%
Regular contact (12+/year)	15.4%	15.8%	13.6%	20.0%	0.0%	16.7%	4.8%	7.5%
Not sure	0.0%	2.6%	6.2%	5.7%	0.0%	0.0%	4.8%	0.0%

Facilities serving SPA 4 (Metro Los Angeles) and SPA 6 (South Los Angeles and South Cities) report significantly more frequent levels of contact with affordable and permanent supportive housing service organizations than facilities located in other Los Angeles County Service Planning Areas, potentially indicative of contact bias due to geographic proximity to these service providers and/or tendency for more contact due to being located in areas of greater population density.

Market User Views on the Permanency of the Housing

In interviews with senior leaders of agencies and organizations with interface to Market ARFs and RCFEs as a source of housing and continuing care for individuals within vulnerable populations, there was no agreement as to whether or not these facilities are to be regarded as a permanent or temporary housing resource for such individuals. This is further complicated by HUD guidelines that delineate ARFs and RCFEs outside of the Federal agency's definitions of housing, despite the enduring reality of resident experiences.

Many Market Users contend that the permanency of the resource, especially at ARFs, largely depends on the capability of the facility to assist residents to regain or relearn capabilities and competency to deliver activities of daily living (ADLs) themselves. However, this contention was largely refuted by owners and operators of ARFs, who collectively seek greater levels of services and assistance from government and nonprofit agencies to deliver services that help residents to regain some measure of self-sufficiency and capability. There is also a consistent view from many Market Users that a proportion of residents at ARFs will never regain competency and/or capability to leave a facility.

The gap in consensus between Market ARF owners and operators and governmental and nonprofit Market Users regarding who should bear the accountability (and costs) to deliver services that enable at least some individuals to "graduate" from facilities is a key barrier. Without these programs and services, little improvement in the increasing outflows of placement for ARF residents to affordable and/or permanent supportive housing situations requiring lower levels of care and supervision will occur. This dissonance also explains a degree of confusion between the expectations of Market Users and the owners and operators themselves about whether or not ARFs are permanent or temporary housing.

For RCFEs, given the age and given less optimistic opinions about the capability of individuals housed in these licensed facilities to relearn or regain competency to deliver activities of daily living, there were significantly greater levels of consensus from Market Users that these facilities were "more permanent" as a housing resource.

Many external stakeholders shared a common perspective that many Market facilities are being regarded by some Market Users as "human warehouses", specifically using the terminology to describe the conception that vulnerable individuals are being placed at ARFs and RCFEs without sufficiency of access to suitable services and wraparound resources to enable them to effectively treat or address their individual needs.

These contentions correlate substantively with some views expressed by owners and operators of facilities, and facility residents themselves: that many stakeholders across the Market and in the systems that utilize this housing resource regard it as a "dead-end" or "one-way street" for residents. However, there are many stakeholders that expressed opinions that these preconceptions need to be overcome, and that there need to be more examples of successful facilities, programs, and services that enable high rates of "graduation" for residents to live in other, less acute housing and health-oriented service settings.

For the residents of Market facilities, many of those interviewed as part of this study indicated that they would like additional choice and opportunity to move on to other housing types if provided with appropriate assistance, a topic which is explored in greater depth in a later section of this study report. Many residents also have low levels of confidence in the permanency of their Market ARF or RCFE housing, partly due to their lived experiences and traumas leading up to their housing in facilities (another topic explored in detail in a later section).

5.0

Image: Jon Tyson on Unsplash

Market Capabilities to Serve People with Experience of Homelessness

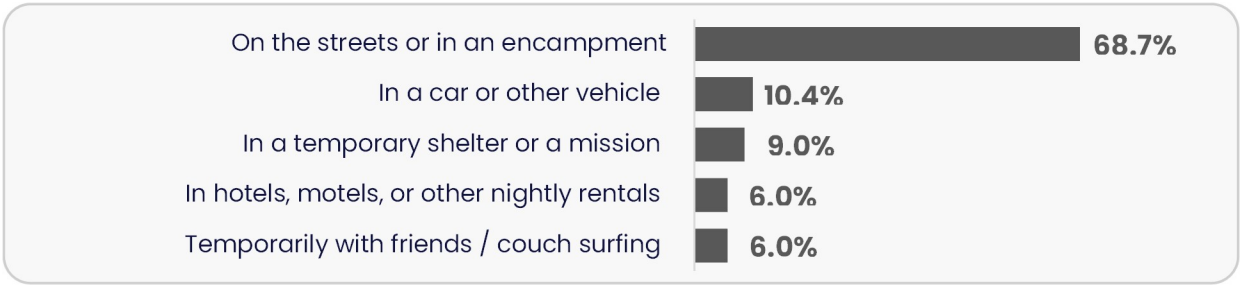
As a primary objective of the study, understanding the capabilities, suitability, and possibilities of ARFs and RCFEs to serve people experiencing homelessness enables market users from the Los Angeles County homelessness Continuum of Care (CoC) to identify key gaps in existing services, policies, perceptions, and strategy that prevent greater interface with, and use of, this Market, to house more individuals from this vulnerable population.

Sleep Locations and Duration of Homelessness

Residents that had moved to their facilities from directly experiencing homelessness were asked to identify where they most commonly slept over the duration of their experiences of homelessness, with responses recoded into whole months for analysis.

RQ 17. "During the period when you were unhoused or homeless, which of the following best describes where you would usually sleep?" (PROMPTED) **AND RQ18.** "For approximately how long did you experience homelessness? (RECODED INTO MONTHS)

RESIDENTS (n=67)



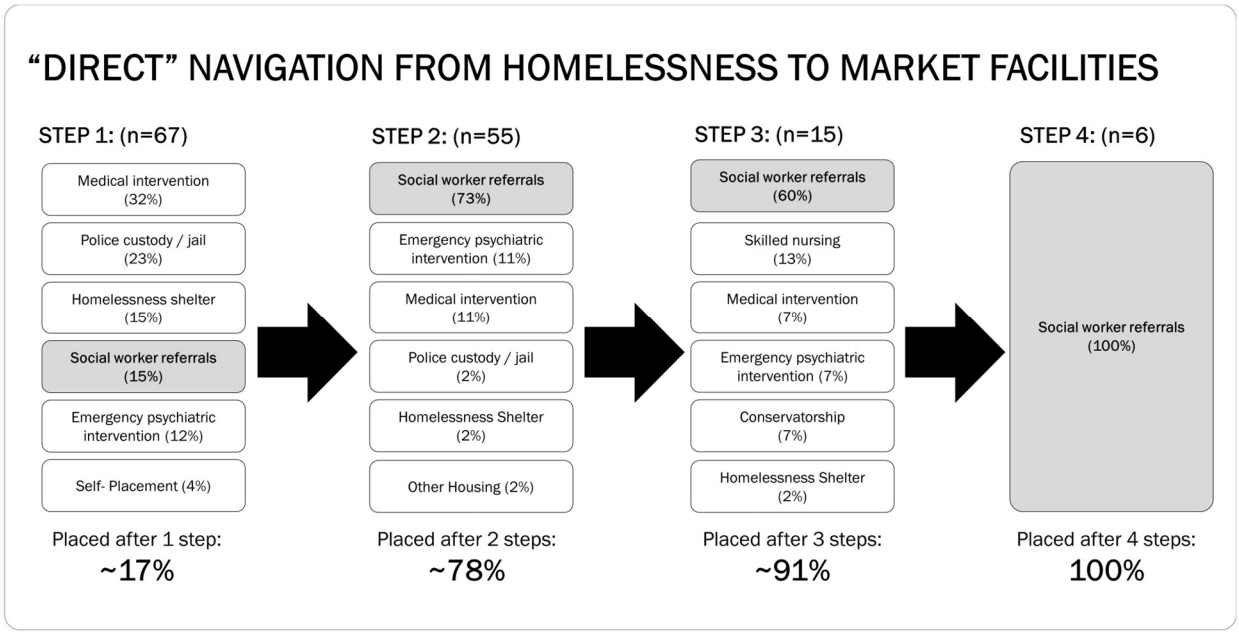
A majority (68.7%) of residents directly moving into Market facilities from experiencing homelessness reported most frequently sleeping directly on the streets or in encampments, with a mean duration for the experience of street homelessness of more than 55 months. Just over 10% of residents with direct experiences of homelessness reported vehicles as their most frequent sleeping place, with a mean duration of experience of approximately 36 months. A comparable proportion of residents (9.0%) had originated from a temporary shelter as their primary sleeping place, with slightly greater durations of experiences at just over 38 months.

Mapping Journeys from Homelessness into Facilities

For residents that considered themselves to have moved from directly experiencing homelessness into facilities, the study attempted to map out the steps taken to move them into facilities by listening to their narratives to map out their movements and assess the systemic and navigational efficiency of the moves.

RQ 19. "Can you tell me about how you moved from experiencing homelessness to living here?" (MR)

RESIDENTS (n=67)



Although many residents reported coming direct from experiences of homelessness, when interviewed in more detail about the steps in the journey they undertook to reach Market facility housing at an ARF or RCFE, it was revealed that these residents frequently pass through more than one system of care or intermediary to get housed, raising questions of Market User and agency notions of what a "direct" or "indirect" move from experiencing homelessness into a facility really is. Only 17% of residents reporting coming directly from experiences of homelessness were placed in a Market ARF or RCFE in just one step, although by two steps, more than 78% of individuals had found placement at their current Market facilities. In the majority of resident journeys direct from homelessness, residents appear to have a "triggering event", either due to medical needs, engagement by law enforcement, emergency psychiatric intervention, or shelter placement, which eventually initiates Market ARF or RCFE placement.

As many people experiencing homelessness are observed by Market Users to have significant co-occurring health and other service needs, not all residents experiencing homelessness can immediately transition ("directly") to facility placement in merely one step. The most vital interaction that appeared to correlate with the placement of people experiencing homelessness into Market facilities, after any number of steps, was interaction with a social worker, the typical party responsible for delivering referrals to facilities across nearly all formerly unhoused residents. This also correlates with feedback provided by both Market Users and facility owners and operators alike, that people experiencing homelessness require more extensive triage and transitional services to fully assess their needs and prepare them for housing at a Market ARF or RCFE, before rapid re-housing in a facility without consideration of the housing and services against their individual needs.

"Direct" vs. "Indirect" Resident Moves from Homelessness

Only 10.6% of residents reported originating "direct" from experiencing homelessness into Market facilities, somewhat corroborated with slightly lower owner and operator estimates of only 7.9% of their overall resident populations, The aforementioned figures do not include any "indirect" movements of people from homelessness into facilities, in particular for ARFs. The study defined indirect movements from homelessness as involving stays at facilities within other systems of care (or detention) for any reasonably distinguishable period of time, from an individual's perspective, distinct from other experiences. The study also adopted the initial perspective that as homelessness is largely regarded by practitioners across systems of care as a lived experience, largely defined by the individual, that the study would extend this understanding in enabling respondents to define their own experiences of moves from homelessness as having been "direct", or not.

However, even residents that self-reported direct origination from experiencing homelessness frequently indicated "other steps" in their journeys into Market housing that could be reasonably understood as "indirect" (referenced in the prior section). As unhoused individuals are frequently observed by Market Users to require treatment for multiple, serious medical and mental health needs prior to facility placement, as well has having negative interactions with the criminal justice system, a considerable amount of indirect movement from homelessness into ARFs and RCFEs is observed by Market Users serving across multiple systems of care.

From conversations with a range of Market Users across systems of care and other stakeholders, there were constant references to a lack of optimality in client movement amongst systems of care, the Market, and in the behaviors of individuals from vulnerable populations that move out of care's reach. Circular movements throughout these systems of care and rapid placements of individuals into care facilities that do not suit their whole-person care needs contribute to these challenges (covered in a later section of this study). These systemic issues contribute challenges in establishing external consensus regarding the directness of moves from experiencing homelessness into Market ARFs and RCFEs. The study attempted to compensate for this anticipated dilemma in the design of resident surveys, by posing an additional question to ascertain if residents had any experience with homelessness in adulthood, which revealed that nearly half of the 625 residents interviewed (47.8%) indeed had. This data was also segmented against prior resident origins:

Table 5.1: Resident Origins, Adult Experience of Homelessness vs. Select Study Factors	EXPERIENCE OF HOMELESSNESS AS AN ADULT
In-patient medical, residential	18.1%
In-patient mental health, res.	7.7%
Jail, prison, or detention	1.7%

Given the proportions of individuals that moved from medical and mental health residential settings into Market facilities with experiences of homelessness in adulthood, it must be assumed that a substantive proportion of these residents previously experienced homelessness prior to these other situations, with reported mean durations of stay within these other residential systems of care of up to 4.5 years.

At issue, how to account for residents with experiences of homelessness currently housed in a Market ARF or RCFE after an extended stay in a medical health, mental health, carceral, or other setting, for a period of years? What criteria to should be used to determine if such movement, and up to what duration of stay is a direct (or indirect) move from homelessness? The issue of indirect movements could not be resolved by the study, as any applicable criteria sought had the tendency to be subjective, rather than objectively defined, depending on the relationship of the observer to those experiencing homelessness and the observer's location across many programs, services, and systems of care.

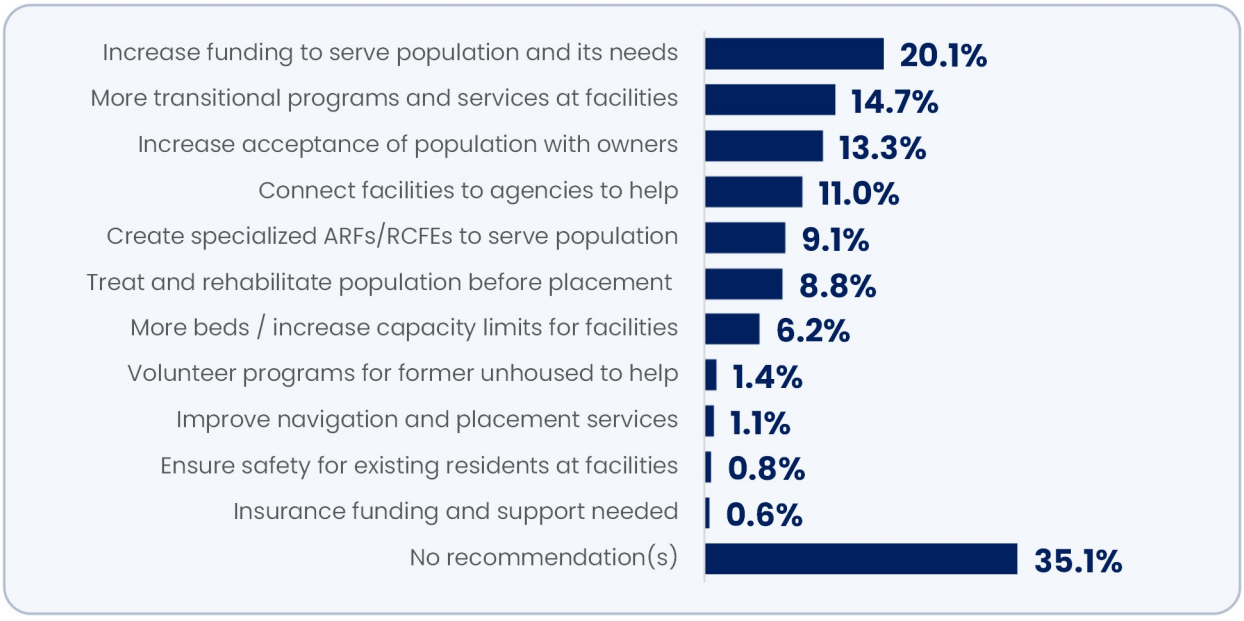
Based on discussions with expert Market Users regarding these types of movements and in consideration of other evidence, an informal estimate of indirect movements of residents who had experiences of homelessness moving into Market ARFs and RCFEs from these other systems of care could be as high as an additional 15% of Market resident population, on top of the self-identified 10.6% reported by the residents as direct moves from experiencing homelessness, suggesting that up to an estimated 25% of all Market residents could have originated from experiencing homelessness, directly or indirectly.

A Greater Role for the Market in Addressing Homelessness

Facility respondents were asked to share their perceptions of how ARFs and RCFEs can play a greater role in addressing the issue of homelessness across communities.

FQ75. "How can ARFs and RCFEs play a greater role in addressing the issue of homelessness in our communities?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



Increasing funding for ARFs and RCFEs to serve the population of people experiencing homelessness (PEH) and their distinctive needs (20.1%) was the most frequent suggestion for how to improve the role of the Market in addressing homelessness in Los Angeles County communities, followed by enabling a greater number of transitional programs and services at facilities (14.7%).

A sizeable proportion of respondents indicated that there was a need to increase the acceptance rate of serving people who had experience of homelessness with facility owners (13.3%), a role that many saw fit for government agencies and nonprofit advocates to deliver. Respondents also sought greater connection of

facilities with agencies (11.0%), such as those operated by Los Angeles County, so that facilities could provide increased help with homelessness.

An intriguing proposition, 9.1% of facility owners and/or operators recommended that specialized ARFs and RCFEs are created specifically to provide services to people with experience of homelessness, and a further 8.8% sought other entities, such as governments or nonprofits to treat and rehabilitate people with experience of homelessness prior to their placement at facilities, to assure that placements are more effective and reduce potential disruption to the well-being (or safety) of other residents within their communities.

35.1% of respondents from facilities did not offer any recommendations as to how ARFs and RCFEs could play a greater role in addressing the issue of homelessness in Los Angeles County communities.

Table 5.2: Playing a Greater Role in Addressing Homelessness, by License Class	ARF	RCFE	ALL
Increase funding to serve population and its needs	14.0%	24.0%	20.1%
More transitional programs and services at facilities	20.6%	11.1%	14.7%
Increase acceptance of population with owners	17.6%	10.6%	13.3%
Connect facilities to agencies to help	12.5%	10.1%	11.0%
Create specialized ARFs/RCFEs to serve population	11.0%	7.8%	9.1%
Treat and rehabilitate population before placement	8.1%	9.2%	8.8%
More beds / increase capacity limits for facilities	8.8%	4.6%	6.2%
Volunteering programs for former unhoused to help	2.2%	0.9%	1.4%
Improve navigation and placement services	0.0%	1.8%	1.1%
Ensure safety for existing residents at facilities	0.0%	1.4%	0.8%
Insurance funding / support needed	0.7%	0.5%	0.6%
No recommendation(s)	31.6%	37.3%	35.1%

A significantly lower proportion of ARF respondents suggest increasing funding offered to facilities to serve people with experience of homelessness in comparison to RCFE owners/operators. ARF respondents recommend more programs and services inside facilities to transition the population, increasing the acceptance rate of the population with facilities, and increasing beds and facility capacity limits (by regulation) in significantly greater proportions than their RCFE counterparts.

Sizeable proportions of ARF and RCFE owners and/or operators (31.6% and 37.3%, respectively) offered no specific recommendations to provide in regard to seeking a greater role for facilities in addressing homelessness. Anecdotally, several respondents offering "no recommendation(s)" as a response informally characterized the question as "not possible to answer" due to concerns with what they characterized as the already, critically-low levels of public funding currently allocated for them to serve any vulnerable population.

Table 5.3: Playing a Greater Role in Addressing Homelessness, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Increase funding to serve population and its needs	22.5%	18.7%	14.9%
More transitional programs and services at facilities	10.3%	22.7%	18.9%
Increase acceptance of population with owners	12.3%	14.7%	14.9%
Connect facilities to agencies to help	8.8%	13.3%	14.9%
Create specialized ARFs/RCFEs to serve population	6.4%	16.0%	9.5%
Treat and rehabilitate population before placement	8.4%	9.0%	10.9%
More beds / increase capacity limits for facilities	4.9%	9.3%	6.8%
Volunteering programs for former unhoused to help	2.0%	0.0%	1.4%
Improve navigation and placement services	0.5%	1.3%	2.7%
Ensure safety for existing residents at facilities	1.0%	0.0%	1.4%
Insurance funding / support needed	0.5%	0.0%	1.4%
No recommendation(s)	41.2%	22.7%	31.1%

Owners and/or operators at facilities serving populations of 7 to 60 licensed beds recommended more programs and services in facilities to transition the PEH population, creating specific ARFs/RCFEs to serve the population, and more beds by increasing capacity limits at facilities in significantly greater proportions than respondents at larger or smaller facilities.

Larger facilities generally recommended connecting facilities with government agencies to help in greater proportions than facilities licensed for 6 or fewer beds. Respondents at facilities serving 6 or fewer licensed beds offered no recommendation(s) and recommended increasing funding to serve the PEH population and its needs in significantly greater proportions than larger facilities. Significantly greater proportions of facilities with 6 or fewer licensed beds offered no recommendation(s).

Market User Views on Capabilities to Reduce Homelessness

One of the primary objectives of this study was to understand how ARFs and RCFEs are utilized to reduce the population experiencing homelessness in Los Angeles County. All Market Users agreed that ARFs and RCFEs are an appropriate, long-term part of solutions to end homelessness, and an important part of the housing continuum. Market Users who were specialized as health or mental health practitioners agreed that for their clients with experience of homelessness, Market ARFs and RCFEs are a type of supportive housing that can provide stable, high-quality integration with medical or mental health services. A majority of Market Users also identified that more investment is required for capability from Market ARFs and RCFEs to be sustained, preventing closures, providing more consistent service access, and becoming more ideal homes.

In examining the interface of ARFs and RCFEs with homelessness services across the Continuum of Care, and from conversations with senior stakeholders and representatives from many agencies, including the Los Angeles Homeless Services Authority (LAHSA) itself, it is clear that no formal policy, funding, or operational integration exists that would enable LAHSA, its Coordinated Entry System (CES) providers, or homelessness services nonprofits to formally utilize the capabilities of or understand the impacts from their casual, unorganized usage of ARFs and RCFEs in reducing street homelessness across the County, despite assertions of high-quality interface and connections with County agencies to fulfill this very purpose. The Market of ARFs and RCFEs is a significant blind spot in the public policy discourse on ending structural homelessness, largely unidentified for action or support by most elected officials serving in executive roles across the City of Los Angeles, 87 other Los Angeles County municipalities, and the State of California, with the noted exception of the Los Angeles County Board of Supervisors. The lack of mentions by elected officials is particularly difficult for Market Users (and owners and operators) to understand, in consideration of the real capabilities and successes that Market ARFs and RCFEs have in serving people with the experience of homelessness through connection to enhanced services at the County-level that enable greater stability, compared to other housing.

Many Market Users identified the considerable amounts of funding that has been allocated across all levels of government over many years to build affordable and permanent supportive housing to address the structural issue of homelessness in Los Angeles County. Simultaneous to the funding and creation of new housing units capable of serving fewer individuals from vulnerable populations, owners and operators of Market ARFs and RCFEs, reliant on streams of public benefit to serve the same populations, have identified that they have undergone significant financial shocks, largely due to perceived gaps in funding that have only increased with the onset of significant inflation across the national economy in the wake of the COVID-19 pandemic. Many of these stakeholders continue to feel ignored by decision-makers responsible for considering solutions to address the issue of homelessness, especially for the service capabilities with vulnerable populations that they already deliver on behalf of multiple systems of care. Many Market owners and operators believe that many of their residents have high probabilities of experiencing future homelessness if not served, and appropriately funded, at ARFs and RCFEs.

A key point of consideration for policy decision-makers at local, county, state, and federal government levels should revert to the classic question of whether or not to “buy, build, or borrow?” Market Users assert that ARFs and RCFEs provide legislators and elected officials with opportunity to have greater choice across all of the aforementioned options, producing higher magnitude results in production of “new” housing to reduce street homelessness on a significantly shorter timeframe than construction of individual units.

With an estimated capacity of more than 6,400 underutilized beds identified as available across the Market by the study, much of this capacity exists with RCFEs that require additional funding and wraparound services to

transition and house seniors experiencing homelessness that may not be ideal for placement in more independent settings due to their health and service needs. Countless more vacant and underutilized beds are likely to exist in RCFEs across the State of California that could be leveraged to house seniors currently experiencing structural homelessness.

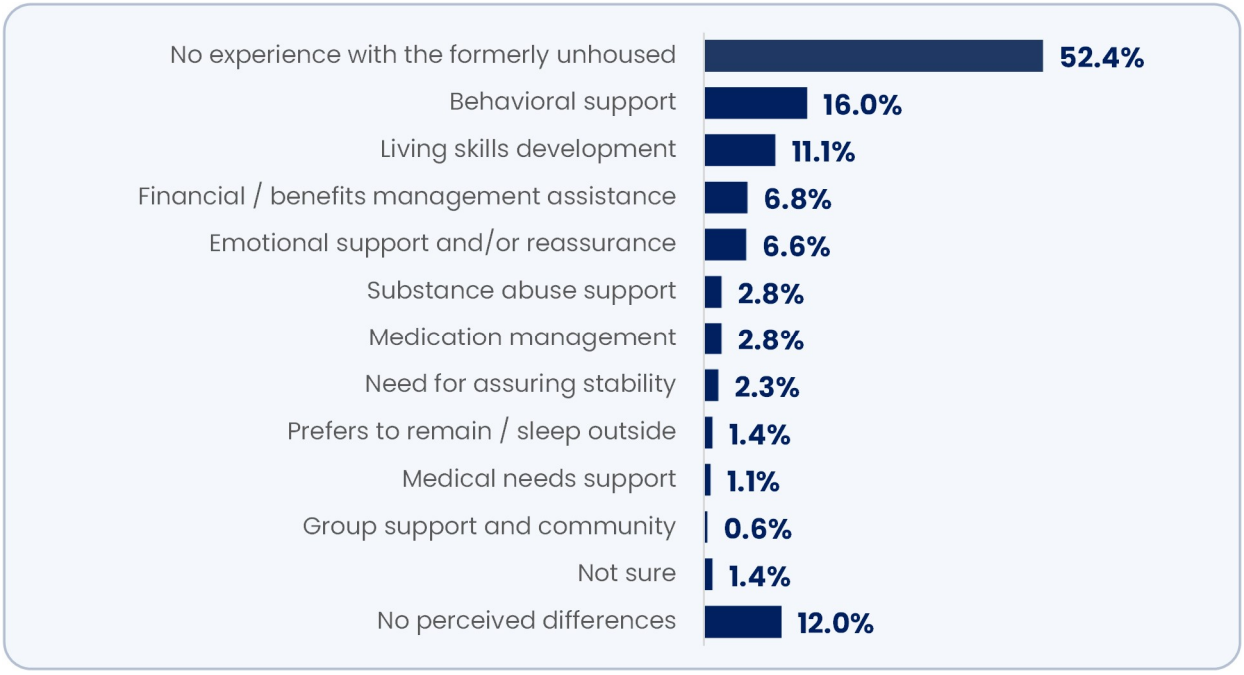
Many Market Users, owners, and operators have also identified the opportunity for government to directly fund the creation of new ARFs and RCFEs, operated by commercial and/or nonprofit entities, to specifically house and serve individuals transitioning from the experience of homelessness with greater duration and consistency of service delivery than other temporary or bridge housing facilities, such as shelters. It was identified from ARF owners that there are relatively few market incentives for new operators to readily establish new ARFs to serve vulnerable populations (other than those affiliated with Regional Centers for service to those living with developmental disability), and that the development and creation of new ARFs is a gap that governments should consider addressing, especially in terms of funding and incentive supports.

How Needs of Residents with Experience of Homelessness Differ

Respondents from facilities were asked to identify, based on their experiences, how the needs of any residents who had experience of homelessness differed from that of other residents.

F31. "How do the specific needs of people who have experienced homelessness differ from those of other residents?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



A significantly high proportion of Market facility owners and/operators (52.4%), despite expressed willingness to serve the vulnerable population, indicated that they had no experience or were unaware of their experiences with formerly unhoused residents. These responses ran contrary to residents that self-identified as having experienced homelessness as an adult (at 47.8% of residents interviewed).

The most frequent perceptions were that residents who had previously experienced homelessness required enhanced behavioral support from facility staff (16.0%), followed by need for additional development of living skills (11.1%), compared to residents who had not experienced homelessness. Slightly lower proportions of

respondents also suggested that residents who had experienced homelessness needed additional financial and/or benefits management (6.8%) and emotional support and/or reassurance from facility staff (6.6%)

Only 12.0% of respondents indicated that they did not perceive any differences in the needs of residents who had experience of homelessness in comparison to the remainder of their resident populations. Many of these Market owners and operators identified that individuals who had experienced homelessness either shared similar needs to those who had not or indicated awareness of the high proportions of their residents who had lived experience of homelessness at some point in their lives.

Table 5.4: Differences in PEH Needs, by License Class	ARF	RCFE	ALL
No experience with the formerly unhoused	23.5%	70.7%	52.4%
Behavioral support	22.1%	12.1%	16.0%
Living skills development	17.6%	7.0%	11.1%
Financial / benefits management assistance	9.6%	5.1%	6.8%
Emotional support and/or reassurance	11.8%	3.3%	6.6%
Medication management	5.9%	0.9%	2.8%
Substance abuse support	5.1%	1.4%	2.8%
Need for assuring stability	4.4%	0.9%	2.3%
Prefers to remain / sleep outside	1.5%	1.4%	1.4%
Medical needs support	0.7%	1.4%	1.1%
Group support and community	1.5%	0.0%	0.6%
Not sure	3.7%	0.0%	1.4%
No perceived differences	19.9%	7.0%	12.0%

Given the lower proportions of residents with experiences of homelessness served by RCFEs, as self-reported by both owners/operators and residents themselves, the finding that 70.7% of RCFE owners/operators have no recollection of experiences in serving the formerly unhoused was not surprising. This correlates with generally larger proportions of Los Angeles County RCFEs not currently willing to serve members of identified, vulnerable populations in the Market. ARF owners/operators identified more distinctive needs of unhoused residents in significantly greater proportions compared to RCFE respondents, namely behavioral support, living skills development, medication management, substance abuse support, and a need to assure stability in housing. A significantly greater proportion of ARF owners/operators also identified that they perceived no differences between the previously unhoused and the current populations that they serve, in comparison to RCFE owners and/or operators.

Table 5.5: Differences in PEH Needs, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
No experience with the formerly unhoused	73.5%	24.3%	21.9%
Behavioral support	9.3%	21.6%	28.8%
Living skills development	4.4%	16.2%	24.7%
Financial / benefits management assistance	3.9%	8.1%	13.7%
Emotional support and/or reassurance	4.9%	9.5%	8.2%
Medication management	0.5%	5.4%	6.8%
Substance abuse support	1.5%	2.7%	6.8%
Need for assuring stability	1.0%	5.4%	2.7%
Prefers to remain / sleep outside	0.5%	4.1%	1.4%
Medical needs support	1.0%	1.4%	1.4%
Group support and community	0.5%	0.0%	1.4%
Not sure	1.0%	2.7%	1.4%
No perceived differences	7.4%	23.0%	13.7%

A significant proportion of owners and/or operators at facilities licensed to serve 6 beds or less indicated that they had no experience with the formerly unhoused, in relation to owners and/or operators of larger facilities. Owner/operators at larger facilities indicated that previously unhoused residents need behavioral support, living skills development, and medication management in greater proportions than 6 bed or less operators.

7 to 60 licensed bed and 61 or more licensed bed respondents also indicated that the previously unhoused also require emotional support and/or reassurance and substance abuse support in greater proportions. Owners and/or operators serving at 7 to 60 bed facilities reported not perceiving differences between the formerly homeless and the other populations in significantly greater proportions than smaller or larger licensed facilities.

Effectiveness in Serving People with Experience of Homelessness

Owners and/or operators of licensed facilities were asked to evaluate the distinctive effectiveness of their facilities in serving the specific needs of people with experience of homelessness. This question was posed utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating not effective at all, and 10 indicating complete effectiveness.

FQ32. "On a scale of 0-10, how effective do you think your facility is in serving the specific needs of people who have experienced homelessness?"

FACILITY OWNERS & OPERATORS (N=353)

Table 5.6: Effectiveness in Serving PEH, by License Class	ARF	RCFE	ALL
	8.80	7.01	7.85

ARF owners and/or operators reported significantly greater means for the perceived effectiveness of their facility in serving the needs of people with experience of homelessness in relation to their RCFE counterparts.

Table 5.7: Effectiveness in Serving PEH, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	7.10	8.64	8.47

Larger facilities reported greater means for perceived effectiveness of their facilities in serving the needs of the previously unhoused, in comparison to owners and/or operators of facilities licensed to serve 6 or fewer beds.

Table 5.8: Effectiveness in Serving PEH, by License and Size	ARF	RCFE
≤ 6 BEDS	9.03	6.12
7–60 BEDS	8.86	8.19
≥ 61 BEDS	8.44	8.50

ARFs with 6 or fewer beds reported significantly greater means for their perceived facility effectiveness in serving residents with experience of homelessness, in particular comparison to RCFEs serving 6 or fewer licensed beds, who reported among the lowest means for assessed effectiveness in serving this population.

Table 5.9: Effectiveness in Serving PEH, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	6.11	7.93	8.00	8.69	7.40	9.28	6.40	7.67

Facility owners and operators in SPA 1 (Antelope Valley) and SPA 7 (East Los Angeles and South East Cities) evaluated their effectiveness in serving the previously unhoused with significantly lower means than those located in other Los Angeles County Service Planning Areas. Respondents from SPA 6 (South Los Angeles and South Cities) reported significantly greater means in self-assessed effectiveness for serving residents with experience of homelessness, in comparison to other SPAs.

Table 5.10: Effectiveness in Serving PEH, by SPA and License Class	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
ARF	9.33	8.67	8.79	8.75	8.00	9.30	7.38	9.00
RCFE	5.50	7.74	7.65	8.40	6.50	9.00	5.29	6.38

Although the lowest mean perceived effectiveness score for ARFs by SPA was 7.38 in SPA 7 (East Los Angeles and South East Cities), significantly lower than other SPAs, significantly lower mean effectiveness scores were reported for RCFEs serving SPA 1 (Antelope Valley) and SPA 7 (East Los Angeles and South East Cities), significantly lower than other RCFEs across SPAs. Generally low mean RCFE effectiveness scores were also reported in several other SPAs, including SPA 5 (West Los Angeles and West Cities) and SPA 8 (South Bay and Coastal Cities).

Facilities serving SPA 6 (South Los Angeles and South Cities) reported greater mean effectiveness scores than any other SPA in their estimation of capability to serve residents with experience of homelessness across both categories of licensed facilities.

Table 5.11: Effectiveness in Serving PEH, by SPA and Facility Size	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
≤ 6 BEDS	6.29	8.00	5.69	8.67	8.25	9.57	6.00	6.07
7–60 BEDS	4.50	7.71	9.25	8.80	8.00	8.33	7.67	9.21
≥ 61 BEDS	NaN*	7.91	8.63	8.50	6.60	9.60	6.50	9.20

*No facilities with 61 or more licensed beds were qualified and agreed to take part in the research from SPA 1

Significantly lower mean scores for effectiveness in serving residents with experience of homelessness were observed in 6 or fewer licensed bed facilities in SPA 3 (San Gabriel Valley), SPA 7 (East Los Angeles and South East Cities), and SPA 8 (South Bay and Coastal Cities). Facilities serving 7 to 60 beds in SPA 1 reported significantly lower mean effectiveness scores than other SPAs, and facilities in SPA 5 (West Los Angeles and West Cities) and SPA 7 with 61 or more licensed beds reported significantly lower mean scores than facilities of comparable size in other SPAs.

Facility size did not appear to affect significantly greater means observed from SPA 6 respondents in assessing their effectiveness to serve residents with experience of homelessness.

Market User Views on ARF & RCFE Effectiveness

Given the diversity of facilities under the broad ARF and RCFE license classes regulated by the California Department of Social Services (CDSS) Community Care Licensing Division (CCLD), evaluating how effective Market ARFs and RCFEs are is difficult for most Market Users to ascertain. Market Users identify a diversity and range of services available to residents of Market ARFs and RCFEs: partly driven by the efforts of individual owners and operators to take more customized measures to connect their residents with services, and partly relating to the significant efforts of County agencies and nonprofit partners to effectively manage their distribution of services to facilities of all sizes and compositions of resident populations. Facilities offer many variations of service formats and resident-based specializations, and are physically distributed across nearly all the communities of Los Angeles County.

In considering Market Users that offer critical views on Market ARF and RCFE effectiveness, they express concerns that many that ARFs are often located in socio-economically depressed areas, where potential predators can prey on clients, exposing them to elevated crime rates and facilitating ease of access to drugs and alcohol. Many Market Users did not consider RCFEs as an option for their clients, with citing a disparate range of facilities within the class: with some delivering services to individuals reliant on public benefit up to those serving an exclusive, privately-funded clientele of residents. These views were often explained or restated as the "typical preconceptions" of others by the very same Market Users who initially provided them.

Some Market Users, particularly those affiliated with hospitals, including medical clinics and recuperative care facilities, among others, identify regulatory limitations as a barrier to continuing care delivery to clients, and/or inability to properly handover and case conference a former client's medical care needs with their new medical service provider. This lack of continuation of care created difficulty for these Market Users to adequately assess the effectiveness of placing their former clients in residence at Market ARFs and RCFEs.

For Market Users familiar with the Full-Service Partnership (FSP) program offered by DMH, the consensus was that Market facilities participating in programs with a high range of wraparound services made them highly-effective. Nearly all Market Users familiar with FSP, including agencies, hospitals, nonprofits, housing and ICMS providers, identified genuine need for more capacity in programs and initiatives like FSP, to keep clients stabilized, out of hospitals, jails, or to prevent eviction. Market Users also indicated that onboarding new clients to the FSP program was challenging, due to high demand and a significant waitlist.

There was general consensus from Market Users that facilities are least effective in serving residents from vulnerable populations without providing appropriate, community-based wraparound services, with most seeking an increase in these services across all types of community settings. County agencies should consider continuing to expand and enhance coverage (and funding) of programs that deliver effective wraparound services to enable residents of ARFs and RCFEs to get the services they need and enhance outcomes across the Market.

In consideration of the generally positive assessments provided by the residents themselves across nearly all measures of resident experience and satisfaction (presented in a later section of this study), the strong majority of residents validate and assert the effectiveness of the services they experience from their housing and care at Market ARFs and RCFEs.

6.0

Image: www.dreamstime.com

Understanding Resident Needs

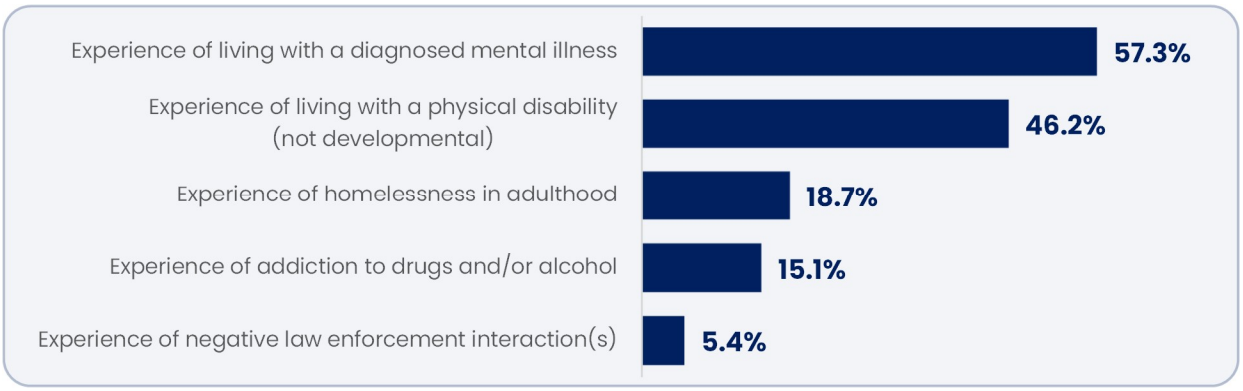
Providing service to residents is the primary reason why facility owners, Market Users, and the community at-large realize value and benefit from Market ARFs and RCFEs. To better inform Market Users and the public about the diverse backgrounds, lived experiences, and circumstances of residents with greater clarity, 625 interviews were conducted within the Market resident population to better understand their specific reasons for living at facilities, vulnerabilities, drivers, prior experiences, and unmet needs.

Facility Estimations of Key Resident Life Experience Factors

Owners and/or operators were asked to provide their best estimates for the proportions of their resident population that had experience of several key study factors, including experience of living with a diagnosed mental illness, experience of homelessness as an adult, experience of living with a physical disability (not developmental), experience with negative law enforcement interaction while in residence at a facility, and experience of substance addiction.

FQ25. to FQ29. "Approximately what percentage of your residents do you know to have…?"

FACILITY OWNERS & OPERATORS (N=353)



Owners and/or operators indicated that more than 57% of residents currently living at their facilities had experience of living with a diagnosed mental illness, a significant proportion which can be partly attributed to the study requirement that a facility must be willing to serve those living with mental illness. 46.2% of resident populations within the study sample were identified by facility respondents as living with physical disability. Although indicating that less than 8% of residents came to their facility directly from any experience of homelessness, respondents indicated that 18.7% of their current populations had experience of homelessness at some point in their adult lives, reconfirming the suitability of ARFs and RCFEs as both effective and prevalent in serving those who have lived experiences of homelessness.

Table 6.1: Estimates of Resident Population Factors, by License Class	ARF	RCFE	ALL
Experience living with a diagnosed mental illness	88.1%	38.0%	57.3%
Experience living with a physical disability	19.7%	62.9%	46.2%
Experience of homelessness in adulthood	35.6%	8.2%	18.7%
Experience of addiction to drugs and/or alcohol	30.1%	5.7%	15.1%
Experience of negative law enforcement interaction(s)	11.4%	1.4%	5.4%

Owners and/or operators of ARFs estimated significantly greater proportions of residents living with a diagnosed mental illness, experience of homelessness as an adult, negative law enforcement interaction (while in facility residence), and living with addiction / substance misuse than their RCFE counterparts, who estimated significantly greater proportions of residents living with physical disability than ARFs.

Table 6.2: Estimates of Resident Population Factors, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Experience of living with a diagnosed mental illness	46.6%	76.3%	67.3%
Experience of living with a physical disability	57.0%	27.2%	35.9%
Experience of homelessness in adulthood	11.7%	29.4%	27.2%
Experience of addiction to drugs and/or alcohol	8.3%	26.8%	22.0%
Experience of negative law enforcement interaction(s)	4.7%	3.6%	9.2%

Respondents at larger facilities or more reported significantly greater proportions of residents living with a diagnosed mental illness, experience of homelessness as an adult, and experience of addiction / substance misuse than those owning or operating small facilities of 6 or fewer licensed beds. Respondents at 61 or more bed facilities also estimated the greatest proportion of residents with negative law enforcement interactions since they have been in residence.

Facility owners and/or operators licensed for 6 or fewer beds estimated significantly greater proportions of residents living with a physical disability than respondents at larger facilities.

Table 6.3: Estimates of Resident Population Factors, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Experience of living with a diagnosed mental illness	44.5%	46.5%	42.4%	84.6%	70.1%	77.6%	57.0%	67.1%
Experience of living with a physical disability	44.9%	63.5%	49.9%	30.7%	58.6%	18.9%	42.8%	41.3%
Experience of homelessness in adulthood	15.3%	12.9%	9.9%	37.6%	27.7%	40.1%	12.9%	18.3%
Experience of addiction to drugs and/or alcohol	6.8%	9.1%	10.2%	30.5%	19.6%	31.5%	11.5%	16.2%
Experience of negative law enforcement interaction(s)	6.2%	2.0%	3.7%	11.9%	14.7%	7.7%	4.0%	5.0%

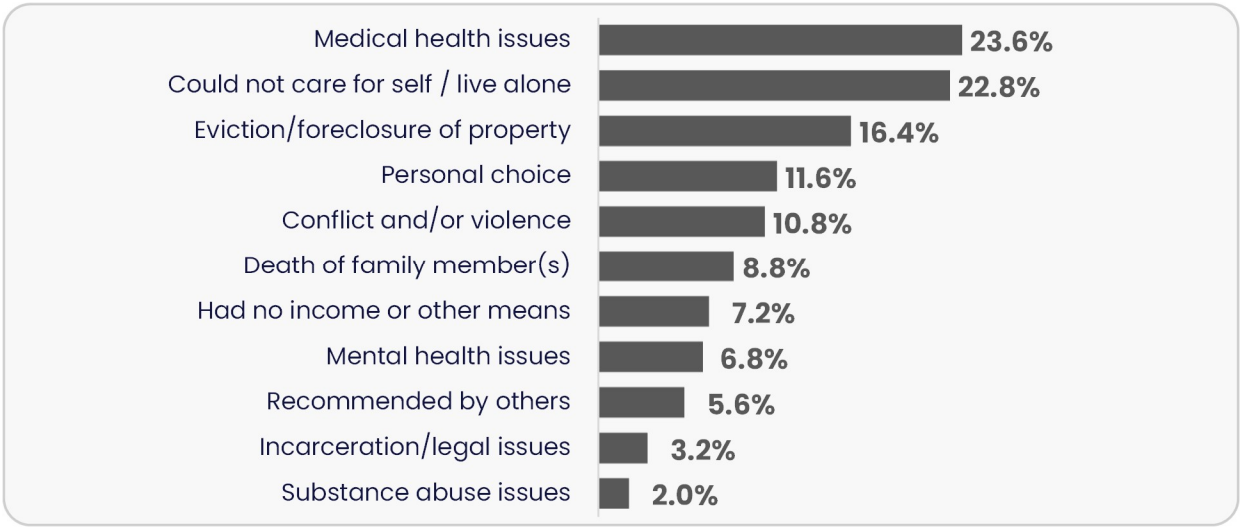
Facilities located in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities), and SPA 6 (South Los Angeles and South Cities) generally estimate the greatest proportions of residents with experiences across all key study factors, with the exception in SPAs 4 and 6 of residents living with physical disability, which were reported in significantly lower proportions.

Resident Reasons for Leaving Most Recent Housing

ARF and RCFE residents who came directly from a previous housing situation of their choosing, such as renting or owning a property alone or with others, living with family and/or friends, or living in affordable or permanent supportive housing were asked to identify the reasons that they believed were responsible for their needing to leave their previous housing situation:

RQ22. "What happened that led you to stop living in your previous housing?" (MR)

RESIDENTS (n=251)



The top reasons that residents provided for leaving their most recent housing of choice included medical health issues (23.6%), the fact that they could not care for themselves / live alone (22.8%), or from eviction or foreclosure of their property (16.4%).

Table 6.4: Reason(s) for Leaving Prior Housing, by License Class	ARF	RCFE	ALL
Medical health issues	8.2%	33.6%	23.6%
Could not care for self / live alone	9.2%	31.6%	22.8%
Eviction/foreclosure of property	21.4%	13.2%	16.4%
Personal choice	16.3%	8.6%	11.6%
Conflict and/or violence	17.3%	6.6%	10.8%
Death of family member(s)	12.2%	6.6%	8.8%
Had no income or other means	6.1%	7.9%	7.2%
Mental health issues	13.3%	2.6%	6.8%
Recommended by others	4.1%	6.6%	5.6%
Incarceration/legal issues	8.2%	0.0%	3.2%
Substance abuse issues	3.1%	1.3%	2.0%

Resident respondents at RCFEs reported leaving their prior housing of choice due to medical health issues (33.6%) and/or that they could not care for themselves / live alone (31.6%) in significantly greater proportions than residents at ARFs (who mentioned these reasons in significantly lower proportions), likely as a result of the median age differences between the populations.

Residents of ARFs reported leaving their prior housing of choice due to eviction or foreclosure (21.4%), conflict and/or violence (17.3%), personal choice (16.3%), mental health-related issues (13.3%), death of family members (12.2%), and incarceration/legal issues (8.2%) in significantly greater proportions than their RCFE counterparts, indicative of increased social vulnerability identified across the population served by ARFs.

Table 6.5: Reason(s) for Leaving Prior Housing, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Medical health issues	30.9%	22.6%	19.0%
Could not care for self / live alone	34.6%	11.3%	19.8%
Eviction/foreclosure of property	12.3%	18.9%	18.1%
Personal choice	8.6%	17.0%	11.2%
Conflict and/or violence	16.0%	11.3%	6.9%
Death of family member(s)	7.4%	7.5%	10.3%
Had no income or other means	8.6%	1.9%	8.6%
Mental health issues	2.5%	9.4%	8.6%
Recommended by others	6.2%	5.7%	5.2%
Incarceration/legal issues	0.0%	3.8%	5.2%
Substance abuse issues	0.0%	1.9%	3.4%

Residents at facilities licensed to serve populations of 6 or fewer beds reported their inability to care for themselves or live alone (34.6%) as a reason for leaving their prior housing of choice in significantly greater proportions than respondents from larger facilities, along with leaving their prior chosen housing due to conflict and/or violence (16.0%). Residents from mid-sized licensed ARFs and RCFEs (7 to 60 licensed beds) and larger licensed facilities (62 beds or more) reported leaving their prior housing of choice for reasons of eviction or foreclosure, mental health issues, incarceration/legal issues, and substance abuse issues in greater proportions than resident respondents from licensed facilities of 6 or fewer beds.

Table 6.6: Reason(s) for Leaving Prior Housing, by Age Range	18-54	55-61	62+
Medical health issues	10.1%	12.5%	32.2%
Could not care for self / live alone	14.5%	15.6%	28.2%
Eviction/foreclosure of property	21.7%	21.9%	12.8%
Personal choice	13.0%	18.8%	9.4%
Conflict and/or violence	17.4%	12.5%	7.4%
Death of family member(s)	4.3%	12.5%	10.1%
Had no income or other means	2.9%	21.9%	6.0%
Mental health issues	18.8%	0.0%	2.7%
Recommended by others	2.9%	3.1%	7.4%
Incarceration/legal issues	8.7%	6.3%	0.0%
Substance abuse issues	1.4%	3.1%	2.7%

Resident respondents 62 years of age or older reported medical health issues, an inability to care for themselves and/or live alone, and being recommended by others to leave their prior housing of choice in significantly greater proportions than younger respondent age groups.

Respondents in the 18 to 54 and 55 to 61 age groups reported leaving their prior housing of choice due to eviction or foreclosure in greater proportions than those in the 62 years of age or older cohort, whilst resident respondents in the 18 to 54 age group reported leaving their prior housing of choice due to mental health-related issues, conflict and/or violence in significantly greater proportions than respondents from older age groups.

Incarceration and/or legal issues were reported in significant proportions in both the 18 to 54 and 55 to 61 age groups but were absent in reporting from the 62 years of age or older group.

Table 6.7: Reason(s) for Leaving Prior Housing, by Gender Identity	FEMALE	MALE
Medical health issues	21.6%	25.2%
Could not care for self / live alone	30.6%	16.5%
Eviction/foreclosure of property	14.4%	18.0%
Personal choice	13.5%	10.1%
Conflict and/or violence	6.3%	14.4%
Death of family member(s)	8.1%	9.4%
Had no income or other means	5.4%	8.6%
Mental health issues	5.4%	7.9%
Recommended by others	7.2%	4.3%
Incarceration/legal issues	3.6%	2.9%
Substance abuse issues	1.8%	2.2%

Few significant differences were observed in segmentation of resident respondents on the basis of gender identity, with the exception of a significantly greater proportion of female residents reporting that they left their prior housing of choice due to their inability to care for themselves / live alone, and a greater proportion of male respondents identifying leaving prior housing of choice due to conflict and/or violence.

Table 6.8: Reason(s) for Leaving Prior Housing, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN*	PACIFIC ISLANDER*	MIDDLE EASTERN*
Medical health issues	24.6%	13.0%	20.5%	34.3%	40.0%	0.0%	0.0%
Could not care for self / live alone	24.6%	15.2%	33.3%	14.3%	0.0%	0.0%	100.0%
Eviction/foreclosure of property	13.9%	19.6%	25.6%	14.3%	0.0%	0.0%	0.0%
Personal choice	10.7%	23.9%	7.7%	20.0%	0.0%	100.0%	0.0%
Conflict and/or violence	9.0%	10.9%	15.4%	5.7%	60.0%	0.0%	0.0%
Death of family member(s)	9.8%	10.9%	10.3%	0.0%	0.0%	0.0%	0.0%
Had no income or other means	6.6%	8.7%	10.3%	5.7%	0.0%	0.0%	0.0%
Mental health issues	6.6%	4.3%	10.3%	14.3%	0.0%	100.0%	0.0%
Recommended by others	8.2%	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Incarceration/legal issues	4.9%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Substance abuse issues	0.8%	4.3%	2.6%	2.9%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Asian / Asian American respondents reported leaving their prior housing of choice due to medical health and mental health-related issues than respondents from most other racial identity groups, with Black / African American respondents reporting leaving prior housing of choice for reasons of personal choice in greater proportions than respondents in other groups. Black / African American respondents also reported leaving prior housing of choice due to substance abuse-related issues in significantly greater proportions than respondents from other identity groups. Hispanic / Latino / Latinx respondents reported leaving their prior housing of choice due to being unable to care for themselves or live alone, eviction or foreclosure of housing, and conflict and/or violence in significantly greater proportions than respondents from other identity groups.

Table 6.9: Reason(s) for Leaving Prior Housing, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Medical health issues	10.4%	16.9%	32.0%	17.3%	24.2%
Could not care for self / live alone	10.4%	9.1%	31.1%	7.7%	17.7%
Eviction/foreclosure of property	23.5%	22.1%	14.8%	21.2%	6.5%
Personal choice	9.6%	7.8%	8.2%	11.5%	11.3%
Conflict and/or violence	17.4%	19.5%	11.5%	15.4%	16.1%
Death of family member(s)	9.6%	11.7%	5.7%	7.7%	17.7%
Had no income or other means	10.4%	3.9%	4.9%	7.7%	4.8%
Mental health issues	13.0%	9.1%	4.1%	5.8%	9.7%
Recommended by others	4.3%	3.9%	4.1%	3.8%	3.2%
Incarceration/legal issues	7.0%	5.2%	3.3%	13.5%	3.2%
Substance abuse issues	2.6%	0.0%	1.6%	0.0%	4.8%

In relation to groups of residents with lived experiences relating to key study factors, respondents who self-identified as living with mental illness and/or having experienced homelessness as an adult reported leaving their prior housing of choice due to eviction or foreclosure and mental health-related issues in significantly greater proportions than others. Understandably, residents that reported living with physical disability reported leaving their prior housing of choice due to medical health-related issues and inability to care for themselves or live alone in significantly greater proportions than others. Residents with experience of incarceration or experience living with mental illness correlated experiences in significantly greater proportions than others.

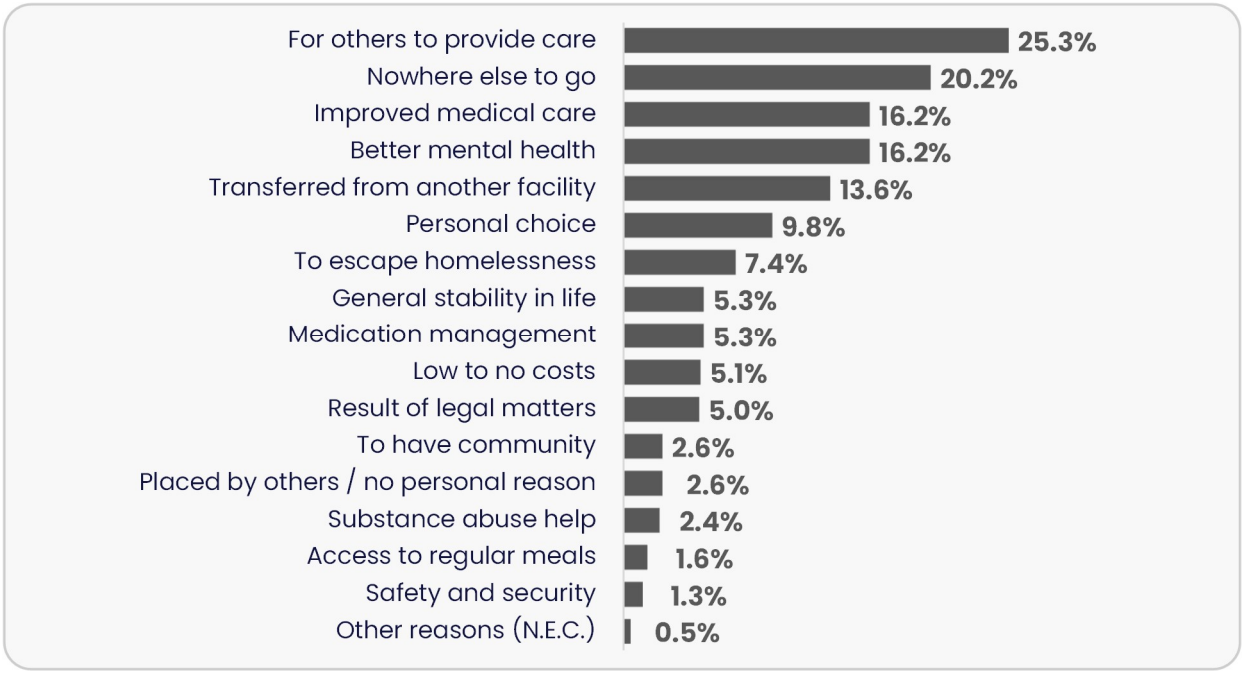
Resident respondents with experience of addiction of drugs and/or alcohol reported leaving their prior housing of choice due to medical health-related issues, the death of family members, mental health related, and substance abuse-related reasons in higher proportions than most other respondents. Respondents across all groups identifying key study factors reported leaving their prior housing of choice for reasons related to conflict and/or violence in significantly greater proportions to respondents who did not identify as having these experiences, with the exception of those living with physical disability.

Resident Reasons for Market ARF & RCFE Housing

Residents were asked to identify the primary reasons why they thought they were living at their current ARF or RCFE at time of interview:

RQ25. "What do you see as the main reason or reasons that led you to be living here right now?" (MR)

RESIDENTS (N=625)



The primary reason that residents reported for their current housing in a Market ARF or RCFE was for others to provide them with care (25.3%), and that they had nowhere else to go (20.2%). Comparable proportions of residents believed that the reason for their facility residence was for better outcomes in medical and/or mental health (each at 16.2%). Only 7.4% of residents viewed escaping from homelessness as a main reason for their current residence in a licensed facility within the Market.

Table 6.10: Reason(s) for Facility Housing, by License Class	ARF	RCFE	ALL
For others to provide care	9.8%	43.4%	25.3%
Nowhere else to go	21.7%	18.4%	20.2%
Better mental health	25.2%	5.6%	16.2%
Improved medical care	6.8%	27.1%	16.2%
Transferred from another facility	16.6%	10.1%	13.6%
Personal choice	10.4%	9.0%	9.8%
To escape homelessness	9.5%	4.9%	7.4%
Medication management	7.1%	3.1%	5.3%
General stability in life	9.2%	0.7%	5.3%
Low to no costs	4.2%	6.3%	5.1%
Result of legal matters	6.8%	2.8%	5.0%
Placed by others / no personal reason	2.4%	2.8%	2.6%
To have community	2.4%	2.8%	2.6%
Substance abuse help	4.2%	0.3%	2.4%
Access to regular meals	2.7%	0.3%	1.6%
Safety and security	1.8%	0.7%	1.3%

Resident respondents at RCFEs reported that their primary reasons for living at their current facility was so that others could care for them and to have access to improved medical care in significantly greater proportions than residents at ARFs. Seeking better mental health was the most frequent, primary reason for ARF residents to mention regarding their current housing situation, also noted in significantly greater proportions in comparison to residents of RCFEs. ARF residents also reported reasons of achieving general stability, reasons resulting from legal matters, requiring help with substance abuse / addiction, and having access to regular meals in significantly greater proportions than resident respondents from RCFEs.

Table 6.11: Reason(s) for Facility Housing, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
For others to provide care	38.3%	24.2%	20.2%
Nowhere else to go	17.0%	12.1%	25.4%
Better mental health	7.8%	22.3%	16.8%
Improved medical care	19.1%	16.6%	14.7%
Transferred from another facility	9.9%	15.9%	14.1%
Personal choice	8.5%	7.0%	10.7%
To escape homelessness	3.5%	10.2%	7.6%
Medication management	3.5%	7.6%	4.9%
General stability in life	5.0%	5.7%	5.2%
Low to no costs	1.4%	7.6%	5.5%
Result of legal matters	2.1%	6.4%	5.5%
Placed by others / no personal reason	2.1%	2.5%	2.8%
To have community	2.1%	0.6%	3.7%

Resident respondents from Market facilities with 6 or fewer beds reported a primary reason of needing others to care for them in significantly greater proportions than respondents at larger facilities. Conversely, residents from 6 licensed bed or fewer facilities reported being transferred from another facility, escaping homelessness, results of legal matters, and low or no costs of living in significantly lower proportions than residents interviewed from larger facilities. Better mental health was reported as a primary reason for current residence from respondents residing at mid-sized facilities of between 7 and 60 licensed beds in significantly greater proportions than residents at smaller or larger licensed facilities in the Market. Residents at facilities with 62 or more licensed beds reported primary reasons for residence as having nowhere else to go and to have access to community in significantly greater proportions than residents living at smaller licensed facilities.

Table 6.12: Reason(s) for Facility Housing, by Age Range	18-54	55-61	62+
For others to provide care	13.7%	13.8%	39.6%
Nowhere else to go	21.4%	23.4%	18.2%
Better mental health	27.0%	18.1%	6.1%
Improved medical care	8.1%	13.8%	24.3%
Transferred from another facility	16.1%	14.9%	10.7%
Personal choice	8.9%	8.5%	9.6%
To escape homelessness	8.9%	11.7%	4.6%
Medication management	6.9%	6.4%	3.6%
General stability in life	9.7%	4.3%	1.8%
Low to no costs	4.4%	10.6%	5.0%
Result of legal matters	4.0%	4.3%	0.4%
Placed by others / no personal reason	1.2%	3.2%	3.6%
To have community	2.4%	1.1%	3.2%
Substance abuse help	4.4%	1.1%	1.1%
Access to regular meals	2.7%	0.3%	1.6%

Residents aged 62 years or older reported primary reasons for current facility residence of needing others to care for them and access to improved medical care in significantly greater proportions than respondents from younger age cohorts (reporting this reason in significantly lower proportions). Residents in the ARF/RCFE transitional age cohort of 55-61 reported reasons of escaping homelessness, low to no costs, and access to regular meals in significantly greater proportions than residents of the 18-54 or 62 or older age groups.

Respondents from the 18-54 age group reported seeking better mental health, seeking general stability in life, and seeking substance abuse help as reasons for their current residence in significantly greater proportions than respondents in older age groups/cohorts.

Table 6.13: Reason(s) for Facility Housing, by Gender Identity	FEMALE	MALE
For others to provide me with care	30.9%	21.5%

Resident respondents of female gender identity reported their primary reason for their current facility housing as needing others to care for them in significantly greater proportions than respondents identifying as male gendered.

Table 6.14: Reason(s) for Facility Housing, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
For others to provide me with care	28.7%	20.0%	21.4%	37.5%	25.0%	0.0%	0.0%
Nowhere else to go	20.6%	26.5%	20.4%	15.6%	18.8%	50.0%	0.0%
Better mental health	16.3%	19.4%	17.3%	12.5%	18.8%	50.0%	50.0%
Improved medical care	18.4%	14.8%	13.3%	20.3%	12.5%	50.0%	0.0%
Transferred from another facility	12.4%	16.8%	15.3%	12.5%	12.5%	0.0%	0.0%
Personal choice	9.2%	9.0%	11.2%	10.9%	12.5%	50.0%	0.0%
To escape homelessness	7.1%	9.0%	7.1%	9.4%	6.3%	0.0%	50.0%
Medication management	6.7%	4.5%	6.1%	6.3%	0.0%	50.0%	0.0%
General stability in life	4.6%	8.4%	4.1%	7.8%	12.5%	0.0%	0.0%
Low to no costs	5.3%	5.2%	6.1%	7.8%	0.0%	0.0%	50.0%
Result of legal matters	3.2%	2.6%	3.1%	1.6%	6.3%	0.0%	0.0%
Placed by others / no pers. reason	3.5%	1.3%	3.1%	1.6%	0.0%	0.0%	0.0%
To have community	1.8%	3.2%	3.1%	3.1%	0.0%	0.0%	0.0%
Substance abuse help	2.8%	2.6%	4.1%	1.6%	6.3%	0.0%	0.0%
Access to regular meals	1.4%	0.6%	3.1%	3.1%	0.0%	0.0%	0.0%
Safety and security	0.7%	1.9%	0.0%	3.1%	6.3%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid statistical analysis or comparison with other groups for this question

Black / African American residents reported their primary reasons for ARF/RCFE residence as having nowhere else to go and seeking better mental health in significantly greater proportions than residents in other racial identity groups.

Asian / Asian American resident respondents identified needing others to care for them, improved medical care, and medication management assistance in significantly greater proportions than respondents in other identity groups.

Black / African American, Asian / Asian American, and Native American / Alaskan Native respondents mentioned seeking general stability in life in significantly greater proportions than respondents with other racial identities, with Native American / Alaskan Native respondents also noting safety and security in greater proportions than residents of other identities.

Table 6.15: Reason(s) for Facility Housing, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
For others to provide me with care	14.3%	15.7%	32.4%	12.0%	17.0%
Nowhere else to go	23.4%	25.8%	17.9%	24.5%	20.3%
Better mental health	24.2%	21.7%	13.6%	17.4%	21.7%
Improved medical care	9.9%	13.7%	22.2%	9.8%	14.2%
Transferred from another facility	15.4%	14.0%	14.2%	16.3%	16.5%
Personal choice	8.6%	7.0%	6.8%	7.1%	8.5%
To escape homelessness	9.9%	12.0%	7.7%	10.3%	7.1%
Medication management	6.8%	5.0%	5.9%	6.0%	6.1%
General stability in life	7.6%	7.4%	3.4%	7.6%	7.5%
Low to no costs	8.3%	7.0%	4.9%	7.6%	5.2%
Result of legal matters	2.3%	2.0%	1.9%	2.2%	2.4%
Placed by others / no pers. reason	2.6%	2.7%	1.5%	2.7%	2.8%
To have community	3.6%	3.0%	2.2%	7.6%	2.8%
Substance abuse help	3.6%	3.7%	2.2%	4.3%	6.6%
Access to regular meals	1.8%	2.0%	1.2%	2.2%	1.9%
Safety and security	1.3%	1.3%	1.2%	1.1%	1.4%

With the exception of those living with physical disability and/or living with experience of addiction to drugs and/or alcohol, respondents self-identifying experiences of living with mental illness, homelessness as an adult, and/or incarceration of greater than 30 days reported the primary reason for facility residence of needing others to care for them in significantly lower proportions than other groups of respondents. Those living with mental illness and those having experienced incarceration of greater than 30 days also reported seeking improved medical care in significantly diminished proportion to others.

Those self-identifying as living with mental illness, having experience of addiction to drugs and/or alcohol, and/or experience of homelessness as an adult identified the primary reason of seeking better mental health outcomes in significantly greater proportions than other groups of resident respondents.

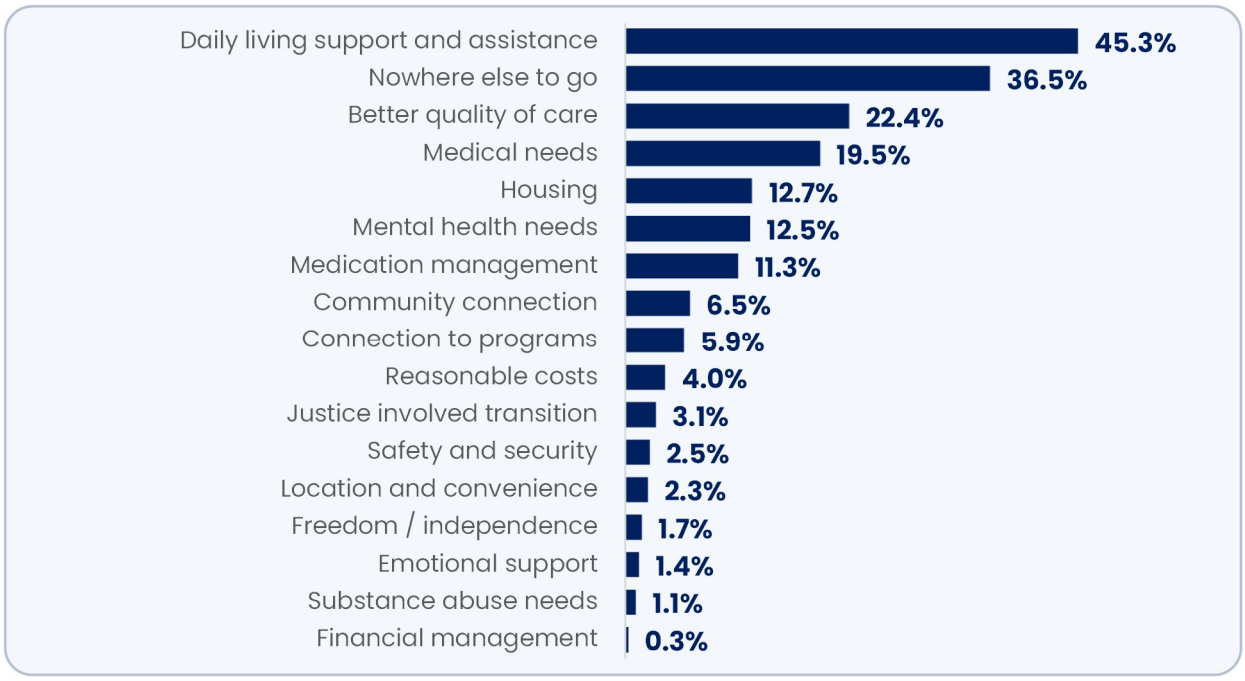
Those living with mental illness also reported medication management as a primary reason for current housing in significantly greater proportions than other respondents, as those who had previously experienced homelessness as an adult also indicated escaping homelessness in greater proportions than other resident groups. Similar significant proportions for key study factors were also found between groups of respondents who had experience of incarceration of more than 30 days and/or addiction to drugs and/or alcohol and respectively related factors.

Facility Perceptions of Reasons for Residence

Facility owners and/or operators were asked to characterize the reasons that they perceived for their residents to seek housing at their licensed ARF or RCFE.

FQ20. "What are some of the primary reasons that lead residents to seek housing here?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



The primary reasons that owners and/or operators perceive for facility residence included daily living support and assistance (45.3%), having nowhere else to go (36.5%), better quality of care (22.4%), and fulfillment of medical needs (19.5%). A general need for housing (12.7%), mental health needs (12.5%), and medication management (11.3%) rounded out respondent-perceived top reasons for facility residence.

Table 6.16: Facility Reasons for Housing, by License Class	ARF	RCFE	ALL
Daily living support and assistance	27.9%	56.2%	45.3%
Nowhere else to go	41.9%	33.2%	36.5%
Better quality of care	16.2%	26.3%	22.4%
Medical needs	11.8%	24.4%	19.5%
Housing	23.5%	6.0%	12.7%
Mental health needs	25.7%	4.1%	12.5%
Medication management	14.7%	9.2%	11.3%
Community connection	4.4%	7.8%	6.5%
Connection to programs	12.5%	1.8%	5.9%
Reasonable costs	1.5%	5.5%	4.0%
Justice involved transition	6.6%	0.9%	3.1%
Safety and security	2.2%	2.8%	2.5%
Location and convenience	2.9%	1.8%	2.3%
Freedom / independence	2.9%	0.9%	1.7%
Emotional support	1.5%	1.4%	1.4%
Substance abuse needs	2.2%	0.5%	1.1%
Financial management	0.0%	0.5%	0.3%

A significantly greater proportion of RCFE respondents asserted that daily living support and assistance as a reason for facility residence in comparison to owners and/or operators of ARFs, who identified medical needs, housing, mental health needs, connection to programs, and justice-involved transitions as reasons in significantly greater proportions than their RCFE counterparts.

Table 6.17: Facility Reasons for Housing, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Daily living support and assistance	49.0%	34.7%	45.9%
Nowhere else to go	31.4%	48.0%	39.2%
Better quality of care	26.5%	21.3%	12.2%
Medical needs	24.0%	16.0%	10.8%
Housing	8.8%	18.7%	17.6%
Mental health needs	8.3%	18.7%	17.6%
Medication management	7.4%	10.7%	23.0%
Community connection	5.4%	6.7%	9.5%
Connection to programs	3.4%	13.3%	5.4%
Reasonable costs	4.9%	2.7%	2.7%
Justice involved transition	0.0%	5.3%	1.4%
Safety and security	2.0%	1.3%	5.4%
Location and convenience	1.5%	5.3%	1.4%
Freedom / independence	1.5%	0.0%	4.1%
Emotional support	2.5%	0.0%	0.0%
Substance abuse needs	0.0%	5.3%	0.0%
Financial management	0.0%	1.3%	0.0%

RCFE respondents at 61 or more bed licensed facilities perceived better quality of care, medical needs as reasons for facility residence in significantly lower proportions than respondents at smaller facilities.

Respondents from facilities licensed for 7 to 60 beds identified daily living support and assistance as a reason for facility residence in significantly lower proportions than residents at larger or smaller facilities. However, a significantly greater proportion of these respondents identified having nowhere else to go and connection to (public) programs as a reason for facility residence.

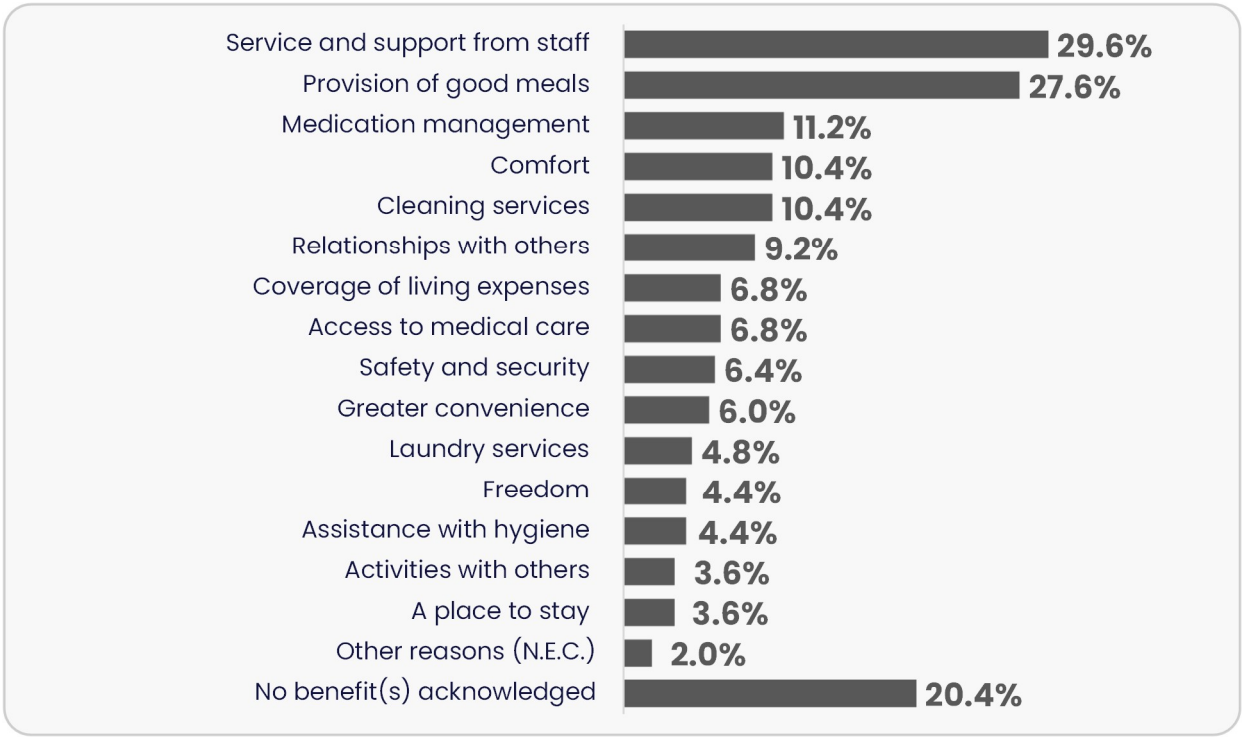
Lower proportions of owners and/or operators of facilities licensed for 6 or fewer beds indicated housing, mental health needs, and medication management as reasons for residence, in comparison to facilities of greater capacity.

Resident Benefits of Market ARF & RCFE Housing

Resident respondents were asked to identify what they believe to the benefits of their current residence at facilities over their most prior housing situation:

RQ22. "Are there any benefits that you get by living here, in comparison to your previous housing?" (MR)

RESIDENTS (N=625)



While 29.6% of residents viewed service and support from staff as a primary benefit from facility residents and 27.6% of residents viewed the provision of good meals as such, 20.4% of residents of ARFs and RCFEs did not report or acknowledge any benefit from their residence at their facility.

Table 6.18: Benefits of Facility Housing, by License Class	ARF	RCFE	ALL
Service and support from staff	17.3%	37.5%	29.6%
Provision of good meals	16.3%	34.9%	27.6%
Medication management	12.2%	10.5%	11.2%
Cleaning services	9.2%	11.2%	10.4%
Comfort	5.1%	13.8%	10.4%
Relationships with others	8.2%	9.9%	9.2%
Access to medical care	7.1%	6.6%	6.8%
Coverage of living expenses	13.3%	2.6%	6.8%
Safety and security	6.1%	6.6%	6.4%
Greater convenience	7.1%	5.3%	6.0%
Laundry services	6.1%	3.9%	4.8%
Assistance with hygiene	1.0%	6.6%	4.4%
Freedom	6.1%	3.3%	4.4%
A place to stay	3.1%	3.9%	3.6%
Activities with others	2.0%	4.6%	3.6%
No benefit(s) acknowledged	29.6%	14.5%	20.4%

RCFE resident respondents acknowledged the benefits of receiving service and support from staff, provision of good meals, and assistance with hygiene in significantly greater proportions than their counterparts at ARFs.

A significantly greater proportion of Market ARF residents reported not acknowledging any benefits from their facility housing in relation to RCFE residents. Greater proportions of ARF resident respondents also reported the benefits of coverage of living expenses than RCFE residents.

Table 6.19: Benefits of Facility Housing, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Service and support from staff	45.7%	28.8%	18.8%
Provision of good meals	28.4%	17.3%	31.6%
Medication management	7.4%	19.2%	10.3%
Cleaning services	4.9%	9.6%	14.5%
Comfort	11.1%	9.6%	10.3%
Relationships with others	6.2%	11.5%	11.1%
Access to medical care	4.9%	5.8%	8.5%
Coverage of living expenses	2.5%	9.6%	8.5%
Safety and security	4.9%	9.6%	6.0%
Greater convenience	3.7%	9.6%	6.0%
Laundry services	1.2%	3.8%	7.7%
Assistance with hygiene	6.2%	1.9%	4.3%
Freedom	3.7%	1.9%	6.0%
A place to stay	1.2%	1.9%	6.0%
Activities with others	1.2%	1.9%	6.0%
No benefit(s) acknowledged	19.8%	23.1%	19.7%

Residents at Market facilities with 6 licensed beds or fewer reported service and support from staff as a benefit of their facility housing in greater proportions than residents at 7 to 60 licensed bed or 61 licensed bed or more facilities. Lower proportions of residents at these smaller facilities reported medication management and relationships with others as a perceived benefit.

An elevated proportion of residents from mid-sized facilities (from 7 to 60 licensed beds) viewed medication management as a reason for residence, or perceived no benefits from their residence at an ARF or RCFE over those residing at smaller or larger Market facilities.

Table 6.20: Benefits of Facility Housing, by Age Range	18-54	55-61	62+
Service and support from staff	21.7%	21.2%	35.1%
Provision of good meals	14.5%	24.2%	34.5%
Medication management	13.0%	18.2%	8.8%
Cleaning services	13.0%	12.1%	8.8%
Comfort	5.8%	3.0%	14.2%
Relationships with others	10.1%	6.1%	10.1%
Access to medical care	8.7%	15.2%	4.1%
Coverage of living expenses	8.7%	12.1%	4.7%
Safety and security	8.7%	6.1%	5.4%
Greater convenience	7.2%	6.1%	5.4%
Laundry services	7.2%	6.1%	3.4%
Assistance with hygiene	1.4%	0.0%	6.8%
Freedom	4.3%	6.1%	4.1%
A place to stay	4.3%	3.0%	3.4%
Activities with others	2.9%	3.0%	4.1%
No benefit(s) acknowledged	29.0%	24.2%	15.5%

Resident respondents aged 62 years or older indicated service and support from staff, the provision of good meals, comfort, and assistance with hygiene were benefits derived from their facility housing in significantly greater proportions than residents from younger age cohorts. A significantly greater proportion of residents aged between 55 and 61 years of age indicated that medication management and coverage of living expenses were a benefit, compared to residents in older or younger age groups.

Significantly greater proportions of residents in the 18 to 54 and 55 to 61 age groups reported no benefits from their residence at a facility, in comparison to resident respondents aged 62 or older.

Table 6.21: Benefits of Facility Housing, by Gender Identity	FEMALE	MALE
Service and support from staff	34.5%	25.7%
Provision of good meals	34.5%	22.1%
Medication management	10.9%	11.4%
Cleaning services	12.7%	8.6%
Comfort	15.5%	6.4%
Relationships with others	10.9%	7.9%
Access to medical care	5.5%	7.9%
Coverage of living expenses	5.5%	7.9%
Safety and security	6.4%	6.4%
Greater convenience	6.4%	5.7%
Laundry services	7.3%	2.9%
Assistance with hygiene	4.5%	4.3%
Freedom	4.5%	4.3%
A place to stay	6.4%	2.1%
Activities with others	1.8%	5.0%
No benefit(s) acknowledged	12.7%	26.4%

Residents with female gender identity reported service and support from staff, the provision of good meals, comfort, and laundry services as benefits in significantly greater proportions than their male-gendered counterparts, while a significantly greater proportion of respondents of male gender acknowledged no benefits from their facility housing.

Table 6.22: Benefits of Facility Housing, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN*	PACIFIC ISLANDER*	MIDDLE EASTERN*
Service and support from staff	28.0%	22.9%	34.1%	42.9%	16.7%	0.0%	0.0%
Provision of good meals	32.8%	20.8%	19.5%	25.7%	16.7%	0.0%	0.0%
Medication management	12.0%	12.5%	7.3%	14.3%	0.0%	0.0%	100.0%
Cleaning services	15.2%	6.3%	4.9%	5.7%	0.0%	0.0%	0.0%
Comfort	9.6%	6.3%	17.1%	11.4%	0.0%	100.0%	0.0%
Relationships with others	11.2%	6.3%	7.3%	8.6%	0.0%	0.0%	0.0%
Access to medical care	7.2%	2.1%	4.9%	17.1%	33.3%	0.0%	0.0%
Coverage of living expenses	4.8%	12.5%	7.3%	2.9%	33.3%	0.0%	0.0%
Safety and security	8.0%	0.0%	7.3%	8.6%	0.0%	0.0%	0.0%
Greater convenience	4.8%	4.2%	12.2%	0.0%	16.7%	0.0%	0.0%
Laundry services	4.8%	8.3%	4.9%	0.0%	0.0%	0.0%	0.0%
Assistance with hygiene	6.4%	2.1%	4.9%	0.0%	0.0%	0.0%	0.0%
Freedom	3.2%	8.3%	2.4%	2.9%	16.7%	100.0%	0.0%
A place to stay	2.4%	2.1%	7.3%	5.7%	0.0%	0.0%	0.0%
Activities with others	4.0%	2.1%	2.4%	5.7%	0.0%	100.0%	0.0%
No benefit(s) acknowledged	17.6%	39.6%	19.5%	11.4%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Black / African American residents reported that they did not perceive any benefits from their housing at an ARF / RCFE, in comparison to respondents belonging to other, racial identity groups. The pool of Black / African American respondents identified coverage of living expenses and freedom as benefits in greater proportions than other groups of respondents.

Greater proportions of Asian / Asian American and Hispanic / Latino / Latinx respondents acknowledged service and support from staff in comparison with others, while White / Caucasian resident respondents identified the provision of good meals and cleaning services as benefits of facility living in greater proportions than other respondents.

Hispanic / Latino / Latinx resident respondents reported realizing benefits from comfort, greater convenience, and medication management in greater proportions than respondents from other racial identity groups. Asian / Asian American residents identified access to medical care in significantly greater proportions than respondents of other identity groups.

Table 6.23: Benefits of Facility Housing, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Service and support from staff	22.6%	23.4%	30.9%	25.0%	32.3%
Provision of good meals	22.6%	26.0%	30.9%	15.4%	24.2%
Medication management	14.8%	15.6%	13.8%	13.5%	11.3%
Cleaning services	12.2%	10.4%	16.3%	9.6%	16.1%
Comfort	7.8%	7.8%	13.8%	9.6%	9.7%
Relationships with others	9.6%	7.8%	10.6%	3.8%	9.7%
Access to medical care	7.8%	6.5%	5.7%	11.5%	4.8%
Coverage of living expenses	7.8%	14.3%	8.9%	11.5%	9.7%
Safety and security	7.8%	7.8%	6.5%	7.7%	8.1%
Greater convenience	8.7%	6.5%	3.3%	3.8%	4.8%
Laundry services	7.0%	6.5%	6.5%	5.8%	8.1%
Assistance with hygiene	2.6%	5.2%	7.3%	1.9%	3.2%
Freedom	7.8%	3.9%	2.4%	5.8%	4.8%
A place to stay	4.3%	5.2%	3.3%	5.8%	4.8%
Activities with others	3.5%	2.6%	3.3%	0.0%	1.6%
No benefit(s) acknowledged	20.0%	16.9%	13.8%	25.0%	17.7%

A significantly greater proportion of individuals who had experience of incarceration of greater than 30 days acknowledged no benefit from their ARF or RCFE residence than individuals who had experienced other key study factors. However, this same group reported recognition of benefits from the provision of good meals, access to medical care, and coverage of living expenses in significantly greater proportions than residents in other groups.

Residents living with mental illness or experience of homelessness as an adult indicated that service and support from staff and medication management as benefits in significantly lower proportions than respondents with other experiential study factors. Residents living with a physical disability and those living with addiction to drugs and/or alcohol also acknowledged the benefit of cleaning services in significantly greater proportions than residents in other groups.

Facility Perceptions of Resident Housing Benefits-

Facility respondents were asked to describe the benefits that residents realize from their housing at a licensed ARF or RCFE.

FQ21. "What are some of the benefits that residents receive by living here, compared to any previous housing type they might have chosen for themselves?" (MR)

FACILITY OWNERS & OPERATORS (N=353)

Respondents owning or operating facilities identified the provision of quality food service, medication management, and overall quality of care as the primary benefits delivered to residents from their ARF or RCFE. A large proportion of facility respondents also identified the aspects of community / socialization with others, access to medical appointments, and assistance with Activities of Daily Living (ADLs) as primary benefits to residents.

Table 6.24: Facility Benefits of Housing, by License Class	ARF	RCFE	ALL
3 meals a day / quality food service	48.5%	42.9%	45.0%
Medication management	40.4%	30.9%	34.6%
Overall quality of care	21.3%	28.6%	25.8%
Community / socialization with others	18.4%	24.9%	21.5%
Access to medical appointments	26.5%	16.6%	20.4%
Assistance with ADLs	5.1%	24.9%	17.3%
Individualized care	10.3%	15.7%	13.6%
Continuous (24/7) care	5.9%	17.5%	13.0%
Entertainment activities	15.4%	11.5%	13.0%
Supervision	8.8%	8.3%	8.5%
Access to mental health appointments	17.6%	1.8%	7.9%
Freedom and independence	10.3%	6.0%	7.6%
Transportation services	5.1%	6.0%	5.7%
Laundry services	5.9%	5.1%	5.4%
Safety and security	8.8%	2.8%	5.1%
A place to stay	7.4%	3.2%	4.8%
Clean environment	5.1%	4.6%	4.8%
Comfort	3.7%	3.2%	3.4%
Exercise activities	2.2%	3.7%	3.1%
Life skills activities	5.1%	0.9%	2.5%
Financial management	5.1%	0.0%	2.0%
Convenience of location	0.0%	2.3%	1.4%
Cultural acceptance / multicultural	0.7%	1.8%	1.4%
Case management services	2.9%	0.0%	1.1%
Family integration	0.7%	1.4%	1.1%
Lower or no cost of care	0.0%	1.4%	0.8%
Substance misuse prevention	2.2%	0.0%	0.8%

Overall, respondents across ARFs and RCFEs evaluated the delivery of 3 meals per day / quality food service and medication management as key benefits. Significantly lower proportions of owners and/or operators at ARFs offered overall quality of care, assistance with activities of daily living (ADLs), and continuous 24/7 (around-the-clock) care as benefits of ARF/RCFE housing in relation to their counterparts at larger facilities. However, respondents at ARFs viewed life skills activities, financial management, case management services, and substance abuse prevention as benefits in significantly greater proportions than RCFE respondents.

Table 6.25: Facility Benefits of Housing, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
3 meals a day / quality food service	41.2%	46.7%	54.1%
Medication management	28.4%	34.7%	51.4%
Overall quality of care	28.4%	28.0%	16.2%
Community / socialization with others	24.0%	20.0%	20.3%
Access to medical appointments	15.7%	24.0%	29.7%
Assistance with ADLs	19.6%	4.0%	24.3%
Individualized care	18.1%	9.3%	5.4%
Continuous (24/7) care	12.7%	12.0%	14.9%
Entertainment activities	10.8%	13.3%	18.9%
Supervision	8.3%	5.3%	12.2%
Access to mental health appointments	4.4%	14.7%	10.8%
Freedom and independence	9.3%	5.3%	5.4%

Table 6.25: Facility Benefits of Housing, by Facility Size (continued)	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Transportation services	2.9%	1.3%	17.6%
Laundry services	3.4%	6.7%	9.5%
Safety and security	2.9%	8.0%	8.1%
A place to stay	3.4%	5.3%	8.1%
Clean environment	2.9%	6.7%	8.1%
Comfort	4.4%	2.7%	1.4%
Exercise activities	2.5%	5.3%	2.7%
Life skills activities	4.4%	0.0%	0.0%
Financial management	1.0%	2.7%	4.1%
Convenience of location	1.5%	0.0%	2.7%
Cultural acceptance / multicultural	1.0%	1.3%	2.7%
Case management services	0.0%	4.0%	1.4%
Family integration	1.5%	0.0%	1.4%
Lower or no cost of care	1.0%	1.3%	0.0%
Substance misuse prevention	0.0%	2.7%	1.4%

Respondents serving facilities with 61 or more licensed beds reported offering 3 meals a day / quality food service, medication management, entertainment activities, supervision, and transportation services as benefits of facility residence in significantly greater proportions than respondents from smaller licensed capacity facilities.

Owners and/or operators at 7 to 60 licensed bed and 62 or more licensed bed capacity facilities reported access to medical appointments, access to mental health appointments, laundry services, safety and security, and a clean environment as benefits in greater proportions than 6 or fewer licensed bed facilities.

7 to 60 licensed bed and 6 or fewer licensed bed facility respondents reported overall quality of care in greater proportions than respondents at 61 or more licensed bed facilities. Respondents from 6 or fewer licensed bed facilities identified individualized care in significantly greater proportions, along with freedom and independence, and comfort in greater proportions, as benefits of facility residence over respondents representing larger facility populations.

Resident Unmet Needs

Residents were asked if their current housing at an ARF or RCFE provided them with everything they wanted and needed from a place to live:

RQ26. "Does living here give you everything that you want and need from a place to live? (MR)

RESIDENTS (N=625)

Table 6.26: Wants and Needs Are Met, by License Class	ARF	RCFE	ALL
Yes	92.0%	85.8%	89.1%
No	7.4%	13.9%	10.4%

A genuinely positive indicator conveying the experiences of residents across the Market, 89.1% of respondents indicated that the ARFs and RCFEs where they reside provide everything that they wanted and needed from a place to live. Considering the diversity of experiences, needs, and backgrounds of the facility residents taking part in this research sample, this finding is significant in correlation to the measurement of overall satisfaction for residents.

A slightly elevated proportion of residents of licensed ARFs indicated that their wants and needs were met by their facility over resident respondents from RCFEs.

Table 6.27: Wants and Needs Are Met, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Yes	91.5%	87.9%	88.7%
No	8.5%	12.1%	10.4%

A greater proportion of resident respondents from facilities with 6 or fewer licensed beds indicated that their wants and needs were met compared to residents of larger facility sizes.

Table 6.28: Wants and Needs Are Met, by Age Range	18-54	55-61	62+
Yes	92.3%	93.6%	85.0%
No	7.3%	6.4%	14.3%

A lower proportion of resident respondents aged 62 or older indicated that their wants and needs were met by their facilities than respondents in the 18-54 or 55-61 age cohorts.

Table 6.29: Wants and Needs Are Met, by Gender Identity	FEMALE	MALE
Yes	89.1%	89.1%
No	10.5%	10.4%

There were no substantively observable differences regarding the fulfillment of resident wants and needs at facilities on the basis of gender identity.

Table 6.30: Wants and Needs Are Met, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Yes	87.4%	86.4%	90.4%	98.5%	82.4%	66.7%	66.7%
No	12.6%	13.6%	9.6%	1.5%	17.6%	33.3%	33.3%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Asian / Asian American resident respondents indicated that their wants and needs were successfully delivered by their ARF or RCFE than residents identifying with other racial identity groups. Slightly lower proportions of White/Caucasian and Black / African American residents reported having their wants and needs fulfilled by their facilities, while a significantly lower proportion of Native American / Alaska Native respondents indicated that their wants and needs were fulfilled by their facilities.

Table 6.31: Wants and Needs Are Met, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Yes	90.6%	90.3%	87.0%	91.8%	87.7%
No	8.9%	9.4%	12.7%	8.2%	11.3%

Comparable proportions of residents with experience across most key study factors reported their wants and needs being fulfilled by their facility, with the exception of slightly elevated proportions of people with experience of living with physical disability and people with experience of substance addiction reporting having wants and needs not provided by facilities.

Facility Perceptions of Resident Unmet Needs

Owners and/or operators were similarly asked to identify any unmet needs of their resident populations from their residence at their facility, with the potential to identify any particular characteristics of residents with unmet needs. Overall, a low proportion of facility respondents reported any resident groups or individual unmet needs among the populations at their facilities.

FQ23. "What are some of the specific, unmet needs of the different populations your facility serves?" (MR)

OWNERS & OPERATORS (N=353)

Table 6.32: No Residents with Unmet Needs, by License Class	ARF	RCFE	ALL
	35.3%	41.5%	39.1%

Although facility owners and operators identified that their residents had no unmet needs in lower proportions to residents themselves, there was a considerable amount of concern expressed by owners and/or operators in the framing of the question, with 39.1% insisting that their ARF or RCFE fulfilled all resident needs regardless of the characteristics, backgrounds, or experiences of the individuals served.

A greater proportion of RCFE owners and/or operators did not perceive that any resident populations had unmet needs, in relation to their ARF counterparts.

Table 6.33: No Residents with Unmet Needs, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	45.1%	24.3%	37.3%

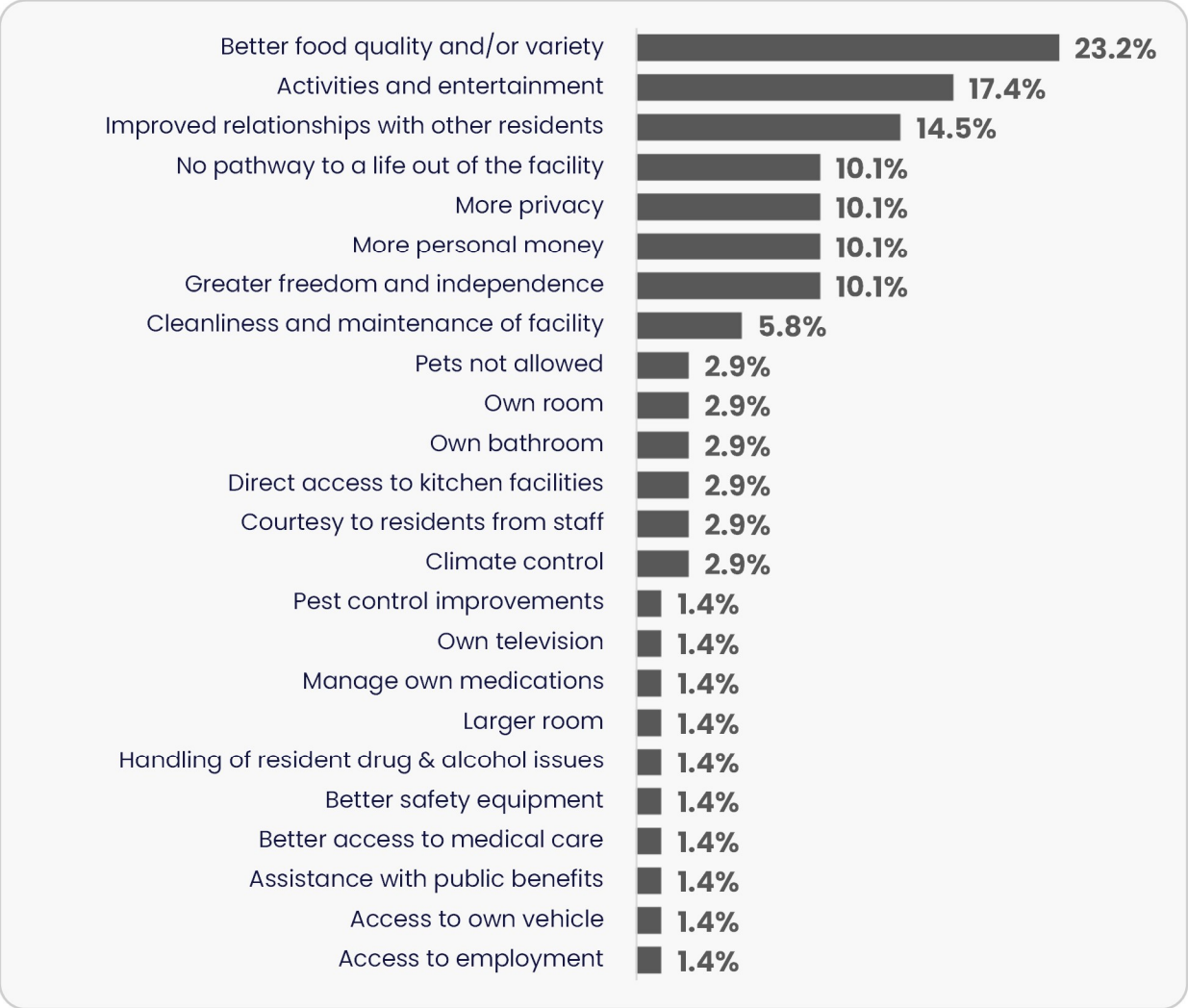
Facility owners and/or operators serving 7 to 60 licensed bed ARFs and RCFEs reported that their residents had unmet needs in significantly lower proportions than respondents and larger or smaller facilities.

Identifying Unmet Resident Needs

Residents were asked to identify any unmet need that they have experienced from living in their current housing at an ARF or RCFE.

RQ27. What are some of the things you want and need that living here doesn't provide?" (MR)

RESIDENTS (n=68)



Nearly a quarter (23.2%) of residents reported the unmet need of seeking better food quality and/or variety from their ARF or RCFE, indicating a significant presence of this issue across the Market. 17.4% of residents indicated that they had unmet needs relating to activities and entertainment, and a further 14.5% sought improvement in their relations with the other residents at their facility.

10.1% of residents had an unmet need in receiving assistance to have a pathway for a life outside of their facility. This corresponds with other study findings identifying a gap in wraparound services and programs offered to assist residents that have the desire or capability to graduate to lower levels of care or housing. Comparable proportions of residents also cited an unmet need for greater freedom and independence, more privacy, and more personal spending money.

Table 6.34: Unmet Wants and Needs, by License Class	ARF	RCFE	ALL
Better food quality and/or variety	22.2%	24.4%	23.2%
Activities and entertainment	11.1%	22.0%	17.4%
Improved relationships with other residents	14.8%	14.6%	14.5%
Greater freedom and independence	7.4%	12.2%	10.1%
More personal money	7.4%	12.2%	10.1%
More privacy	22.2%	2.4%	10.1%
No pathway to a life out of the facility	14.8%	7.3%	10.1%
Cleanliness and maintenance of facility	11.1%	2.4%	5.8%
Climate control	0.0%	4.9%	2.9%
Courtesy to residents from staff	7.4%	0.0%	2.9%
Direct access to kitchen facilities	7.4%	0.0%	2.9%
Own bathroom	3.7%	2.4%	2.9%
Own room	3.7%	2.4%	2.9%
Pets not allowed	3.7%	2.4%	2.9%
Access to employment	0.0%	2.4%	1.4%
Access to own vehicle	0.0%	2.4%	1.4%
Assistance with public benefits	3.7%	0.0%	1.4%
Better access to medical care	0.0%	2.4%	1.4%
Better safety equipment	0.0%	2.4%	1.4%
Handling of resident drug & alcohol issues	3.7%	0.0%	1.4%
Larger room	0.0%	2.4%	1.4%
Manage own medications	3.7%	0.0%	1.4%
Own television	3.7%	0.0%	1.4%
Pest control improvements	3.7%	0.0%	1.4%

ARF residents indicated that more privacy, cleanliness and maintenance of the facility, courtesy to residents from staff, and direct access to kitchen facilities as unmet needs in significantly greater proportions over RCFE residents. A significantly greater proportion of residents from RCFEs reported activities and entertainment, and climate control as an unmet need compared to residents of ARFs. A variety of other unmet needs were recorded and categorized from responses that appeared uniquely from respondents at either license class in low numbers.

Table 6.35: Unmet Wants and Needs, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Better food quality and/or variety	0.0%	21.1%	32.4%
Activities and entertainment	33.3%	10.5%	16.2%
Improved relationships with other residents	8.3%	15.8%	16.2%
Greater freedom and independence	16.7%	5.3%	10.8%
More personal money	0.0%	26.3%	5.4%
More privacy	16.7%	5.3%	10.8%
No pathway to a life out of the facility	8.3%	10.5%	8.1%
Cleanliness and maintenance of facility	0.0%	10.5%	5.4%
Climate control	0.0%	5.3%	5.4%
Courtesy to residents from staff	0.0%	0.0%	5.4%
Direct access to kitchen facilities	8.3%	5.3%	0.0%
Own bathroom	0.0%	0.0%	5.4%
Own room	8.3%	0.0%	2.7%
Pets not allowed	0.0%	10.5%	0.0%
Access to employment	0.0%	5.3%	0.0%
Access to own vehicle	0.0%	0.0%	2.7%
Assistance with public benefits	0.0%	0.0%	2.7%
Better access to medical care	0.0%	0.0%	2.7%

Table 6.35: Unmet Wants and Needs, by Facility Size (continued)	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Better safety equipment	0.0%	0.0%	2.7%
Handling of resident drug & alcohol issues	0.0%	0.0%	2.7%
Larger room	0.0%	5.3%	0.0%
Manage own medications	8.3%	0.0%	0.0%
Own television	0.0%	5.3%	0.0%
Pest control improvements	0.0%	0.0%	2.7%

Resident respondents living at 61 or more licensed bed ARFs and RCFEs reported better food quality and/or variety and courtesy to residents from staff in significantly greater proportions than those of smaller facilities. Residents of larger facility sizes reported climate control as an unmet need in significantly greater proportions than those at facilities serving populations of 6 or fewer licensed beds.

Mid-sized facility (7 to 60 licensed beds) resident respondents reported more personal money and cleanliness and maintenance of the facility in significantly greater proportions than residents at larger or smaller facilities.

Activities and entertainment, greater freedom and independence, more privacy, improved relationships with other residents, and direct access to kitchen facilities were reported as unmet needs by residents of 6 or fewer licensed beds in greater proportions than residents at larger facilities of 7 to 60 licensed beds or 61 or more licensed beds.

Table 6.36: Unmet Wants and Needs, by Age Group	18-54	55-61	62+
Better food quality and/or variety	5.3%	50.0%	28.6%
Activities and entertainment	5.3%	0.0%	26.2%
Improved relationships with other residents	15.8%	33.3%	9.5%
Greater freedom and independence	10.5%	0.0%	11.9%
More personal money	26.3%	16.7%	2.4%
More privacy	15.8%	0.0%	9.5%
No pathway to a life out of the facility	10.5%	0.0%	11.9%
Cleanliness and maintenance of facility	10.5%	16.7%	2.4%
Climate control	0.0%	0.0%	4.8%
Courtesy to residents from staff	5.3%	16.7%	0.0%
Direct access to kitchen facilities	10.5%	0.0%	0.0%
Own bathroom	5.3%	0.0%	2.4%
Own room	10.5%	0.0%	0.0%
Pets not allowed	10.5%	0.0%	0.0%
Access to employment	0.0%	0.0%	2.4%
Access to own vehicle	0.0%	0.0%	2.4%
Assistance with public benefits	5.3%	0.0%	0.0%
Better access to medical care	0.0%	0.0%	2.4%
Better safety equipment	0.0%	0.0%	2.4%
Handling of resident drug & alcohol issues	5.3%	0.0%	0.0%
Larger room	5.3%	0.0%	0.0%
Manage own medications	0.0%	0.0%	2.4%
Own television	5.3%	0.0%	0.0%
Pest control improvements	0.0%	16.7%	0.0%

Residents in the 55- to 61-year-old age cohort reported better food quality and/or variety, improved relationships with other residents, cleanliness and maintenance of the facility, and courtesy to residents from staff in significantly greater proportions than residents of older or younger age groups. More personal money and more privacy were reported as unmet needs in significantly greater proportions by those in the 18 to 55

age cohort than residents in older age cohorts, while residents aged 62 years or older identified activities and entertainment as an unmet need in significantly greater proportions than respondents in younger age cohort.

Table 6.37: Unmet Wants and Needs, by Gender Identity	FEMALE	MALE
Better food quality and/or variety	46.4%	7.5%
Activities and entertainment	17.9%	17.5%
Improved relationships with other residents	10.7%	17.5%
Greater freedom and independence	7.1%	12.5%
More personal money	10.7%	10.0%
More privacy	7.1%	12.5%
No pathway to a life out of the facility	3.6%	15.0%
Cleanliness and maintenance of facility	7.1%	5.0%
Climate control	3.6%	2.5%
Courtesy to residents from staff	0.0%	5.0%
Direct access to kitchen facilities	3.6%	2.5%
Own bathroom	3.6%	2.5%
Own room	3.6%	2.5%
Pets not allowed	7.1%	0.0%
Access to employment	3.6%	0.0%
Access to own vehicle	0.0%	2.5%
Assistance with public benefits	0.0%	2.5%
Better access to medical care	3.6%	0.0%
Better safety equipment	3.6%	0.0%
Handling of resident drug & alcohol issues	3.6%	0.0%
Larger room	0.0%	2.5%
Manage own medications	0.0%	2.5%
Own television	0.0%	2.5%
Pest control improvements	3.6%	0.0%

A significantly greater proportion of female-gendered resident respondents indicated that better food quality and/or variety was an unmet need than male residents. Male-gendered resident respondents indicated that improved relationships with other residents, no pathway to a life out of the facility, and courtesy to residents from staff were unmet needs in significantly greater proportions than female residents.

Table 6.38: Unmet Wants and Needs, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER	MIDDLE EASTERN

The table for segmentation by resident racial identity has been intentionally omitted, as valid comparison of responses for unmet resident needs is not possible due to the low proportions of residents that identified unmet needs overall, given the nature of the question.

Table 6.39: Unmet Wants and Needs, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Better food quality / variety	27.8%	27.6%	19.0%	26.7%	26.9%
Activities and entertainment	5.6%	13.8%	14.3%	13.3%	19.2%
Improved relations. w/ other res.	5.6%	13.8%	16.7%	20.0%	15.4%
Greater freedom and independence	11.1%	10.3%	16.7%	6.7%	7.7%
More personal money	13.9%	10.3%	7.1%	6.7%	3.8%
More privacy	16.7%	13.8%	9.5%	26.7%	7.7%
No pathway to a life out / facility	11.1%	6.9%	7.1%	6.7%	15.4%
Cleanliness / maintenance	11.1%	10.3%	7.1%	0.0%	7.7%
Climate control	2.8%	3.4%	2.4%	0.0%	0.0%
Courtesy to residents from staff	5.6%	3.4%	2.4%	0.0%	3.8%
Direct access to kitchen facilities	5.6%	6.9%	0.0%	0.0%	0.0%
Own bathroom	2.8%	6.9%	4.8%	6.7%	3.8%
Own room	5.6%	3.4%	2.4%	6.7%	3.8%
Pets not allowed	5.6%	6.9%	2.4%	0.0%	3.8%
Access to employment	2.8%	3.4%	2.4%	0.0%	0.0%
Access to own vehicle	2.8%	3.4%	2.4%	6.7%	3.8%
Assistance with public benefits	2.8%	0.0%	0.0%	0.0%	3.8%
Better access to medical care	0.0%	3.4%	0.0%	0.0%	0.0%
Better safety equipment	2.8%	3.4%	2.4%	0.0%	0.0%
Handling of res. drug & alcohol	2.8%	0.0%	2.4%	0.0%	3.8%
Larger room	0.0%	3.4%	2.4%	6.7%	3.8%
Manage own medications	2.8%	0.0%	2.4%	0.0%	3.8%
Own television	0.0%	3.4%	2.4%	0.0%	3.8%
Pest control improvements	2.8%	3.4%	2.4%	26.7%	3.8%

Significantly greater proportions of resident respondents who experience living with mental illness and those who had experienced homelessness as an adult reported variety, cleanliness and maintenance of the facility, and direct access to kitchen facilities as unmet needs in comparison to other groups.

Residents who had experience of incarceration for a period of 30 or more days reported more privacy, improved relationships with other residents, and desire for improved pest control as unmet needs in significantly greater proportions than residents with other experiential study factors.

Residents with experience of addiction to drugs and/or alcohol reported that having no pathway to a life outside of facility was an unmet need in significantly greater proportion than residents with other key study factors.

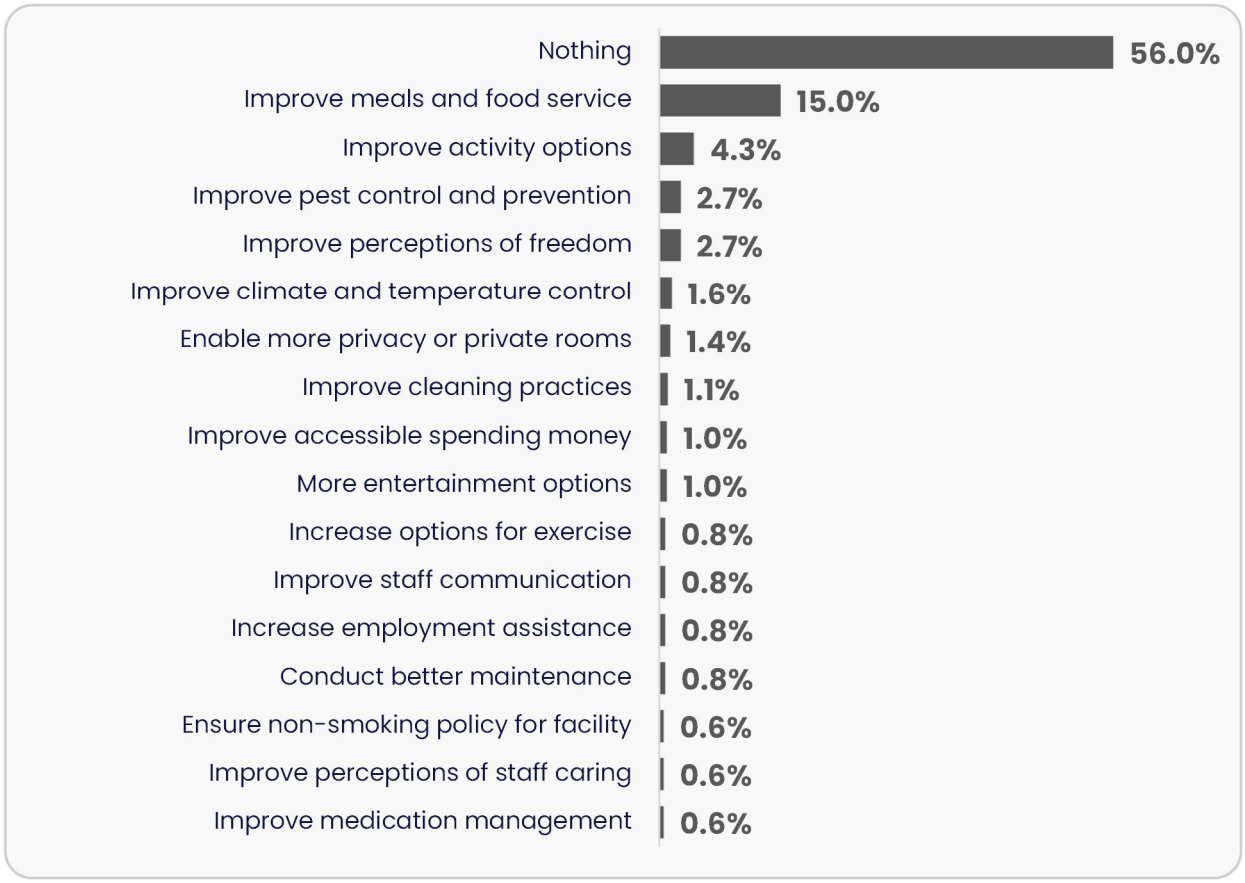
Residents who reported living with physical disability indicated greater freedom and independence in significantly greater proportions than other resident factor groups.

Changes or Improvements Sought by Residents

Residents were asked to identify any changes or improvements that they would like to see at the ARFs and RCFEs that house them. No further instructions were provided in regard to the nature of changes or improvements sought were provided, and further prompting was offered to ensure that a maximum number of suggestions was elicited from each respondent.

RQ72. "Is there anything about your life or living conditions here that you would like to have improved or changed?" (MR)

RESIDENTS (N=625)



As the last question in the resident interview process, designed to be confirmatory that residents were given ample opportunity to define any issues or improvements sought in their living conditions, 56.0% of residents, when asked to recommend any variety of improvement or changes in their living conditions at their facility, indicated that they sought nothing for to be changed or improved.

15.0% of residents indicated that they sought improvement in meals and food service, correlating with resident responses related to unmet needs.

Table 6.40: Changes or Improvements, by License Class	ARF	RCFE	ALL
Nothing	57.9%	53.8%	56.0%
Improve meals and food service	12.5%	18.1%	15.0%
Improve activity options	1.8%	7.3%	4.3%
Improve perceptions of freedom	3.6%	1.7%	2.7%
Improve pest control and prevention	4.2%	1.0%	2.7%
Improve climate and temperature control	1.5%	1.7%	1.6%
Enable more privacy or private rooms	2.1%	0.7%	1.4%
Improve cleaning practices	0.9%	1.4%	1.1%
More entertainment options	0.9%	1.0%	1.0%
Improve accessible spending money	0.9%	1.0%	1.0%
Conduct better maintenance	0.9%	0.7%	0.8%
Increase employment assistance	1.5%	0.0%	0.8%
Improve staff communication	0.3%	1.4%	0.8%
Increase options for exercise	0.6%	1.0%	0.8%
Improve medication management	0.9%	0.3%	0.6%
Improve perceptions of staff caring	0.9%	0.3%	0.6%
Ensure non-smoking policy for facility	1.2%	0.0%	0.6%

Greater proportions of residents from RCFEs sought better activity options at their facilities than residents of ARFs. A greater proportion of ARF residents sought improvement in pest control than residents at RCFEs.

Table 6.41: Changes or Improvements, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Nothing	66.7%	52.2%	53.2%
Improve meals and food service	7.1%	16.6%	17.7%
Improve activity options	5.0%	3.8%	4.9%
Improve perceptions of freedom	4.3%	1.9%	2.4%
Improve pest control and prevention	0.7%	3.8%	3.1%
Improve climate and temperature control	0.7%	3.2%	1.2%
Enable more privacy or private rooms	1.4%	2.5%	0.9%
Improve cleaning practices	0.0%	1.9%	1.2%
More entertainment options	0.7%	1.3%	0.9%
Improve accessible spending money	0.0%	0.6%	1.5%
Conduct better maintenance	0.0%	1.9%	0.6%
Increase employment assistance	1.4%	1.3%	0.3%
Improve staff communication	1.4%	0.6%	0.6%
Increase options for exercise	0.7%	1.9%	0.3%
Improve medication management	0.0%	1.3%	0.6%
Improve perceptions of staff caring	0.9%	0.3%	0.6%
Ensure non-smoking policy for facility	0.0%	1.3%	0.6%

Although a significantly greater proportion of residents at ARFs and RCFEs with 6 or fewer licensed beds sought no changes or improvements than residents at larger facilities, significantly lower proportions of residents from these facilities sought improvements in meals and food service and in their perceptions of freedom (and independence).

Table 6.42: Changes or Improvements, by Age Range	18-54	55-61	62+
Nothing	58.5%	54.3%	53.9%
Improve meals and food service	9.7%	20.2%	18.2%
Improve activity options	2.4%	7.4%	5.7%
Improve perceptions of freedom	4.4%	1.1%	1.8%
Improve pest control and prevention	5.2%	4.3%	0.0%
Improve climate and temperature control	2.0%	1.1%	1.8%
Enable more privacy or private rooms	2.0%	0.0%	1.4%
Improve cleaning practices	1.2%	1.1%	1.1%
More entertainment options	1.2%	0.0%	1.1%
Improve accessible spending money	0.4%	1.1%	1.4%
Conduct better maintenance	1.6%	0.0%	0.4%
Increase employment assistance	2.0%	0.0%	0.0%
Improve staff communication	0.4%	1.1%	1.1%
Increase options for exercise	1.2%	0.0%	0.7%
Improve medication management	0.8%	0.0%	0.7%
Improve perceptions of staff caring	0.9%	0.3%	0.6%
Ensure non-smoking policy for facility	0.8%	2.1%	0.0%

Greater proportions of residents aged 55 to 61 sought improvements in meals and food service and activity options at their facilities than residents of older or younger age cohorts.

Table 6.43: Changes or Improvements, by Gender Identity	FEMALE	MALE
Nothing	53.9%	57.8%
Improve meals and food service	18.0%	12.8%
Improve activity options	5.1%	4.4%
Improve perceptions of freedom	2.7%	2.7%
Improve pest control and prevention	2.7%	2.7%
Improve climate and temperature control	2.0%	1.4%
Enable more privacy or private rooms	1.2%	1.6%
Improve cleaning practices	1.2%	1.1%
More entertainment options	0.8%	1.1%
Improve accessible spending money	2.0%	0.3%
Conduct better maintenance	0.4%	1.1%
Increase employment assistance	0.4%	1.1%
Improve staff communication	1.2%	0.5%
Increase options for exercise	0.0%	1.4%
Improve medication management	0.4%	0.8%
Improve perceptions of staff care for residents	0.8%	0.5%
Ensure non-smoking policy for facility	0.0%	1.1%

There were no significant observable differences in the changes or improvements sought by residents based on gender identity, other than an elevated proportion of female-gendered residents who sought improvement from their facilities in meals and food service over their male-gendered counterparts.

Table 6.44: Changes or Improvements, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN*	PACIFIC ISLANDER*	MIDDLE EASTERN*
Nothing	56.9%	51.9%	54.8%	64.2%	52.9%	100.0%	100.0%
Improve meals and food service	15.9%	17.9%	13.5%	9.0%	11.8%	0.0%	0.0%
Improve activity options	4.4%	4.9%	5.8%	4.5%	0.0%	0.0%	0.0%
Improve perceptions of freedom	2.0%	4.3%	2.9%	0.0%	11.8%	0.0%	0.0%
Improve pest control / prevention	2.0%	3.7%	2.9%	1.5%	5.9%	0.0%	0.0%
Improve climate/temp. control	1.4%	1.2%	2.9%	0.0%	0.0%	0.0%	0.0%
Enable more privacy/private rms.	1.0%	1.9%	2.9%	1.5%	0.0%	0.0%	0.0%
Improve cleaning practices	0.3%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%
More entertainment options	1.0%	0.6%	1.9%	0.0%	0.0%	0.0%	0.0%
Improve accessible spend money	1.0%	0.6%	1.0%	0.0%	0.0%	0.0%	0.0%
Conduct better maintenance	0.7%	0.6%	1.0%	1.5%	0.0%	0.0%	0.0%
Increase employment assistance	1.0%	0.0%	1.0%	1.5%	0.0%	0.0%	0.0%
Improve staff communication	0.7%	1.2%	1.0%	0.0%	0.0%	0.0%	0.0%
Increase options for exercise	1.0%	1.2%	1.0%	0.0%	0.0%	0.0%	0.0%
Improve med. management	1.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Improve perceptions of staff care	1.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Ensure non-smoking policy	1.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Asian / Asian American resident respondents sought no changes or improvements at their facilities, in comparison to residents of other racial identity groups. A slightly elevated proportion of Black / African American residents seek to have their facility improve resident perceptions of freedom over respondents from other groups.

Table 6.45: Changes or Improvements, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Nothing	54.2%	54.5%	48.1%	58.2%	48.1%
Improve meals and food service	15.9%	16.4%	17.6%	12.0%	17.9%
Improve activity options	3.6%	3.3%	5.6%	4.3%	5.2%
Improve perceptions of freedom	2.9%	4.0%	2.2%	5.4%	3.8%
Improve pest control / prevention	3.1%	3.3%	3.1%	4.9%	3.8%
Improve climate/temp. control	2.3%	1.7%	1.5%	2.7%	2.4%
Enable more privacy/private rms.	1.6%	2.0%	1.5%	2.7%	2.8%
Improve cleaning practices	1.3%	1.0%	1.9%	0.0%	1.4%
More entertainment options	0.5%	0.7%	0.0%	0.0%	1.4%
Improve accessible spend money	1.0%	1.3%	0.9%	0.5%	0.5%
Conduct better maintenance	0.8%	0.7%	0.6%	1.1%	0.9%
Increase employment assistance	1.0%	1.0%	0.9%	1.1%	1.9%
Improve staff communication	0.3%	0.3%	1.2%	0.0%	0.5%
Increase options for exercise	0.8%	0.7%	0.6%	1.1%	0.9%
Improve med. management	0.5%	0.3%	1.2%	0.5%	0.5%
Improve perceptions of staff care	0.5%	1.3%	0.6%	0.5%	0.0%
Ensure non-smoking policy	0.8%	0.7%	0.6%	0.5%	0.9%

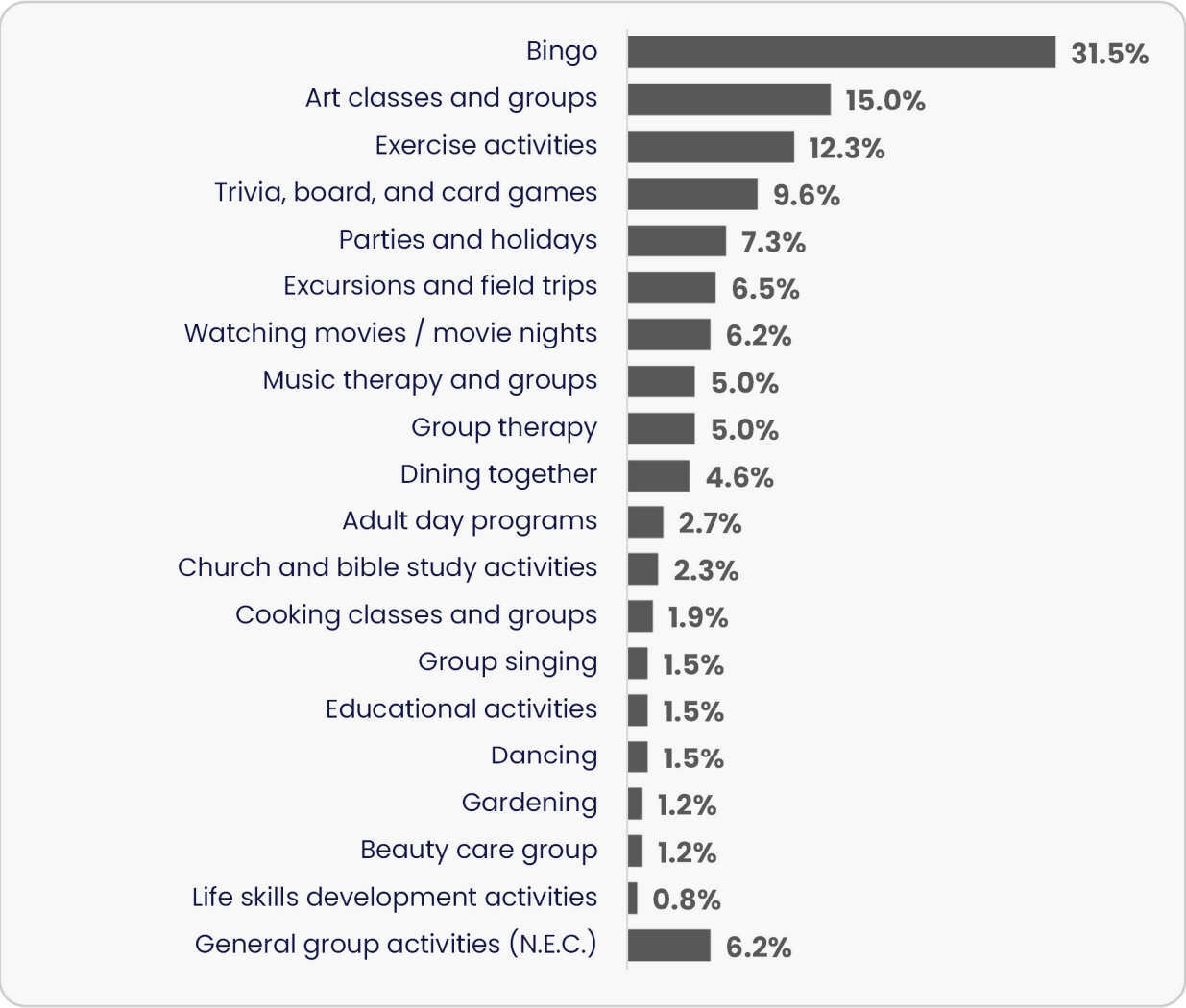
Greater proportions of residents living with a physical disability or living with experience of addiction to drugs and/or alcohol sought changes from their facilities. A greater proportion of residents living with a physical disability sought improvement in activity options than other study factor groups. An elevated proportion of residents who had experienced incarceration for a period of 30 or more days sought improvements in their perceptions of freedom (independence) than other groups.

Activities that Residents Look Forward To

Residents were asked to identify any activities that they look forward to, to better identify options for the simple purpose of encouraging Market facilities and program funders to consider propagating them across more facilities to improve resident quality of life, as slightly more than 58% of residents overall did not identify any activities that they looked forward to during field study interviews.

RQ50. "Are there any activities that you look forward to attending?" (MR)

RESIDENTS (n=260)



The above chart is provided informationally to identify the common types of activities and service offerings looked forward to by residents of Market facilities for the purposes of prospective continuous improvement and enhancement of activities service offerings by owners and operators, and not for evaluative purposes. Thus, segmentation tables for this question have been intentionally omitted. However, it should be noted that 45.4% of residents (not shown) indicated that there were no activities that they looked forward to attending, a result that the research team determined was influenced by activity, movement, and safety restrictions put in place due to the COVID-19 pandemic, with many restrictions still ongoing at the time of fieldwork.

Resident Access to Prescription Medicines

Resident respondents were asked if they experienced any difficulty in access to medicines that they had been prescribed by any health or mental health professional, for any purpose. Residents were also provided the option to identify if they did not have any prescriptions.

RQ53. "Do you have any difficulty in getting access to any medications that have been prescribed to you?"

RESIDENTS (N=625)

Table 6.46: Difficulty Accessing Prescriptions, by License Class	ARF	RCFE	ALL
Yes	4.7%	4.5%	4.6%
No	94.1%	92.4%	93.3%
(No Current Prescriptions)	0.9%	2.1%	1.4%

A very strong majority of residents (93.3%) confirmed that they experience no difficulty in accessing any medications that were prescribed to them by health professionals, confirming generally high-quality outcomes across the Market of licensed facilities in enabling and managing resident access to their prescriptions. Resident respondents at both ARFs and RCFEs identified comparably high levels of access to their prescription medicines.

Table 6.47: Difficulty Accessing Prescriptions, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Yes	5.0%	7.0%	3.4%
No	92.9%	90.4%	94.8%
(No Current Prescriptions)	1.4%	1.3%	1.5%

A slightly elevated proportion of resident respondents at mid-sized facilities, serving populations between 7 and 60 licensed beds, identified difficulties in accessing their prescriptions in relation to facilities with greater or smaller population sizes.

Table 6.48: Difficulty Accessing Prescriptions, by Age Range	18-54	55-61	62+
Yes	3.2%	5.3%	5.7%
No	95.2%	94.7%	91.4%
(No Current Prescriptions)	0.8%	0.0%	2.5%

No significant differences in access to prescription medicines were observed based on resident age groups, with only a slightly elevated proportion of residents aged 18 to 55 reporting any difficulties.

Table 6.49: Difficulty Accessing Prescriptions, by Gender Identity	FEMALE	MALE
Yes	4.3%	4.6%
No	93.0%	93.7%
(No Current Prescriptions)	2.0%	1.1%

No differences in resident access to prescription medicines were observed based on resident gender identity.

Table 6.50: Difficulty Accessing Prescriptions, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Yes	5.1%	3.1%	2.9%	7.5%	23.5%	0.0%	33.3%
No	91.5%	95.7%	94.2%	91.0%	76.5%	100.0%	66.7%
(No Current Prescriptions)	2.4%	0.6%	1.9%	1.5%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Native American / Alaska Native residents reported difficulties in access to prescription medicines than residents identifying with other racial groups. A somewhat elevated proportion of Asian / Asian American respondents also identified difficulties in access to prescription medicines.

Table 6.51: Difficulty Accessing Prescriptions, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Yes	4.2%	3.7%	6.5%	4.9%	6.6%
No	94.5%	94.3%	91.7%	92.9%	92.0%
(No Current Prescriptions)	0.8%	1.3%	1.2%	1.6%	0.5%

Slightly elevated proportions of residents who experience living with a physical disability and have experience with addiction to drugs and/or alcohol reported difficulty in access to their prescription medicines in relation to residents experiencing other key study factors.

Resident Perceptions of Medication Suitability

Residents were asked if they thought that they were receiving the right amount of prescription medications for any need they might have, inclusive of prospective medications for any physical health, mental health, and/or substance abuse treatment needs.

RQ54. "Do you feel like you have the right amount of medication for any medical or mental health conditions you have been diagnosed with?"

RESIDENTS (N=625)

Table 6.52: Right Amount of Medication, by License Class	ARF	RCFE	ALL
Yes	89.6%	86.8%	88.3%
No	6.5%	6.6%	6.6%
Not Sure	1.8%	3.1%	2.4%
(Not Applicable)	2.1%	2.8%	2.4%

88.3% of residents perceived that the prescription medications they had been assigned from health professionals were the "right amount" for their individual needs, which can be considered toward assessing the general quality of health care that residents have access to, and how responsive medical and mental health professionals are in considering efficacy and suitability across the often co-occurring, acute care needs of individual residents.

Overall, there are no significant differences in resident perceptions relating to the suitability of medicines prescribed between populations of respondents living at ARFs and RCFEs.

Table 6.53: Right Amount of Medication, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Yes	88.7%	85.4%	89.6%
No	5.7%	8.9%	5.8%
Not Sure	2.1%	3.2%	2.1%
(Not Applicable)	2.8%	1.9%	2.4%

A greater proportion of residents living at facilities licensed for 7 to 60 beds reported that they were not receiving the right amount of prescription medications that were suitable for their needs, in relation to resident respondents and larger or smaller facility sizes.

Table 6.54: Right Amount of Medication, by Age Range	18-54	55-61	62+
Yes	88.7%	88.3%	88.2%
No	6.5%	11.7%	5.0%
Not Sure	2.8%	0.0%	2.9%
(Not Applicable)	2.0%	0.0%	3.6%

A significantly greater proportion of residents aged 55 to 61 reported that they were not receiving the right amount of prescription medicines for their needs, in comparison to residents in older or younger age groups.

Table 6.55: Right Amount of Medication, by Gender Identity	FEMALE	MALE
Yes	87.1%	89.1%
No	7.4%	6.0%
Not Sure	2.3%	2.5%
(Not Applicable)	3.1%	1.9%

There were no substantive differences in the perceptions of medication suitability based on resident gender identity.

Table 6.56: Right Amount of Medication Needs, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Yes	87.4%	90.1%	86.5%	91.0%	94.1%	100.0%	100.0%
No	5.8%	6.2%	9.6%	4.5%	5.9%	0.0%	0.0%
Not Sure	2.7%	1.9%	1.9%	1.5%	0.0%	0.0%	0.0%
(Not Applicable)	4.1%	1.9%	1.9%	1.5%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of resident respondents who identified as Hispanic / Latino / Latinx indicated that they did not perceive they were receiving the right amount of medication for their needs, in relation to respondents of other racial identity groups.

Table 6.57: Right Amount of Medication, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Yes	89.6%	88.3%	86.4%	88.4%	85.4%
No	7.0%	6.7%	8.6%	6.2%	11.3%
Not Sure	2.1%	2.7%	2.8%	2.5%	2.4%
(Not Applicable)	1.3%	2.3%	1.9%	2.5%	0.9%

A significantly greater proportion of resident respondents who had experience of addiction to drugs and/or alcohol indicated that they did not perceive they were receiving the right amount of medication for their needs, compared to residents identifying other experiential factors of focus to the study.

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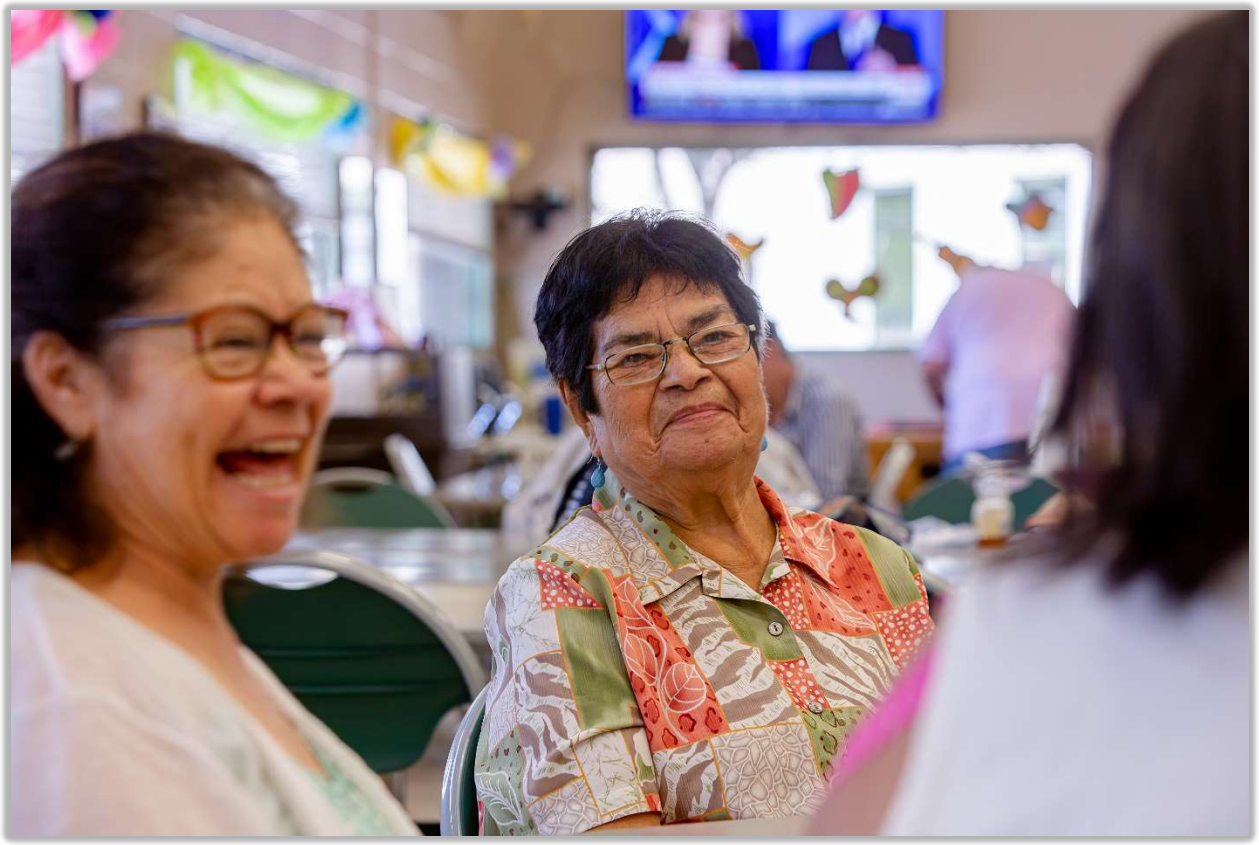

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Resident Experience and Satisfaction

To assess the effectiveness of Market of ARFs and RCFEs in serving the needs of their resident populations, the study measured resident perceptions across a range of quality of life and service factors designed to elicit greater understanding of resident experiences and satisfaction with their housing and care in Market facilities.

Resident Perceptions of Loneliness

Residents were asked to assess their feelings of loneliness in relation to the last place of residence that they had any choice in selecting.

RQ35. "Compared to the previous housing that you last chose, do you feel lonelier living here, less lonely here, or about the same level of loneliness?"

RESIDENTS (N=625)

Table 7.1: Perceptions of Loneliness, by License Class	ARF	RCFE	ALL
Less lonely living at facility	55.5%	47.9%	52.0%
About the same level of loneliness	27.9%	32.3%	29.9%
Lonelier living here	11.9%	15.6%	13.6%
Not sure	4.2%	3.1%	3.7%

The effect of ARFs and RCFEs on reducing feelings of loneliness amongst resident populations is well-defined, with 52.0% residents reporting that they feel less lonely than they felt in their previous housing of choice, and another 29.9% reporting that they did not experience any increase in loneliness from their most previous housing experience. Residents of RCFEs expressed somewhat elevated proportions of feeling more lonely living in their current facility housing in comparison to ARF residents. Residents of larger ARF and RCFE facilities also reported greater proportions of feeling less lonely at facilities compared to their most recent housing of choice than residents at facilities with smaller licensed bed counts.

Table 7.2: Perceptions of Loneliness, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Less lonely living at facility	49.6%	49.0%	54.4%
About the same level of loneliness	29.8%	34.4%	27.8%
Lonelier living here	17.0%	12.1%	12.8%
Not sure	2.8%	4.5%	3.7%

An elevated proportion of residents living at 6 or fewer licensed bed facilities indicated that they felt lonelier living in their facility than at their most recent housing of choice.

Table 7.3: Perceptions of Loneliness, by Age Range	18-54	55-61	62+
Less lonely living at facility	58.1%	41.5%	50.4%
About the same level of loneliness	26.6%	37.2%	30.0%
Lonelier living here	12.1%	18.1%	13.6%
Not sure	2.8%	2.1%	5.0%

A significantly greater proportion of ARF and RCFE residents aged 18 to 54 (58.1%) reported feeling less lonely in their current housing in comparison to the last housing of their choice, while residents aged 55-61 reported significantly greater proportions of feeling lonelier (18.1%) in their current facility housing compared to their most recent housing of choice than older or younger groups of residents.

Table 7.4: Perceptions of Loneliness, by Gender Identity	FEMALE	MALE
Less lonely living at facility	55.9%	49.3%
About the same level of loneliness	31.6%	28.6%
Lonelier living here	9.4%	16.6%
Not sure	2.7%	4.4%

More female-gendered residents (55.9%) reported feeling less lonely in their current facility housing in relation to their male counterparts (49.3%), while a significant proportion of male respondents (16.6%) reported feeling lonelier than they did while living in the last housing of their choice.

Table 7.5: Perceptions of Loneliness, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Less lonely living at facility	53.7%	55.6%	44.2%	56.7%	35.3%	33.3%	66.7%
About the same level of loneliness	29.6%	27.8%	34.6%	20.9%	29.4%	66.7%	33.3%
Lonelier living here	11.9%	13.0%	17.3%	16.4%	17.6%	0.0%	0.0%
Not sure	3.7%	3.1%	3.8%	6.0%	5.9%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Residents who identified as Hispanic/Latino/Latinx and Native American/Alaska Native expressed significantly greater proportions of feeling lonelier living in their current facility housing in comparison to their most recent housing of choice in relation to residents of other racial identity groups, at 17.3% and 17.6% respectively.

Table 7.6: Perceptions of Loneliness, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Less lonely living at facility	55.7%	53.5%	49.1%	54.9%	52.8%
About the same level of loneliness	27.6%	27.8%	32.4%	27.7%	27.8%
Lonelier living here	12.2%	14.7%	16.0%	12.0%	15.1%
Not sure	3.9%	3.3%	1.9%	4.3%	3.8%

Residents who reported living with a diagnosed mental illness or who had experienced incarceration for a period of greater than 30 days reported greater proportions of feeling less lonely in their current facility housing than most recent housing of choice than residents with other key factors in the study. Residents who reported living with a physical disability or having experienced addiction to drugs and/or alcohol reported an elevated proportion of feeling lonelier in their facility than their previous housing of choice.

Resident Perceptions of Safety

Similar to loneliness, residents were asked to assess their perceptions of personal safety while living at their current facility in relation to the last place of residence that they had choice in selecting.

RQ36. "Thinking again about the previous housing that you last chose, do you feel safer living here, less safe here, or about the same level of safety?"

RESIDENTS (N=625)

Table 7.7: Perceptions of Safety, by License Class	ARF	RCFE	ALL
More safe living here	62.9%	66.7%	64.6%
About the same level of safety	24.6%	28.1%	26.2%
Less safe living here	11.3%	3.5%	7.7%
Not sure	0.9%	1.7%	1.3%

Nearly two-thirds (64.6%) of respondents reported experiencing perceptions of increased safety from being housed at their facilities, indicative of another prevalent benefit that residents receive from ARFs and RCFEs. Although comparable proportions of ARF and RCFE residents feel more safe living in their current facility

housing in relation to the most recent housing of their choosing, a significantly greater proportion of ARF residents (11.3%) reported feeling less safe in their current housing than in their previous housing of choice.

Table 7.8: Perceptions of Safety, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
More safe living here	69.5%	64.3%	62.7%
About the same level of safety	24.8%	26.1%	26.9%
Less safe living here	3.5%	8.3%	9.2%
Not sure	2.1%	1.3%	0.9%

A greater proportion of resident respondents from facilities with 6 licensed beds or less reported feeling safer in their current housing over their prior housing of choice than counterparts housed in facilities with larger licensed bed counts.

Table 7.9: Perceptions of Safety, by Resident Age Range	18-54	55-61	62+
More safe living here	64.1%	55.3%	67.9%
About the same level of safety	27.0%	25.5%	26.1%
Less safe living here	8.1%	17.0%	4.3%
Not sure	0.8%	1.1%	1.8%

Residents aged between 55 and 61 of age reported feeling less safe in their current facility housing compared to previous housing of choice in significantly greater proportions than younger (18-54) or older (62+) cohorts of residents.

Table 7.10: Perceptions of Safety, by Gender Identity	FEMALE	MALE
More safe living here	68.8%	61.9%
About the same level of safety	23.0%	28.3%
Less safe living here	5.9%	9.0%
Not sure	2.3%	0.5%

A significantly greater proportion (68.8%) of female-gendered resident respondents reported feeling safer in their current facility housing over the most previous housing of their choosing, in comparison to their male resident counterparts.

Table 7.11: Perceptions of Safety, by Resident Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
More safe living here	65.3%	63.6%	57.7%	71.6%	64.7%	33.3%	100.0%
About the same level …	26.5%	28.4%	25.0%	23.9%	29.4%	66.7%	0.0%
Less safe living here	6.8%	8.0%	13.5%	4.5%	5.9%	0.0%	0.0%
Not sure	1.4%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Residents who identified as Asian/Asian-American feel safer in their current facility than their previous housing of choice in significantly greater proportions (71.6%) than resident respondents from any other racial identity group, with residents who identified as Hispanic/Latino/Latinx reporting that they feel less safe in their current facility than in previous housing of personal choosing in significantly greater proportions (57.7%).

Table 7.12: Perceptions of Safety, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
More safe living here	66.1%	65.2%	65.1%	63.0%	64.2%
About the same level …	23.7%	24.7%	23.8%	26.6%	25.0%
Less safe living here	9.1%	9.0%	9.6%	9.2%	9.9%
Not sure	0.8%	1.0%	1.5%	0.5%	0.9%

Residents across all key study factors (inclusive of people diagnosed and living with mental illness, people with experience of homelessness as an adult, people living with a physical disability, people with experience of incarceration of greater than 30 days, and people with experience of addiction to drugs and/or alcohol) reported slightly, but consistently elevated proportions of feeling less safe in their current facility housing in comparison to the last housing situation of their choosing, in relation to other residents.

Resident Perceptions of Home and Community

Residents were asked to consider if their facility feels like a home to them and if their facility provides them with a sense of being part of a community.

RQ37. "Does this place feel like a home to you?" **AND RQ39.** "Living here with the other residents, do you feel like you are part of a community?"

RESIDENTS (N=625)

Table 7.13: Perceptions of Home and Community, by License Class	ARF	RCFE	ALL
Facility feels like a home	80.4%	74.3%	77.6%
Facility feels like a community	85.2%	76.7%	81.3%

A strong majority of residents agree with statements that their "ARF or RCFE feels like a community" (88.3%) and that their "facility feels like a home" (77.6%), indicating that a strong majority of licensed facilities are successful in promoting collective activities and enabling regular patterns of positive, resident interaction to assure significant levels of integration across the resident populations of their facilities. In considering resident satisfaction and experience measures, residents who identify their facility as a home likely also feel a sufficiency of comfort, security, and essential needs met from housing and care received at facilities. Greater proportions of residents from ARFs reported feeling that their facility feels like a home and feels like a community over their counterparts living at RCFEs.

Table 7.14: Perceptions of Home and Community, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Facility feels like a home	75.2%	79.6%	77.7%
Facility feels like a community	75.2%	84.1%	82.6%

A greater proportion of residents from larger facilities felt that their facility felt like a home in comparison to residents from facilities with 6 licensed beds or less, with significantly greater proportions of residents at larger facilities expressing that their facility felt like a community.

Table 7.15: Perceptions of Home and Community, by Age Range	18-54	55-61	62+
Facility feels like a home	79.4%	80.9%	75.4%
Facility feels like a community	89.1%	75.5%	76.1%

Residents from the 18-54 and 55-61 age groups expressed that their facility felt like a home in greater proportions than residents in the 62+ age group, while a significant proportion of residents aged 18-54 indicated that their facility felt like a community over residents from older age groups.

Table 7.16: Perceptions of Home and Community, by Gender Identity	FEMALE	MALE
Facility feels like a home	76.2%	78.5%
Facility feels like a community	80.9%	81.5%

No substantive differences across resident perceptions were observed based on gender identity.

Table 7.17: Perceptions of Home and Community, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Facility feels like a home	76.3%	72.2%	82.7%	89.6%	82.4%	100.0%	100.0%
Facility feels like a community	80.7%	80.2%	85.6%	83.6%	94.1%	66.7%	100.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Asian/Asian-American resident respondents (89.6%) indicated that their facility feels like a home than any other racial identity group, while the proportion of Black/African-American resident respondents who expressed that their facility feels like a home was significantly lower (72.2%) than any other group.

Native American/Alaska Native resident respondents reported that their facility feels like a community in significantly greater proportions (94.1%) in comparison to other groups, with an elevated proportion of Hispanic/Latino/Latinx respondents (85.6%) expressing greater perceptions of Market facilities feeling like a community.

Table 7.18: Perceptions of Home and Community, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Facility feels like a home	79.7%	76.3%	74.4%	78.8%	78.8%
Facility feels like a community	86.2%	82.3%	77.5%	84.2%	80.7%

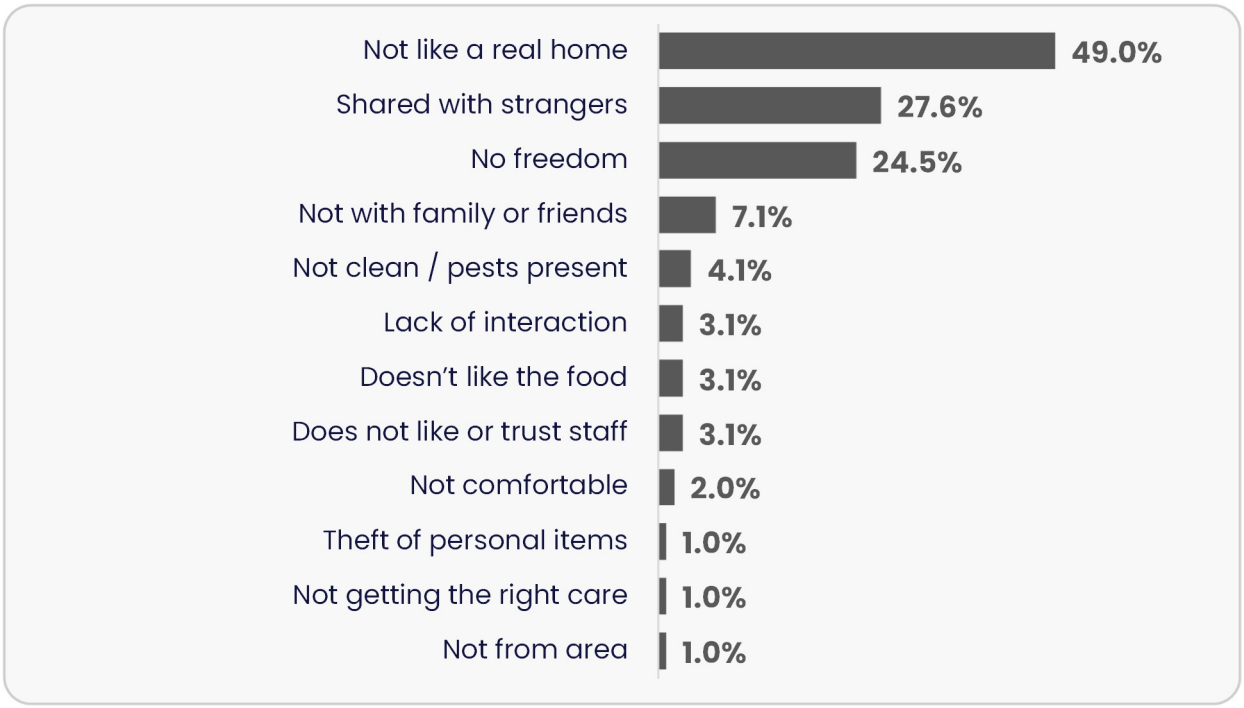
Residents of facilities living with physical disability reported lower proportions of sentiment that their facility feels like a home in relation to other residents, while facility residents living with mental illness expressed that their facility provided them with a sense of community in greater proportions than others. Those who had previously experienced incarceration for a period of more than 30 days also reported that their facility felt like a community in greater proportions.

Reasons Why a Facility Doesn't Feel Like a Home

Residents who indicated that they their ARF or RCFE did not feel like a home were asked to identify the reason(s) why they felt that way.

RQ38. "Why doesn't this place feel like a home to you?" (MR)

RESIDENTS (n=98)



49% of the low proportion of residents who did not feel that their Market ARF or RCFE felt like a home conveyed sentiments that facilities (generally) are not like a real home, with a further 27.6% not considering it a home because it was shared with strangers, and an additional 24.5% expressing that they did not feel enough of a sense of freedom (or independence) to regard their facility as feeling like a home.

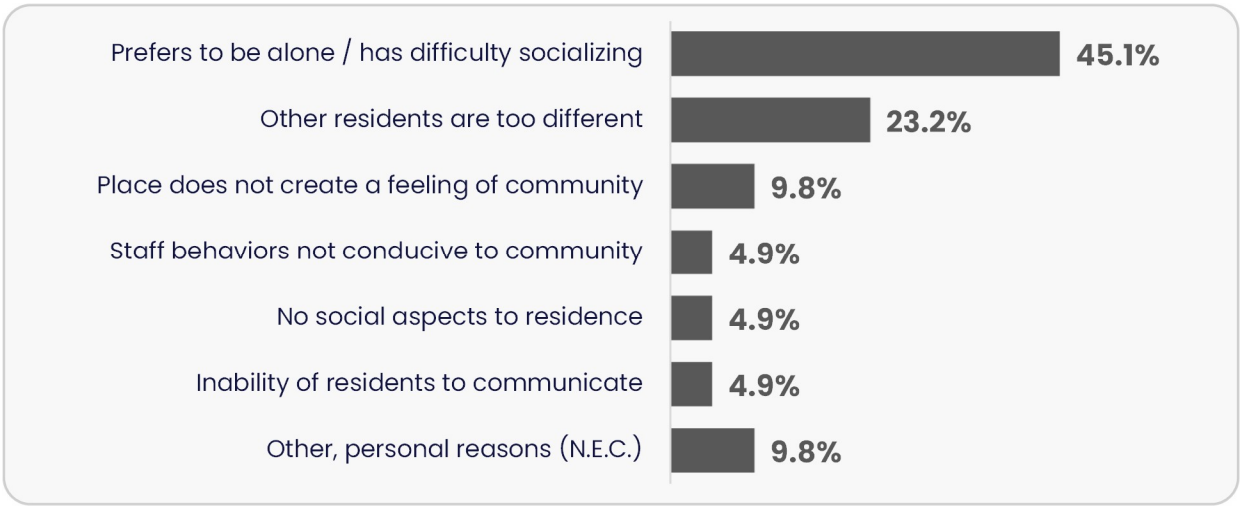
No segmentation was applied to data from this question, as it represents a small proportion of the overall sample of N=625 residents, for which results would likely not be valid.

Reasons Why a Facility Doesn't Feel Like a Community

Residents who indicated that they their ARF or RCFE did not feel like a home were asked to identify the reason(s) why they felt that way.

RQ38. "Why don't you feel like you are part of a community with the other residents living here?" (MR)

RESIDENTS (n=82)



Many of the 45.1% of residents that did not feel like their Market facility conveyed a sense of community to them indicated that they had personal preferences and self-identified behavioral aspects that prevented them from perceiving their facility as a community. 23.2% of residents felt uncomfortable with the differences between themselves and other residents, preventing them from feeling a sense of community, with another 9.8% of residents indicating that the facility itself, as a place, did not lend itself to a sense of community.

A further 4.9% of respondents identified that negative or disruptive behaviors from the staff at their ARF or RCFE prevented them from experiencing a sense of community.

No further segmentation was applied to this question, as it represents a smaller proportion of the overall sample of N=625 residents for which results may not be valid.

Resident Experience: Quality of Life and Access to Services

Residents were asked to evaluate their experiences and satisfaction across a series of factors relating to their personal quality of life and access to services at their ARFs or RCFEs. Each of these questions were posed utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating completely dissatisfied, and 10 indicating completely satisfied.

RQ53 to RQ67. "On a scale of 0-10, tell me how satisfied you feel about different aspects of your quality of life living here…"

RESIDENTS (N~625)

Table 7.19: Resident Experience Factors, by License Class	ARF	RCFE	ALL
Access to medical care	8.85	8.78	8.82
Staff service and communication	8.57	8.67	8.62
Facility cleanliness	8.43	8.75	8.58
Overall satisfaction	**8.56**	**8.54**	**8.55**
Personal safety in neighborhood	8.25	8.84	8.52
Access to nearby shopping	8.70	8.09	8.43
Staff responsiveness to resident complaints	8.41	8.38	8.39
Access to entertainment	8.17	8.53	8.34
Access to spending money	8.43	8.14	8.29
Relations with other residents	7.98	7.80	7.90
Access to mental health services	8.70	6.60	7.88
Quality of meals and snacks	7.78	7.71	7.75
Group activities	7.12	6.08	6.63
Access to substance abuse treatment	5.78	2.02	4.14

Overall, ARF and RCFE residents reported comparable mean levels of satisfaction across the majority of service access and quality factors measured. With mean overall satisfaction of 8.55 out of a possible 10.00, resident respondents tended to evaluate their overall resident experience at Market facilities very positively. However, ARF residents were observed to experience significantly greater mean levels of satisfaction with their access to mental health services and substance abuse treatment than residents of RCFEs, while RCFE residents reported elevated mean satisfaction with their personal safety in the neighborhoods and surroundings of their facilities.

Given the context of the COVID-19 pandemic and its limiting effects on the delivery of group activities, significant proportions of residents evaluated this factor more negatively than others. Also, with a majority of residents not requiring or necessarily aware of the needs of others for substance abuse treatment services, this factor was evaluated considerably more poorly by more respondents than any other.

Utilizing linear regression analysis (not shown), the resident experience factors most significantly correlated to overall resident satisfaction were access to medical care, quality of meals and snacks, and responsiveness of staff to resident complaints.

Facilities owners/operators (not shown) perceived mean resident levels of satisfaction only slightly higher than the residents themselves (8.87 vs. 8.55. a +0.32 differential of means), indicating that their estimations of overall resident satisfaction tend to be largely accurate overall.

Table 7.20: Resident Experience Factors, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Access to medical care	8.90	8.93	8.73
Staff service and communication	8.86	8.68	8.49
Facility cleanliness	9.21	8.50	8.34
Overall satisfaction	8.84	8.58	8.41
Personal safety in neighborhood	9.02	8.33	8.39
Access to nearby shopping	8.07	8.65	8.46
Staff responsiveness to resident complaints	8.94	8.41	8.16
Access to entertainment	8.48	8.25	8.33
Access to spending money	8.27	8.05	8.42
Relations with other residents	7.86	7.85	7.94
Access to mental health services	6.95	8.22	8.04
Quality of meals and snacks	8.16	7.75	7.58
Group activities	5.94	6.52	6.98
Access to substance abuse treatment	2.95	4.86	4.20

Significantly greater mean levels of satisfaction were observed from residents at smaller facilities with 6 or fewer licensed beds, across facility cleanliness, personal safety in the neighborhood of the facility, staff responsiveness to resident complaints, and in regard to the quality of meals and snacks offered, compared to residents at facilities with larger licensed bed counts.

Residents at mid-sized (from 7 to 60 licensed beds) and larger facilities (61 licensed beds or more) reported elevated mean levels of satisfaction with their access to mental health and substance abuse treatment services, in comparison to facilities with 6 or fewer licensed beds. Residents at 61+ licensed bed facilities also reported greater mean levels of satisfaction with group activities than residents at smaller facilities.

Table 7.21: Resident Experience Factors, by Age Range	18-54	55-61	62+
Access to medical care	8.86	8.89	8.74
Staff service and communication	8.64	8.31	8.70
Facility cleanliness	8.54	8.28	8.71
Overall satisfaction	8.62	8.26	8.58
Personal safety in neighborhood	8.45	7.94	8.77
Access to nearby shopping	8.74	8.49	8.10
Staff responsiveness to resident complaints	8.36	7.95	8.56
Access to entertainment	8.20	8.28	8.47
Access to spending money	8.48	8.19	8.15
Relations with other residents	8.15	7.88	7.66
Access to mental health services	8.59	8.56	6.77
Quality of meals and snacks	7.93	7.36	7.71
Group activities	7.19	6.98	5.98
Access to substance abuse treatment	5.99	4.80	1.84[10]

Residents aged 18-54 experienced greater mean levels of satisfaction from relations with other residents, group activities, and access to substance abuse treatment services than residents of other age groups. Personal safety in the neighborhood, staff responsiveness to resident complaints, and quality of meals and snacks provided generated lower mean levels of satisfaction from residents aged 55-61 than other age groups.

[10] Although residents aged 62+ reported drastically lower mean levels of satisfaction to substance abuse treatment services than other cohorts, caution should be applied in interpretation of this finding due to a low proportion within this age cohort that responded to this question, with many opting to skip this response.

Table 7.22: Resident Experience Factors, by Gender Identity	FEMALE	MALE
Access to medical care	8.90	8.76
Staff service and communication	8.79	8.50
Facility cleanliness	8.80	8.42
Overall satisfaction	8.64	8.49
Personal safety in neighborhood	8.55	8.50
Access to nearby shopping	8.20	8.60
Staff responsiveness to resident complaints	8.55	8.29
Access to entertainment	8.38	8.31
Access to spending money	8.05	8.49
Relations with other residents	8.03	7.81
Access to mental health services	7.40	8.20
Quality of meals and snacks	7.69	7.80
Group activities	6.67	6.63
Access to substance abuse treatment	3.60	4.49

Other than greater levels of mean satisfaction expressed by male residents in regard to access to mental health services, there were no other significant differences across other service access and quality factors observed between gender identities.

Table 7.23: Resident Experience Factors, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Access to medical care	8.87	8.91	8.56	8.84	8.22	*7.33*	*10.00*
Staff service and communication	8.54	8.57	8.73	8.75	8.65	*8.00*	*10.00*
Facility cleanliness	8.59	8.33	8.76	8.75	9.25	*8.00*	*9.33*
Overall satisfaction	8.48	8.44	8.71	8.91	8.18	*7.33*	*9.67*
Personal safety in neighborhood	8.61	8.42	8.48	8.64	6.82	*9.00*	*10.00*
Access to nearby shopping	8.37	8.47	8.60	8.49	8.06	*8.33*	*10.00*
Staff resp. to res. complaints	8.36	8.40	8.40	8.10	8.07	*9.00*	*10.00*
Access to entertainment	8.32	8.33	8.28	8.61	8.12	*8.33*	*9.33*
Access to spending money	8.10	8.72	8.00	8.69	7.43	*6.67*	*10.00*
Relations with other residents	7.84	7.85	8.25	7.90	7.62	*6.33*	*10.00*
Access to mental health services	7.68	8.01	8.41	7.18	8.04	*9.00*	*10.00*
Quality of meals and snacks	7.70	7.36	8.12	8.11	7.71	*8.33*	*9.33*
Group activities	6.31	6.49	6.74	7.62	7.36	*8.67*	*6.67*
Access to sub. abuse treatment	3.46	4.86	5.27	2.87	1.73	*6.67*	*6.67*

* Insufficient sample exists from these racial identity groups for valid analysis or comparison

Hispanic/Latino/Latinx residents expressed greater mean levels of satisfaction with their relations with other residents and quality of meals and snacks provided than residents in most other racial identity groups. Asian/Asian-American respondents also expressed greater mean levels of satisfaction with the quality of meals and snacks and group activities than most other identity groups.

Residents of Native American/Alaska Native identity expressed significantly lower mean levels of satisfaction across many factors surveyed than other identity groups, including overall satisfaction.

Table 7.24: Resident Experience Factors, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Access to medical care	8.80	8.63	8.70	8.75	8.67
Staff service and communication	8.58	8.38	8.46	8.39	8.43
Facility cleanliness	8.43	8.36	8.49	8.33	8.20
Overall satisfaction	8.53	8.46	8.44	8.47	8.30
Personal safety in neighborhood	8.32	8.13	8.44	8.45	8.35
Access to nearby shopping	8.64	8.52	8.13	8.61	8.69
Staff resp. to res. complaints	8.37	8.15	8.23	8.20	8.04
Access to entertainment	8.29	8.13	8.38	8.31	7.94
Access to spending money	8.31	8.34	7.98	8.63	8.18
Relations with other residents	8.01	7.86	7.84	8.10	7.75
Access to mental health services	8.50	8.32	7.43	8.47	8.39
Quality of meals and snacks	7.69	7.58	7.50	7.67	7.17
Group activities	6.84	6.55	6.16	6.65	6.60
Access to sub. abuse treatment	5.01	4.78	3.57	5.56	5.37

Mean satisfaction across most factors is within a normative range for most groups of people with experiences relating to the study's key factors, with the exception of people living with physical disability, who expressed lower levels of mean satisfaction with access to nearby shopping, access to mental health services, group activities, and access to substance abuse treatment services than members of any other experiential cohort.

Table 7.25: Resident Experience Factors, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Access to medical care	9.29	8.53	8.84	9.01	9.00	9.05	8.74	8.81
Staff service and communication	9.33	8.54	8.59	8.69	8.26	8.74	8.57	8.65
Facility cleanliness	8.47	8.60	8.66	8.36	8.33	8.16	9.05	8.65
Overall satisfaction	8.93	8.47	8.48	8.67	7.48	8.71	8.93	8.65
Personal safety in neighborhood	8.93	8.31	8.86	8.10	9.04	8.55	8.62	8.42
Access to nearby shopping	7.80	8.35	8.19	8.77	8.91	8.81	8.26	8.48
Staff resp. to res. complaints	8.67	8.40	8.23	8.58	7.83	8.83	8.50	8.34
Access to entertainment	8.80	8.30	8.45	8.20	8.81	8.84	8.07	8.09
Access to spending money	9.40	8.05	8.03	8.64	7.78	8.55	8.78	8.34
Relations with other residents	6.60	7.74	8.01	8.05	7.89	8.00	8.10	7.87
Access to mental health services	6.64	7.43	7.31	8.99	8.79	8.68	8.10	7.61
Quality of meals and snacks	7.73	7.52	7.65	8.08	7.30	7.84	8.21	7.79
Group activities	1.86	6.42	7.33	7.89	6.79	6.14	4.45	6.43
Access to sub. abuse treatment	0.83	3.47	3.30	6.71	6.33	6.25	3.21	3.09

Residents located in SPA 1 (Antelope Valley) were observed to have greater differences in mean satisfaction levels across a range of factors in relation to residents located at facilities in other SPAs across Los Angeles County, which can be partly attributed to differences in access to services and geography that are observed to exist in this area, compared to other SPAs.

Mean resident satisfaction in access to mental health services and substance abuse treatment services was significantly greater in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities), and SPA 6 (South Los Angeles and South Cities) in comparison to all other SPAs, indicating substantive evidence of differences in access to these services, concentrating in the most centrally-located and population-dense areas of Los Angeles County, also coinciding with greater concentrations of the primary operating locations for County agencies and nonprofit service providers.

Resident Trust in Staff

Residents were asked to characterize the level of trust that they place in the staff at their ARF or RCFE to look after their needs and interests. An absolute, Likert scale measure of 0 to 10 was utilized with residents, with 0 indicating no trust at all (in staff), and 10 indicating complete trust (in staff).

RQ68. "On a scale of 0-10, how much do you trust the staff here to look after your personal needs and interests?"

RESIDENTS (N=625)

Table 7.26: Trust in Staff, by License Class	ARF	RCFE	ALL
	8.37	8.57	8.47

With a mean of 8.47 out of a possible 10.00, resident trust in staff to look after their individual needs is high, at almost equivalent levels to overall resident satisfaction (8.55), another strong indicator of generally positive resident sentiment and experience across the Market. Residents of Market RCFEs provided only slightly greater mean trust scores than residents at ARFs, demonstrating a general consistency in the levels of trust expressed by residents, regardless of license class.

Facility owners and/or operators (not shown above) reflected a reasonably accurate estimation of their perceived levels of trust from their residents in staff, with a mean of 9.01 reflecting a +0.53-mean gap in perceptions of trust from residents. As no significant gap related to perceptions of trust was detected, no further analysis was performed.

Table 7.27: Trust in Staff, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	8.93	8.58	8.21

Although residents provide comparable mean scores for trust in staff between ARF and RCFE facility license classes, a relationship was observed between the size of the facility and mean trust score, where groups of respondents in smaller facilities provided greater trust scores. Resident respondents at facilities with 6 or fewer licensed beds provided significantly greater mean trust scores than those at facilities with 61 or more licensed beds.

Table 7.28: Trust in Staff, by Age Range	18-54	55-61	62+
	8.46	8.16	8.57

Residents aged 55-51 provided generally lower mean scoring for trust in staff at their facilities than respondents who were from younger (18-54) or older (62+) age cohorts.

Table 7.29: Trust in Staff, by Gender Identity	FEMALE	MALE
	8.53	8.43

There were no significant differences in means for resident trust in staff based on gender identity.

Table 7.30: Trust in Staff, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
	8.47	8.10	8.73	8.73	8.43	8.00	10.00

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Black/African-American residents of facilities provided significantly lower mean scores for their trust in staff to look after their personal interests compared to residents of other racial identity groups.

Table 7.31: Trust in Staff, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESSAS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	8.42	8.14	8.32	8.13	8.09

Residents with experiences of homelessness as an adult, experience of incarceration of greater than 30 days, and experience with substance addiction were observed to express significantly lower levels of mean trust in facility staff to look after their needs and interests than other groups with key experience factors within the study.

Resident Confidence in the Permanence of Housing

The research team asked residents of ARFs and RCFEs to rate their level of confidence that their current housing at their facility would be permanent, utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating no confidence at all, and 10 indicating absolute confidence.

RQ41. "On a scale of 0-10, how confident are you that this place will be your permanent home?"

RESIDENTS (N=625)

Table 7.32: Confidence in Housing Permanence, by License Class	ARF	RCFE	ALL
	5.91	6.34	6.11

Residents expressed generally reduced levels of confidence in relation to their perceptions of the permanence of their housing at ARFs and RCFEs. In conversations with residents, many expressed doubts about permanency of Market housing due to previous experiences and traumas experienced in their lives.

Given some of the disappointments and challenges related to facility living that many residents communicated during interviews (such as changes in experience brought on by the COVID-19 pandemic, the visible effects of inflation on facility services and activities offered, and the sense of ongoing vulnerability that residents who rely on public benefits can face), coupled with the historical traumas and ongoing fears stemming from the life circumstances of individuals from vulnerable populations, levels of reduced confidence and expectations for the stability of housing expressed by residents can be rationally understood by any reasonable observer.

Overall, mean confidence in the permanence of facility housing was 6.11 out of a possible 10.00, indicating lower mean levels of confidence from a significant proportion of respondents. Residents of ARFs expressed somewhat reduced mean levels of confidence in the permanence of their facility housing in comparison to residents of RCFEs.

Table 7.33: Confidence in Housing Permanence, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	6.54	5.56	6.18

Residents of facilities with 6 licensed beds or less expressed significantly greater levels of confidence in the permanence of their facility housing, while residents of mid-sized facilities of 7 to 60 beds expressed significantly lower mean levels of confidence in the facility housing permanence than residents of smaller or larger ARFs and RCFEs.

Table 7.34: Confidence in Housing Permanence, by Age Range	18-54	55-61	62+
	5.76	5.67	6.57

The 62+ age cohort of residents expressed significantly greater levels of confidence in the permanence of their housing at a facility in comparison to residents in the 18-54 or 55-61 age cohorts.

Table 7.35: Confidence in Housing Permanence, by Gender Identity	FEMALE	MALE
	6.56	5.79

Female resident respondents expressed a significantly greater mean level of confidence in the permanence of their facility housing than their male counterparts.

Table 7.36: Confidence in Housing Permanence, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
	6.36	4.96	6.46	7.63	4.94	1.67	8.67

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Residents of Black/African American and Native American /Alaska Native identities are significantly less confident in the permanence of their housing at facilities than other racial identity groups, with resident respondents of Asian/Asian-American identity expressing significantly greater mean confidence in the permanence of their facility housing than residents from other groups.

Table 7.37: Confidence in Housing Permanence, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	5.83	5.42	5.99	5.46	5.72

With the exception of residents living with physical disability, residents who had lived experience with any of the other key study factors, inclusive of those living with mental illness, those who have experienced homelessness as an adult, those who have experienced incarceration for a period of 30 days or more, and those who have experienced addiction to drugs and/or alcohol, expressed reduced or significantly reduced mean confidence in the permanence of their housing at a facility than other residents.

Resident Belief in Experiencing Homelessness Without Current Housing

Resident respondents were asked if they believed that they would be homeless without their current housing at an ARF or RCFE.

RQ70. "If you didn't live here, do you believe that you would be homeless?"

RESIDENTS (N=625)

Table 7.38: Belief in Being Homeless Without Facility, by License Class	ARF	RCFE	ALL
	60.8%	37.5%	50.1%

Residents were somewhat divided on the question of whether or not they believed that they would be homeless without their housing at their facility, with differences in demographic factors providing better insight into the reasoning behind perceptions on this question. A significantly greater proportion of ARF residents (60.8%) believe they would revert to being unhoused or homeless without their current facility housing than their counterparts at RCFEs (37.5%), largely hypothesized to relate to the enhanced incidence rates of vulnerabilities and the median age of the population of this license class.

Table 7.39: Belief in Being Homeless Without Facility, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	32.6%	55.4%	55.0%

Residents at facilities serving 6 or fewer licensed beds believe that they would be homeless without their current housing in significantly lower proportions (32.6%) than residents at facilities serving 7 to 60 licensed beds (55.2%) or 61 or more licensed beds (55.0%).

Table 7.40: Belief in Being Homeless Without Facility, by Age Range	18-54	55-61	62+
	64.9%	55.3%	35.7%

64.9% of residents between the ages of 18-54 believe that they would experience homelessness if not for the current housing at their facility, a significantly greater proportion than that of residents aged between 55-61 (55.3%), and residents aged 62+ (35.7%). These proportions identify a strong correlation between resident age and belief that their housing at an ARF/RCFE is preventing a resident from experiencing homelessness.

Table 7.41: Belief in Being Homeless Without Facility, by Gender Identity	FEMALE	MALE
	43.0%	55.0%

A significantly lower proportion of female resident respondents (43.0%) believed that they would experience homelessness without their current facility housing than their male counterparts (55.0%).

Table 7.42: Belief in Being Homeless Without Facility, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
	43.7%	53.1%	66.3%	44.8%	52.9%	66.7%	66.7%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Significantly greater proportions of resident respondents identifying as Hispanic/Latino/Latinx (66.3%) believed that they would experience homelessness without their current housing at a licensed facility, while significantly lower proportions of White/Caucasian (43.7%) and Asian/Asian-American (44.8%) resident respondents believed that they would experience homelessness without access to their ARF/RCFE housing situation.

Table 7.43: Belief in Being Homeless Without Facility, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	62.0%	71.9%	51.5%	65.8%	67.0%

A significant proportion of residents who had previously experienced homelessness as an adult (71.9%) believed that they would experience homelessness again if they did not have access to their current housing at an ARF/RCFE. Residents who experience living with mental illness, experienced incarceration of greater than 30 days, or experienced addiction to drugs and/or alcohol also expressed significantly greater levels of belief that they would experience homelessness if not for their current housing at an ARF/RCFE.

Resident Willingness to Suggest Market Housing to Others

Residents were asked to identify how willing they would be to suggest housing at a facility similar to theirs (ARF or RCFE) to others who had similar needs or circumstances to their own. This question was posed utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating that a resident would never be willing to suggest such housing to others, and 10 indicating that a resident would always be willing to suggest such housing to others.

RQ69. "On a scale of 0-10, and considering other people with circumstances similar to yours, how willing would you be to suggest that they seek housing in a place like this?"

RESIDENTS (N=625)

Table 7.44: Willingness to Suggest Facility Housing to Others, by License Class	ARF	RCFE	ALL
	8.30	8.25	8.28

Residents expressed high levels of willingness to suggest housing at an ARF or RCFE to others with similar experiences and needs, correlating strongly with their largely positive experiences overall, as expressed by high mean levels of overall satisfaction and trust with facilities and in their staff. Residents at both ARFs and RCFEs expressed comparable mean levels of willingness to suggest facility housing to others with similar needs and situations to their own.

Table 7.45: Willingness to Suggest Facility Housing to Others, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	8.65	8.13	8.25

Residents from facilities serving 6 licensed beds or fewer expressed somewhat elevated mean levels of willingness to suggest facility housing to others in need, in comparison to residents at larger facility sizes.

Table 7.46: Willingness to Suggest Facility Housing to Others, by Age Range	18-54	55-61	62+
	8.35	8.34	8.21

No substantive differences were observed in mean levels of willingness to suggest facility housing to others with similar needs or circumstances between age cohorts.

Table 7.47: Willingness to Suggest Facility Housing to Others, by Gender Identity	FEMALE	MALE
	8.52	8.13

Female residents expressed greater mean levels of willingness to suggest facility housing to others with situations and needs similar to their own than their male counterparts.

Table 7.48: Willingness to Suggest Facility Housing to Others, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
	8.26	8.01	8.43	8.47	8.49	7.00	9.67

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Black/African American resident respondents expressed slightly lower levels of willingness to suggest comparable facility housing to others with similar needs and situations than residents of other identity groups.

Table 7.49: Willingness to Suggest Facility Housing to Others, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	8.27	8.15	8.18	8.01	8.20

Residents who had experienced incarceration for a period of greater than 30 days expressed slightly reduced levels of willingness to recommend housing at an ARF/RCFE to others with similar needs and circumstances to their own, in comparison to other groups of individuals across the key study factors. Overall, residents with experiences relating to key study factors reported comparable levels of willingness to suggest facility housing to others as most residents did.

8.0

Image: www.dreamstime.com

Resident Future Housing Intentions & Capabilities

Understanding the possibility for residents to graduate from ARFs and RCFEs to other forms of housing, such as independent living, affordable housing, and permanent supportive housing will deliver significant benefits to all Market Users, especially individuals from vulnerable populations experiencing homelessness or unable to find housing and care that suits their complex and diverse needs. Identifying barriers and gaps in wraparound services that prevent residents from developing the skills and capability to potentially move on from the Market to lower levels of care is a key objective of the research study.

Resident Preference for Another Housing Type

Residents were asked if they would prefer to live in another type of housing instead of their current ARF or RCFE in the future.

RQ28. "Is there another type of housing that you would rather be living in?"

RESIDENTS (N=625)

Table 8.1: Preference for Another Housing Type, by License Class	ARF	RCFE	ALL
	48.1%	41.3%	45.0%

Almost half (45.0%) of residents interviewed indicated that they would prefer to live in another type of housing over their current housing at a Market ARF or RCFE. In considering the general differences in population needs for this finding, many residents with more acute medical and mental health needs and/or those requiring direct assistance with their Activities of Daily Living (ADLs) indicated that they did not believe that it would be possible or practical for them to move into a different housing setting, especially for residents who made it a point to note their reliance on public benefits in relation to this question. This finding reinforces the notion that there is strong demand for the provision of wraparound services and engagement to build skills and capabilities that enable residents with a desire to move from Market facilities to be assisted to do so.

Residents of RCFEs reported preferences for another type of housing in lower proportions than their counterparts at ARFs, a finding attributed to enhanced incidence rates of medical health needs and increased impairment rates for physical capability across the generally-older population within this license class.

Table 8.2: Preference for Another Housing Type, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	41.1%	42.7%	47.7%

Resident respondents living at facilities with 6 or fewer licensed beds expressed preference for another housing type in significantly lower proportions than residents at larger facilities with 61 or more licensed beds. Residents at mid-sized facilities also expressed substantively lower proportions of interest for another housing type than residents at larger facilities.

Table 8.3: Preference for Another Housing Type, by Age Range	18-54	55-61	62+
	46.8%	48.9%	42.1%

A significantly lower proportion of residents aged 62 and older indicated that they had preferences for another housing type over the facility they reside in, a finding consistent with social norms and expectations for individuals in a later phase of their lifecycle.

Table 8.4: Preference for Another Housing Type, by Gender Identity	FEMALE	MALE
	41.4%	47.4%

Residents of female gender identity reported significantly lower proportions of preference to live in another housing type in comparison to respondents of male gender.

Table 8.5: Preference for Another Housing Type, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
	44.4%	56.8%	35.6%	34.3%	58.8%	100.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

A significantly greater proportion of Black / African American and Native American / Alaska Native resident respondents expressed preference to live in a housing type other than an ARF or RCFE in comparison to other residents of other racial identity groups.

A significantly lower proportion of Hispanic / Latino / Latinx and Asian / Asian American resident respondents expressed preference in residing in a different housing type to their facility, in comparison to other identity groups.

Table 8.6: Preference for Another Housing Type, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	49.5%	50.5%	46.9%	56.0%	50.9%

A greater proportion of resident respondents who had experience with incarceration for a period of more than 30 days (with significance), addiction to drugs and/or alcohol, experience with homelessness as an adult, or living with mental illness expressed preferences for living in another housing type over their current ARF or RCFE, in comparison to other residents.

Facility Perceptions of Resident Preference for Other Housing

Owners and/or operators were asked to estimate the percentage of residents in their facilities that had expressed a desire to live in another housing type.

FQ24. "What percentage of your residents have ever expressed any desire to seek another type of housing?"

FACILITY OWNERS & OPERATORS (N=353)

Table 8.7: Residents with Preference for Other Housing, by License Class	ARF	RCFE	ALL
	12.4%	7.7%	9.5%

There were significant differences in perception between residents, and the perceptions of resident preference expressed by owners and operators for other housing types. Owner and operator estimations of resident preferences were more than 30% lower than resident responses to the same question posed directly, indicating that the desires of some residents to graduate to other forms of housing may remain unidentified by facilities. This finding indicates a key gap in perceptions that needs to be resolved to enable greater utilization and optimality of Market facilities for all users, especially those from identified, vulnerable populations.

Although consistently lower than resident-reported preferences, facility respondents at RCFEs reported lower proportions of residents that had indicated that they wished to live in another housing type than ARFs, likely due to differences in median resident age and capabilities to sustain a move to a different housing situation.

Table 8.8: Residents with Preference for Other Housing, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	8.6%	10.7%	10.8%

Perceptions of preference by residents to move to a different housing type are comparable across facility size ranges, without significant differences in proportions.

Table 8.9: Residents with Preference for Other Housing, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	6.0%	8.5%	8.4%	15.2%	12.5%	13.3%	5.1%	9.4%

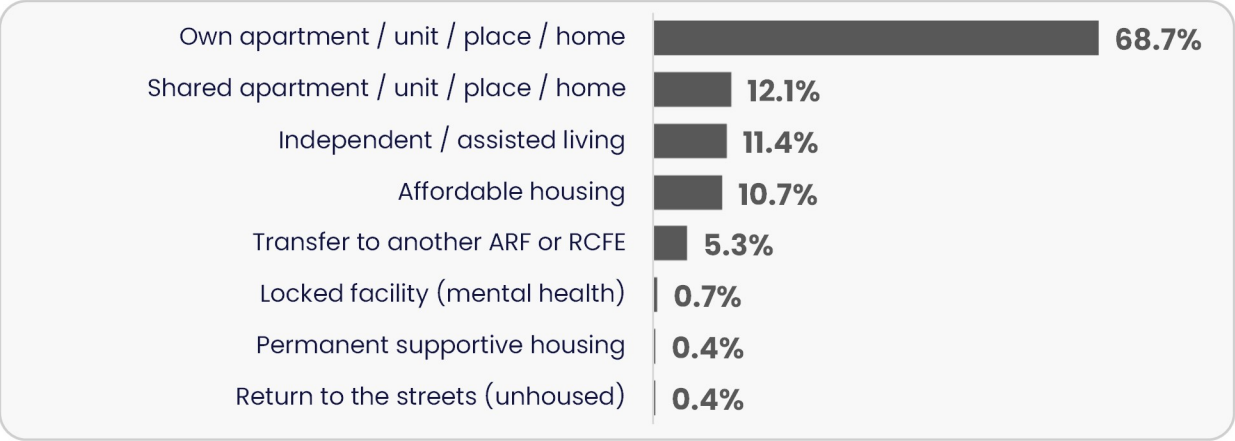
Owners and/or operators of facilities located in SPA 4 (Metro Los Angeles and Center Cities), SPA 5 (West Los Angeles and West Cities) and SPA 6 (South Los Angeles and South Cities) reported greater proportions of residents who had expressed interest in moving to a different type of housing, in relation to other Los Angeles County Service Planning Areas, where facilities in SPA 1 (Antelope Valley) and SPA 7 (East Los Angeles and South East Cities) reported the lowest proportions of residents expressing desire to seek a move.

Preferred Alternative Housing Types for Residents

Residents were asked to identify any types of future housing that they would prefer to live in over their current housing at an ARF or RCFE.

RQ29. "Can you describe for me what the housing that you would rather be living in might look like?" (MR)

RESIDENTS (n=281)



More than two-thirds (68.7%) of residents that expressed desire or preference for another housing type wanted access to their own apartment, place, or home, with only an additional 12.1% seeking a form of shared accommodation, and a further 11.4% seeking placement with independent and/or assisted living.

Although 10.7% of residents stated a preference for affordable housing, only 0.4% of residents identified permanent supportive housing as their preference, indicating relatively low levels of awareness for this housing type amongst Market facility residents. 5.3% of residents expressed a desire to transfer to another Market ARF or RCFEs as their preference.

Table 8.10: Preferred Other Housing Types, by License Class	ARF	RCFE	ALL
Own apartment / unit / place / home	64.8%	73.9%	68.7%
Shared apartment / unit / place / home	13.0%	10.9%	12.1%
Independent / assisted living	12.3%	10.1%	11.4%
Affordable housing	16.7%	3.4%	10.7%
Transfer to another ARF or RCFE	5.6%	5.0%	5.3%
Locked facility (mental health)	0.6%	0.8%	0.7%
Return to the streets (unhoused)	0.0%	0.8%	0.4%
Permanent supportive housing	0.6%	0.0%	0.4%

A greater proportion of RCFE residents indicated a preference for future housing in their own apartment unit, place, or home in comparison to ARF residents. ARF residents indicated a preference for a future affordable housing placement in significantly greater proportions than RCFE resident respondents. No RCFE respondents indicated a future preference for permanent supportive housing.

Table 8.11: Preferred Other Housing Types, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Own apartment / unit / place / home	77.6%	62.7%	67.9%
Shared apartment / unit / place / home	12.1%	4.5%	15.4%
Independent / assisted living	5.2%	19.4%	10.3%
Affordable housing	8.6%	9.0%	12.2%
Transfer to another ARF or RCFE	5.2%	7.5%	4.5%
Locked facility (mental health)	0.0%	1.5%	0.6%
Return to the streets (unhoused)	0.0%	0.0%	0.6%
Permanent supportive housing	0.0%	0.0%	0.6%

A significantly greater proportion of residents of facilities licensed for 6 beds or fewer reported a future housing preference for their own apartment unit, place, or home over residents of larger, licensed bed counts. Residents at mid-sized, 7 to 60 licensed bed facilities expressed significantly greater proportions of preference for future placement in independent/assisted living than residents at smaller or larger licensed facilities, also expressing somewhat elevated proportions of preference for future transfer to another ARF or RCFE.

Table 8.12: Preferred Other Housing Types, by Age Range	18-54	55-61	62+
Own apartment / unit / place / home	66.4%	63.0%	72.9%
Shared apartment / unit / place / home	12.1%	10.9%	12.7%
Independent / assisted living	11.2%	6.5%	13.6%
Affordable housing	12.9%	15.2%	6.8%
Transfer to another ARF or RCFE	5.2%	15.2%	1.7%
Locked facility (mental health)	1.7%	0.0%	0.0%
Return to the streets (unhoused)	0.0%	2.2%	0.0%
Permanent supportive housing	0.9%	0.0%	0.0%

Residents in the 55- to 61-year-old age cohort expressed significantly lower proportions of future housing preference for their own apartment unit, place, or home, affordable housing, or transfer to another ARF or RCFE than residents of older or younger age groups. A significantly greater proportion of residents aged 62 or older expressed preference for being housing in independent / assisted living in the future over residents from the 55- to 61-year-old age group.

Table 8.13: Preferred Other Housing Types, by Gender Identity	FEMALE	MALE
Own apartment / unit / place / home	67.9%	69.0%
Shared apartment / unit / place / home	14.2%	10.3%
Independent / assisted living	10.4%	12.1%
Affordable housing	11.3%	10.3%
Transfer to another ARF or RCFE	4.7%	5.7%
Locked facility (mental health)	0.9%	0.6%
Return to the streets (unhoused)	0.0%	0.6%
Permanent supportive housing	0.0%	0.6%

No significant differences were observed in relation to future housing preference based on respondent gender identity.

Table 8.14: Preferred Other Housing Types, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Own apt./unit/place/home	74.8%	67.4%	64.9%	68.2%	45.5%	0.0%	NaN
Shared apt./unit/place/home	9.2%	12.0%	18.9%	22.7%	9.1%	50.0%	NaN
Independent / assisted living	11.5%	10.9%	8.1%	4.5%	27.3%	50.0%	NaN
Affordable housing	9.2%	9.8%	13.5%	18.2%	18.2%	0.0%	NaN
Transfer to another ARF or RCFE	3.1%	8.7%	2.7%	4.5%	18.2%	0.0%	NaN
Locked facility (mental health)	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	NaN

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

White / Caucasian resident respondents expressed significantly greater proportions of preference for their own apartment unit, place, or home in the future over residents from other racial identity groups. Significantly greater proportions of Asian / Asian American and Hispanic / Latino / Latinx resident respondents preferred future housing in a shared apartment unit, place, or home than others. Native American / Alaska Native residents preferred a future independent / assisted living housing placement in significantly greater proportion over residents from other identity groups.

A significantly greater proportion of Asian / Asian American and Native American / Alaska Native residents also expressed preference for future affordable housing placement than residents in most other identity groups. Significantly greater proportions of Black / African American and Native American / Alaska Native residents preferred transfer to a different ARF or RCFE in the future over other identity group respondents.

Table 8.15: Preferred Other Housing Types, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Own apt./unit/place/home	61.6%	69.5%	71.1%	71.8%	66.7%
Shared apt./unit/place/home	13.7%	9.9%	12.5%	4.9%	9.3%
Independent / assisted living	14.7%	11.3%	9.9%	12.6%	8.3%
Affordable housing	14.2%	16.6%	12.5%	13.6%	16.7%
Transfer to another ARF or RCFE	6.3%	4.0%	3.3%	4.9%	8.3%
Locked facility (mental health)	1.1%	1.3%	1.3%	1.0%	1.9%

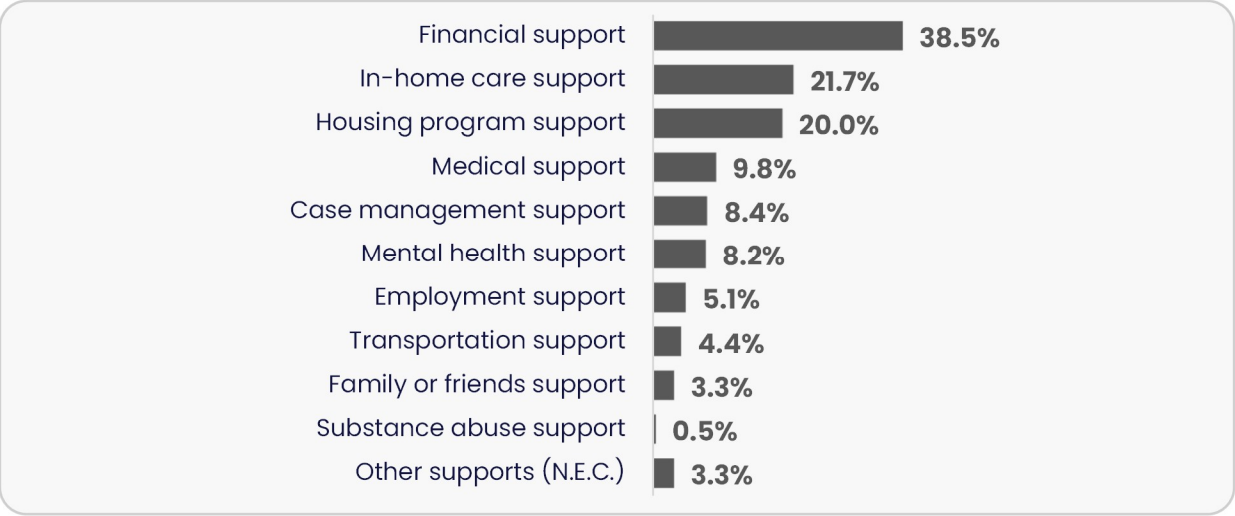
Residents living with mental illness expressed future preference for their own apartment unit, place, or home in the future in significantly lower proportions than other groups of residents experiencing key study factors, with those having experienced incarceration for a period of 30 days or more expressing significantly lower proportions of preference for shared apartment unit, place, or home housing than others in the future. A significantly greater proportion of residents who had experience with homelessness as an adult or addiction to drugs and/or alcohol expressed interest in affordable housing in comparison to residents from other key study factor groups.

Resident Supports Needed to Move to Housing of Choice

Residents were asked to describe any forms of support that they believed would be required to support them in a move to a preferred form of housing in the future.

RQ34. "What types of assistance would need to move back to housing of your own choosing in the future?" (MR)

RESIDENTS (n=281)



A need for financial support (38.5%), in-home care support (21.7%), and housing program support (20.0%) were the primary types of assistance required by residents of Market ARFs and RCFEs to make a move into their preferred future housing situation in the future.

Table 8.16: Supports Needed to Move, by License Class	ARF	RCFE	ALL
Financial support	45.1%	28.5%	38.5%
In-home care support	14.8%	32.0%	21.7%
Housing program support	25.7%	11.6%	20.0%
Medical support	5.8%	15.7%	9.8%
Case management support	10.1%	5.8%	8.4%
Mental health support	8.6%	7.6%	8.2%
Employment support	5.8%	4.1%	5.1%
Transportation support	4.3%	4.7%	4.4%
Family or friends support	1.9%	5.2%	3.3%
Substance abuse support	0.8%	0.0%	0.5%

ARF residents indicated that they would need financial support and support from housing programs to move into their preferred housing type in the future in significantly greater proportions than RCFE residents. In-home care and medical support were identified by RCFE residents in significantly greater proportions than ARF residents.

Table 8.17: Supports Needed to Move, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Financial support	23.5%	46.5%	39.7%
In-home care support	30.9%	20.2%	19.2%
Housing program support	11.1%	23.7%	21.4%
Medical support	17.3%	5.3%	9.4%
Case management support	6.2%	10.5%	8.1%
Mental health support	6.2%	12.3%	6.8%
Employment support	3.7%	5.3%	5.6%
Transportation support	7.4%	5.3%	3.0%
Family or friends support	11.1%	1.8%	1.3%
Substance abuse support	0.0%	1.8%	0.0%

A significantly greater proportion of residents from facilities with 7 to 60 licensed beds identified that they would need financial support to move to their preferred housing type over residents from smaller or larger facility sizes, with an elevated proportion also indicating that they would require mental health support.

Significantly greater proportions of residents from facilities with licensed capacities of 6 beds or less indicated they would need in-home care support, medical support, housing program support, or the support of friends and family to move into their future housing preference over residents from facilities of greater licensed capacities.

Table 8.18: Supports Needed to Move, by Age Range	18-54	55-61	62+
Financial support	43.0%	53.4%	26.5%
In-home care support	15.0%	17.8%	31.5%
Housing program support	21.2%	31.5%	13.6%
Medical support	5.2%	15.1%	13.0%
Case management support	9.3%	9.6%	6.8%
Mental health support	11.9%	2.7%	6.2%
Employment support	8.8%	2.7%	1.9%
Transportation support	4.7%	2.7%	4.9%
Family or friends support	2.6%	0.0%	5.6%
Substance abuse support	2.6%	4.1%	3.7%

A significantly greater proportion of residents aged 62 or older indicated that they would require in-home care support to move into their future housing preference than residents from younger age cohorts.

Financial support, housing program support, and medical support were identified as integral to achieving future housing preference for residents aged 55 to 61 in greater proportions than residents from older or younger age groups.

Residents aged between 18 and 54 years of age reported that they would need access to employment support in significantly greater proportions than residents of other age cohorts to move into their preferred future housing type.

Table 8.19: Supports Needed to Move, by Gender Identity	FEMALE	MALE
Financial support	37.6%	39.3%
In-home care support	24.2%	20.4%
Housing program support	15.9%	22.2%
Medical support	11.5%	8.9%
Case management support	7.6%	8.9%
Mental health support	11.5%	6.3%
Employment support	2.5%	6.7%
Transportation support	5.7%	3.7%
Family or friends support	3.2%	3.3%
Substance abuse support	1.3%	0.0%

An elevated proportion of female gendered residents indicated that they would require mental health support to move into their preferred future housing type over their male gendered counterparts, who indicated that they would require housing program support in greater proportions than female respondents.

Table 8.20: Supports Needed to Move, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN*	PACIFIC ISLANDER*	MIDDLE EASTERN*
Financial support	35.6%	40.6%	42.5%	39.0%	50.0%	66.7%	100.0%
In-home care support	22.0%	23.4%	13.8%	31.7%	28.6%	0.0%	0.0%
Housing program support	17.5%	25.0%	20.0%	19.5%	28.6%	0.0%	0.0%
Medical support	11.3%	5.5%	10.0%	12.2%	14.3%	33.3%	0.0%
Case mgmt. support	5.6%	10.9%	5.0%	9.8%	28.6%	0.0%	0.0%
Mental health support	9.6%	7.0%	10.0%	2.4%	7.1%	33.3%	50.0%
Employment support	4.5%	7.8%	6.3%	2.4%	0.0%	0.0%	0.0%
Transportation support	4.5%	3.9%	7.5%	9.8%	14.3%	0.0%	0.0%
Family or friends support	4.0%	2.3%	3.8%	2.4%	0.0%	0.0%	0.0%
Substance abuse support	0.6%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Asian / Asian American resident respondents indicated that they would require in-home care and transportation supports to move into their future housing preference in greater proportions than respondents from other racial identity groups.

Black / African American residents indicated that they would need housing program support in significantly greater proportions than residents of other racial identities, with the exception of Native American / Alaska Native respondents (N.B.: without validity in relation to significance due to a lower, total sample size for this question).

Table 8.21: Supports Needed to Move, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Financial support	42.1%	45.0%	35.4%	47.3%	44.9%
In-home care support	18.8%	17.7%	25.1%	18.7%	18.6%
Housing program support	24.7%	26.0%	17.9%	28.7%	25.1%
Medical support	6.2%	8.2%	13.9%	6.7%	6.6%
Case mgmt. support	10.3%	10.0%	9.9%	8.7%	9.6%
Mental health support	11.0%	9.5%	8.1%	6.7%	9.0%
Employment support	5.5%	6.5%	2.2%	6.0%	3.6%
Transportation support	3.8%	3.5%	4.5%	2.0%	2.4%
Family or friends support	2.4%	1.7%	3.6%	2.7%	2.4%
Substance abuse support	0.7%	0.9%	0.4%	0.7%	1.2%

A significantly greater proportion of residents with experience of living with a physical disability, experience of incarceration for a period of 30 days or more, and experience with addiction to alcohol and/or drugs reported needing financial support and housing program support to move to a preferred housing type in the future in comparison to other study factor groups.

Resident respondents who experience living with a physical disability reported requiring in-home care and medical support in significantly greater proportions to move to preferred housing type compared to residents from other groups.

Resident Willingness to Undertake Conditional Paid Work

Residents were asked if they would be willing to undertake paid work that aligned with their personal preferences and capabilities on the basis that it did not interfere with any benefit(s) they were currently receiving.

RQ71. "If made aware of a job that matched your skills and capabilities AND if your public benefits would not be affected, would you be willing to perform paid work that you liked?"

RESIDENTS (N=625)

Table 8.22: Willingness to Undertake Paid Work Conditionally, by License Class	ARF	RCFE	ALL
	73.9%	44.4%	60.3%

Further advancing understanding of the Market's unrealized potential for residents to graduate to a lower level of care and housing, especially those at Market ARFs, many residents informally reported that they have been enabled to take on paid work, up to a limitation of hours or total remuneration received.

A majority of respondents (60.3%) indicated that they were willing to undertake paid work that they liked that matched their skills and capabilities on the condition that it would not adversely impact their public benefits. This finding is in line with experiences designed to aid vulnerable populations, in particular for people living with mental illness, to engage in supportive work programs to enable social integration and skills development to advance their capabilities and well-being, without impacting their safety by freezing or removing public benefits.[11]

A significantly greater proportion of residents of ARFs were willing to undertake paid work in consideration of their preferences and capabilities (that would not reduce their benefits) in comparison to RCFE residents, largely due to considerations of capability, age, health factors, and lifecycle expectations.

Table 8.23: Willingness to Undertake Paid Work Conditionally, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	47.5%	67.5%	62.4%

Residents of mid-sized (7 to 60 licensed beds) and larger (61 or more bed) facilities indicated their willingness to undertake conditional paid work in significantly greater proportions than residents of facilities licensed for 6 or fewer beds.

Table 8.24: Willingness to Undertake Paid Work Conditionally, by Age Range	18-54	55-61	62+
	77.0%	75.5%	40.4%

Significantly greater proportions of residents aged 18 to 54 and 55 to 61 expressed willingness to undertake conditional paid work, compared to resident respondents of the 62 or older age cohort.

[11] Examples of such studies include: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3942865/, and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7681163/.

Table 8.25: Willingness to Undertake Paid Work Conditionally, by Gender Identity	FEMALE	MALE
	53.9%	64.9%

A greater proportion of male gendered resident respondents indicated their willingness to undertake conditional paid work than their female gendered counterparts.

Table 8.26: Willingness to Undertake Paid Work Conditionally, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
	54.2%	69.8%	71.2%	52.2%	70.6%	66.7%	33.3%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Significantly greater proportions of Hispanic / Latino / Latinx, Native American / Alaskan Native, and Black / African American residents indicated their willingness to undertake conditional paid work than individuals of other racial identities.

Table 8.27: Willingness to Undertake Paid Work Conditionally, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESSAS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
	70.6%	72.2%	56.5%	77.2%	77.4%

Residents with experiences of addiction to drugs and/or alcohol, incarceration for periods of more than 30 days, homelessness as an adult, and living with mental illness indicated significantly greater proportions of willingness to undertake conditional paid work in relation to other residents interviewed.

9.0

Image: www.dreamstime.com

Facility Service Quality

Given the range of differences in facilities across Los Angeles County ARFs and RCFEs, assessment of key factors relating to the range and relative quality of services offered can advance additional funding, identify supplemental resources, and support beneficial conversations to drive continuous improvement of service delivery to residents across the Market. Owners and operators were asked to identify operational characteristics such as access to services, methods and practices in their service delivery, frequency of medical, mental health, and substance abuse treatment service visits, and other factors to help the study establish a normative basis for assessment of facility quality.

Market Staff-to-Resident Ratios

Consideration of staff-to-client ratios is a common factor in the evaluation of service delivery quality, efficiency, and effectiveness across many human-centric industries, government services, and continuums of care. A calculation of staff-to-resident ratio was established from interviews with ARF and RCFE owners and operators, based on the number of full-time equivalent (FTE) staff employed directly by a facility against the total, licensed resident headcount for each facility by the market regulator, CCLD.

FQ6. "To confirm, what is your total licensed bed count?" **AND FQ9.** "How many directly employed staff currently work here, in any capacity?

FACILITY OWNERS & OPERATORS (N=353)

Table 9.1: Staff to Resident Ratio, by License Class (FULL CAPACITY)	ARF	RCFE	ALL
	0.92	0.82	0.86

The mean staff-to-resident ratio across all ARFs and RCFEs is 0.86 residents per licensed bed, which is the assumed ratio if all facilities are operating at their maximum, licensed bed capacity. Given the wide range of differences between facility sizes, service models, mix of population needs, acuities of resident care needs, and other factors, this reference ratio is presented only for general considerations of the Market as a whole.

There were no significantly observable differences in overall staffing ratios between ARFs and RCFEs as license classes, with ARFs reporting slightly greater mean staff to resident ratios. However, when further segmentation was applied to the data to explore differences between both facility license class and size, several significant differences emerged:

Table 9.2: Staff to Resident Ratio, by License Class and Facility Size (FULL CAPACITY)	ARF	RCFE
≤ 6 BEDS	1.75	0.92
7–60 BEDS	0.44	0.59
≥ 61 BEDS	0.23	0.62

In consideration of the natural efficiencies of service gained from scalability, larger ARFs and RCFEs serving upwards of 7 licensed beds for the identified, vulnerable populations have a natural tendency to employ far fewer staff per resident than facilities that serve resident populations of 6 beds or fewer.

Although some variances are observable from staff-to-resident ratios across Los Angeles County Service Planning Areas (SPAs), the research team does not believe that these differences are substantial enough to generate insights due to extended variances in the compositions and service methods of the facilities serving each area. However, in relation to insights generated from facility Service Planning Area and/or License Class, key differences are observable that can be substantiated by the research:

Table 9.3: Staff to Resident Ratio, by SPA and License Class	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
ARF (FULL CAPACITY)	2.83	1.06	1.20	0.60	0.40	1.02	1.40	0.60
RCFE (FULL CAPACITY)	1.05	0.81	0.76	0.82	0.92	0.80	0.80	0.78

Significantly lower staff-to-resident ratios were observed from ARFs serving SPA 4 (Metro Los Angeles and Center Cities) and SPA 5 (West Los Angeles and West Cities) in comparison to facilities located in other SPAs. ARFs serving SPA 1 (Antelope Valley) had significantly greater and somewhat disproportionate staff-to-resident ratios compared to other SPAs. This has been attributed a greater proportion of facilities in SPA 1's sample which reported service to a mixed population, inclusive of people living with developmental disabilities (although not exclusively) alongside the identified, vulnerable population.

In examining prospective differences between RCFEs located across Los Angeles County Service Planning Areas, staff-to-resident ratios were observed to fall within a normative range.

Table 9.4: Staff to Resident Ratio, by SPA and Facility Size	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
6 BEDS OR LESS (FULL CAPACITY)	1.32	1.02	1.12	1.18	0.96	1.59	1.39	0.95
7 TO 60 BEDS (FULL CAPACITY)	0.58	0.42	0.59	0.51	0.67	0.28	0.68	0.43
61 OR MORE BEDS (FULL CAPACITY)	NaN*	0.42	0.65	0.28	0.40	0.31	0.24	0.37

Facilities with resident populations of 6 or fewer licensed beds located in SPA 1 (Antelope Valley) and SPA 6 (South Los Angeles and South Cities) were observed to have significantly greater staff-to-resident ratios than facilities located in other SPAs, with the lowest staff-to-resident ratios for 6 or fewer licensed bed facilities observed in SPA 5 (West Los Angeles and West Cities) and SPA 8 (South Bay and Coastal Cities).

Facilities with resident populations ranging from 7 to 60 licensed beds maintained relatively normalized proportions of staff-to-resident ratios, with the exception of facilities of this size serving SPA 6 (South Los Angeles and South Cities), which displayed significantly lower staff-to-resident ratios than facilities in other SPAs.

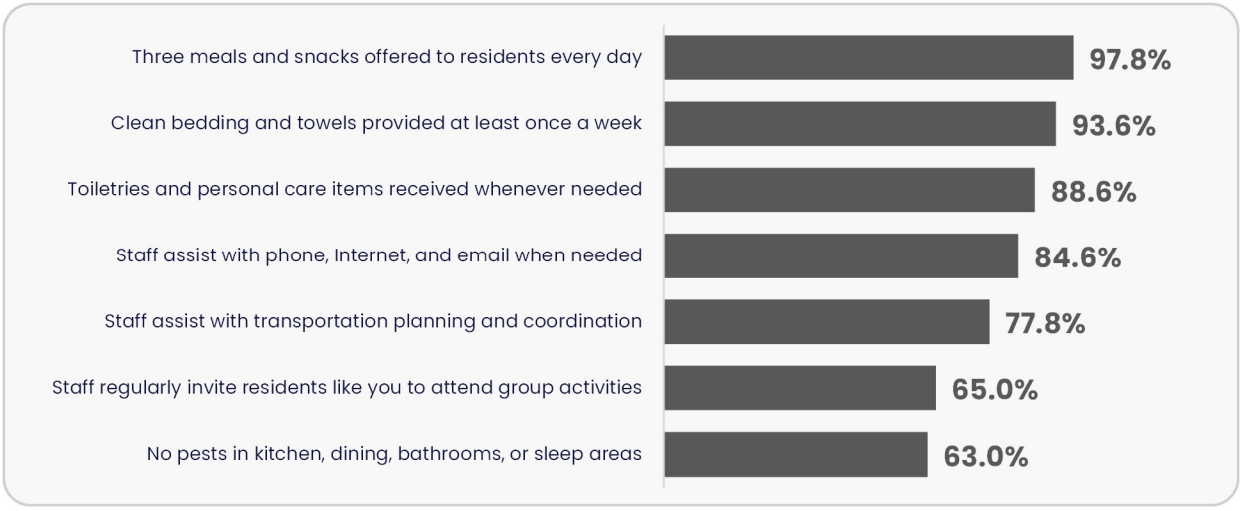
For facilities that serve resident populations of 61 licensed beds or more, SPA 4, SPA 6, and SPA 7 were observed to have lower staff to resident ratios than other SPAs (Note: this segmentation excludes SPA 1, where no 61 or more bed licensed facilities from a low population in this class were identified to be qualified and/or agreed to participate in the research).

Resident-Assessed Service Quality Factors

Residents were asked a series of questions to identify facility quality factors to better understand how Market ARFs and RCFEs manage the quality of cleaning, maintenance, and services from a resident's perspective.

RQ42. TO RQ48. "Do you (experience these factors) …?"

RESIDENTS (N=625)



No resident facility quality factor was reported universally at 100.0%, with even the requisite three meals and snack service for residents reported at 97.8%. There were some observed differences in two additional factors which are identified by CCLD as required by licensees to deliver acceptable levels of service at facilities[12]: the provision of clean bedding and towels at least once a week (88.6%) and toiletries and personal care items

[12] https://www.cdss.ca.gov/Portals/9/ARF-Self-Assessment-032917-%20FINAL.pdf?ver=2017-04-07-155125-297

received whenever needed (88.6%) were at lower-than-expected values. Given how the effects of the COVID-19 pandemic and its effects on resident movement and group activities, the observed value for staff regularly inviting residents ("like or similar to each individual respondent") to group activities is at somewhat predictably lower proportions (65.0%).

A key quality issue that requires greater attention from many ARF and RCFE facilities is pest control, as only 63.0% of residents reported that they did not encounter any pests in kitchens, dining areas, bathrooms, or their rooms (sleep areas). This is a well-documented, but ever-challenging aspect for many types of businesses providing accommodation and food service, including those in general hospitality, but especially for congregate living facilities like ARFs and RCFEs. A priority for government or nonprofit Market Users should be to fund or supply technical and/or material assistance to owners and operators to enable more consistent practices for the remediation of pests, given the wide-ranging potential for impacts on resident quality of life, public health, and vector control across communities. Owners and operators of facilities should also seek out best practice in establishing greater levels of uniform quality with peer facilities across the Market for pest control, given potential for reputational harm to the Market as a whole.

Table 9.5: Resident Quality Factors, by License Class	ARF	RCFE	ALL
Three meals and snacks offered to residents every day	97.9%	97.6%	97.8%
Clean bedding and towels provided at least once a week	93.5%	93.8%	93.6%
Toiletries and personal care items received whenever needed	93.8%	82.6%	88.6%
Staff assist with phone, Internet, and email when needed	83.7%	85.8%	84.6%
Staff assist with transportation planning and coordination	81.0%	74.0%	77.8%
Staff regularly invite residents like you to attend group activities	68.2%	61.1%	65.0%
No pests in kitchen, dining, bathrooms, or sleep areas	57.6%	69.4%	63.0%

Residents from ARFs reported slightly lower proportions of staff assisting with phone, Internet, and email when needed, and the absence of pests in comparison to RCFE respondents. Lower proportions of RCFE respondents reported receipt of toiletries and personal care items whenever needed, staff assistance with transportation planning, and staff invitations to group activities than ARF residents.

Table 9.6: Resident Quality Factors, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Three meals and snacks offered to residents every day	95.7%	98.5%	98.1%
Clean bedding and towels provided at least once a week	93.6%	91.7%	94.5%
Toiletries and personal care items received whenever needed	87.9%	92.4%	87.1%
Staff assist with phone, Internet, and email when needed	83.7%	88.5%	83.1%
Staff assist with transportation planning and coordination	66.7%	83.4%	79.8%
Staff regularly invite residents like you to attend group activities	41.8%	57.3%	78.6%
No pests in kitchen, dining, bathrooms, or sleep areas	82.2%	61.8%	55.3%

While significantly lower proportions of residents living at licensed facilities with 6 or fewer beds indicated that their ARF or RCFE assisted with transportation planning and coordination, or regularly invited residents to group activities, a significantly greater proportion ensured the absence of pests in their facility's resident service areas. Residents at 7 and 60 bed facilities reported that their facility assisted with phone, internet, and email when needed in significantly greater proportions than smaller or larger facility size ranges.

Table 9.7: Resident Quality Factors, by Age Range	18-54	55-61	62+
Three meals and snacks offered to residents every day	97.2%	97.9%	98.2%
Clean bedding and towels provided at least once a week	92.7%	96.8%	93.2%
Toiletries and personal care items received whenever needed	94.8%	94.7%	81.1%
Staff assist with phone, Internet, and email when needed	84.7%	85.1%	85.0%
Staff assist with transportation planning and coordination	81.8%	76.6%	74.6%
Staff regularly invite residents like you to attend group activities	66.5%	66.0%	62.9%
No pests in kitchen, dining, bathrooms, or sleep areas	62.1%	54.3%	67.5%

A significantly greater proportion of residents aged 62 or older reported that they did not receive toiletries and personal care items from their facilities whenever needed, compared to residents in younger age cohorts. Residents aged between 55 and 61 also reported that their facility was free of pests in significantly lower proportions than residents of younger or older age cohorts.

Table 9.8: Resident Quality Factors, by Gender Identity	FEMALE	MALE
Three meals and snacks offered to residents every day	97.7%	97.8%
Clean bedding and towels provided at least once a week	92.2%	94.6%
Toiletries and personal care items received whenever needed	85.5%	90.7%
Staff assist with phone, Internet, and email when needed	85.2%	84.7%
Staff assist with transportation planning and coordination	73.4%	80.9%
Staff regularly invite residents like you to attend group activities	63.3%	66.2%
No pests in kitchen, dining, bathrooms, or sleep areas	61.3%	64.6%

There were minimal differences observed on the basis of resident gender identity, other than a reduced proportion of female-gendered residents reporting staff assistance with receiving toiletries and personal care items whenever needed, along with transportation planning and coordination.

Table 9.9: Resident Quality Factors, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Three meals and snacks offered to residents every day	96.9%	98.1%	99.0%	100.0%	100.0%	100.0%	100.0%
Clean bedding and towels provided at least once a week	93.9%	94.4%	94.2%	92.5%	94.1%	100.0%	100.0%
Toiletries and personal care items received when needed	88.4%	91.4%	93.1%	88.1%	70.6%	66.7%	100.0%
Staff assist with phone, Internet, email when needed	83.9%	84.3%	89.2%	91.0%	70.6%	100.0%	66.7%
Staff assist with transportation planning and coordination	76.7%	81.1%	82.5%	74.6%	82.4%	100.0%	66.7%
Staff regularly invite residents like you to group activities	65.1%	64.8%	64.7%	71.2%	76.5%	33.3%	66.7%
No pests in kitchen, dining, bathrooms, or sleep areas	59.9%	58.7%	66.3%	70.3%	43.8%	33.0%	33.0%

* Insufficient sample exists from these racial identity groups for valid analysis or comparison with other groups

Black / African American and Hispanic / Latino / Latinx residents reported being invited to group events in lower proportions than residents from other racial identity groups, with Native American / Alaska Native respondents indicating receiving toiletries and personal care items, assistance with phone, internet, and email, and having a pest-free facility in significantly lower proportions than residents of other identity groups.

Table 9.10: Resident Quality Factors, by Key Study Factors	LIVING WITH MENTAL ILLNESS	HOMELESSNESS AS AN ADULT	PHYSICAL DISABILITY	INCARCERATION >30 DAYS	SUBSTANCE ADDICTION
Three meals and snacks offered to residents every day	98.2%	97.7%	97.5%	98.3%	98.1%
Clean bedding and towels provided at least once a week	94.0%	94.6%	94.4%	94.6%	92.4%
Toiletries and personal care items received when needed	92.7%	90.6%	88.6%	95.1%	91.0%
Staff assist with phone, Internet, email when needed	85.2%	83.6%	85.8%	86.9%	84.9%
Staff assist with transportation planning and coordination	79.2%	80.3%	77.8%	81.5%	79.2%
Staff regularly invite residents like you to group activities	68.5%	67.2%	59.6%	70.1%	66.0%
No pests in kitchen, dining, bathrooms, or sleep areas	55.7%	53.8%	61.4%	57.6%	53.3%

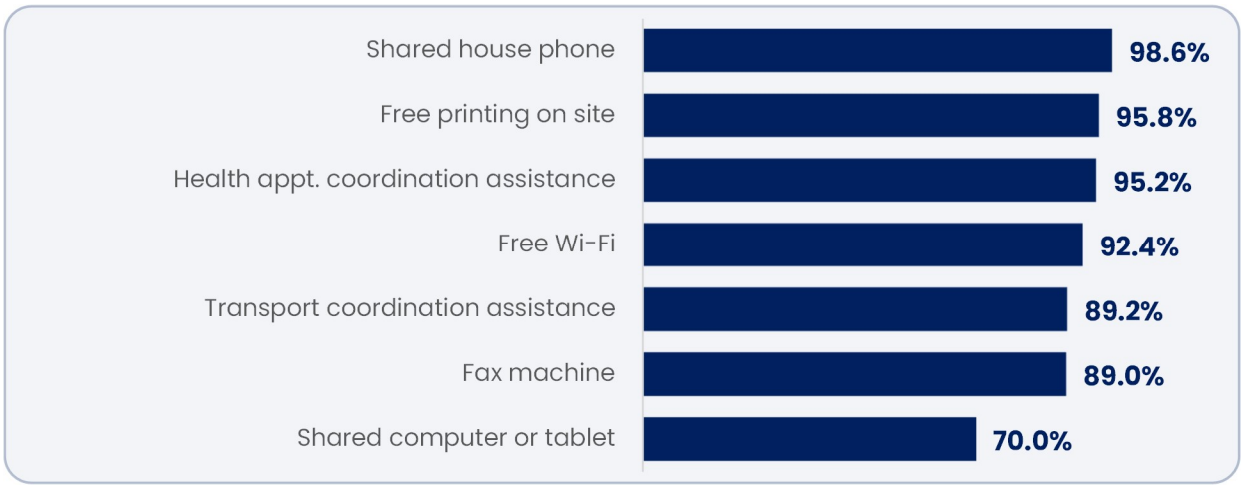
Residents living with physical disability reported being invited to group activities in significantly lower proportions than others, while people with experience of homelessness as an adult and those with experience of substance addiction reported that their facility was pest free in significantly lower proportions than others.

Market Provision of Access and Communications Services

The study asked Owners and Operators of facilities to identify key services provided that enhanced resident capability to communicate and access basic services outside of the facility:

FQ40 to FQ46. "Does your facility offer residents access to…"

FACILITY OWNERS & OPERATORS (N=353)



Although some of the communications and coordination services prompted for Market facility owners and/or operators are effectively required as a condition of licensing for the delivery of service to the identified, vulnerable populations and their care needs, access to such services, such as access to a house phone and assistance with health appointment coordination, such basic services were not universally identified by facilities as provided. More than 10% of facilities indicated that they did not provide residents with any assistance with coordinating their transportation needs.

There appears to remain a digital divide in services across the Market of ARFs and RCFEs, with a greater proportion of facilities indicating that they do not provide residents with access to shared internet devices and/or wi-fi, in comparison to other communications and coordination services. These low-cost digital services and assets can enable many residents to self-service at least some portion of their care, communications, and information needs. There have been several, beneficial programs in recent years from Los Angeles County Departments and the nonprofit, Mental Health Hookup (MHHU)[13], among others, designed to address this specific unmet need at no additional cost to facility operators or residents.

These well-intentioned efforts by government and nonprofit players successfully distributed hundreds of tablet devices for use by residents across facilities in Los Angeles County serving identified, vulnerable populations, but feedback relating to these programs also identified substantive need to provide essential training to enhance the capabilities of the staff and residents of facilities to effectively manage and make the best use of these technologies. Additionally, there are discounted access programs with major telecommunications services providers for low-cost Wi-Fi access, including Mobile Citizen[14] and the California Teleconnect Fund[15] (hosted by the California Public Utilities Commission), which provides discounted internet access and wi-fi services to social welfare agencies and client organizations.

[13] https://www.mentalhealthhookup.org/
[14] https://mobilecitizen.org/customer-types/social-welfare/
[15] https://www.cpuc.ca.gov/ctf/

Table 9.11: Access to C&C Services, by License Class	ARF	RCFE	ALL
Shared house phone	98.5%	98.6%	98.6%
Free printing on site	96.3%	95.4%	95.8%
Health appointment coordination assistance	98.5%	93.1%	95.2%
Free Wi-Fi	86.8%	95.9%	92.4%
Transport coordination assistance	94.1%	86.2%	89.2%
Fax machine	87.5%	89.9%	89.0%
Shared computer or tablet	67.6%	71.4%	70.0%

Owners and operators across both ARFs and RCFEs reported furnishing comparable levels of communication and coordination services for residents across most features evaluated. However, RCFEs reported providing access to a shared computer or tablet for internet access to residents in slightly greater proportions than ARFs, as ARFs reported providing access to transportation coordination assistance to their residents in greater proportions than did RCFEs.

Table 9.12: Access to C&C Services, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Shared house phone	99.0%	97.3%	98.6%
Free printing on site	95.6%	93.3%	98.6%
Health appointment coordination assistance	93.1%	96.0%	100.0%
Free Wi-Fi	99.5%	85.3%	79.7%
Transport coordination assistance	85.8%	98.6%	89.3%
Fax machine	86.3%	86.7%	98.6%
Shared computer or tablet	72.5%	68.0%	64.9%

ARFs and RCFEs with 61 or more licensed beds reported providing their residents with access to assistance in making and managing vital appointments and furnishing access to a fax machine in significantly greater proportions than did facility cohorts with fewer licensed beds.

Mid-sized facilities with 7 to 60 beds reported the provision of access to transportation coordination assistance in significantly greater proportions than facility groups with fewer or greater licensed bed capacities, while ARFs and RCFEs with 6 or fewer licensed beds reported providing free Wi-Fi to their residents in significantly greater proportions than larger facility sizes.

Table 9.13: Access to C&C Services, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Shared house phone	100.0%	100.0%	97.6%	100.0%	92.9%	96.7%	100.0%	98.5%
Free printing on site	100.0%	97.4%	94.0%	97.1%	92.9%	90.0%	100.0%	95.5%
Health appointment coordination assistance	88.5%	93.5%	97.6%	100.0%	100.0%	90.0%	90.5%	97.0%
Free Wi-Fi	100.0%	93.5%	92.8%	85.7%	100.0%	93.3%	100.0%	86.6%
Transport coordination. assistance	73.1%	90.9%	90.4%	91.4%	100.0%	93.3%	85.7%	88.1%
Fax machine	76.9%	92.2%	88.0%	91.4%	92.9%	90.0%	95.2%	86.6%
Shared computer or tablet	84.6%	68.8%	69.9%	68.6%	57.1%	63.3%	76.2%	70.1%

Significantly lower proportions of respondents serving facilities in SPA 1 (Antelope Valley) reported furnishing residents with access to transportation coordination assistance, health appointment coordination assistance, and access to fax machines than facilities located in other SPAs.

Owners and/or operators of facilities located in SPA 5 (West Los Angeles and West Cities) reported furnishing a shared computer or tablet for residents to access the internet and email in significantly lower proportions than facilities in other SPAs.

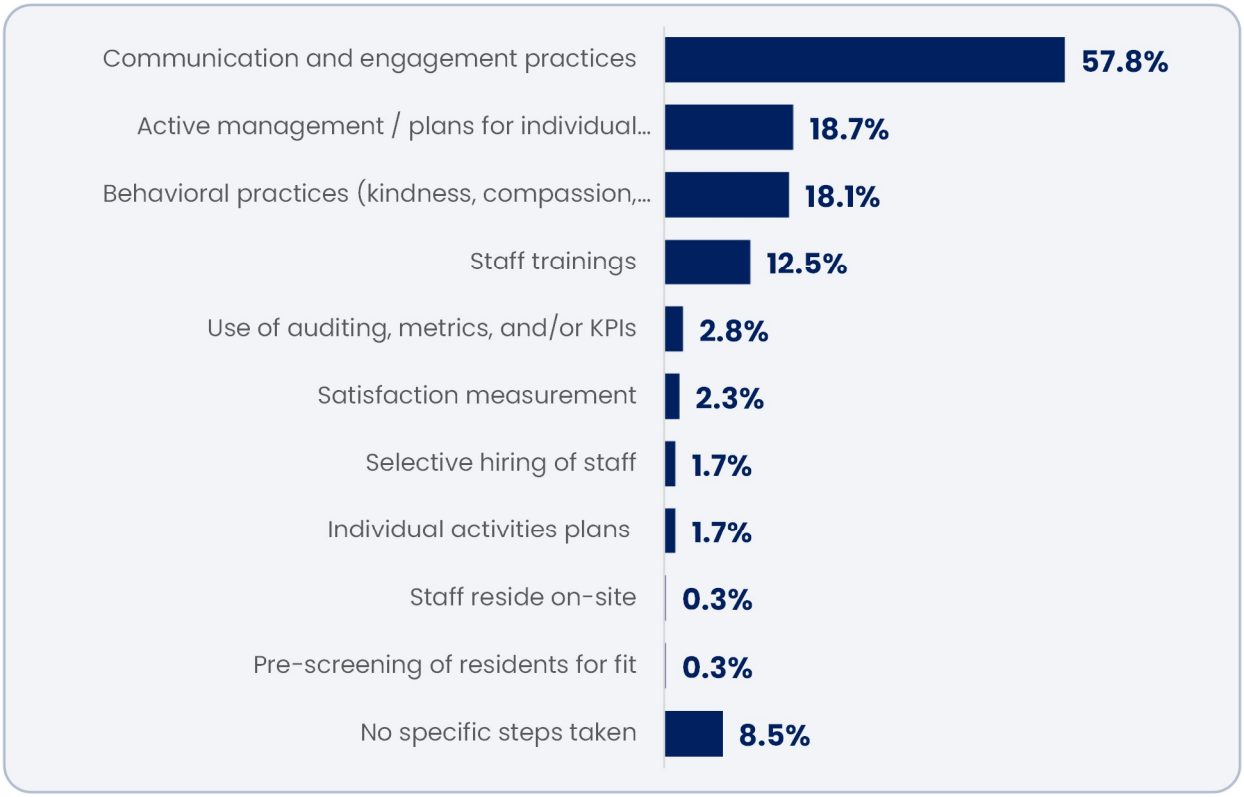
Respondents across several SPAs reported generally lower proportions of the provision of communications technology and coordination services to their resident populations, indicating possible need for additional funding and outreach to facilities to ensure more equitable access and distribution to these basic technologies and services for Market residents across Los Angeles County.

Steps Taken to Ensure Quality of Resident Services

Facility owners and/or operators were asked to identify any steps, methods, or activities that their facilities engaged to ensure the level of quality for resident service delivery.

FQ35. "What are the key steps that you and the staff take to ensure quality in the delivery of services to residents?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



Communications and engagement practices were the most reported step or method utilized by ARFs and RCFEs to ensure the quality of services delivered to residents. As a largely informal practice without codified or written instruction, respondents indicated that seeking greater levels of feedback and evaluating the responsiveness of residents to service offered on a regular basis was largely successful in providing indications that could be used to evaluate, and make improvements to quality in service delivery.

More than 18% of ARFs and RCFEs reported the formal approach of utilizing active management / plans for individual resident care needs and another informal approach, specifically utilizing behavioral practices with residents, such as directing expressions of kindness, compassion, or concern from facility staff, to ensure quality of service delivery.

8.5% of facility respondents indicated that their facility took no specific steps or engaged methods to ensure quality in service delivery to their resident populations.

Table 9.14: Steps for Quality of Services, by License Class	ARF	RCFE	ALL
Communication and engagement practices	62.5%	54.8%	57.8%
Active mgmt. / plans for indiv. resident care needs	19.1%	18.4%	18.7%
Behavioral practices (kindness, compassion, etc....)	14.7%	20.3%	18.1%
Staff trainings	9.6%	14.3%	12.5%
Satisfaction measurement	1.5%	2.8%	2.3%
Individual activities plans	2.2%	1.4%	1.7%
Selective hiring of staff	2.2%	1.4%	1.7%
Use of auditing, metrics, and/or KPIs	3.0%	2.7%	2.8%
Pre-screening of residents for fit	0.7%	0.0%	0.3%
Staff reside on-site	0.7%	0.0%	0.3%
No specific steps taken	7.4%	9.2%	8.5%

A consistent majority of both ARFs and RCFEs indicated that they utilize communication and engagement practices to check with residents to ensure that service quality levels are maintained. Comparable levels of service quality practices can be evidenced across ARFs and RCFEs, with low levels of ARFs and RCFEs indicating that they engage no specific steps to ensure resident services quality, especially after being re-prompted to ensure that this response was understood correctly during interviews.

Table 9.15: Steps for Quality of Services, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Communication and engagement practices	54.4%	64.9%	60.0%
Active mgmt. / plans for indiv. resident care needs	18.6%	24.3%	13.3%
Behavioral practices (kindness, compassion, etc.)	21.1%	9.5%	18.7%
Staff trainings	13.2%	16.2%	6.7%
Satisfaction measurement	0.5%	8.1%	1.3%
Individual activities plans	2.5%	1.4%	0.0%
Selective hiring of staff	2.0%	2.7%	0.0%
Use of auditing, metrics, and/or KPIs	1.0%	4.1%	1.3%
Pre-screening of residents for fit	0.5%	0.0%	0.0%
Staff reside on-site	0.0%	0.0%	1.3%
No specific steps taken	9.8%	2.7%	10.7%

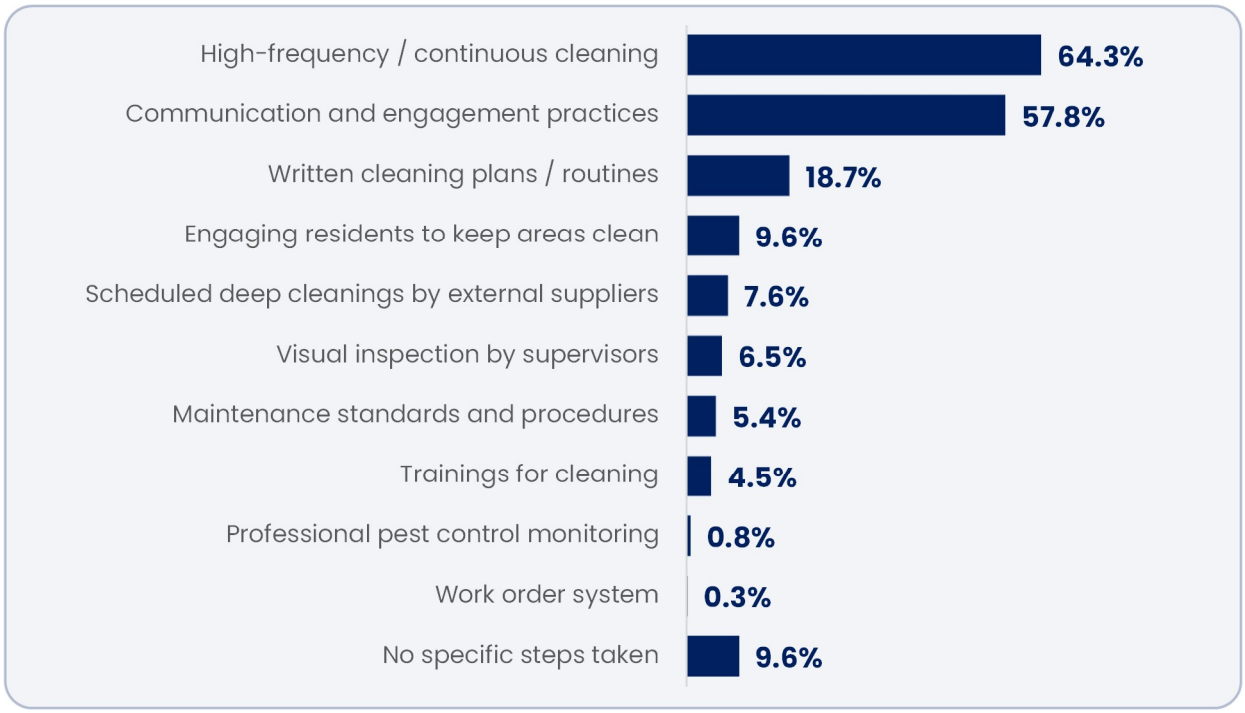
Significantly greater proportions of mid-sized facilities serving between 7 and 60 beds reported use of satisfaction measurement and auditing, metrics, and/or KPIs to ensure quality of resident services, in comparison to larger or smaller licensed facilities. These 7 to 60 bed facilities also reported utilizing behavioral practices in significantly lower proportions than facilities of larger or smaller licensed bed counts.

Steps Taken Ensure Quality in Cleanliness and Maintenance

Respondents representing facilities were asked to identify any steps taken to ensure quality in the cleanliness and maintenance of their facilities.

FQ36. "What are the key steps that you and the staff take to ensure quality in the cleanliness and maintenance of your facility?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



High frequency / continuous cleaning was the most reported step or method to ensure the quality and/or maintenance within facilities, with 64.3% of respondents indicating this as their practice. Many facility owners and/or operators qualitatively linked high frequency / continuous cleaning practices with the ongoing COVID-19 pandemic at time of interview, given pressing (and directed) needs to maintain superior infection control and biosecurity among facility populations. Less than 20% of facility respondents indicated that they made use of written cleaning plans / routines with their staff to ensure quality. 9.6% of facility respondents indicated that they used the practice of engagement with residents to keep areas of the facility clean.

Overall, few facility owners and/or operators conveyed consistent practices relating to facility maintenance (not identifiable as cleaning activity), with 9.6% of respondents indicating that their facility took no specific steps to ensure the quality of cleanliness and maintenance practices.

The relatively-low level of formality reported in the steps that most Market facilities in the sample take regarding cleanliness and maintenance practices identifies considerable opportunity to increase the sharing of formal learning and best practice between facilities, possibly via specification for an ARF/RCFE facility quality management training offering with CCLD providers of Continuing Education Credits (CECs), through industry associations, or commonly-accepted service standards established by standards organizations[16].

[16] https://www.cdss.ca.gov/inforesources/community-care/administrator-certification/initial-and-continuing-education-vendor-regulations

Table 9.16: Cleanliness and Maintenance Steps, by License Class	ARF	RCFE	ALL
High-frequency / continuous cleaning	59.6%	67.3%	64.3%
Written cleaning plans / routines	18.4%	18.9%	18.7%
Engaging residents to keep areas clean	19.9%	3.2%	9.6%
Scheduled deep cleanings by external suppliers	5.1%	9.2%	7.6%
Visual inspection by supervisors	2.9%	8.8%	6.5%
Maintenance standards and procedures	3.7%	6.5%	5.4%
Trainings for cleaning	2.9%	5.5%	4.5%
Professional pest control monitoring	1.5%	0.5%	0.8%
Work order system	0.0%	0.5%	0.3%
No specific steps	11.8%	8.3%	9.6%

A significantly greater proportion of ARFs engaged with their residents to ensure the cleanliness of the facility, in comparison to their RCFE counterparts. RCFEs utilized inspection by supervisors in significantly greater proportions than ARFs.

Table 9.17: Cleanliness and Maintenance Steps, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
High-frequency / continuous cleaning	64.2%	72.0%	56.8%
Written cleaning plans / routines	20.6%	8.0%	24.3%
Engaging residents to keep areas clean	6.9%	14.7%	12.2%
Scheduled deep cleanings by external suppliers	8.3%	5.3%	8.1%
Visual inspection by supervisors	4.4%	6.7%	12.2%
Maintenance standards and procedures	2.5%	2.7%	16.2%
Trainings for cleaning	3.9%	8.0%	2.7%
Professional pest control monitoring	0.0%	2.7%	1.4%
Work order system	0.0%	0.0%	1.4%
No specific steps	10.8%	8.0%	8.1%

Facilities with 61 or more licensed beds reported utilizing visual inspections by supervisors and used maintenance standards and procedures to ensure quality, in significantly greater proportions than smaller ARFs and RCFEs. 7 to 60 licensed bed facilities reported use of high frequency / continuous cleaning practices and delivered staff trainings for cleaning in significantly greater proportions than smaller or larger licensed facilities, also reporting use of written cleaning plans / routines in significantly lower proportions than other licensed facility sizes.

Facility-Observed Frequencies of Health Service Visits

Owners and operators of ARFs and RCFEs were asked to estimate the average frequency of visits from medical professionals, mental health professionals, and substance abuse treatment professionals undertaken with their populations of residents. **N.B.: The figures presented in the tables below are the mean number of visits in weeks, within a category, for the residents of a segment.**

FQ47. TO FQ49. "On average, how frequently do your residents meet with a (medical / mental health / substance abuse) professional?[17]" (ADJUSTED TO WEEKS)

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Table 9.18: Mean Resident Health Visits (In Weeks), by License Class	ARF	RCFE	ALL
Medical professionals	6.65	6.56	6.60
Mental health professionals	4.11	8.03	5.89
Substance abuse treatment professionals	2.28	10.50	4.27

Mean visit frequencies reported by owners and/or operators for residents were lower for residents requiring visits from substance abuse treatment professionals (4.27 weeks), and for visits with mental health professionals (5.89 weeks), than they were for visits with medical health professionals (6.60 weeks).

Owners and operators of ARFs and RCFEs reported comparable mean frequencies of medical visits for their residents, while ARF owners and operators reported significantly greater frequencies of visits for residents needing access to mental health-related and substance abuse treatment-related professionals in comparison to RCFEs.

Table 9.19: Mean Resident Health Visits (In Weeks), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Medical professionals	7.25	6.99	4.51
Mental health professionals	7.92	4.17	4.24
Substance abuse treatment professionals	3.44	7.17	2.12

Facilities with resident populations of 61 or more licensed beds reported significantly lower mean frequencies of visits across medical health, mental health, and substance abuse treatment services, with the exception of mental health treatment frequencies at 7 to 60 licensed bed facilities.

Table 9.20: Mean Resident Health Visits (In Weeks), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Medical professionals	7.29	7.43	6.50	8.50	2.79	6.55	10.60	4.15
Mental health professionals	13.80	7.26	7.31	3.45	3.27	3.67	6.53	4.10
Substance abuse treatment professionals	NaN*	4.36	3.23	9.25	1.00	1.00	1.00	2.46

*No facilities with 61 or more licensed beds were qualified and agreed to take part in the research from SPA 1

Facilities located in SPA 4 (Metro Los Angeles and Center Cities) and SPA 7 (East Los Angeles and South East Cities) reported the significantly greater mean frequencies for resident visitation with medical professionals, with those in SPA 4 also reporting significantly greater mean frequencies of visitation for substance abuse treatment professionals. Facilities located in SPA 1 (Antelope Valley) reported significantly greater mean durations for visitations with mental health professionals, in comparison to facilities located in other SPAs.

[17] For frequency of services from mental health professionals and substance abuse treatment professionals, these questions were further prompted with the caveat of "only for residents with identified need of these services".

Annual Facility Calls to Emergency Services

Facility owners and/or operators were asked to provide an estimate of the total number of calls that their facility placed to emergency services (police, fire, paramedics, and mental health crisis response) within the 12 months prior to interview.

FQ30. "Approximately how many times did your facility place a call to emergency services due to resident actions or behaviors within the last year, including 911 services, such as police, paramedics, fire, or an emergency psychiatric response team?"

FACILITY OWNERS & OPERATORS (N=353)

Table 9.21: Mean Emergency Services Calls (Prior 12 Months), by License Class	ARF	RCFE	ALL
	19.9	15.2	17.0

ARFs reported an elevated mean of calls to emergency services in the preceding 12 months in comparison to their RCFE counterparts.

Table 9.22: Mean Emergency Services Calls (Prior 12 Months), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	4.8	13.4	54.3

An expected value for observation, the natural demand for calls to emergency services over 12 months from Market ARFs and RCFEs correlates with the increasing size of the population served by a licensed facility.

Table 9.23: Mean Emergency Services Calls (Prior 12 Months), by License Class and Facility Size	ARF	RCFE
≤ 6 BEDS	5.6	4.6
7–60 BEDS	12.2	15.7
≥ 61 BEDS	56.3	52.7

Across Market facilities licensed to serve 6 licensed beds or fewer, or serving populations of 61 licensed beds or more, ARFs report greater mean calls for the prior 12 months than RCFEs. However, among mid-sized facilities serving between 7 and 60 licensed beds, RCFEs reported an elevated mean number of calls to emergency services in comparison to ARFs.

Table 9.24: Mean Emergency Services Calls (Prior 12 Months), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	5.3	12.5	21.1	13.5	38.1	11.0	6.3	25.2

ARFs and RCFEs located in SPA 5 (West Los Angeles and West Cities) and SPA 8 (South Bay and Coastal Cities) reported placing a significantly greater mean number of calls to emergency services in the prior 12 months than facilities located in other SPAs. Facilities located in SPA 1 (Antelope Valley) and SPA 7 (East Los Angeles and South East Cities) reported significantly lower mean numbers of emergency calls in relation to other facilities in the 12 months prior to interview.

Table 9.25: Mean Emergency Services Calls (Prior 12 Months), by SPA and License Class	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
ARF	5.0	11.8	16.6	14.7	45.3	11.5	8.8	38.8
RCFE	5.3	12.6	22.7	8.7	32.8	8.8	3.5	14.8

Segmenting the SPAs by facility class confirms significantly greater mean calls being placed to emergency services from ARFs and RCFEs serving SPA 5 (West Los Angeles and West Cities) and ARFs serving SPA 8 (South Bay and Coastal Cities) in comparison to facilities located in other SPAs.

Table 9.26: Mean Emergency Services Calls (Prior 12 Months), by SPA and Facility Size	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
≤ 6 BEDS	3.7	3.9	3.9	3.2	34.3	4.1	2.6	4.1
7–60 BEDS	25.0	14.2	18.4	11.0	30.0	11.8	2.2	10.8
≥ 61 BEDS	NaN*	50.3	54.1	29.3	44.0	28.7	42.0	86.5

*No facilities with 61 or more licensed beds were qualified and agreed to take part in the research from SPA 1

SPA 5 (West Los Angeles and West Cities) serving 6 beds or less reported significantly greater mean numbers of calls than facilities located elsewhere, with mid-sized facilities serving populations of between 7 and 60 licensed beds in SPA 1 (Antelope Valley), SPA 3 (San Gabriel Valley) and SPA 5 reporting significantly greater mean numbers of calls to emergency services in the prior 12 months than others.

Facilities licensed to serve populations of 61 beds or more located in SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities) reported significantly lower mean numbers of calls to emergency services in the 12 months prior to interview compared to other large facilities in most SPAs, with the exception of facilities located in SPA 8 (South Bay and Coastal Cities), reporting significantly greater mean numbers of calls placed.

10.0

Image: www.dreamstime.com

The Needs of Market Facility Owners and Operators

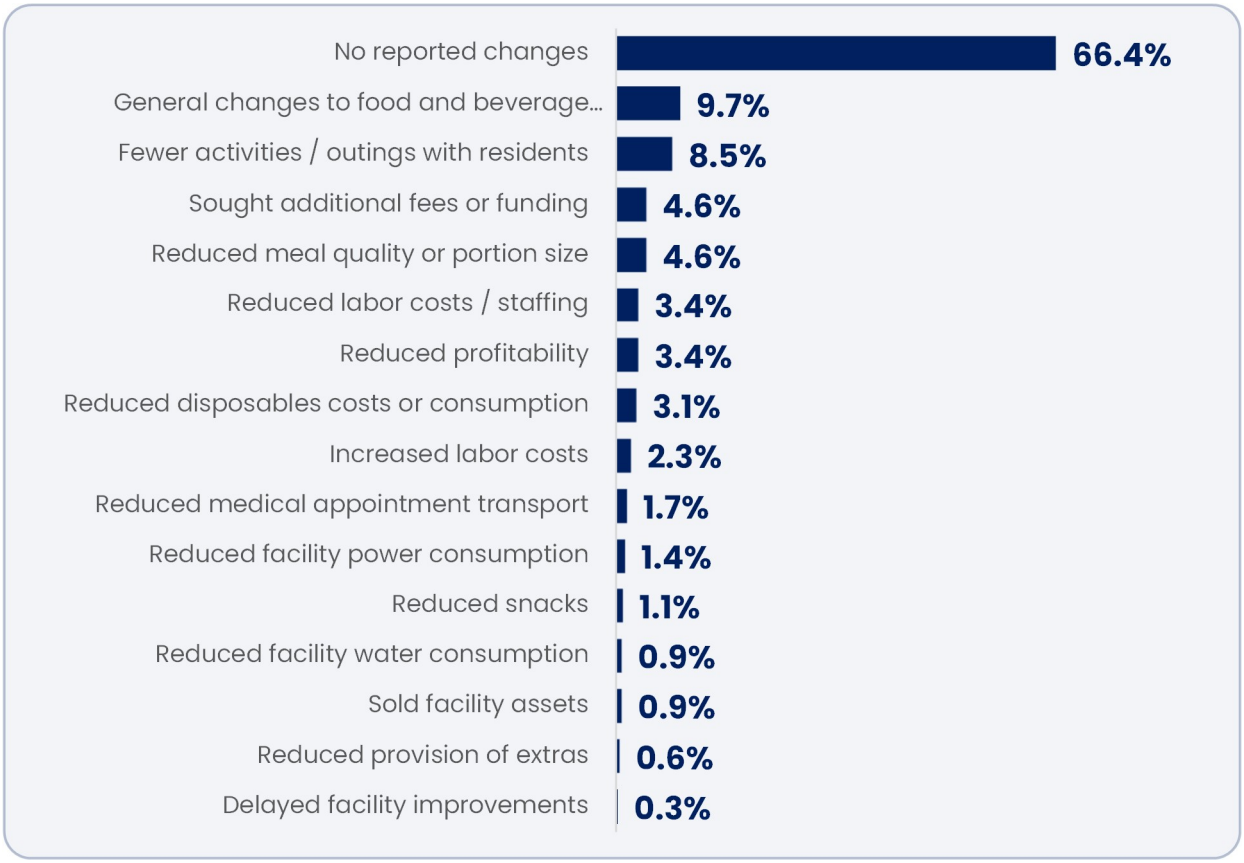
Market owners and operators play a valuable role in delivering public value and benefit in service to identified, vulnerable populations. They also have critical responsibilities and accountabilities to themselves to ensure the profitability and survival of their businesses. The study examines key factors affecting business survivability and sustainability for Market participants, considering interface, funding, and experience with different layers of public agencies and services across government, identifying recommendations for potential improvements in service delivery provided to Market ARFs and RCFEs and their residents.

Changes to Control Costs and Offset Inflation

Facilities owners and operators were asked if they had deployed changes to resident services or deployed any changes to their businesses as a result of increased pressure from inflation on the costs of goods and services:

FQ37. "Is there anything that you've stopped providing to residents over the past year, as a result of increasing costs or inflation?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



Nearly two-thirds (66.4%) of respondents indicated that their facility had not made any changes in response to widely-reported increases across operational costs in goods and services from inflation. The most reported changes that were directly attributable to inflationary pressures were general changes to food and beverage services and purchasing (9.7%) and fewer activities / outings with residents (8.5%).

In conversations with Market facility owners and operators, there is no way to understate the cumulative impacts of the COVID-19 pandemic on finances and survivability for many ARFs and RCFEs. In addition to decreases in revenue from placements of new residents, increased expenditure in costs from disposables and personal protective equipment (PPE) for both staff and residents, and costly disruptions to the processes and methods of service delivery for business owners that required additional expenditure and workarounds, most Market facilities had to contend with ongoing funding and reimbursement disruptions that are a part of their ordinary business experience.

Although many Market ARFs and RCFEs were able to access Federal funding mechanisms, such as the Paycheck Protection Program loans (PPP) and other philanthropic mechanisms to partly weather difficulties imposed by COVID-19, there was anecdotal feedback from Market Users that some Market facilities continue to bear the effects of pandemic-era changes in service delivery, and have learned make do with cost reductions that could have long-lasting effects on their capabilities to deliver services to residents from the identified, vulnerable population.

Table 10.1: Changes from Rising Costs and Inflation, by License Class	ARF	RCFE	ALL
No reported changes	65.4%	67.0%	66.4%
Gen. changes to food/beverage services/purchasing	9.6%	9.8%	9.7%
Fewer activities / outings with residents	14.0%	5.1%	8.5%
Reduced meal quality or portion size	5.9%	3.7%	4.6%
Sought additional fees or funding	0.7%	7.0%	4.6%
Reduced profitability	2.9%	3.7%	3.4%
Reduced labor costs / staffing	2.2%	4.2%	3.4%
Reduced disposables costs or consumption	2.9%	3.3%	3.1%
Increased labor costs	2.9%	1.9%	2.3%
Reduced medical appointment transport	2.2%	1.4%	1.7%
Reduced facility power consumption	1.5%	1.4%	1.4%
Reduced snacks	1.5%	0.9%	1.1%
Sold facility assets	1.5%	0.5%	0.9%
Reduced facility water consumption	0.7%	0.9%	0.9%
Reduced provision of extras	0.7%	0.5%	0.6%
Delayed facility improvements	0.7%	0.0%	0.3%

Although the proportions of ARFs and RCFEs who reported not having made changes as a result of rising costs and inflation were similar (approximately 2/3rds of each license class), the remaining ARFs were significantly more likely to have reduced access to activities and outings, as well as meal quality and/or portion size, than RCFEs who made service changes. For the RCFEs that made changes, facilities were more likely than ARFs to seek additional fees or funding from residents or reduce their labor costs and staffing.

Table 10.2: Changes from Rising Costs and Inflation, by License Class	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
No reported changes	69.3%	60.0%	64.9%
Gen. changes to food/beverage services/purchasing	10.9%	6.6%	9.5%
Fewer activities / outings with residents	6.9%	8.0%	13.6%
Reduced meal quality or portion size	4.0%	5.3%	5.4%
Sought additional fees or funding	4.0%	5.3%	5.5%
Reduced profitability	1.5%	4.0%	8.1%
Reduced labor costs / staffing	5.0%	1.3%	1.4%
Reduced disposables costs or consumption	2.5%	5.3%	2.7%
Increased labor costs	1.5%	4.0%	2.7%
Reduced medical appointment transport	1.5%	4.0%	0.0%
Reduced facility power consumption	1.0%	2.7%	1.4%
Reduced snacks	1.5%	1.3%	0.0%
Sold facility assets	0.5%	1.3%	1.4%
Reduced facility water consumption	1.0%	1.3%	0.0%
Reduced provision of extras	0.5%	1.3%	0.0%
Delayed facility improvements	0.0%	1.3%	0.0%

Facilities serving populations from 7 to 60 licensed beds, reported more frequent service changes due to rising costs and inflation more often than facilities with larger or smaller licensed bed capacities, likely due to factors relating to the scaling of costs relative to the size of their resident populations.

Mid-sized facilities were also more likely to have deployed cost reductions for disposables costs and consumption (single-usage sanitary materials and personal protective equipment), reported increased labor costs more frequently, and indicated that they had more frequently reduced transportation services for medical appointments than other facility sizes.

Small facilities serving resident populations of 6 or fewer residents had a significantly greater proportion of facilities that reported reductions in labor costs and staffing, in comparison to facilities serving larger resident

populations. The largest facilities, with licensed bed capacities of 61 or more, had a significantly greater proportion of facilities that reported reducing resident activities and outings, and experiencing greater reductions in profitability for the business, than smaller facilities.

Asset Quality Improvement Priorities

Owners and/or operators were asked to consider what physical assets at their facility they would prioritize for improvement if funding and/or costs were not an issue to prevent them from commencing works.

FQ38. "If you had instant access to the right amount of grant funding, what physical improvements would you prioritize at your facility?" (MR)

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The greatest priority for facility asset quality improvements across Market owners and/or operators were improvements to landscaping/outdoor areas/gardens for resident use (23.0%), followed by new furniture (17.9%), improvements to wet service areas, such as restrooms, bathrooms, and showers (14.5%).

Relatively high proportions of respondents (>11%) also prioritized improvements to the general comfort and finishings of facilities, painting, and general maintenance and remodeling, without more providing more specifics when further prompted. Nearly 10% of respondents also prioritized improvements for disability access features at facilities.

Only 15.4% of owners and/or operators were unable to identify improvements in physical asset quality that they would prioritize for their respective facilities.

Table 10.3: Priorities for Asset Improvement, by License Class	ARF	RCFE	ALL
Landscaping / outdoor areas / garden	20.6%	24.5%	23.0%
New furniture	18.4%	17.6%	17.9%
Restrooms / bathrooms / showers	16.9%	13.0%	14.5%
General comfort / finishings	9.6%	13.4%	11.9%
Painting	14.7%	9.3%	11.4%
General maintenance / remodel	15.4%	8.3%	11.1%
Disability access features	5.9%	12.0%	9.7%
Climate control	14.0%	5.6%	8.8%
Flooring	5.1%	10.6%	8.5%
Kitchen and appliance remodel	8.1%	7.4%	7.7%
Increase resident rooms / bed capacity	8.1%	7.4%	7.7%
New beds and mattresses	11.8%	5.1%	7.7%
Roofing	10.3%	2.8%	5.7%
Plumbing	8.8%	3.2%	5.4%
Security systems	4.4%	2.3%	3.1%
Window repair and improvements	5.9%	0.5%	2.6%
Exercise room / gym	2.9%	1.9%	2.3%
Technology for internet access	2.2%	1.9%	2.0%
Solar power conversion	3.0%	0.9%	2.3%
Garage / parking lot	2.9%	1.4%	2.0%
Transport van	1.5%	2.3%	2.0%
Television and entertainment devices	2.2%	1.4%	1.7%
Electrical and lighting improvements	1.5%	1.4%	1.4%
Storage area	2.2%	0.5%	1.1%
Elevator system	1.5%	0.5%	0.9%
Generator for emergency use	0.7%	0.9%	0.9%
Service tech and appliances	0.0%	1.4%	0.9%
Staff room / bathroom	0.7%	0.5%	0.6%
Swimming pool	0.0%	0.9%	0.6%
Medical service area	0.0%	0.5%	0.3%
No asset improvement priorities	9.6%	18.5%	15.1%

Greater proportions of ARFs have prioritized asset improvement for general maintenance and remodeling, painting, climate control, roofing, plumbing systems, and window repair in comparison to RCFEs. A significantly greater proportion of RCFEs have prioritized disability access improvements over their ARF counterparts.

A greater proportion of RCFE respondents also indicated that they had no priorities for asset quality improvements over their ARF counterparts.

Table 10.4: Priorities for Asset Improvement, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Landscaping / outdoor areas / garden	25.6%	24.3%	14.7%
New furniture	13.8%	28.4%	18.7%
Restrooms / bathrooms / showers	14.3%	8.1%	21.3%
General comfort / finishings	10.3%	16.2%	12.0%
Painting	8.9%	10.8%	18.7%
General maintenance / remodel	6.4%	18.9%	16.0%
Disability access features	11.8%	6.8%	6.7%
Climate control	3.9%	13.5%	17.3%
Flooring	5.4%	13.5%	12.0%
Kitchen and appliance remodel	8.9%	2.7%	9.3%
Increase resident rooms / bed capacity	8.4%	10.8%	2.7%
New beds and mattresses	5.9%	10.8%	9.3%
Roofing	3.9%	4.1%	12.0%
Plumbing	3.0%	10.8%	6.7%
Security systems	1.5%	9.5%	1.3%
Window repair and improvements	0.0%	4.1%	8.0%
Exercise room / gym	3.0%	2.7%	0.0%
Technology for internet access	3.4%	0.0%	1.3%
Solar power conversion	1.5%	2.7%	2.7%
Garage / parking lot	1.5%	4.1%	1.3%
Transport van	2.0%	2.7%	1.3%
Television and entertainment devices	0.0%	1.4%	5.3%
Electrical and lighting improvements	1.5%	1.4%	1.3%
Storage area	1.0%	0.0%	2.7%
Elevator system	0.0%	4.1%	0.0%
Generator for emergency use	1.0%	0.0%	1.3%
Service tech and appliances	0.5%	1.4%	1.3%
Staff room / bathroom	1.0%	0.0%	0.0%
Swimming pool	1.0%	0.0%	0.0%
Medical service area	0.0%	1.4%	0.0%
No asset improvement priorities	19.7%	10.8%	6.7%

Small and mid-sized ARFs and RCFEs serving populations of 6 beds or less and 7 to 60 beds identified prioritization of outdoor areas, including landscaping and garden access, over larger facilities serving 61 licensed beds or more. Facilities serving populations of 6 or fewer beds also prioritized disability access features over facilities licensed to serve greater populations. A greater proportion of facilities with 6 licensed beds or less also indicated that they had no priorities for improvements, in comparison to larger sizes of facilities. Significantly greater proportions of mid-sized and large facilities serving 7 to 60 and 61 or more licensed beds reported prioritizing general maintenance / remodeling over smaller facilities.

Mid-sized facilities serving 7 to 60 licensed beds prioritized improvements in new furniture, security systems, garage/parking lots, and elevator systems in significantly greater proportions than smaller or larger facilities.

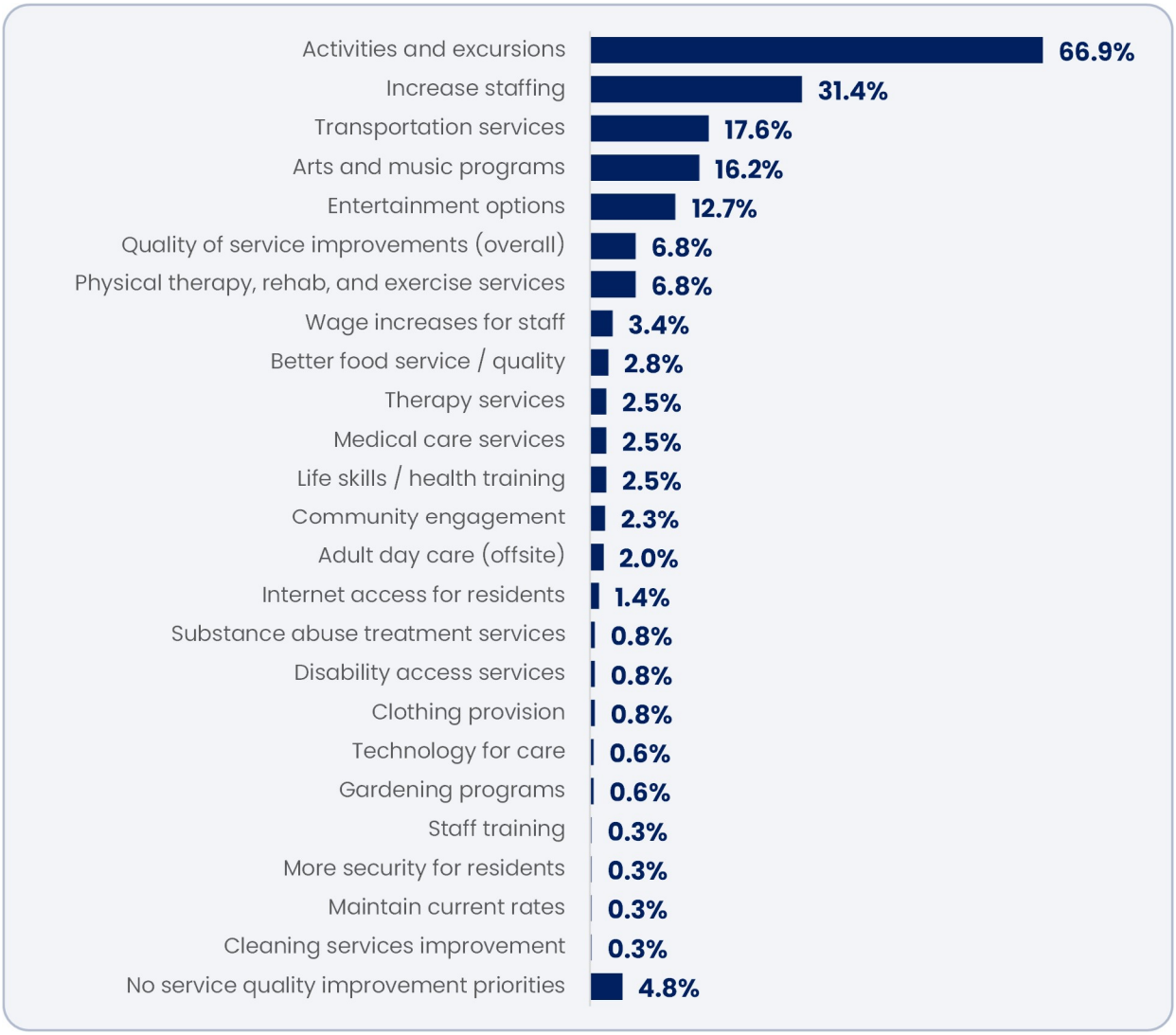
Facilities serving 61 or more licensed beds prioritized improvements for restrooms, bathrooms, and showers, painting, climate control, window repair, and television and entertainment devices in significantly greater proportions than smaller facilities.

Service Quality Improvement Priorities

Owners and/or operators were also asked to consider what quality of service improvements for residents they would prioritize for improvement, again, under the hypothetical direction that funding and/or costs would not be an issue to prevent them from undertaking improvements.

FQ39. "If you had instant access to the right amount of grant funding, what improvements in resident services would you prioritize at your facility?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



Unlike prioritization of physical asset conditioning, nearly all facilities owners and/or operators identified priorities for service quality improvements. Improving the frequency and variety of activities and excursions was identified by a majority of Market ARF and RCFE owners and/or operators as the most important service quality improvement priority (66.9%).

This finding correlates from feedback received from respondents in relation to the significant reduction in activities and excursions brought about by the COVID-19 pandemic, and strong desire by facilities to rectify this particular gap in services once the pandemic (had) subsided. A similarly and frequently expressed rationale also relates to the re-establishment of resident transportation services (17.6%), which were also disrupted by the pandemic.

Nearly a third (31.4%) of respondents prioritized an increase in staffing that would lead to improvement in service quality for residents, which does not necessarily correlate with expressed intentions for increasing head count overall. This is largely surmised to be the result of the hypothetical direction that was offered with this question: that funding and/or costs would not be an issue to prevent them from undertaking improvement(s).

Table 10.5: Priorities for Service Quality Improvement, by License Class	ARF	RCFE	ALL
Activities and excursions	73.5%	62.7%	66.9%
Increase staffing	27.9%	33.6%	31.4%
Transportation services	14.0%	19.8%	17.6%
Arts and music programs	8.8%	20.7%	16.2%
Entertainment options	14.0%	12.0%	12.7%
Physical therapy, rehab, and exercise services	3.7%	8.8%	6.8%
Quality of service improvements (overall)	7.4%	6.5%	6.8%
Wage increases for staff	5.1%	2.3%	3.4%
Better food service / quality	3.7%	2.3%	2.8%
Life skills / health training	6.6%	0.0%	2.5%
Medical care services	0.7%	3.7%	2.5%
Therapy services	3.7%	1.8%	2.5%
Community engagement	1.5%	2.8%	2.3%
Adult day care (offsite)	2.2%	1.8%	2.0%
Internet access for residents	2.2%	0.9%	1.4%
Clothing provision	0.7%	0.9%	0.8%
Disability access services	0.0%	1.4%	0.8%
Substance abuse treatment services	2.2%	0.0%	0.8%
Gardening programs	0.7%	0.5%	0.6%
Technology for care	0.0%	0.9%	0.6%
Cleaning services improvement	0.0%	0.5%	0.3%
Maintain current rates	0.0%	0.5%	0.3%
More security for residents	0.7%	0.0%	0.3%
Staff training	0.7%	0.0%	0.3%
No service quality improvement priorities	0.7%	7.4%	4.8%

High proportions of both ARFs and RCFEs reported seeking to improve the quality of activities and excursions and increase staffing to levels that promote better quality of service to residents, confirmed from additional feedback from owners and operators relating to the impacts from the COVID-19 pandemic, which vastly reduced their capabilities in delivering activities and excursions to residents and limited their ability to recruit (and retain) staff.

Only proportions of ARF respondents indicated that they sought to improve life skills / health training and substance abuse treatment services for residents, whereas no RCFEs indicated this as a priority. A significantly greater proportion of RCFE respondents indicated that they had no priorities for resident service quality improvement in comparison to ARF respondents.

Table 10.6: Priorities for Service Quality Improvement, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Activities and excursions	63.2%	69.3%	74.3%
Increase staffing	26.5%	37.3%	39.2%
Transportation services	13.7%	20.0%	25.7%
Arts and music programs	14.2%	6.7%	5.4%
Entertainment options	10.8%	18.7%	12.2%
Physical therapy, rehab, and exercise services	9.8%	1.3%	4.1%
Quality of service improvements (overall)	5.9%	5.3%	10.8%
Wage increases for staff	3.4%	1.3%	5.4%
Better food service / quality	1.5%	2.7%	6.8%
Life skills / health training	2.0%	4.0%	2.7%
Medical care services	3.9%	1.3%	0.0%
Therapy services	1.5%	4.0%	4.1%
Community engagement	3.4%	1.3%	0.0%
Adult day care (offsite)	2.0%	4.0%	0.0%
Internet access for residents	1.5%	0.0%	2.7%
Clothing provision	0.0%	0.0%	4.1%
Disability access services	1.5%	0.0%	0.0%
Substance abuse treatment services	0.5%	1.3%	1.4%
Gardening programs	1.0%	0.0%	0.0%
Technology for care	0.0%	0.0%	2.7%
Cleaning services improvement	0.5%	0.0%	0.0%
Maintain current rates	0.0%	1.3%	0.0%
More security for residents	0.0%	0.0%	1.4%
Staff training	0.0%	1.3%	0.0%
No service quality improvement priorities	8.3%	0.0%	0.0%

A significantly greater proportion of facilities serving populations of 61 or more licensed beds reported priority for service quality improvements across activities and excursions, increasing staffing, transportation services, overall quality of service improvements, better food service quality, clothing provision, and technologies for care in comparison to ARFs and RCFEs licensed to serve smaller populations.

Mid-sized facilities serving between 7 and 60 beds reported prioritizing entertainment options and offsite adult day care services as service quality priorities for improvements over larger or smaller capacity facilities, while also reporting physical therapy, rehabilitation, and exercise services as quality improvement priorities in significantly lower proportions than other facilities.

Although facilities serving smaller populations of 6 or fewer beds prioritized improvement of medical care services and community engagement for residents in greater proportions than larger facilities, respondents indicated having no priorities for service improvement in significantly greater proportions than respondents from facilities serving greater licensed population capacity.

Intentions for Future Resident Capacity

Facility owners and/or operators were asked to identify their future intentions to expand the licensed bed count of their ARF or RCFE.

FQ8. "Does your facility have any plans to increase or decrease its licensed bed count?"

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Table 10.7: Resident Capacity / Bedcount Intentions, by License Class	ARF	RCFE	ALL
Increase bed count	22.1%	16.6%	18.7%
Neither / remain the same	75.7%	82.9%	80.2%
Decrease bed count	2.2%	0.5%	1.1%

More than 80% of facility respondents indicated that their Market ARF or RCFE intended to keep licensed bed counts at current levels. Nearly 1 in 5 (18.7%) of facility owners and/or operators indicated that they intended to increase the licensed bed count of their facility, effectively forecasting expansion for the capacity of the Market to serve the identified, vulnerable populations, if successful.

Given the need for regulatory review by CCLD and other, local government entities for the expansion of licensed beds at an ARF or RCFE, as well as other factors such as securing of financing or funding to improve physical assets supporting expansion of facilities, it is difficult to surmise or predict the timing and success that facilities will achieve from these expressed intentions. However, given the need to ensure additional capacity to meet unmet demand to serve identified, vulnerable populations, CCLD, prospective funders for facility expansion and capacity, as well as municipal regulators, should take notice of these intentions by licensed facilities to expand, and find ways to streamline and support such expansions, wherever possible and practicable, to increase service levels and maximize realization of public benefit.

A very small proportion of Market respondents (only 1.1%) indicated intentions to decrease the licensed bed count of their ARF or RCFE, with a further 3.7% of facility respondents indicating that they were not sure of their future intentions regarding changes in bed count.

Greater proportions of ARF owners and/or operators expressed intentions to either increase or decrease bed count in comparison to RCFE respondents, indicative of enhanced responsiveness to potentially more challenging market conditions for licensees at ARF facilities. Given changes in demand that can affect the size of a facility, such as preferences in agency service models and a potentially greater need to keep up with costs from inflation, these potential effects are hypothesized to be more visible in ARF intentions to scale bed count downwards.

Table 10.8: Resident Capacity / Bedcount Intentions, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Increase bed count	18.1%	22.7%	16.2%
Neither / remain the same	80.4%	76.0%	83.8%
Decrease bed count	1.5%	1.3%	0.0%

Greater proportions of respondents at facilities serving 7 to 60 licensed beds indicated intentions to increase their bed count than those at smaller or larger facilities, suggesting that a greater proportion of this population of owners and/or operators seek to optimize facility size, possibly in response to adverse market conditions such as inflation.

No respondent from a facility licensed to serve 61 or more beds indicated that they had intentions to decrease their licensed bed count.

Table 10.9: Resident Capacity / Bedcount Intentions, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Increase bed count	23.1%	15.6%	13.3%	34.3%	14.3%	26.7%	9.5%	19.4%
Neither / remain the same	76.9%	83.1%	85.5%	62.9%	78.6%	73.3%	90.5%	80.6%
Decrease bed count	0.0%	1.3%	1.2%	2.9%	7.1%	0.0%	0.0%	0.0%

While a significantly greater proportion of respondents from facilities located in SPA 4 (Metro Los Angeles and West Cities) indicated intentions to increase the licensed bed count of facilities, a significantly greater proportion of facilities located in SPA 5 (West Los Angeles and West Cities) indicated their intention to decrease their licensed bed count, a potentially unfortunate finding due to the relatively low, total number of licensed beds currently located in this Service Planning Area willing to serve identified vulnerable populations.

Intentions for Future Staff Headcount

Facility owners and/or operators were also asked to identify their future intentions to expand the headcount of permanent staff retain to serve the needs of residents. This question was evaluated as particularly important in the context of the COVID-19 pandemic, where many owners and operators of facilities expressed anecdotes and concerns regarding unmet needs for facility staffing to the research team during the pre-research phase.

FQ10. "Does your facility have any plans to increase or decrease the size of its staff?

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Table 10.10: Staff Headcount Intentions, by License Class	ARF	RCFE	ALL
Increase staff headcount	42.6%	37.5%	39.5%
Neither / remain the same	55.9%	61.1%	59.1%
Decrease staff headcount	1.5%	1.4%	1.4%

A positive indicator, more than 98% of respondents from Market ARFs and RCFEs serving the identified, vulnerable population seek to maintain or increase the number of permanent, full-time equivalent (FTE) staff employed. 39.4% of respondents intended to increase FTE staffing levels at facilities, with many identifying a need to recover from reductions in staff levels brought about by the COVID-19 pandemic. Faced with difficult choices to maintain resident service quality and safety during the pandemic, many facility owners and/or operators communicated needing to reallocate staff roles and duties, especially those relating to the delivery of activities and excursions for resident populations.

From qualitative discussions, some facility respondents indicated significant difficulties in retaining staff during the pandemic due to common perceptions and fears of enhanced personal risk of infection and/or personal injury from staff members serving in congregate facilities. The range of enhanced protocols for safety and biosecurity deployed at Market ARFs and RCFEs were reported to increase hours, shift length, stress levels, and levels of fatigue experienced by staff, with some facilities reporting greater levels of staffing churn as a result. Outside of these extraordinary circumstances, many respondents also expressed ongoing concern with the ability of their business to attract and retain quality staff to serve in roles.

Most intentions to increase staff headcount over current levels have been evaluated to be restorative, rather than aimed at increasing staffing levels over pre-pandemic norms for the purposes of quality-of-service enhancement. Relatively high proportions of facilities across both license classes seek to increase their staff headcount, with a slightly greater proportion of ARFs seeking to add permanent staff over their RCFE counterparts. Proportions of facilities seeking to decrease staff headcount were consistently low by proportion across both license classes.

Table10.11: Staff Headcount Intentions, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Increase staff headcount	35.0%	48.6%	42.7%
Neither / remain the same	63.5%	50.0%	56.0%
Decrease staff headcount	1.5%	1.4%	1.3%

A significantly greater proportion of 7 to 60 licensed bed facilities indicated that they seek to increase their staff headcount, in comparison to facilities licensed to serve 6 or fewer beds, which expressed intentions to maintain their facilities at current staffing levels in greater proportions than larger licensed facilities.

Table 10.12: Staff Headcount Intentions, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Increase staff headcount	53.8%	35.5%	38.6%	45.7%	21.4%	50.0%	38.1%	35.8%
Neither / remain the same	46.2%	61.8%	60.2%	54.3%	71.4%	46.7%	61.9%	64.2%
Decrease staff headcount	0.0%	2.6%	1.2%	0.0%	7.1%	3.3%	0.0%	0.0%

Significantly greater proportions of facilities located in SPA 1 (Antelope Valley), SPA 4 (Metro Los Angeles and Center Cities), and SPA 6 (South Los Angeles and South Cities) indicated that they are seeking to increase their permanent staff headcount, in relation to facilities located in other SPAs.

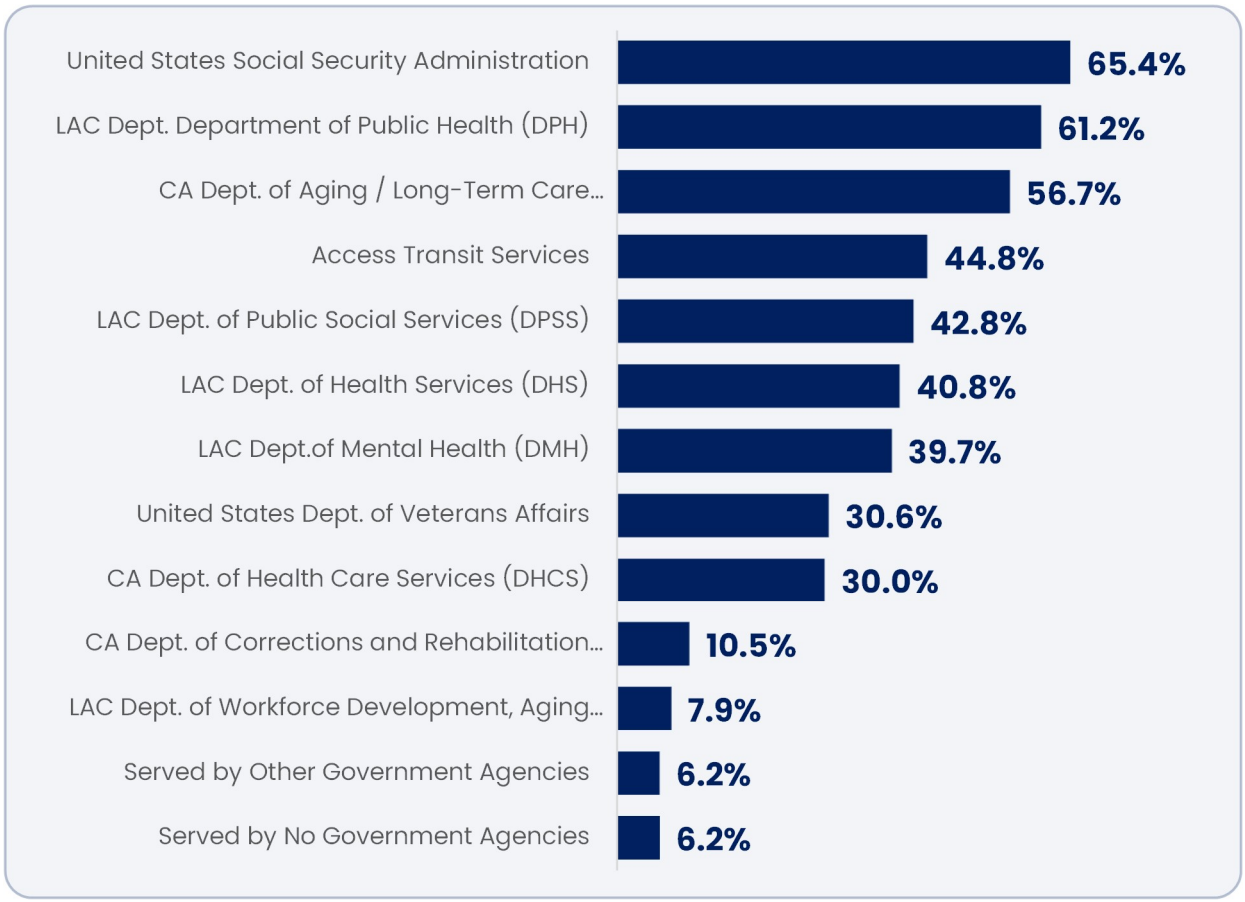
Another key warning indicator for SPA 5 (West Los Angeles and West Cities) that signals potential future reduction in service capability to identified, vulnerable populations, a significantly greater proportion of facility respondents in SPA 5 indicated intentions to reduce staff headcount than in other SPAs.

Service Interface with Government Agencies

Owners and/or operators of Market ARFs and RCFEs were prompted with a list of Los Angeles County agencies, Joint Powers Authorities, California State agencies, and Federal agencies, to identify any that they recalled residents (or their facility) receiving service from within the three years prior to interview.

FQ67. "Has your facility or residents received any services from any of the following public agencies within the past 3 years?" (PROMPTED)

FACILITY OWNERS & OPERATORS (N=353)



Market respondents identified the U.S. Social Security Administration (65.4%) as the most frequent government agency at any level that they believed delivered residents services, an expected value given the high proportion of residents from the identified, vulnerable population receiving SSI and SSDI payments to fund their room, board, and care (further evaluated in a later section). 56.7% of facilities reported resident service interface with the California Department of Aging's Long-Term Care Ombudsman.

Amongst Los Angeles County agencies, the Department of Public Health (DPH) was the most frequent agency reported to deliver services to facility residents at 61.2%, a figure which is hypothesized to have skewed somewhat higher than normative levels due to the ongoing COVID-19 pandemic during the period in which research interviews were conducted. The next, most reported County agencies with service interface at ARFs and RCFEs were the Department of Public Social Services (DPSS) at 42.8%, the Department of Health Services (DHS) at 40.8%, and the Department of Mental Health (DMH) at 39.7%.

Service interface with Access Transit Services, a joint-powers authority (JPA) delivering customized transport delivery solutions to a wide range of vulnerable populations, was reported by as delivering services to 44.8% of Market facility respondents.

Table 10.13: Services Received from Agencies, by License Class	ARF	RCFE	ALL
U.S. Social Security Administration	83.8%	53.9%	65.4%
LAC Dept. of Public Health (DPH)	72.1%	54.4%	61.2%
CA Dept. of Aging / Long Term Care Ombudsman	34.6%	70.5%	56.7%
Access Transit Services	55.1%	38.2%	44.8%
LAC Dept. of Public Social Services (DPSS)	61.0%	31.3%	42.8%
LAC Dept. of Health Services (DHS)	52.9%	33.2%	40.8%
LAC Dept. of Mental Health (DMH)	71.3%	19.8%	39.7%
U.S. Dept. of Veterans Affairs (VA)	26.5%	33.2%	30.6%
CA Dept. of Health Care Services (DHCS)	44.9%	20.7%	30.0%
CA Dept. of Corrections and Rehab. (CDCR)	22.8%	2.8%	10.5%
LAC Dept. of Work. Dev, Aging, Comm. Services. (WDACS)	10.3%	6.5%	7.9%
Served by other government agencies	8.1%	5.1%	6.2%
Served by no government agencies	2.9%	8.3%	6.2%

ARFs generally reported significantly greater proportions of service interface with Los Angeles County Agencies than RCFEs, in particular, the Department of Mental Health (DMH), the Department of Health Services (DHS), and the Department of Public Social Services (DPSS). ARF owners also reported significantly more service interface with the U.S. Social Security Administration.

RCFE owners and operators reported significantly greater service interface with the California Department of Aging / Long-Term Care Ombudsman and the U.S. Department of Veterans Affairs than ARFs. A significantly greater proportion of RCFE respondents perceived that they had no service interface with government agencies than ARF respondents.

Table 10.14: Services Received from Agencies, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
U.S. Social Security Administration	52.5%	82.4%	84.0%
LAC Dept. of Public Health (DPH)	48.0%	77.0%	81.3%
CA Dept. of Aging / Long Term Care Ombudsman	55.4%	45.9%	70.7%
Access Transit Services	30.4%	58.1%	70.7%
LAC Dept. of Public Social Services (DPSS)	30.4%	52.7%	66.7%
LAC Dept. of Health Services (DHS)	29.4%	44.6%	68.0%
LAC Dept. of Mental Health (DMH)	21.1%	59.5%	70.7%
U.S. Dept. of Veterans Affairs (VA)	19.1%	33.8%	58.7%
CA Dept. of Health Care Services (DHCS)	19.1%	41.9%	48.0%
CA Dept. of Corrections and Rehab. (CDCR)	6.9%	18.9%	12.0%
LAC Dept. of Work. Dev, Aging, Comm. Services. (WDACS)	4.9%	9.5%	14.7%
Served by other government agencies	6.9%	4.1%	6.7%
Served by no government agencies	9.8%	2.7%	0.0%

Similar to levels observed with participation in government benefit programs, ARFs and RCFEs that serve the largest resident populations, 61 beds or more, report significantly more service interface with nearly all government agencies prompted. It is notable that facilities with populations of 6 beds or fewer were the most likely to indicate that they were not receiving service from any government agencies (14.7%). These findings identify that improvement in the distribution of government services and interface with smaller Market facilities is an urgent need.

Table 10.15: Services Received from Agencies, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
U.S. Social Security Administration	65.4%	57.1%	54.2%	88.6%	71.4%	83.3%	61.9%	68.7%
LAC Dept. of Public Health (DPH)	73.1%	48.1%	57.8%	68.6%	57.1%	70.0%	42.9%	74.6%
CA Dept. of Aging / Long Term Care Ombudsman	76.9%	49.4%	69.9%	37.1%	42.9%	30.0%	57.1%	65.7%
Access Transit Services	30.8%	40.3%	44.6%	62.9%	21.4%	60.0%	38.1%	46.3%
LAC Dept. of Public Social Services (DPSS)	42.3%	31.2%	37.3%	65.7%	42.9%	56.7%	42.9%	44.8%
LAC Dept. of Health Services (DHS)	34.6%	33.8%	41.0%	54.3%	42.9%	56.7%	38.1%	37.3%
LAC Dept. of Mental Health (DMH)	19.2%	28.6%	32.5%	77.1%	42.9%	56.7%	28.6%	44.8%
U.S. Dept. of Veterans Affairs (VA)	23.1%	29.9%	28.9%	54.3%	21.4%	26.7%	9.5%	34.3%
CA Dept. of Health Care Services (DHCS)	19.2%	27.3%	32.5%	45.7%	28.6%	36.7%	33.3%	22.4%
CA Dept. of Corrections and Rehab. (CDCR)	0.0%	2.6%	4.8%	37.1%	35.7%	20.0%	9.5%	7.5%
LAC Dept. of Work. Dev, Aging, Comm. Services. (WDACS)	7.7%	6.5%	7.2%	11.4%	14.3%	6.7%	4.8%	9.0%
Served by other government agencies	3.8%	7.8%	3.6%	5.7%	0.0%	10.0%	14.3%	6.0%
Served by no government agencies	7.7%	9.1%	9.6%	0.0%	14.3%	3.3%	4.8%	1.5%

There appear to be substantive differences in the concentration and distribution of services from government agencies across the Los Angeles County Service Planning Areas (SPAs), in particular, with Los Angeles County Agencies. Many County agencies appear to have a skewed service distribution pattern, as reported by Market facilities, that can produce significantly greater proportions of interface across SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities), in comparison to other Service Planning Areas. As previously noted, this finding largely follows the high concentration of population density in these areas, but may also relate to primary service locations and field team deployment patterns managed by the various Los Angeles County agencies.

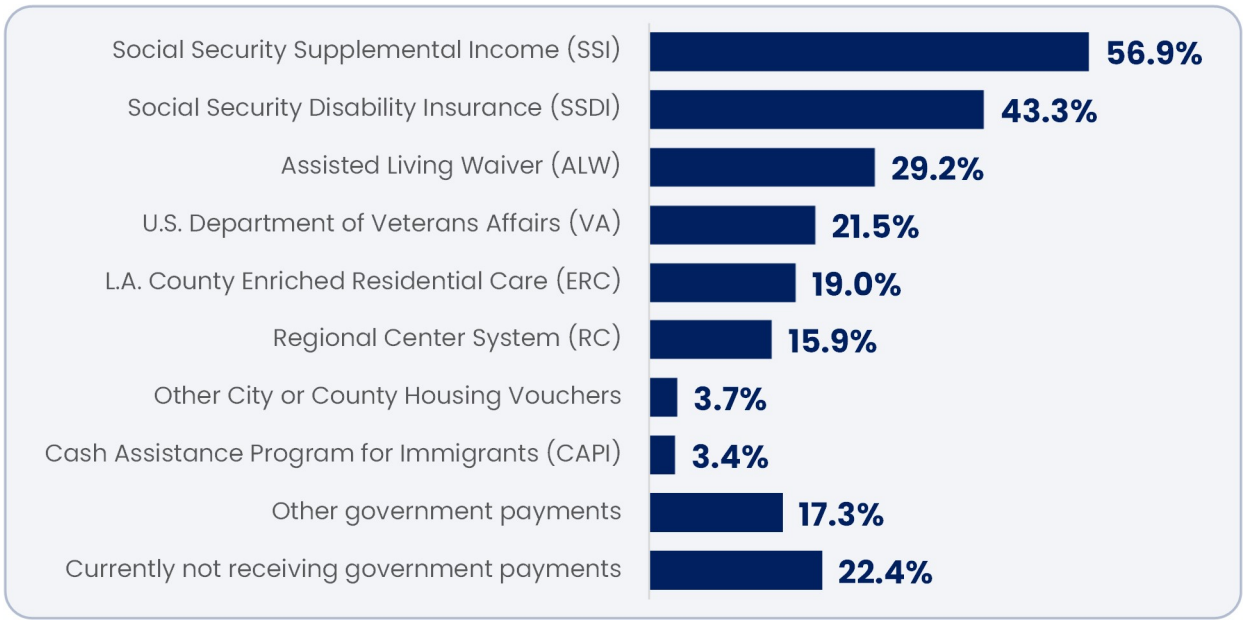
Although the research sample for this study was not specifically designed to critically assess or evaluate the performance of any government agency or entity in regard to service distribution, the data above suggests that government agencies should examine and perform further research into this potential issue to assure greater consistency and optimality in service design and distribution to Market ARFs and RCFEs serving all areas of Los Angeles County. Without this continuous and evaluative process in place, agency stakeholders should expect ongoing gaps in the consistency and optimality of service delivery and outcomes for individuals from the identified, vulnerable population.

Public Benefits Received for Resident Room, Board, and Care

Market ARF and RCFE owners and operators draw on an extended range of public benefits to support residents from vulnerable populations with little to no other means to pay for their care. Respondents were prompted to identify any streams and/or sources of public funding that they were aware of which are utilized to directly cover the costs from resident room, board, and care at their Market facilities.

FQ63. "What sources of direct government payments does your facility receive to pay for resident room, board, and services?" (PROMPTED)

FACILITY OWNERS & OPERATORS (N=353)



Largely consistent with observed proportions of government agency service interface, 56.9% of market facilities reported receiving Social Security Supplemental Income (SSI) payments and 43.9% reported receiving Social Security Disability Insurance (SSDI) payments from the U.S. Social Security Administration to pay for resident room, board, and care. Also, at the level of federally-administered benefits, 21.5% of facilities indicated residents supported by the Department of Veterans Affairs (VA) to cover direct resident costs.

Nearly a third (29.2%) of respondents reported benefits for residents from the Assisted Living Waiver (ALW) program, administered by the State of California Department of Health Care Services (DHCS), along with 15.9% of facilities reporting receiving payments for resident care from the state-funded Regional Center system (Note: these facilities indicated providing service to additional populations, not with exclusivity to residents living with developmental disabilities). Approximately 1 in 5 (19.0%) of ARFs and RCFEs reported that their residents received payments from the Los Angeles County Enhanced Residential Care (ERC) program, serving a range of individuals across identified, vulnerable populations via the Department of Health Services (DHS) and Department of Mental Health (DMH).

17.3% of facilities made unprompted mentions about receiving benefit payments from other governmentally-directed sources to fund the room, board, and care of residents, although not all of these mechanisms were verifiable by the research team, such as:

- Adult Protective Services
- Office of the Public Guardian
- U.S. Dept. of Housing and Urban Development (HUD)
- PACE program
- Orange County, CA Interim Funds
- Indirect payments via agency service agreements with nonprofits

Overall, 22.3% of facility respondents, principally from RCFEs, indicated not currently receiving any form of government benefits or payments to pay for resident room, board, or care, despite expressed willingness to serve the identified, vulnerable population through pre-qualification to participate in the study.

Table 10.16: Benefit Payments for Resident Care, by License Class	ARF	RCFE	ALL
Social Security Supplemental Income payments (SSI)	82.4%	41.0%	56.9%
Social Security Disability Insurance payments (SSDI)	66.9%	28.6%	43.3%
Assisted Living Waiver payments (ALW)	31.6%	27.6%	29.2%
U.S. Department of Veterans Affairs payments (VA)	19.9%	22.6%	21.5%
L.A. County Enriched Residential Care payments (ERC)	35.3%	8.8%	19.0%
Regional Center payments (RC)	32.4%	5.5%	15.9%
Other City or County Housing Voucher payments	7.4%	1.4%	3.7%
Cash Assistance Program for Immigrants payments (CAPI)	8.1%	0.5%	3.4%
Other government payments	25.7%	12.0%	17.3%
Currently not receiving government payments	0.0%	36.4%	22.4%

A significantly greater proportion of Market ARF owners and operators reported receiving Social Security Supplemental Income (SSI) payments, Social Security Disability Insurance (SSDI) payments, and Los Angeles County Enriched Residential Care (ERC) program payments to fund the housing and care of their resident populations in relation to RCFE owners and operators.

Consistent with anecdotal evidence learned from senior stakeholders representing market users across government and nonprofits, ARFs were more likely to be receiving nearly all sources of government benefits on behalf of their resident populations in relation to their Market RCFE counterparts, with the exception of greater levels of RCFE participation in the Assisted Living Waiver (ALW) program administered by the State of California and payments received from residents by the United States Department of Veterans Affairs (VA).

No Market ARF identified that they did not receive funding from government agencies, while a significant proportion of RCFEs reported not receiving payments from any governmental source for their current residents, despite indicating current willingness and ability to serve individuals from the identified, vulnerable population.

Table 10.17: Benefit Payments for Resident Care, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Social Security Supplemental Income payments (SSI)	37.7%	81.3%	85.1%
Social Security Disability Insurance payments (SSDI)	22.5%	68.0%	75.7%
Assisted Living Waiver payments (ALW)	16.2%	29.3%	64.9%
U.S. Department of Veterans Affairs payments (VA)	11.3%	24.0%	47.3%
L.A. County Enriched Residential Care payments (ERC)	8.3%	28.0%	39.2%
Regional Center payments (RC)	19.1%	13.3%	9.5%
Other City or County Housing Voucher payments	2.0%	9.3%	2.7%
Cash Assistance Program for Immigrants payments (CAPI)	0.5%	2.7%	12.2%
Other government payments	10.8%	26.7%	25.7%
Currently not receiving government payments	32.8%	9.3%	6.8%

Smaller Market facilities, with licensed resident populations of 6 beds or fewer, were significantly less participatory in receiving benefits from nearly all government benefits sources, a proportion weighed down heavily by the presence of the RCFEs in this sample segment. Many owners and operators of smaller facilities (and even larger facilities) indicated that the procedural and bureaucratic burden of processing many forms and working across the complexities of many governmental systems for reimbursement serves as a key deterrent for greater participation by small facilities, due to labor cost (time) commitment.

Large Market facilities with 61 licensed beds or more evidenced significantly greater levels of participation across nearly all channels of public benefit participation in comparison to smaller facilities, including government assistance programs that were less prevalent across the Market, such as the Cash Assistance Program for Immigrants (CAPI). This correlates well with the finding across small facilities in the Market: that facilities of greater size and staffing have better participation in government benefit programs, as they have better capability to offset the labor cost and time required from staff to enable participation in government benefit and reimbursement programs.

Table 10.18: Benefit Payments for Resident Care, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Social Security Supplemental Income payments (SSI)	46.2%	48.1%	53.0%	85.7%	50.0%	80.0%	47.6%	55.2%
Social Security Disability Insurance payments (SSDI)	34.6%	29.9%	38.6%	62.9%	28.6%	56.7%	23.8%	61.2%
Assisted Living Waiver payments (ALW)	23.1%	31.2%	26.5%	45.7%	42.9%	30.0%	14.3%	25.4%
U.S. Department of Veterans Affairs payments (VA)	3.8%	24.7%	16.9%	34.3%	21.4%	26.7%	4.8%	26.9%
L.A. County Enriched Residential Care payments (ERC)	3.8%	14.3%	20.5%	28.6%	35.7%	33.3%	14.3%	14.9%
Regional Center payments (RC)	3.8%	5.2%	16.9%	31.4%	21.4%	23.3%	23.8%	16.4%
Other City or County Housing Voucher payments	0.0%	2.6%	6.0%	2.9%	7.1%	3.3%	4.8%	3.0%
Cash Assistance Program for Immigrants payments (CAPI)	0.0%	1.3%	2.4%	11.4%	0.0%	10.0%	4.8%	1.5%
Other government payments	11.5%	24.7%	10.8%	20.0%	21.4%	20.0%	19.0%	14.9%
Currently not receiving government payments	23.1%	32.5%	31.3%	2.9%	21.4%	0.0%	28.6%	17.9%

Significantly greater proportions of public benefits acceptance were reported from Market ARFs and RCFEs located in SPA 4 (Metro Los Angeles and Center Cities), SPA 6 (South Los Angeles and South Cities), and SPA 5 (West Los Angeles and West Cities) in comparison to facilities located across other SPAs.

Evaluating the geographic distribution of participation in government benefit programs produces a finding that utilization of Social Security (SSI/SSDI) payments, Assisted Living Waiver (ALW) payments, and Enriched Residential Care (ERC) program payments is dominant amongst Market ARFs and RCFEs located in the most central service areas of Los Angeles County. This suggests that greater service priority and capability should be exercised by government agencies to increase uptake and participation for these funding mechanisms from facilities located outside of the most metropolitan or central SPAs to enhance optimality and service outcomes.

Significantly greater proportions of owner and/or operator respondents located in SPAs 2 (San Fernando Valley), SPA 3 (San Gabriel Valley), and SPA 7 (East Los Angeles and South East Cities) reported not currently receiving government payments for their residents, in comparison to other SPAs. These respondents largely correlate with populations of RCFEs licensed to serve 6 beds or fewer that are willing to accept residents receiving public benefits from the identified vulnerable population groups.

Satisfaction with Social Security (SSI) Funding Levels

Facility respondents receiving payments from the U.S. Social Security Administration, supplemented by funds from the State of California, for Social Security Supplemental (SSI) payments to pay for the costs associated with Market resident room, board, and care, were asked to assess their level of satisfaction regarding the totality of such payments, utilizing an absolute Likert scale measure of 0 to 10, with 0 indicating completely dissatisfied, and 10 indicating completely satisfied.

FQ64. "On a scale of 0-10, how satisfied are you with the amount of basic Social Security funding (or SSI) that your facility receives to pay resident room, board, and services?"

FACILITY OWNERS & OPERATORS (n=198)

Owners and/or operators at Market facilities displayed high, mean levels of dissatisfaction with the level of SSI funding made available to their facilities to pay for resident housing and care needs. This measure returned the lowest levels of mean satisfaction out of any measure asked during the facility owner/operator research process. Without further explanation, the 4.07 mean satisfaction score (out of a possible 10.00) suggests that resolution of the SSI funding level issue is core to addressing the operational needs of facilities serving individuals reliant on public benefit.

Table 10.19: Satisfaction with SSI Funding Levels, by License Class	ARF	RCFE	ALL
	3.99	4.18	4.07

Consistently low mean levels of satisfaction for SSI funding levels were reported from both ARFs and RCFEs respondents serving the Market.

Table 10.20: Satisfaction with SSI Funding Levels, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	3.90	4.30	4.07

Consistently low mean levels of satisfaction for SSI funding levels were also reported across Market facilities, regardless of licensed bed count.

Table 10.21: Satisfaction with SSI Funding Levels, by License Class and Facility Size	ARF	RCFE
≤ 6 BEDS	4.06	3.76
7–60 BEDS	3.95	5.27
≥ 61 BEDS	3.97	4.17

RCFEs serving licensed bed counts of between 7 and 60 beds reported significantly greater levels of mean satisfaction with SSI funding levels than other Market facilities, but not characterizable as "high" levels of satisfaction.

Table 10.22: Satisfaction with SSI Funding Levels, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	4.17	3.66	3.64	4.77	1.71	3.90	4.67	4.73

Significantly lower levels of mean satisfaction with SSI funding levels were reported across facilities serving SPA 5 (West Los Angeles and West Cities), in comparison to facilities across all other SPAs.

Estimates of Residents Fully-Reliant on Public Benefits

Market facility respondents were asked to estimate the proportion of their current resident populations that were 100% funded by public benefits (provided by governmental entities) to pay for the total costs of resident room, board, and care.

RQ13. "Approximately what percentage of your residents are completely reliant on public benefits to pay for their stay here?"

FACILITY OWNERS & OPERATORS (N=353)

Table 10.23: 100% Publicly Funded Residents, by License Class	ARF	RCFE	ALL
	95.2%	29.9%	55.0%

According to estimates provided by owners and/or operators of Market ARFs and RCFEs, approximately 55.0% of their total resident populations are 100% funded (exclusively) by public benefits. These benefits are identified as coming directly or indirectly from any public entity at the local, county, state, and/or federal agency level. More than 95.2% of residents at ARFs are 100% funded by public / governmental benefits, a significantly greater proportion than residents of RCFEs, at 29.9% overall, reflective of greater diversity of funding mechanisms for the populations served by RCFEs.

Table 10.24: 100% Publicly Funded Residents, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	39.3%	81.3%	71.8%

Larger facilities of 7 to 60 licensed beds and 61 or more licensed beds have significantly greater proportions of populations 100% served by public benefits, in relation to facilities serving 6 beds or less.

Table 10.25: 100% Publicly Funded Residents, by License Class and Size	ARF	RCFE
≤ 6 BEDS	91.0%	20.3%
7–60 BEDS	98.2%	49.4%
≥ 61 BEDS	98.0%	51.9%

ARFs of all sizes have significantly greater proportions of residents that are completely reliant on public benefits, compared to RCFEs. However, RCFEs serving 7 to 60 licensed beds and 61 or more licensed bed populations have significantly greater proportions of residents 100% funded and reliant on public benefits from governmental entities, in comparison to those serving populations of 6 beds or less. ARFs licensed for 6 beds or fewer have a reduced proportion of residents who are 100% funded by public benefits in comparison to facilities licensed to serve larger populations.

Table 10.26: 100% Publicly Funded Residents, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	38.7%	42.1%	43.6%	88.5%	58.6%	84.2%	60.2%	57.6%

ARFs and RCFEs serving SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities) have significantly greater proportions of residents reliant on public benefits, in comparison to facilities located in other Los Angeles County Service Planning Areas. A significantly lower proportion of residents housed at facilities in SPA 1 (Antelope Valley), SPA 2 (San Fernando Valley), and SPA 3 (San Gabriel Valley) are 100% funded or reliant on public benefits in comparison to other SPAs.

Market User Views on Public Funding Levels

Market Users of ARFs and RCFEs across Los Angeles County shared a near-universal concern regarding a lack of parity in funding available to Market ARFs and RCFEs in comparison with other systems of care where identified, vulnerable individuals also receive services, including hospitals, skilled nursing facilities, interim shelters, recuperative care settings, and permanent supportive housing. While each of these segments across systems of care represent distinctive care levels and funding channels, there are limitations imposed by public policy and funding regulations that deny effective use of resources that could stabilize vulnerable populations and better address their needs. Market Users across multiple systems of care support increased rates from government funding sources to address the disparities in support levels provided to Market ARFs and RCFEs, especially in contrast with sources of funding that differing, vulnerable populations reliant on public benefits utilize at significantly higher rates for room, board, care, and service reimbursement.

Many Market Users with direct roles within both permanent supportive housing and the homelessness Coordinated Entry System (CES) shared concerns regarding the disproportionate use of State and local resources to build more units, especially considering the high levels of potentially inappropriate placements observed within such housing from across these systems of care. These observations indicate a need for a more diversified approach to the distribution of funding to reduce street homelessness, such as equalizing contributions and rates for Market ARFs and RCFEs.

ICMS providers reported frequent encounters with gravely-disabled individuals on the street, unable to be transported to shelters, with ready to use "vouchers" distributed due to the health conditions of the individuals they encounter. If Market ARFs and RCFEs were enabled to make use of such housing vouchers, stakeholders believed that their clients could move through almost immediately to Market facilities and remain in their care. In public and private hospital settings, expensive emergency room encounters and inpatient admissions lead patients to be discharged back to the streets to have their medical conditions re-emerge, or become more gravely disabled as time goes on because of the inadequate funding of navigation from most hospitals into Market facilities. The view from County hospitals providing psychiatric services is that the costs of care for taxpayers when someone cannot step down from their facilities into another, less acute mental health setting are exorbitant, and would be better spent to stabilize individuals within better-funded Market ARFs and RCFEs.

Market Users serving across the homelessness Continuum of Care (CoC) reported shelter rates at comparable levels to some Market ARF SSI rates, while at the higher end of the services continuum, for recuperative "interim" housing, considerably higher levels of expenditure per client occurs. Market Users generally supported the idea that ARFs and RCFEs could play a greater role in solutions to homelessness. However more investment is believed to be required to see visible improvements in facilities and the quality of care provided. A majority of owners and operators of Market ARFs and RCFEs that accept SSI have identified desperate need for a greater parity of funding to support room, board, and more care for vulnerable populations served. Owners and operators have also identified that the base SSI rate is insufficient for facilities to provide adequate care for residents, to deliver living wages and benefits for staff, and to ensure consistent quality of supervision and care interface for residents.

Several systems of care have augmented SSI rates through provision of supplementary "patches" to attempt to address the gap in SSI payments for Market facilities, due to desperate community need to utilize these underfunded facilities. These "patches" are deployed across the County through Enriched Residential Care payments, Full-Service Partnership payments, and private hospital patches (often short-term). The Los Angeles County DHS Enriched Residential Care (ERC) program has a tiered-payment scale based on the level of acuity of their clients, providing reimbursement rates more similar to those found within the Regional Center system and the Assisted Living Waiver Program (ALW) program. While many of these patches may have kept some Market facilities from going out of business, the adjusted rates are reportedly still insufficient to consistently deliver the funding of quality care, nor are a majority of Market facilities aware of how to avail themselves of these additional resources.

Most Market Users agree that ARFs and RCFEs need reimbursement rates more similar to those found with the Regional Center System, funded by the California Department of Developmental Services. Successful legislation provided a pathway for the State of California to offer services not otherwise available through Medi-Cal to serve people living with developmental disabilities in their own homes and communities[18]. This tiered

[18] https://www.dds.ca.gov/wp-content/uploads/2023/02/Lanterman_2023_Pub.pdf

system of payment allows for other, non-Market ARFs and RCFEs to cover the cost of room, board and care, while paying for qualified staff and support services to facilitate stability and quality provision of care to their consumers. The Department of Developmental Services established the Community Placement Plan (CPP) and Community Resource Development Plan (CRDP) for Regional Centers to enhance the capacity of their community service delivery system, and to reduce the reliance on other restrictive living environments. These programs provide funding to the Regional Centers for the development of a variety of enhanced resources, including, but not limited, to residential development, transportation, day services, and mental health and crisis services[19]. These funds include the resources to develop safe, affordable, and sustainable homes as a residential option. CPP and CRDP funds create permanent housing through the "Buy It Once" model where a housing developer organization (HDO) owns the property for the restricted use by Regional Center consumers. However, no equivalent California-state mechanism exists for Market facilities delivering services to other vulnerable populations.

Some Market RCFEs have been approved as Assisted Living Waiver (ALW) facilities which receive additional resources for Long Term Care individuals (Medi-Cal / Medicare) for the elderly, who have several medical conditions, and may also be living with acute mental illness. Facilities who sought to apply for the program reported that it is a long and arduous process. One Market User representing senior housing residents said that due to the long wait times associated with ALW, they often refer clients to the Program of All-Inclusive Care for the Elderly (PACE) program, providing a patch and medical case management services and transportation when someone can no longer live independently. Several Market RCFE owners and operators reported having residents who were engaged in the PACE program.

Whenever the question of funding levels or the notion of parity was raised during study interviews and conversations with Market Users, Market facility owners and/operators, or community stakeholders, virtually all conceded that Market ARFs and RCFEs have been persistently under-resourced with regard to all varieties of public funding for many years, and that decisive action is required to address the inequities to fully support the costs of equitable service, housing, and quality of care to vulnerable individuals across all categories of lived experiences. Some Market Users offered additional opinions that such policy decisions were linked to value judgements regarding the challenging life circumstances and presumed histories of individuals from the identified, vulnerable population.

[19] As described in the California Welfare and Institutions Code sections 4418.25 and 4679(a): https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=4.1.&title=&part=1.&chapter=&article=

Satisfaction with Local Government (Cities) and Services

Market ARF and RCFE owners and/or operators were asked to express their level of satisfaction with local government (municipalities, not agencies of the County of Los Angeles, as explored in other measurement) and the services provided to their facility by local government jurisdictions utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating no satisfaction at all, and 10 indicating complete satisfaction.

FQ68. "On a scale of 0-10, how satisfied are you with the overall performance of your local government's (city's) services, such as police, fire, zoning, planning, and other functions, in serving your facility and its residents?"

FACILITY OWNERS & OPERATORS (N=353)

Table 10.27: Overall Satisfaction with Local Government, by License Class	ARF	RCFE	ALL
	7.12	8.46	7.94

Facility owners and/or operators display moderately high levels of mean, overall satisfaction (7.94 out of 10.00) with services delivered from their cities and local governments. Enactment of specific improvements, especially those relating to the quality of delivery from police, 911, and emergency service categories (presented in the next section) will further elevate respondent perceptions of city and local government experience. With generally positive levels of mean satisfaction expressed overall, owners and/or operators of Market RCFEs report generally greater mean levels of satisfaction with their corresponding local governments and services, in comparison to ARF respondents, who reported significantly lower levels of mean satisfaction with local governments and services.

Table 10.28: Overall Satisfaction with Local Government, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	8.35	7.85	6.90

Market facilities with licensed bed counts of 61 or more reported significantly lower mean levels of satisfaction with local government and services in comparison to facilities licensed to serve smaller resident populations. Facilities serving 6 or fewer licensed beds reported elevated levels of mean satisfaction with local government and services in relation to larger facilities.

Table 10.29: Overall Satisfaction with Local Government, by License Class and Facility Size	ARF	RCFE
≤ 6 BEDS	7.80	8.55
7–60 BEDS	7.29	8.92
≥ 61 BEDS	5.69	7.85

Market ARFs licensed to serve 61 or more beds reported significantly lower levels of satisfaction with local government than any other size or license class of facility. In consideration of the distribution of the means of satisfaction scoring for this segment, many owners and/or operators of these larger facilities reported substantively more negative experience in their interactions and services received from local governments.

Table 10.30: Overall Satisfaction with Local Government, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	9.12	8.08	8.13	7.26	7.54	6.60	8.35	8.01

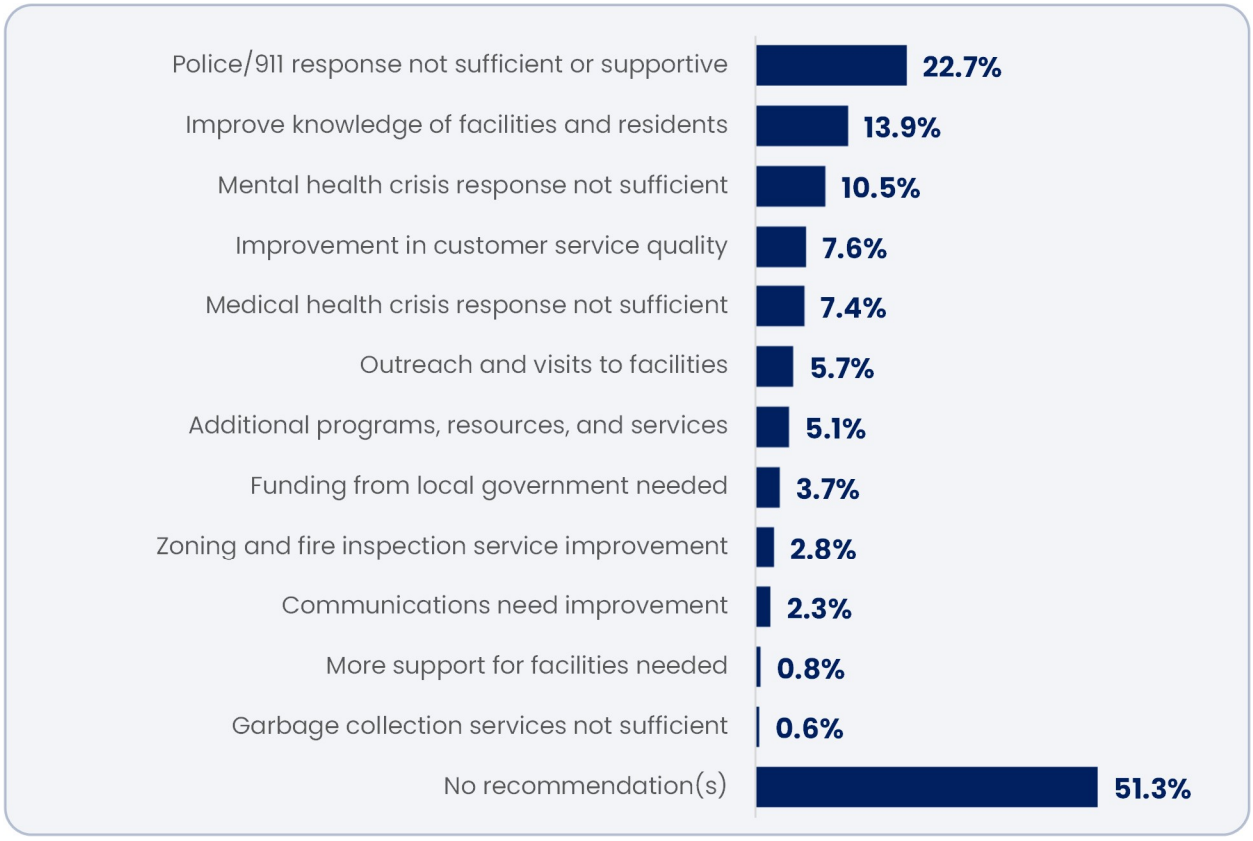
Owners and/or operators representing SPA 1 (Antelope Valley) reported significantly greater mean levels of satisfaction with local government and their service provision, while Market owners and/or operators serving facilities located in SPA 6 (South Los Angeles and South Cities) reported significantly lower mean levels of satisfaction with their local government service experiences.

Recommendations to Local Government (Cities) for Service Improvement

Market facility respondents were asked to provide recommendations for their local government to improve the quality of services that their facility and residents receive from these jurisdictions.

FQ69. "What are some steps that your local government (cities) could take to improve their services and relationship with facilities like yours?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



Although slightly more than half (51.3%) of respondents had no recommendation(s) for their local government entities to improve service delivery for Market ARFs and RCFEs, correlating with expressed levels of satisfaction for services delivered, 22.7% reported that their police / 911 services were not sufficient, responsive, or supportive enough, indicating the potential for improvement in service quality and delivery to better meet the needs of facilities. This finding is confirmed from executive interviews undertaken with senior stakeholders serving with both the Los Angeles Police Department (LAPD) and Pasadena Police Department (PPD), who identified that improvement in the cooperation, interface, and sharing of knowledge between police, emergency services, and facilities has the capability to be further optimized and improved with more outreach and engagement, by both Market facility stakeholders and the respective Departments.

13.9% of owners and/or operators indicated that their local governments required better knowledge of facilities and their resident populations to improve service quality and delivery, with a further 10.5% indicating that local government jurisdictions need to do more to improve response across service channels for mental health crises, despite available and dedicated support from Los Angeles County resources for this purpose, such as the DMH Psychiatric Mobile Response Team (PMRT).

Table 10.31: Recommendations to Local Government, by License Class	ARF	RCFE	ALL
Police/911 response not sufficient or supportive	36.0%	14.3%	22.7%
Improve knowledge of facilities and residents	22.8%	8.3%	13.9%
Mental health crisis response not sufficient	20.6%	4.1%	10.5%
Improvement in customer service quality	5.9%	8.8%	7.6%
Medical health crisis response not sufficient	8.1%	6.9%	7.4%
Outreach and visits to facilities	8.1%	4.1%	5.7%
Additional programs, resources, and services	5.1%	5.1%	5.1%
Funding from local government needed	3.7%	3.7%	3.7%
Zoning and fire inspection service improvement	2.2%	3.2%	2.8%
Communications need improvement	2.2%	2.3%	2.3%
More support for facilities needed	0.0%	1.4%	0.8%
Garbage collection services not sufficient	0.7%	0.5%	0.6%
No recommendation(s)	37.5%	59.9%	51.3%

Significantly greater proportions of Market ARF respondents recommend that local government improves police and 911 services, mental health crisis response capabilities within local jurisdictions, and local government knowledge of facilities and their populations, in comparison to respondents serving RCFEs. A significantly lesser proportion of ARF respondents held no recommendations for local governments to improve the quality of services delivered.

Table 10.32: Recommendations to Local Government, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Police/911 response not sufficient or supportive	12.3%	38.7%	35.1%
Improve knowledge of facilities and residents	8.8%	20.0%	21.6%
Mental health crisis response not sufficient	3.9%	22.7%	16.2%
Improvement in customer service quality	6.9%	8.0%	9.5%
Medical health crisis response not sufficient	6.9%	5.3%	10.8%
Outreach and visits to facilities	4.9%	8.0%	5.4%
Additional programs, resources, and services	6.4%	5.3%	1.4%
Funding from local government needed	3.9%	2.7%	4.1%
Zoning and fire inspection service improvement	2.0%	1.3%	6.8%
Communications need improvement	1.5%	1.3%	5.4%
More support for facilities needed	0.5%	0.0%	2.7%
Garbage collection services not sufficient	1.0%	0.0%	0.0%
No recommendation(s)	61.8%	40.0%	33.8%

Larger Market facilities licensed to serve populations of 7 to 60 and 61 or more beds recommend that local government improve police and 911 services, improve their knowledge of facilities and their residents, and improve mental health crisis response in their local jurisdiction in significantly greater proportions than those serving facilities with 6 licensed beds or less. 61 or more licensed bed facilities recommend that local government improve zoning and fire inspection practices, communication to facilities, and support for facilities in significantly greater proportions than smaller licensed ARFs and RCFEs. A majority (61.8%) of facilities serving 6 licensed beds or less had no recommendations for local government services, a significantly greater proportion than larger facilities.

Table 10.33: Recommendations to Local Government, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Police/911 response not sufficient or supportive	0.0%	19.5%	28.9%	37.1%	7.1%	26.7%	23.8%	20.9%
Improve knowledge of facilities and residents	3.8%	11.7%	19.3%	20.0%	0.0%	30.0%	14.3%	6.0%
Mental health crisis response not sufficient	3.8%	6.5%	10.8%	25.7%	7.1%	23.3%	0.0%	7.5%
Improvement in customer service quality	7.7%	2.6%	12.0%	5.7%	0.0%	6.7%	9.5%	10.4%
Medical health crisis response not sufficient	3.8%	9.1%	7.2%	5.7%	7.1%	6.7%	4.8%	9.0%
Outreach and visits to facilities	3.8%	3.9%	1.2%	14.3%	0.0%	10.0%	9.5%	7.5%
Additional programs, resources, and services	7.7%	5.2%	6.0%	2.9%	0.0%	3.3%	4.8%	6.0%
Funding from local government needed	0.0%	6.5%	6.0%	0.0%	7.1%	0.0%	4.8%	1.5%
Zoning and fire inspection service improvement	0.0%	1.3%	4.8%	0.0%	14.3%	0.0%	4.8%	3.0%
Communications need improvement	3.8%	1.3%	1.2%	8.6%	0.0%	0.0%	4.8%	1.5%
More support for facilities needed	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%
Garbage collection services not sufficient	0.0%	1.3%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%
No recommendation(s)	73.1%	53.2%	48.2%	34.3%	64.3%	40.0%	42.9%	58.2%

Market facilities located in SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities) identified that local government should improve police / 911 services, local government knowledge of facilities and their populations, mental health crisis response from local jurisdictions, and the frequency of outreach and visits to facilities in significantly greater proportions than most other facilities located across Los Angeles County SPAs. SPA 4 facilities recommended improved communications from local government in greater proportions than other SPAs.

Market ARFs and RCFEs located in SPA 3 (San Gabriel Valley) also recommended improvement in police / 911 services, local government knowledge of facilities and their populations, overall improvement in customer service quality in significantly greater proportions than most other SPAs. Respondents from facilities located in SPAs 2 (San Fernando Valley), SPA 3 (San Gabriel Valley), and SPA 5 (West Los Angeles and West Cities) recommended that local government should provide more funding for facilities and their resident populations in significantly greater proportions than other SPAs. Significantly greater proportions of facilities located in SPA 1 (Antelope Valley) and SPA 5 (West Los Angeles and West Cities) made no recommendations for the improvement of local government services compared to respondents across the remaining SPAs.

Satisfaction with Los Angeles County Agencies and Services

Market facility respondents were asked to express their level of satisfaction with Los Angeles County agencies and services they provided, utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating no satisfaction at all, and 10 indicating complete satisfaction.

FQ70. "How satisfied are you with the overall performance of Los Angeles County Public Agencies in serving your facility and its residents?"

FACILITY OWNERS & OPERATORS (N=353)

Table 10.34: Overall Satisfaction with L.A. County Agencies, by License Class,	ARF	RCFE	ALL
	7.14	7.67	7.45

Mean overall satisfaction for with Los Angeles County agencies and their services by respondents is generally positive, with a score of 7.45 out of a maximum of 10.00, indicating genuine possibility for County agencies to take simple actions to increase Market owner/operator perceptions of their experiences.

Overall, owners and/operators of Market ARFs and RCFEs reported comparably positive levels of mean satisfaction with Los Angeles County agencies and their services, with ARFs reporting somewhat reduced levels of mean satisfaction with County agencies in relation to their RCFE counterparts.

Table 10.35: Overall Satisfaction with L.A. County Agencies, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	7.37	7.63	7.49

There was relatively little spread in mean satisfaction scores from Market respondents relating to satisfaction with Los Angeles County agencies that could be attributed to the licensed population size of an ARF or RCFE population alone.

Table 10.36: Overall Satisfaction with L.A. County Agencies, by License Class and Size	ARF	RCFE
≤ 6 BEDS	7.00	7.52
7–60 BEDS	7.22	8.46
≥ 61 BEDS	7.22	7.70

Market RCFEs with licensed bed counts of 7 to 60 beds expressed significantly greater levels of satisfaction than other facilities of either license class in relation to mean levels of satisfaction expressed with the services delivered from Los Angeles County agencies.

Table 10.37: Overall Satisfaction with L.A. County Agencies, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	8.12	7.30	7.12	7.41	5.67	6.93	8.06	8.17

Respondents from Market facilities serving SPA 5 reported significantly lower levels of mean satisfaction with Los Angeles County agencies and their services in relation to other SPAs, with facility owners and operators representing SPA 6 (South Los Angeles and South Cities) also conveying slightly reduced means for satisfaction with Los Angeles County agencies and services.

Recommendations to Los Angeles County Agencies for Service Improvement

Respondents from Market ARFs and RCFEs were also asked to provide recommendations for Los Angeles County agencies to improve the quality of services that facilities and residents receive.

FQ71. "What are some steps that Los Angeles County Public Agencies could take to improve their service and relationship with facilities like yours?" (MR)

FACILITY OWNERS & OPERATORS (N=353)

Market owners and/or operators seek increased communication and visits with operators (21.4%) and greater efficiency and responsiveness in services delivered (16.0%) from Los Angeles County agencies more than any other areas of recommended service improvement.

9.1% of Market respondents felt that County agencies could improve the quality of their service delivery by improving the levels of compassion and support communicated publicly by agencies and their staff for facilities. 8.0% of facility respondents would like to see more programs and services delivered from County and its agencies, while 6.9%% sought for agencies to deliver more funding and reimbursement of costs for resident room, board, and care.

Slightly less than half of Market respondents (48.9%) provided no recommendation(s) to County agencies for service improvements, indicating high levels of correlation in the satisfaction with the overall service delivery performance of Los Angeles County agencies.

Table 10.38: Recommendations to L.A. County Agencies, by License Class	ARF	RCFE	ALL
Increase communication and facility visits	24.2%	16.3%	21.4%
Greater efficiency and responsiveness	18.8%	11.6%	16.0%
Improve compassion and support	4.8%	11.2%	9.1%
More programs and services	7.3%	7.4%	8.0%
Provide more County funding / reimbursement	4.2%	7.9%	6.9%
Improve training and education of staff	6.7%	5.1%	6.3%
Display better knowledge of resident needs	4.8%	5.6%	5.7%
Identify offered services and capabilities better	3.0%	4.7%	4.3%
Increase staffing	4.8%	1.9%	3.4%
Better crisis response	6.1%	0.0%	2.9%
Reform regulations to enable more services	1.2%	2.8%	2.3%
Increase mental health focus	2.4%	0.5%	1.4%
Less bureaucracy	0.6%	1.4%	1.1%
Connection with state and federal programs	0.6%	0.5%	0.6%
Evaluate staff performance	0.6%	0.5%	0.6%
Increase medical health focus	0.6%	0.5%	0.6%
Regulate cost of utilities and fees for facilities	0.0%	0.5%	0.3%
No recommendation(s)	33.3%	54.0%	48.9%

Elevated proportions of Market ARF respondents recommend that Los Angeles County agencies increase the frequency of communications and visits with operators, as well as increase operational efficiency and responsiveness in working with facilities to improve services, in comparison to RCFE owners and/or operators. Significantly greater proportions of ARF owners and/or operators recommend that Los Angeles County agencies improve their crisis response and increase mental health focus in services delivered to their facilities for better service delivery. A significantly greater proportion of Market RCFE respondents held no recommendations for the improvement of services delivered by Los Angeles County agencies, in comparison to ARF respondents.

Table 10.39: Recommendations to L.A. County Agencies, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Increase communication and facility visits	19.9%	22.7%	24.3%
Greater efficiency and responsiveness	13.9%	17.3%	20.3%
Improve compassion and support	10.9%	8.0%	5.4%
More programs and services	8.5%	8.0%	6.8%
Provide more County funding / reimbursement	8.5%	5.3%	4.1%
Improve training and education of staff	3.5%	8.0%	12.2%
Display better knowledge of resident needs	6.0%	5.3%	5.4%
Identify offered services and capabilities better	5.0%	4.0%	2.7%
Increase staffing	3.0%	4.0%	4.1%
Better crisis response	1.0%	5.3%	5.4%
Reform regulations to enable more services	3.0%	1.3%	1.4%
Increase mental health focus	0.5%	1.3%	4.1%
Less bureaucracy	2.0%	0.0%	0.0%
Connection with state and federal programs	0.0%	2.7%	0.0%
Evaluate staff performance	0.0%	2.7%	0.0%
Increase medical health focus	0.5%	1.3%	0.0%
Regulate cost of utilities and fees for facilities	0.5%	0.0%	0.0%
No recommendation(s)	48.8%	49.3%	48.6%

Comparably large proportions of Market facilities serving all ranges of licensed bed counts recommend Los Angeles County agencies increase communications and visits with operators, as well as provide greater efficiency and responsiveness in the delivery of services. Significantly greater proportions of facilities serving populations of 61 or more licensed beds recommend that Los Angeles County agencies improve the training and education of staff, deliver better crisis response, and increase focus on delivery of mental health needs, recommendations also seen in elevated proportions with 7 to 60 licensed bed facilities, in comparison to smaller Market facilities.

Table 10.40: Recommendations to L.A. County Agencies, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Increase communication and facility visits	23.1%	14.7%	23.2%	25.7%	21.4%	33.3%	38.1%	13.4%
Greater efficiency and responsiveness	7.7%	14.7%	19.5%	11.4%	21.4%	33.3%	23.8%	7.5%
Improve compassion and support	15.4%	5.3%	9.8%	8.6%	14.3%	13.3%	14.3%	6.0%
More programs and services	3.8%	16.0%	3.7%	17.1%	0.0%	3.3%	4.8%	6.0%
Provide more County funding / reimbursement	0.0%	12.0%	2.4%	8.6%	7.1%	6.7%	9.5%	7.5%
Improve training / education of staff	0.0%	6.7%	8.5%	5.7%	0.0%	10.0%	4.8%	6.0%
Display better knowledge of resident needs	3.8%	6.7%	6.1%	2.9%	0.0%	6.7%	4.8%	7.5%
Identify offered services and capabilities better	3.8%	6.7%	4.9%	11.4%	7.1%	0.0%	0.0%	0.0%
Increase staffing	3.8%	1.3%	6.1%	5.7%	0.0%	0.0%	0.0%	4.5%
Better crisis response	0.0%	1.3%	6.1%	2.9%	0.0%	6.7%	0.0%	1.5%
Reform regulations to enable more services	3.8%	1.3%	3.7%	0.0%	0.0%	3.3%	4.8%	1.5%
Increase mental health focus	0.0%	0.0%	1.2%	8.6%	7.1%	0.0%	0.0%	0.0%
Less bureaucracy	0.0%	1.3%	2.4%	2.9%	0.0%	0.0%	0.0%	0.0%
Connection with state and federal programs	0.0%	1.3%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Evaluate staff performance	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Increase medical health focus	0.0%	1.3%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Regulate cost of utilities and fees for facilities	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
No recommendation(s)	57.7%	41.3%	48.8%	40.0%	64.3%	40.0%	38.1%	62.7%

Significantly greater proportions of Market owners and/or operators from SPA 6 (South Los Angeles and South Cities) and SPA 7 (East Los Angeles and South East Cities) sought improvement from Los Angeles County agencies by increasing communications and visits with operators, as well as providing greater efficiency and responsiveness in the delivery of services for improvement. Facilities with respondents serving SPA 2 (San Fernando Valley) recommend more programs and services, along with increase in County funding and reimbursements, in significantly greater proportions than respondents serving at Market facilities in other SPAs. Respondents in SPA 3 (San Gabriel Valley) recommended increasing staffing and better crisis response from Los Angeles County agencies in significantly greater proportions than other SPAs, with the exception of SPA 6 (South Los Angeles and South Cities), which also displayed significantly greater proportions of respondents recommending improvement in crisis response and improvement in the training and education of staff from Los Angeles County agencies.

Market owners and/or operators serving SPA 4 (Metro Los Angeles and Center Cities) recommend that Los Angeles County agencies identify their services and capabilities for facilities and their populations better, increase focus on mental health services delivery, and reduce the bureaucracy of working with the County in significantly greater proportions than other SPAs. Respondents serving facilities in SPA 1 (Antelope Valley) and SPA 5 (West Los Angeles and West Cities) recommended that Los Angeles County agencies increase the amount of compassion and support that they provide to Market facilities in the delivery of services, in comparison to other SPAs. SPA 1, SPA 5, and SPA 8 (South Bay and Coastal Cities) have significantly greater proportions of respondents who held no recommendations for the improvement of Los Angeles County agency service delivery.

Satisfaction with the Community Care Licensing Division (CCLD)

ARF and RCFE owners and/or operators were asked to express their level of satisfaction with their interaction and the services provided by the Community Care Licensing Division of the California Department of Social Services (CCLD / CDSS), the entity that serves as market regulator for ARF and RCFE facilities statewide. Respondents were asked to evaluate their level of satisfaction utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating no satisfaction at all, and 10 indicating complete satisfaction.

FQ72. "How satisfied are you with the overall performance of the ARF/RCFE market regulator, the Community Care Licensing Division (or CCLD) of the California Department of Social Services (CDSS), in serving your facility and its residents?" (MR)

FACILITY OWNERS & OPERATORS (N=353)

Table 10.41: Overall Satisfaction with CCLD, by License Class	ARF	RCFE	ALL
	7.69	8.03	7.90

Overall mean satisfaction with CCLD, as the regulator for licensing of all ARFs and RCFEs across Los Angeles County (and the State of California), was relatively high, especially considering the Division's core purpose and role of overseeing the minimum standards and practices for facilities. Contextual interpretation of the mean score of 7.90 out of a possible 10.00 identifies several key opportunities for improvement in the experiences of interactions and services delivered by CCLD to facility owners and/or operators.

Owners and/or operators of facilities reported relatively positive levels of satisfaction with CCLD in their experiences, with ARF respondents again reporting slightly reduced levels of satisfaction with this additional government entity, in comparison to their counterparts at RCFEs.

Table 10.42: Overall Satisfaction with CCLD, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	7.97	7.71	7.88

Operators of licensed facilities serving 6 or fewer beds exhibited slightly greater mean levels of satisfaction from their interactions and services provided to them from CCLD than larger licensed facilities.

Table 10.43: Overall Satisfaction with CCLD, by License Class and Facility Size	ARF	RCFE
≤ 6 BEDS	7.95	7.98
7–60 BEDS	7.60	7.92
≥ 61 BEDS	7.38	8.27

ARFs serving populations of 61 or more licensed beds displayed greater mean levels of satisfaction with CCLD than facilities of other sizes and license classes.

Table 10.44: Overall Satisfaction with CCLD, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	8.81	7.52	7.53	7.73	6.21	7.83	8.24	8.78

ARF and RCFE respondents serving SPA 5 (West Los Angeles and West Cities) reported significantly lower mean satisfaction scores with CCLD interactions and services compared to facilities in other SPAs, while respondents serving facilities located in SPA 1 (Antelope Valley) and SPA 8 (South Bay and Coastal Cities) reported significantly greater mean satisfaction scoring for CCLD and its service delivery.

Recommendations to the Community Care Licensing Division (CCLD) for Service Improvement

Although mean satisfaction scores with CCLD can be regarded as generally positive in nature, owners and/operators were asked for specific recommendations for the improvement of services and interactions with the market regulator.

FQ73. "What are some steps that CCLD and CDSS could take to improve their service and relationship with facilities like yours?" (MR)

FACILITY OWNERS & OPERATORS (N=353)

Nearly 1 in 4 (23.4%) of Market facility owners and/or operators recommended that CCLD implement improvements to change perceptions of a generally negative, or adversarial, attitudinal approach of the Division's staff that interact with their facilities. Some facility owners and/or operators expressed frustration with behavioral differences between how CCLD staff communicate with them and their staff at facilities, as well as encountering CCLD expressing preconceptions relating to how they manage or operate their facilities prior to the commencement of a visit or inspection. Ideally, owners and operators suggest that prospective hostility, frustrations, and/or stresses conveyed to them from CCLD staff are not a necessary part of site visits or inspections, and that all communications should be professional in tone and demeanor at all times, especially freed from the potential appearance of bias when investigating claims of potential violations at licensed facilities. Facility owners and operators were generally clear in expressing understanding that CCLD staff should act within their duties to serve the interests and/or protect the welfare of residents in investigations.

Licensed facility owners and/or operators recommend that CCLD improve the frequency and quality of communications both by phone and in-person (18.9%), improve staff knowledge and training (11.7%), provide more assistance and support for compliance and improvement of facilities (11.4%), and ensure more consistency in the approach to regulation amongst CCLD staff and service regions (11.4%). Improving the consistency across CCLD staff serving different service regions was a particular observation from owners with accountability for multiple facilities located across different CCLD regions in Los Angeles County and beyond. Nearly half of facility respondents (49.0%) offered no recommendation(s) for service improvements from CCLD, with correlation in satisfaction scoring indicating that these owners and/or operators were genuinely satisfied with CCLD's regulatory service delivery.

Table 10.45: Recommendations to CCLD, by License Class	ARF	RCFE	ALL
Adversarial approach of staff needs to change	23.0%	23.9%	23.4%
Improve communication frequency and quality, by phone and in-person	22.2%	16.9%	18.9%
Improve staff knowledge and training	9.6%	13.1%	11.7%
More consistent approach to regulation needed	11.1%	11.7%	11.4%
Provide more assistance and support	11.9%	11.3%	11.4%
Licensure processes not efficient enough	2.2%	4.7%	3.7%
Fees for licensure and renewal too high	1.5%	0.5%	0.9%
No recommendation(s)	46.7%	51.2%	49.1%

Many Market ARF and RCFE owners and/or operators made no recommendation(s) for CCLD. However, consistent and relatively high proportions across the remainder of ARF and RCFE respondents recommended that CCLD change the attitudinal approach of staff in interactions with facilities, improving communication frequency and quality with facilities, as well as seeking improvements in CCLD staff knowledge and training.

Table 10.46: Recommendations to CCLD, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Adversarial approach of staff needs to change	23.0%	22.7%	26.0%
Improve communication frequency and quality, by phone and in-person	18.5%	20.0%	19.2%
Improve staff knowledge and training	9.5%	12.0%	17.8%
More consistent approach to regulation needed	9.0%	12.0%	17.8%
Provide more assistance and support	13.5%	6.7%	11.0%
Licensure processes not efficient enough	5.5%	1.3%	1.4%
Fees for licensure and renewal too high	1.0%	1.3%	0.0%
No recommendation(s)	49.0%	50.7%	49.3%

Respondents serving licensed facilities with populations of 61 or more beds recommend improvements in CCLD staff knowledge and training and in the consistency of the approach to regulation of facilities, in significantly greater proportions than those serving smaller facilities. Owners and/or operators of facilities serving 6 or fewer licensed beds recommended improvement in the efficiency and speed of licensure processes in significantly greater proportions than larger licensed facilities.

Table 10.47: Recommendations to CCLD, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Adversarial approach of staff needs to change	11.5%	31.6%	24.7%	28.6%	30.8%	20.0%	15.0%	17.9%
Improve communication frequency and quality, by phone and in-person	11.5%	22.4%	18.5%	17.1%	46.2%	23.3%	15.0%	13.4%
Improve staff knowledge and training	0.0%	14.5%	16.0%	14.3%	7.7%	10.0%	15.0%	7.5%
More consistent approach to regulation needed	3.8%	11.8%	16.0%	11.4%	23.1%	13.3%	15.0%	4.5%
Provide more assistance and support	7.7%	15.8%	11.1%	5.7%	30.8%	3.3%	20.0%	9.0%
Licensure processes not efficient enough	7.7%	2.6%	3.7%	2.9%	0.0%	3.3%	10.0%	3.0%
Fees for licensure and renewal too high	0.0%	1.3%	0.0%	2.9%	0.0%	0.0%	5.0%	0.0%
No recommendation(s)	76.9%	38.2%	45.7%	48.6%	30.8%	56.7%	30.0%	62.7%

Respondents serving at licensed facilities in SPA 2 (San Fernando Valley) and SPA 5 (West Los Angeles and West Cities) recommended modification of the approach and attitude taken by CCLD staff in interactions with their facilities in significantly greater proportions than respondents in other SPAs, with a significantly greater proportion of SPA 5 owners and/or operators also recommending improvements to CCLD in communication frequency and quality, as well as consistency in regulatory approach.

SPA 5 owners and/or operators, along with those representing SPA 7 (East Los Angeles and South East Cities) also recommended CCLD provide more assistance and support to facilities in significantly greater proportions than respondents at other SPAs. Facility owners and/or operators serving in SPA 1 (Antelope Valley) and SPA 7 (East Los Angeles and South East Cities) recommend CCLD improve the efficiency of licensure processes in significantly greater proportions than those located in other SPAs. Respondents from facilities located in SPA 1 (Antelope Valley) and SPA 8 (South Bay and Coastal Cities) held no recommendations for CCLD in significantly greater proportions than those serving across other Los Angeles County Service Planning Areas.

New Ways for Government to Help Market ARFs and RCFEs

Respondents from licensed facilities were asked to identify as many new ways that governments at all levels of government, service categories, and jurisdictions could act to help the success of ARFs and RCFEs serving populations across communities.

FQ74. "What are some new things that government, at any level, could do to help facilities like yours?" (MR)

FACILITY OWNERS & OPERATORS (N=353)

A majority (56.3%) of owners and/or operators of ARFs and RCFEs communicated that increasing funding for resident care is the primary, new way for government at all levels to help facilities become more sustainable and successful. This finding is strongly supported by qualitative concerns expressed by many owners and operators relating to budgetary constraints, namely, increasing costs from inflation, additional one-time costs from the COVID-19 pandemic, and uncertainties about future capabilities to maintain business profitability or sustainability with increasing labor, insurance, and regulatory costs.

12.2% of respondents indicated that they hope to see government introduce new programs to aid residents, 9.4% seek additional material resources (and supplies) to help facilities and residents, while 8.4% seek reform of licensing processes and regulations that could be beneficial to facilities.

Only 12.2% of respondents had no recommendations for new ways in which government at all levels could better aid the sustainability and success of ARFs and RCFEs.

Table 10.48: New Ways for Government to Help Facilities, by License Class	ARF	RCFE	ALL
Increase funding for resident care	66.2%	50.0%	56.3%
Develop new resident programs	12.5%	12.0%	12.2%
Provide facilities with additional material resources	11.8%	7.9%	9.4%
Undertake licensing agency / regulation reform	8.8%	8.3%	8.5%
Deliver better services for specific resident needs	8.1%	4.6%	6.0%
Tax breaks, utility rebates, or other incentives	4.4%	5.1%	4.8%
Enhance community awareness of the important role of facilities	5.1%	4.6%	4.8%
Better communication with facilities	5.9%	3.2%	4.3%
Enhance transport services for residents	2.9%	5.1%	4.3%
Display compassion for owners/operators	1.5%	5.1%	3.7%
Provide training to operators	2.9%	4.2%	3.7%
Reduce bureaucracy	2.2%	3.7%	3.1%
Assist with resident placement (navigation)	0.0%	sign4.2%	2.6%
Reform insurance for facilities	1.5%	2.3%	2.0%
Improve technologies used for government service	1.5%	0.9%	1.1%
Provide assistance with staffing	0.7%	0.9%	0.9%
Integrate government information sharing	1.5%	0.5%	0.9%
Enhance police training	0.7%	0.5%	0.6%
Provide facilities with better knowledge of government	0.0%	0.5%	0.3%
Enhance unlicensed facility enforcement	0.0%	0.5%	0.3%
No recommendation(s)	7.4%	15.3%	12.2%

Significantly greater proportions of ARF owners and/or operators identified that governments should increase funding to facilities for resident care in comparison to RCFE respondents, despite more than half of all respondents (56.3%) identifying that increasing funding (levels) for resident care was a “new” and top priority for government action sought by ARFs and RCFEs. A significantly lower proportion of Market ARFs had “no recommendation(s)” in identifying new ways for government to help facilities.

Table 10.49: New Ways for Government to Help Facilities, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Increase funding for resident care	52.7%	55.4%	66.7%
Develop new resident programs	11.8%	17.6%	8.0%
Provide facilities with additional material resources	10.3%	6.8%	9.3%
Undertake licensing agency / regulation reform	6.9%	10.8%	10.7%
Deliver better services for specific resident needs	4.4%	8.1%	8.0%
Tax breaks, utility rebates, or other incentives	6.4%	1.4%	4.0%
Enhance community awareness of the important role of facilities	4.4%	8.1%	2.7%
Better communication with facilities	3.9%	4.1%	5.3%
Enhance transport services for residents	3.9%	6.8%	2.7%
Display compassion for owners/operators	3.4%	2.7%	5.3%
Provide training to operators	3.0%	6.8%	2.7%
Reduce bureaucracy	4.4%	0.0%	2.7%
Assist with resident placement (navigation)	4.4%	1.4%	1.3%
Reform insurance for facilities	2.5%	1.4%	1.3%
Improve technologies used for government service	1.5%	0.0%	1.3%
Provide assistance with staffing	1.0%	1.4%	0.0%
Integrate government information sharing	0.5%	1.4%	1.3%
Enhance police training	0.0%	1.4%	1.3%
Provide facilities with better knowledge of government	0.0%	1.4%	0.0%
Enhance unlicensed facility enforcement	0.5%	0.0%	0.0%
No recommendation(s)	13.8%	12.2%	8.0%

Facilities serving licensed bed counts of 61 or more sought increased funding for facilities in significantly greater proportions than smaller facilities, with mid-sized facilities serving between 7 and 60 beds seeking government to develop new resident programs, enhance community awareness of the important role of facilities, and provide training to operators in significantly greater proportions than smaller or larger licensed facilities. A significantly lower proportion of Market facilities with 61 licensed beds or more had "no recommendation(s)" in identifying new ways for government to help facilities.

Table 10.50: New Ways for Government to Help Facilities, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Increase funding for resident care	57.7%	51.9%	42.2%	57.1%	57.1%	66.7%	85.7%	62.7%
Develop new resident programs	15.4%	15.6%	13.3%	11.4%	14.3%	6.7%	9.5%	9.0%
Provide facilities with additional material resources	11.5%	7.8%	10.8%	8.6%	14.3%	10.0%	9.5%	7.5%
Undertake licensing agency / regulation reform	7.7%	5.2%	12.0%	17.1%	7.1%	6.7%	14.3%	3.0%
Deliver better services for specific resident needs	3.8%	5.2%	6.0%	11.4%	0.0%	6.7%	0.0%	7.5%
Tax breaks, utility rebates, or other incentives	11.5%	2.6%	4.8%	2.9%	0.0%	3.3%	4.8%	7.5%
Enhance community awareness of the important role of facilities	3.8%	3.9%	3.6%	8.6%	14.3%	0.0%	0.0%	7.5%
Better communication with facilities	7.7%	2.6%	3.6%	11.4%	0.0%	3.3%	0.0%	4.5%
Enhance transport services for residents	0.0%	5.2%	6.0%	8.6%	7.1%	0.0%	0.0%	3.0%
Display compassion for owners/operators	3.8%	5.2%	3.6%	5.7%	7.1%	3.3%	0.0%	1.5%
Provide training to operators	3.8%	2.6%	3.6%	2.9%	7.1%	3.3%	4.8%	4.5%
Reduce bureaucracy	0.0%	3.9%	4.8%	8.6%	0.0%	0.0%	0.0%	1.5%
Assist with resident placement (navigation)	0.0%	10.4%	1.2%	0.0%	0.0%	0.0%	0.0%	3.0%
Reform insurance for facilities	3.8%	5.2%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%
Improve technologies used for government service	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%
Provide assistance with staffing	0.0%	2.6%	0.0%	0.0%	0.0%	3.3%	0.0%	0.0%
Integrate government information sharing	0.0%	0.0%	2.4%	2.9%	0.0%	0.0%	0.0%	0.0%
Enhance police training	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	1.5%
Provide facilities with better knowledge of government	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Enhance unlicensed facility enforcement	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
No recommendation(s)	7.7%	7.8%	22.9%	5.7%	14.3%	16.7%	0.0%	10.4%

Significantly greater proportions of respondents from SPA 6 (South Los Angeles and South Cities) and SPA 7 (East Los Angeles and South East Cities) sought increases in funding for resident care from government at any level in comparison to owners and/or operators located in other SPAs. A significantly lower proportion of respondents from SPA 6 facilities sought government to deliver new, or additional programs. SPA 2 (San Fernando Valley) respondents from ARFs and RCFEs identified that they need increased assistance from government for navigation and placement of residents at facilities and facility insurance reform in significantly greater proportions than respondents from other SPAs. Respondents from SPA 5 (West Los Angeles and West Cities) seeks greater help from government at all levels to provide facilities with additional material resources as well as enhancing community awareness of the importance of the role of facilities, in comparison to others. A significantly greater proportion of owners and/or operators at facilities located in SPA 1 (Antelope Valley) sought enhancements in tax breaks and/or rebates than respondents elsewhere.

Owners and/operators representing licensed facilities in SPA 4 (Metro Los Angeles and Center Cities) sought government to undertake licensing agency and general government (relating to the specific business needs of facilities) regulation reform, delivery of better services for resident needs, better communication with facilities, enhancement of transportation services for residents, and a reduction in the bureaucracy from government (at all levels) in significantly greater proportions than respondents at other SPAs.

Barriers to Resident Care in the Market

Market owners and operators of ARFs and RCFEs report significant barriers in providing care to residents from identified, vulnerable populations. Some of these barriers, such as interface with Market Users, navigation, funding, and access to services have already been identified in this study. But in their interface across many levels of government, from licensing, to County agencies providing referrals, placement, and wraparound services for residents from programs, and from local governments in zoning, fire, police, and other business regulation, many Market facilities feel beset on all sides by both consequential and inconsequential bureaucracy, by many Market Users, agencies, and funding sources to provide care for their identified, vulnerable populations.

The collective administrative burdens required by government across all levels has direct cost which is inversely proportionate to a Market facility's size. Owners and operators of smaller facilities within the Market that have fewer licensed beds have fewer staff, are more likely to be owned and operated by individuals and family members, and have demonstrably less capacity for traditional, paper-based reporting that has not been optimized for efficiency. Even for the largest facilities, with significantly greater headcounts of staff, the administrative burden of paperwork, incompatible systems that require the same information but do not communicate with each other, and high-frequency reporting can generate significant operational costs, which can deprive vulnerable residents in the Market of additional staff service time and care.

Where possible and practicable, governments and their agencies need to undertake continuous improvement of the systems and documentation required to report on the identities, activities, and needs of residents, ensuring full compliance with personally-identifiable data in line with HIPAA and other standards, as well as moving Market facilities away from maintaining key data and information on paper and/or utilizing fax machines, which continues to occur at surprisingly high frequencies across the Market depending on the mix of interactions that facilities have with agencies and Market Users. Cities and municipalities must also consider the costs of not assisting such facilities by appointing them with liaison(s) to assist them with local compliance efforts, or lose eminent public values and benefit derived from the primary functions of these businesses.

Affording the costs of participation in programs with potential public funders is another key issue for most Market facilities. Recent, well-intentioned initiatives from the State of California[20] to provide potential funding for improvement of facility assets have also posed unreasonable burden on Market facilities, with complex and detailed application processes and business requirements. Anecdotally, recent California program application requirements pose significant challenges for even the most well-organized, corporate-level owners of large-scale groups of Market facilities with greater access to external support resources. If the intention of these programs is to create a lifeline or increase the capacity of small-scale facilities in the Market to survive, this intention is not conveyed in any practical sense based on the level of time and resources required to make such applications. It may be preferable for these programs to either consider deployment of simpler processes or to channel facilities to specific, high-touch, technical assistance programs that are engineered to serve the specific business needs and capabilities of smaller Market facilities.

If governments at all levels can make attempts at streamlining or reducing the complexity of documentation for resident program participation, licensing, applications for funding, and other regulatory and permit processes, owners and operators of Market ARFs and RCFEs will have additional capability and reduction in labor costs to innovate new models for resident service delivery, enhance interface and communications with Market User programs serving resident care needs, and improve overall resident quality-of-life.

[20] Such as the Community Care Expansion (CCE) Program, https://www.cdss.ca.gov/inforesources/cdss-programs/community-care-expansion and the Behavioral Health Bridge Housing Program (BHBH): https://www.gov.ca.gov/2023/02/22/nearly-1-billion-in-grants-for-homeless-housing-behavioral-health-needs/, amongst others.

Market Knowledge of Other Systems of Care and Services

Owners and operators of ARFs and RCFEs were asked to identify their level of knowledge regarding systems and care services relevant to the needs of resident populations. An absolute, 0-10 Likert-scale metric was utilized for this self-evaluation, with "0" indicating "no knowledge at all", and "10 indicating "expert-level knowledge".

FQ50. TO FQ60. "On a scale of 0-10, how would you evaluate your level of personal knowledge about the following services in our communities?"

FACILITY OWNERS & OPERATORS (N=353)

Table 10.51: Knowledge of Care Systems and Services, by License Class	ARF	RCFE	ALL
Homelessness	5.60	4.25	4.77
Mental health	8.29	6.31	7.09
Affordable/ permanent supportive housing	5.90	4.25	4.90
Independent living	6.48	6.17	6.29
Re-entry assistance	4.54	2.24	3.15
Skilled nursing	6.60	7.55	7.18
Elderly and aging support	6.23	8.36	7.53
Rehabilitative support	6.25	7.65	7.11
Hospice	5.17	8.98	7.51
Home health care	7.35	8.98	8.36
Substance abuse treatment	6.30	4.39	5.15

Market owners and/or operators conveyed relatively high levels of personal knowledge with elderly and aging support services, hospice services, skilled nursing services, rehabilitative health services, and mental health services to support residents from external service delivery agencies and organizations across Los Angeles County. However, mean for levels of knowledge expressed across independent living, substance abuse treatment, affordable and permanent supportive housing services, and homelessness services were relatively low, with the lowest means for collective knowledge expressed for re-entry services designed to help those with experiences of incarceration and justice-involvement.

Relatively low levels of Market owner/operator knowledge across the aforementioned areas of community services identify significant gaps in service access for their resident populations. The low levels of knowledge from facility respondents relating to homelessness services correlates with the relatively low proportions of residents emerging from experiencing homelessness. Gaps in owner/operator knowledge around independent living services and affordable and permanent supportive housing prevent graduation of residents from facilities who are capable to move on to different housing types. Lower levels of knowledge around accessible substance abuse treatment or re-entry services can lead to these populations within facilities not getting the right amount of support and/or care that they require to succeed in their placement.

These gaps in Market knowledge identify key opportunities for local government, Los Angeles County service agencies, nonprofits, and community advocates to initiate new conversations and introductions so that facilities have comprehensive knowledge and understanding of additional resources that can serve to benefit resident populations. Consideration should be made by Los Angeles County, or state government agencies, such as CCLD / DCHS, to research, publish, and maintain accurate lists of aligned resources for owners / operators of ARFs and RCFEs in Los Angeles County (and all California counties) to better integrate options for delivery of the whole-person care needs of resident populations. Neither ARF or RCFE owners and operators reported significant mean levels of knowledge in relation to homelessness services operating across Los Angeles County communities, a key gap in information which impacts the alignment and interface of Market facilities in serving the needs of people who have experienced homelessness, as well as reduces the ability of ARFs and RCFEs to accept greater numbers of people from this service channel.

Given the statutory focus of the facility license class on delivery of services to the aged, Market RCFE owner and operator respondents reported significantly greater mean levels of knowledge in relation to Elderly and Aging Support Services, Hospice Services, and Home Health Care Services in relation to their ARF counterparts.

A majority of RCFE respondents reported having relatively little knowledge regarding re-entry assistance services that aid justice involved populations. Market ARF respondents reported significantly greater mean levels of knowledge and familiarity with Mental Health Services and Substance Abuse Treatment Services than their RCFE counterparts, which corresponds to greater incidence rates of people living with mental illness and in need of substance abuse treatment services in their facilities.

Table 10.52: Knowledge of Care Systems and Services, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Homelessness	4.33	5.49	5.27
Mental health	6.61	7.99	7.47
Affordable / permanent supportive housing	4.55	4.99	5.73
Independent living	6.26	6.07	6.59
Re-entry assistance	2.76	3.77	3.58
Skilled nursing	7.22	6.73	7.53
Elderly and aging support	7.83	7.07	7.18
Rehabilitative support	7.25	6.69	7.12
Hospice	8.30	6.52	6.32
Home health care	8.67	7.64	8.18
Substance abuse treatment	4.77	5.66	5.64

In examining differences in knowledge across resident-aligned services, there are significant opportunities in providing more information to owners and operators of Market facilities of all sizes to better assist their resident populations and fulfill their needs.

Table 10.53: Knowledge of Care Systems and Services, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Homelessness	5.62	5.01	3.58	5.77	5.36	6.27	4.33	4.45
Mental health	7.27	7.37	6.27	8.38	6.86	8.17	6.71	6.72
Affordable / permanent supportive housing	4.88	5.65	4.23	6.79	4.21	5.67	4.10	3.97
Independent living	6.27	6.88	6.34	6.26	6.00	6.37	5.48	5.90
Re-entry assistance	2.73	3.11	2.32	5.77	3.14	4.60	3.35	2.27
Skilled nursing	7.81	7.61	7.00	7.74	7.36	7.23	6.86	6.43
Elderly and aging support	8.15	7.86	7.89	7.06	5.86	6.53	7.52	7.52
Rehabilitative support	7.81	7.23	7.29	7.29	6.71	6.50	6.00	7.07
Hospice	9.15	8.37	7.54	5.94	7.36	5.93	7.60	7.40
Home health care	9.15	8.69	8.34	7.79	8.50	7.83	8.29	8.19
Substance abuse treatment	5.15	5.39	4.35	6.59	5.50	6.33	5.29	4.45

Market facilities owners and/or operators serving SPA 3 (San Gabriel Valley) reported significantly lower mean levels of knowledge in relation to the provision of homelessness services and substance abuse treatment services in the region, in relation to respondents at other SPAs. Respondents from SPAs 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities) reported significantly greater mean levels of knowledge in relation to mental health services available for their residents, in relation to other SPAs. Mean scores for owner/operator knowledge about affordable and permanent supportive housing services and re-entry services was uniformly low across most areas, with the exception of SPAs 4 and 6, with respondents from SPA 2 (San Fernando Valley) also exhibited greater mean levels of knowledge about affordable and permanent supportive housing than most other SPAs.

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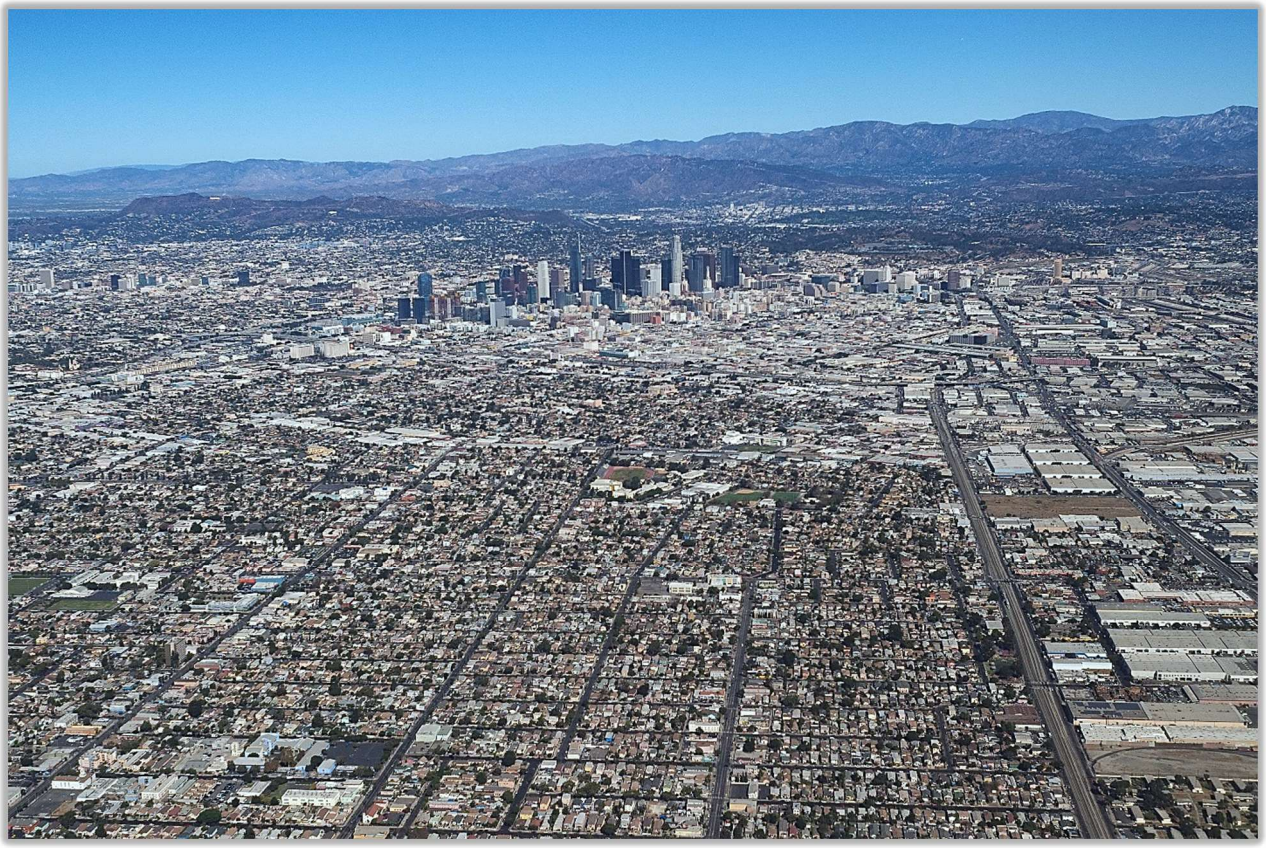

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Market Dynamics and Key Statistics

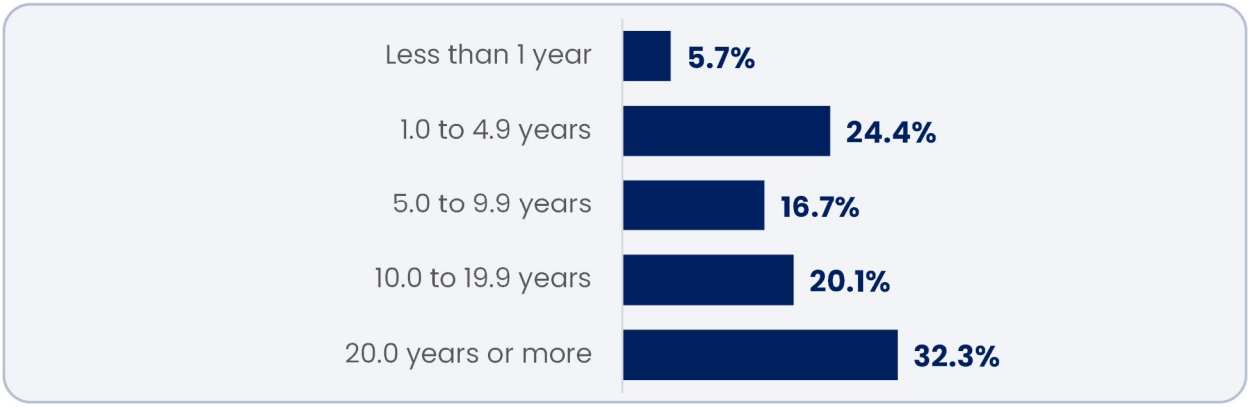
To enable even greater understanding of the Market, additional assessment of key statistics relating to the duration of ownership and operations, future intentions of industry participants, key factors endangering facility sustainability, and satisfaction with ARF and RCFE ownership/ operations were included in the study.

Duration of Market Facility Ownership and Operations (Range and Mean Years)

Data was collected from Market ARFs and RCFEs regarding the continuous operations under the current license class and current owner(s).

FQ14. "How long has your facility been in operation, with both its current license type and owners?"

FACILITY OWNERS & OPERATORS (N=353)



Nearly 1 out of 3 (32.3%) of ARFs or RCFEs willing to serve identified, vulnerable populations of residents as focus for this study have more than 20 years or more of continuous operations under the same license and ownership. Including facilities with 10 or more years of operations, this figure accounts for more than 50% of facilities in the Market. The longevity of facilities illustrates a major issue that many owners and operators encounter with asset condition for the structures that house residents, as well as identifies need for facilities to have access to assistance in the form of grants and/or low interest loans. Such new funding and finance can help with the costs of renovating and maintaining older facilities to keep them compliant with local fire, life, health, and safety regulators and meet (or exceed) state licensing requirements.

Many of the built structures hosting Market ARFs and RCFEs are likely older than the continuous duration of facility ownership and licensure, since many respondents have communicated that their facilities were not built for the specific purpose of hosting an ARF or RCFE. This qualitative finding has been assessed to be most relevant to ARFs, but also applies to the large number of smaller, 6 bed or less RCFEs converted from residential housing stock that lack the scale, access to credit, and funding of many larger, RCFEs that accept a mix of public benefits and privately-funded residents.

About 30% of facilities have been operating in the Market for a period of less than 5 years, including 5.7% for a period of less than one year. This newer segment of the Market reflects significant consolidation in the ownership of licensed facilities over recent years, confirmed from both qualitative interviews and analysis of the State (CCLD) licensing database. However, it is difficult to accurately correlate the age of a building asset or its condition to the duration of facility operations, even under a reasonable assumption that at least some remedial works would have been completed as condition of sale and/or license re-application (transfer).

Table 11.1: Facility Operations (Range), by License Class	ARF	RCFE	ALL
Less than 1 year	3.7%	6.9%	5.7%
1.0 to 4.9 years	23.5%	24.9%	24.4%
5.0 to 9.9 years	13.2%	18.9%	16.7%
10.0 to 19.9 years	16.2%	22.6%	20.1%
20.0 years or more	43.4%	25.4%	32.3%
Not sure	0.0%	1.4%	0.9%

A significantly greater proportion of ARFs reported continuous operation under license and ownership of 20 years or more than RCFEs, consistent with the perceptions of market users that were generally familiar with aspects of multiple ARF facilities.

Table 11.2: Facility Operations (Range), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Less than 1 year	9.3%	0.0%	1.4%
1.0 to 4.9 years	29.9%	17.3%	16.2%
5.0 to 9.9 years	21.1%	14.7%	6.8%
10.0 to 19.9 years	20.6%	16.0%	23.0%
20.0 years or more	18.6%	52.0%	50.0%
Not sure	0.5%	0.0%	2.7%

Significantly greater proportions of ARFs and RCFEs with 6 beds or less reported continuous operations of less than 1 year or between 1 and 5 years under current license and ownership, in comparison to larger facilities, confirming licensing data and anecdotal reports that licensed facilities with 6 beds or less have the greatest proportions of turnover and transfer witnessed across the Market.

Facilities serving 7 to 60 and 61 or more licensed beds or more reported greater proportions of continuous operations under license class and ownership than 6 or fewer bed facilities.

Table 11.3: Facility Operations (Range), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Less than 1 year	0.0%	13.0%	6.0%	0.0%	0.0%	10.0%	0.0%	3.0%
1.0 to 4.9 years	46.2%	28.6%	20.5%	14.3%	57.1%	33.3%	28.6%	9.0%
5.0 to 9.9 years	7.7%	20.8%	18.1%	17.1%	14.3%	26.7%	9.5%	11.9%
10.0 to 19.9 years	26.9%	13.0%	16.9%	31.4%	14.3%	13.3%	28.6%	25.4%
20.0 years or more	19.2%	24.7%	34.9%	37.1%	14.3%	16.7%	33.3%	50.7%
Not sure	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%

Significantly greater proportions of facilities with duration of continuous operations under license and ownership of less than 1 year and 1 to 5 years are observed in SPA 1 (Antelope Valley), SPA 2 (San Fernando Valley), SPA 5 (West Los Angeles and West Cities) and SPA 6 (South Los Angeles and South Cities) than in other Los Angeles County Service Planning Areas, indicating potential opportunities for government agencies and nonprofits to increase directed outreach to newer facility owners and operators serving the identified vulnerable populations that may align with their operational objectives.

More than 50% of facilities serving SPA 8 (South Bay and Coastal Cities) reported continuous operation under owner and license class of 20 years or more, also identifying potential opportunities for directed outreach aligned with governmental and nonprofit program objectives relating to asset conditioning.

Table 11.4: Facility Operations (Mean Years), by License Class	ARF	RCFE	ALL
	17.74	12.50	14.54

With a mean age for facilities across the Market (willing to serve the identified vulnerable populations) at 14.54 years, ARFs report slightly greater means for duration of ownership under current license in comparison to RCFEs.

Table 11.5: Facility Operations (Mean Years), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	9.81	21.55	20.57

Larger licensed facilities serving bed counts of 7 to 60 beds and 61 or more beds demonstrate significantly greater mean durations of continuous ownership and operations (both categories greater than 20.57 years) in

relation to licensed facilities serving 6 beds or less (9.81 years). This finding has significant impacts in understanding the differences in maintaining the physical assets of mid-sized and licensed large facilities in comparison to smaller (6 bed or less) licensed facilities.

Table 11.6: Facility Operations (Mean Years), by License Class and Facility Size	ARF	RCFE
≤ 6 BEDS	11.75	9.08
7–60 BEDS	23.62	17.64
≥ 61 BEDS	19.05	21.78

The greatest mean duration for continuous operations for facilities by both license class and size appears with ARFs serving between 7 and 60 licensed beds, with a mean of 23.62 years, followed by RCFEs serving populations of more than 61 licensed beds.

Table 11.7: Facility Operations (Mean Years), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	12.23	11.83	16.06	18.75	8.55	8.95	14.84	18.17

Facilities serving SPA 3 (San Gabriel Valley) and SPA 4 (Metro Los Angeles and Center Cities) reported the greatest mean durations of continuous operations under license and ownership, in comparison to facilities serving SPA 5 (West Los Angeles and West Cities) and SPA 6 (South Los Angeles and South Cities).

Market Facility Ownership Groups

Anecdotal notions of Market ARF and RCFE ownership communicated by many Market Users and community advocates portray the majority of licensed facilities as being owned and operated by individuals and families. However, the reality of who owns and operates ARFs and RCFEs has evolved considerably, as there is a demonstrated trend of consolidation reported across both ARF and RCFE license classes. The Market exhibits a pattern of increased formation and expansion of groups of facilities within single, multi-facility owners, family groups of multi-facility owners, and consolidated groups of RCFEs within real estate investment trusts (REITs). Few ownership groups are owned by nonprofits, while others are operated within more complex, corporate legal structures.

FQ12. "Do the owners of this facility own another ARF or RCFE?"

FACILITY OWNERS & OPERATORS (N=353)

Table 11.8: Part of Ownership Group by License Class	ARF	RCFE	ALL
	61.0%	58.1%	59.2%

A majority (59.2%) of Market respondents indicated that their facility was owned as part of a group alongside other licensed facilities, either ARFs or RCFEs, both inside and outside of Los Angeles County. To hypothesize from a rational business owner's perspective, the expansion or formation of ARF and RCFE groups represents a natural market behavior which can serve to increase the profitability and viability of the business owner's total holdings.

There is a simple logic to expansion and grouping, especially in consideration of the Market's difficulties in maintaining sustainability and profitability in an inflationary business environment with rising direct and indirect costs. This is made more challenging by persistent levels of funding from government for resident expenses that do not increase proportionately to keep up with inflation. There are additional benefits that can be realized from economies of scale in relation to administration, procurement, and staffing needs with ARFs and RCFEs. Group owners also have the increased benefit of possessing greater portfolios of real estate which could progressively appreciate in value and deliver future financial gains.

This finding highlights a potential strategy to improve the uptake and housing of identified, vulnerable individuals across more facilities, as Los Angeles County agencies and nonprofits can undertake basic database research to correlate and prioritize consolidated approaches with representatives of ownership groups first, then with individual facilities, to increase the numbers of beds made accessible to public funding more quickly.

There is strong, but anecdotal evidence from owners and operators of Los Angeles County facilities that agencies in surrounding jurisdictions (such as Orange and other California counties) are publicly funding the placement of residents from identified, vulnerable populations from other areas in facilities located within Los Angeles County. This practice has been attributed to specific arrangements with ownership groups of facilities that have locations across multiple County jurisdictions. If occurring in any significant numbers, the importation of members of vulnerable populations from other California jurisdictions would place considerable pressure on Market capacity and capability to serve vulnerable residents originating in Los Angeles County communities.

Comparable proportions of facility ownership in groups can be observed across both ARF and RCFE license classes. Further analysis of the CCLD licensing database also indicates that Market ARFs and RCFEs are frequently owned in groups across the different license classes.

Table 11.9: Part of Ownership Group by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	62.3%	50.7%	59.5%

Mid-sized licensed facilities, ranging from 7 to 60 bed resident populations, were reported in significantly lesser proportions to be owned as part of a group than other Market ARFs and RCFEs of greater or smaller resident capacities.

Table 11.10: Part of Ownership Group, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	38.5%	51.9%	66.3%	62.9%	85.7%	43.3%	61.9%	65.7%

From a geographic lens, the greatest proportions of Market facilities which are owned as part of a group were observed in SPA 5 (West Los Angeles and West Cities), with a relatively low number of licensed facilities serving the area. SPA 1 (Antelope Valley) and SPA 6 (South Los Angeles and South Cities) have the lowest reported levels for group ownership of facilities.

Market Facility Sale or Transfer Intentions

Facility owners and/or operators were asked to identify if their facility had previously established or communicated any intention to sell or transfer ownership of their ARF or RCFE within the next 12 months (at time of interview).

FQ11. "Does your facility have any plans to sell the property or transfer ownership within the next 12 months?"

FACILITY OWNERS & OPERATORS (N=353)

Table 11.11: Sale or Transfer Intentions (Within 12 Months) by License Class	ARF	RCFE	ALL
Yes	2.9%	5.1%	4.2%
Not sure	4.4%	6.9%	5.9%
No	92.6%	88.0%	89.8%

Almost 90% of Market facility respondents interviewed indicated that their facility had no known intentions to sell or transfer ownership of their facility within 12 months. Only 4.2% of facilities indicated that their facility had sale or transfer intentions within the year: a figure comparable with data collected for the proportion of facilities that had continuous duration of ownership and license for less than 1 year (5.6%). A presumed

approximation of 5% of facilities either changing licensees or departing the Market each year is consistent with observed opinions and trends expressed by knowledgeable Market Users and industry leaders interviewed.

Approximately 5.9% of owners and/or operators of Market ARFs and RCFEs indicated that they were not sure about their intentions to sell and/or transfer ownership of their facility within 12 months, a figure which reflects both considerable and unknowable risk in reducing the Market capacity and capability to house identified, vulnerable populations.

A greater proportion of Market ARF owners and operators indicated that they had no intention to sell or transfer ownership of their facility within the next 12 months in comparison to RCFE respondents. RCFE owners and/or operators also reported being uncertain about sale or transfer intentions for their facility in slightly elevated proportions over ARF respondents.

Table 11.12: Sale or Transfer Intentions (Within 12 Months), by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Yes	4.4%	8.0%	0.0%
Not sure	4.9%	5.3%	9.5%
No	90.7%	86.7%	90.5%

A significantly greater proportion of Market respondents from 7 to 60 licensed bed facilities indicated intention to sell or transfer their facility from those representing smaller or larger facilities. Facilities serving licensed bed counts of 61 or more reported being not sure about their facility sale or transfer intentions in significantly greater proportions than smaller facilities.

Table 11.13: Sale or Transfer Intentions (Within 12 Months), by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Yes	3.8%	2.6%	13.3%	2.9%	0.0%	0.0%	0.0%	0.0%
Not sure	0.0%	6.5%	12.0%	2.9%	7.1%	13.3%	0.0%	0.0%
No	96.2%	90.9%	74.7%	94.3%	92.9%	86.7%	100.0%	100.0%

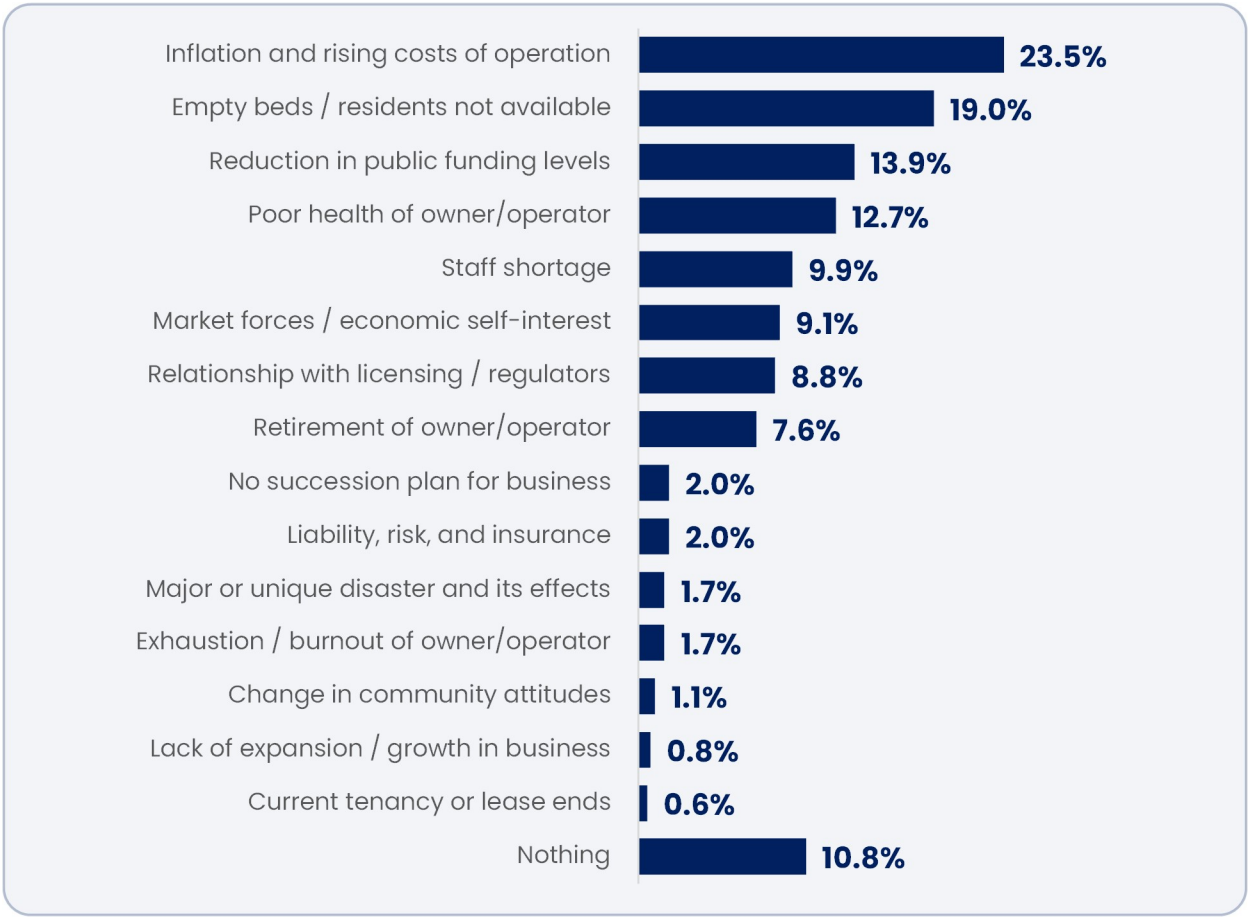
Significantly greater proportions of Market facility owners and/or operators located in SPA 3 (San Gabriel Valley) indicated intentions to sell or transfer the ownership of their facility in the next 12 months in comparison to respondents across all other SPAs. The greatest proportions of respondents who were not sure about facility sale or ownership transfer intentions were located in SPA 3 and in SPA 6 (South Los Angeles and South Cities).

Factors Leading to Closure or Sale of Market Facilities

Market ARF and RCFE owners and/or operators were asked to identify what key factors (or reasons) would directly lead to their facility's closure and/or ownership transfer.

FQ79. "What are the key factors that might lead to your facility's closing and/or sale?" (MR)

FACILITY OWNERS & OPERATORS (N=353)



The most frequently referenced factors by Market owners and operators for facility closure, sale, or transfer, are dominated by 2 primary themes: more than 50% of the factors relate to macroeconomic, funding, and resident capacity mechanisms affecting facilities, while the other 33% generally relate to personal aspects of health, well-being, and prosperity for individual (and family) owners and/or operators, mostly at facilities serving smaller licensed bed counts.

Inflation and the rising costs of operation was identified by 23.5% of owners and/or operators as a factor that could lead to the closure, sale, or transfer of their Market ARF or RCFE, followed by empty beds, reported by 19.0% of respondents. A reduction of funding levels to assist identified, vulnerable individuals was identified as a factor by 13.9% of respondents, followed by poor health of the owner/operator (12.7%), and staff shortage (9.9%). Broader market forces and economic self-interest were identified by 9.1% of respondents, followed by relationship with licensing / regulators at 8.8%, and retirement of the owner/operator at 7.6%. Only 10.8% of Market ARF and RCFE owners and/or operators were confident in stating that nothing (or no factor that they were aware of) could eventuate in the closing, sale, or transfer of their facility.

Table 11.14: Factors Leading to Closure or Sale, by License Class	ARF	RCFE	ALL
Inflation and rising costs of operation	27.9%	20.7%	23.5%
Empty beds / residents not available	13.2%	22.6%	19.0%
Reduction in public funding levels	25.0%	6.9%	13.9%
Poor health of owner/operator	11.8%	13.4%	12.7%
Staff shortage	11.0%	9.2%	9.9%
Market forces / economic self-interest	8.8%	9.2%	9.1%
Relationship with licensing / regulators	6.6%	10.1%	8.8%
Retirement of owner/operator	7.4%	7.8%	7.6%
Liability, risk, and insurance	0.7%	2.8%	2.0%
No succession plan for business	2.9%	1.4%	2.0%
Exhaustion / burnout of owner/operator	2.2%	1.4%	1.7%
Major or unique disaster and its effects	1.5%	1.8%	1.7%
Change in community attitudes	1.5%	0.9%	1.1%
Lack of expansion / growth in business	1.5%	0.5%	0.8%
Current tenancy or lease ends	0.7%	0.5%	0.6%
Nothing	7.4%	12.9%	10.8%

A significantly greater proportion of Market ARF owners and/or operators indicated that a reduction in public funding levels to pay for the room, board, and care of their residents would lead to their closure and/or transfer of ownership in comparison to their RCFE counterparts. ARF respondents also indicted that empty beds or residents not being available would cause their sale or transfer in significantly lower proportions than RCFE respondents, largely reflective of the high level of demand from market users for placements of residents from identified vulnerable populations at ARFs. A slightly elevated proportion of Market RCFE respondents indicated that nothing could lead to their facility's closure and/or transfer, in comparison to ARF respondents.

Table 11.15: Factors Leading to Closure or Sale, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Inflation and rising costs of operation	21.6%	18.7%	33.8%
Empty beds / residents not available	23.0%	10.7%	16.2%
Reduction in public funding levels	10.8%	16.0%	18.9%
Poor health of owner/operator	12.3%	14.7%	12.2%
Staff shortage	12.3%	10.7%	2.7%
Market forces / economic self-interest	6.4%	13.3%	12.2%
Relationship with licensing / regulators	10.8%	6.7%	5.4%
Retirement of owner/operator	9.3%	8.0%	2.7%
Liability, risk, and insurance	1.5%	2.7%	2.7%
No succession plan for business	2.0%	2.7%	1.4%
Exhaustion / burnout of owner/operator	1.5%	1.3%	2.7%
Major or unique disaster and its effects	0.5%	0.0%	6.8%
Change in community attitudes	1.0%	1.3%	1.4%
Lack of expansion / growth in business	1.5%	0.0%	0.0%
Current tenancy or lease ends	1.0%	0.0%	0.0%
Nothing	11.3%	13.3%	6.8%

Significantly greater proportions of Market respondents serving facilities of 61 licensed beds or more reported that inflation and the rising costs of operation, reduction in public funding levels, and a major or unique disaster would be likely to cause the sale or transfer of ownership of their facility, in comparison to facilities licensed to serve smaller populations. For facilities (principally RCFEs) with 6 licensed beds or less, empty beds and residents not being available, market forces and economic self-interest, as well as the facility's relationship with licensing and regulators are key factors for facility closure or transfer in significantly greater proportions than larger licensed facilities.

Table 11.16: Factors Leading to Closure or Sale, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Inflation and rising costs of operation	34.6%	28.6%	25.3%	31.4%	28.6%	13.3%	9.5%	14.9%
Empty beds / residents not available	34.6%	20.8%	13.3%	5.7%	21.4%	20.0%	23.8%	22.4%
Reduction in public funding levels	7.7%	11.7%	13.3%	28.6%	14.3%	23.3%	19.0%	6.0%
Poor health of owner/operator	19.2%	6.5%	7.2%	8.6%	7.1%	13.3%	9.5%	28.4%
Staff shortage	0.0%	11.7%	8.4%	11.4%	7.1%	10.0%	14.3%	11.9%
Market forces / economic self-interest	7.7%	7.8%	15.7%	8.6%	21.4%	6.7%	4.8%	3.0%
Relationship with licensing / regulators	7.7%	13.0%	12.0%	8.6%	7.1%	6.7%	4.8%	3.0%
Retirement of owner/operator	7.7%	10.4%	4.8%	8.6%	0.0%	13.3%	14.3%	4.5%
Liability, risk, and insurance	0.0%	2.6%	3.6%	0.0%	0.0%	0.0%	0.0%	3.0%
No succession plan for business	0.0%	1.3%	0.0%	2.9%	0.0%	3.3%	4.8%	4.5%
Exhaustion / burnout of owner/operator	0.0%	3.9%	0.0%	2.9%	7.1%	0.0%	4.8%	0.0%
Major or unique disaster and its effects	0.0%	0.0%	4.8%	0.0%	7.1%	0.0%	0.0%	1.5%
Change in community attitudes	3.8%	0.0%	1.2%	2.9%	0.0%	3.3%	0.0%	0.0%
Lack of expansion / growth in business	0.0%	1.3%	0.0%	0.0%	0.0%	3.3%	0.0%	1.5%
Current tenancy or lease ends	0.0%	1.3%	0.0%	2.9%	0.0%	0.0%	0.0%	0.0%
Nothing	7.7%	14.3%	18.1%	5.7%	0.0%	0.0%	14.3%	7.5%

Facilities in SPA 1 (Antelope Valley) and SPA 4 (Metro Los Angeles and Center Cities) identified that inflation and rising costs of operation were a factor that could lead to their facility closure or transfer of ownership in significantly greater proportions than other SPAs, with facilities in SPA 1 also identifying empty beds and residents not being available in significantly greater proportions than others. The factor of poor health of the owner was seen in significantly greater proportions in SPA 1 and SPA 8 (South Bay and Coastal Cities).

SPA 4 (Metro Los Angeles and Center Cities) and SPA 6 (South Los Angeles and South Cities) Market respondents identified reduction in public funding levels in significantly greater proportions than owners and/or operators serving in other SPAs. Respondents from SPA 6 and SPA 7 (East Los Angeles and South East Cities) indicated that the retirement of the owner was a factor in significantly greater proportions than other respondents.

SPA 7 respondents also reported staff shortage as a factor of concern in elevated proportions. Greater proportions of respondents serving licensed facilities in SPA 2 (San Fernando Valley) and SPA 3 (San Gabriel Valley) indicated that their relationship with licensing (CCLD) and other regulators were factors that could result in sale or transfer. Respondents from SPA 5 mentioned market forces and economic self-interest in significantly greater proportions than respondents from other SPAs, with the exception of elevated proportions of respondents from SPA 3 (San Gabriel Valley) communicating this factor, as well.

Satisfaction with Ownership / Operation of a Market Facility

Owners and/or operators of Market ARFs and RCFEs were asked to evaluate their overall, personal level of satisfaction that they derived from the ownership and/or operation of a licensed facility, utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating no satisfaction at all, and 10 indicating complete satisfaction. (For all questions specifically related to a facility respondent's personal future intentions or opinions affecting Market participation, segmentation was performed to understand differences based on the role(s) held at Market facilities.)

FQ80. "On a scale of 0-10, what is your overall level of personal satisfaction with owning or operating an ARF/RCFE?"

FACILITY OWNERS & OPERATORS (N=353)

Table 11.17: Overall Satisfaction in Industry Role, by Role	OWNER	OPERATOR	OWNER & OPERATOR
	8.00	9.10	8.63

Market owners and/or operators of licensed ARFs and RCFEs display consistently high levels of overall satisfaction with their participation in the industry and the Market, with an (exceptionally) high mean satisfaction score for all respondents of 8.87 out of a possible 10.00. This figure conveys significant and consistent levels of high satisfaction across respondents serving across the diversity of facilities between license classes, facility sizes, ownership structure, location in Los Angeles County, and variance in populations served.

This finding is of particular interest in the context of difficulties that Market owners and operators have communicated they experience in regard to the hiring and retention of staff. For the benefit of the industry, advocates supporting efforts to enhance staffing and participation in facilities to sustain them should promote the overall job satisfaction levels that most owners and operators have expressed in this regard, supplementing this evidence with identifiable pathways to support skills development and career advancement for staff serving in care and support roles at facilities.

Operators of Market facilities without ownership accountabilities reported slightly greater mean levels of overall satisfaction in comparison to both owners and owner-operators, while respondents identifying as owners (without any regular, operational duties in facilities) reported significantly lower mean levels of overall satisfaction relative to other respondents.

Table 11.18: Overall Satisfaction in Industry Role, by License Class	ARF	RCFE	ALL
	8.75	8.95	8.87

There were no substantive differences in mean overall satisfaction observed between respondents from ARF and RCFE license classes.

Table 11.19: Overall Satisfaction in Industry Role, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	8.83	8.92	8.96

There were no substantive differences in mean overall satisfaction among Market respondents from different facility sizes.

Table 11.20: Overall Satisfaction in Industry Role, by License Class and Facility Size	ARF	RCFE	ALL
≤ 6 BEDS	8.66	8.89	8.83
7–60 BEDS	8.79	9.15	8.92
≥ 61 BEDS	8.84	9.05	8.96

Respondents serving at Market RCFEs licensed to serve populations of 7 to 60 or 61 or more beds reported slightly greater mean levels of overall satisfaction in relation to facilities of other sizes and license classes.

Table 11.21: Overall Satisfaction in Industry Role, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	9.08	8.42	8.88	8.83	8.71	8.75	9.10	9.34

Facility owners and/or operators based in Market facilities serving SPA 1 (Antelope Valley), SPA 7 (East Los Angeles and South East Cities), and SPA 8 (South Bay and Coastal Cities) reported elevated levels of overall satisfaction from facility ownership and/or operation than respondents from other Los Angeles County Service Planning Areas.

Willingness to Suggest Market Facility Ownership to Others

Market facility respondents were asked to identify how willing they would be to suggest ownership to others, utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating they would not be willing to suggest at all, and 10 indicating that they would always suggest it.

FQ81. "On a scale of 0-10, would you be willing to suggest to someone else that they buy or establish an ARF or RCFE?"

FACILITY OWNERS & OPERATORS (N=353)

Table 11.22: Willingness to Suggest Facility Ownership to Others, by Role	OWNER	OPERATOR	OWNER & OPERATOR
	7.00	7.49	7.27

Mean scoring for the willingness of Market owners and/or operators to suggest ownership to others is relatively positive (7.39 out of 10.00), but slightly tempered, especially in comparison to mean overall satisfaction levels expressed by the same pool of respondents. One hypothesis considered for this difference was potential reticence by some owners to invite more competition into the Market. However, this is not supported by feedback from facility owners, especially considering public efforts by advocacy groups and organizations led by owners and operators which have stated support for increases in the number of ARFs and RCFEs (and for new owners and operators) with interest in serving the Market.

Segmenting respondents by their role(s) within facilities, slightly greater proportions of Market operators would suggest facility operations roles to others, in comparison to somewhat reduced means for willingness to suggest facility ownership and/or operations expressed by respondents with roles as facility owners or owner-operators.

Table 11.23: Willingness to Suggest Facility Ownership to Others, by License Class	ARF	RCFE	ALL
	7.17	7.52	7.39

Greater proportions of respondents serving at Market RCFEs are willing to suggest facility ownership and/or operations to others, in comparison to owners and/or operators serving at ARFs.

Table 11.24: Willingness to Suggest Facility Ownership to Others, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
	7.49	6.89	7.59

7 to 60 licensed bed owner and/or operators expressed significantly lower levels of willingness to suggest facility ownership and/or operations to others, in comparison to respondents serving with larger or smaller facilities.

Table 11.25: Willingness to Suggest Facility Ownership to Others, by License Class and Size	ARF	RCFE
≤ 6 BEDS	7.76	7.39
7–60 BEDS	6.75	7.15
≥ 61 BEDS	6.78	8.21

Respondents serving at Market ARFs with licensed bed capacities of 7 to 60 beds and 61 beds or more reported significantly lower levels of mean willingness to suggest facility ownership and/or operations to others, with respondents serving at RCFEs with 61 or more licensed beds reporting significantly greater mean levels of willingness to suggest ownership and/or operating a facility to others.

Table 11.26: Willingness to Suggest Facility Ownership to Others, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
	7.65	6.67	7.51	6.63	7.00	7.83	6.76	8.42

Respondents serving at Market facilities located in SPA 2 (San Fernando Valley), SPA 4 (Metro Los Angeles and Center Cities), and SPA 7 (East Los Angeles and South East Cities) expressed significantly lower mean levels of willingness to suggest facility ownership and/or operations to others in comparison to facility owners and/or operators serving in other SPAs.

Owners and/or operators serving in SPA 8 (South Bay and Coastal Cities) expressed significantly greater levels of willingness to recommend facility ownership to others.

Owner / Operator Intentions for Future Market Participation

Respondents were asked to assess their level of confidence in continuing to serve in their role(s) in the ARF or RCFE industry on a 1-year, 5-year, and 10-year timeframe. This question was posed utilizing an absolute, Likert scale measure of 0 to 10, with 0 indicating no confidence at all, and 10 indicating complete (or total) confidence.

The majority of Market ARF and RCFE owners and operators were very positive in their forward outlook and conveyed high levels of relative confidence in their intentions to remain as owners and professionals serving the Market on a 1-year and 5-year timeframe. However, in considering if they would remain in their roles on a 10-year timeframe, overall confidence for many respondents in continuing to serve dropped considerably.

FQ76. TO FQ78. "On a scale of 0-10, how confident are you that you will continue to own and/or operate a facility in the industry for…?"

FACILITY OWNERS & OPERATORS (N=353)

Table 11.27: Confidence of Remaining in Industry, by License Class	OWNER ONLY	OPERATOR ONLY	OWNER & OPERATOR
Confidence in continuing for 1 year	8.57	9.42	9.14
Confidence in continuing for 5 years	7.86	7.72	8.26
Confidence in continuing for 10 years	7.43	5.80	6.68

With a mean confidence score of 9.28 out of 10.00 from facility respondents to remain in their roles across the Market on a 1-year timeframe, mean confidence scores drop considerably on a 5-year timeframe (-1.32 points), and even more precipitously on a 10-year timeframe (-1.75 points), into reasonably uncertain territory that signifies risks to Market stability. This is often referred to colloquially as the "brain drain" phenomenon.

The implications of progressively increasing exits by current owners and operators on the long-term survival of the Market of ARFs and RCFEs to serve identified, vulnerable populations are significant and highly-impactful.

As increasing numbers of participants serving vital roles in the Market diminishes increasingly over 5-year intervals, collective expertise held with the remaining pool of Market participants could also be reduced proportionately. The Market will require increasing numbers of new staff with little familiarity or expertise to commence ownership and operations roles as existing participants depart. This also places increasing burden on regulators, both from local jurisdictions and CCLD, to bring new players up to speed on regulations and best practice to comply with fundamental business requirements and government expectations for resident care.

This finding also has implications for the participation of Market ARFs and RCFEs in recent asset improvement and funding programs administered by the State of California, with some programs requiring owners to guarantee participation for periods of years to qualify for selection[21], potentially exceeding the suggested timelines of Market participation as interpreted from the diminishing levels of confidence to remain in the industry expressed by many respondents.

Government agencies should consider taking measures to increase long-term confidence among key participants and knowledge holders in the Market to retain them and their expertise in the Market for longer periods of time. This is a vitally important consideration in building and maintaining the Market to be survivable for both established and new business owners alike, to deliver quality and capability to match and exceed the needs of residents, as well as assure maximal public value and benefit against the costs and supports provided by government to ARFs and RCFEs as a vital channel of housing and care.

While operators indicated that they held slightly greater mean levels of confidence in intentions to serve at ARFs and RCFEs on a 1-year timeframe, owner-operators held the slightly greater mean levels of confidence on a 5-year timeframe. Owners of facilities without operational duties expressed significantly greater mean levels of confidence to remain involved in the industry over a 10-year timeframe, albeit at slightly lower levels than their 1-year or 5-year confidence assessments.

Table 11.28: Confidence of Remaining in Industry, by License Class	ARF	RCFE	ALL
Confidence in continuing for 1 year	9.10	9.40	9.28
Confidence in continuing for 5 years	7.86	8.03	7.96
Confidence in continuing for 10 years	6.08	6.30	6.21

In comparing ARF and RCFE respondent mean levels of confidence, RCFE respondents expressed slightly greater mean levels of confidence for continuing in the industry across all timeframes, with a considerable drop in mean confidence levels in considering a 10-year participation timeframe.

Table 11.29: Confidence of Remaining in Industry, by Facility Size	≤ 6 BEDS	7–60 BEDS	≥ 61 BEDS
Confidence in continuing for 1 year	9.39	8.66	9.59
Confidence in continuing for 5 years	8.25	7.37	7.75
Confidence in continuing for 10 years	6.55	5.92	5.58

While respondents serving at 7 to 60 bed ARFs and RCFEs expressed slightly lower mean levels of confidence to remain in their role(s) on a 1-year timeframe, owners and/or operators serving 7 to 60 and 61 or more licensed bed facilities expressed lower levels of confidence in their remaining in the industry on a 10-year timeframe, in comparison to respondents serving at 6 or fewer licensed bed facilities, who also exhibited greater mean levels of confidence across a 5-year timeframe.

[21] Such as Community Care Expansion (CCE), https://www.infrastructure.buildingcalhhs.com/joint-request-for-applications-rfa/

Table 11.30: Confidence of Remaining in Industry, by SPA	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Confidence in continuing for 1 year	9.69	9.01	8.95	9.31	9.50	9.47	9.81	9.51
Confidence in continuing for 5 years	8.96	7.65	7.54	8.37	8.07	8.28	8.43	7.91
Confidence in continuing for 10 years	7.35	5.95	6.01	6.77	6.77	6.38	6.43	5.78

Owners and/operators serving licensed facilities in SPA 1 (Antelope Valley) reported consistently greater mean levels of confidence to remain in their role(s) in the industry on a 1-year, 5-year, and 10-year timeframe, in comparison to respondents across nearly every other timeframe and SPA.

Respondents serving facilities located in SPA 2 (San Fernando Valley) and SPA 8 (South Bay and Coastal Cities) reported lower mean levels of confidence in continuing to serve in their role(s) in the industry on a timeframe of 10-years, in comparison to respondents serving facilities across other Service Planning Areas.

Incentivizing ARF Ownership and Expansion

A common concern expressed amongst governmental and non-governmental ARF Market Users is the perception that too many ARFs are considering leaving, or have already left the market. Other than basic rates paid by public benefits, the rates paid from public benefits for most ARF residents from most vulnerable populations lag significantly behind the rates of funding received for a resident with developmental disabilities or those received to provide care to a privately funded RCFE resident, even without the provision of luxury or enhanced amenities.

The extreme proportion of ARF residents reliant on public benefits to fund room, board, and care prevents these owners and operators from enhancing business survivability and sustainability through the placement of fee-paying clients. Greater public incentives are required for the creation and development of new ARFs, which almost exclusively serve individuals completely reliant on public benefit.

It is difficult to define a rational business case for new players to consider entering the Market to fund development of new ARFs to serve identified, vulnerable populations. Elected officials and legislators can direct the reductions in taxation, fees, and the costs of insurance for ARFs, as well as increasing rates reimbursed for care provided for ARF residents. In concert, many of these actions could make a better business case for potential Market entry by additional, rational players, and increase the number of ARFs serving the needs of vulnerable populations.

Incentivizing Greater RCFE Participation

With a fee-paying, private rate mechanism already in place to sustain the RCFE market base, incentivizing RCFE ownership is not a core issue. RCFEs outnumber ARFs in Los Angeles County, but far fewer RCFEs serve vulnerable populations than ARFs. Annually, the number of licensed RCFEs entering the market exceeds the number of licensed ARFs entering the Los Angeles County Market.

Unlike ARFs, privately-funded or self-funded rates for resident stays at RCFEs in Los Angeles County exist in a broad cost range, varying by several thousand dollars per resident, per month. However, establishing public funding to bridge the gap between low- to mid-level RCFE rates and the rates reimbursed by public assistance programs is critical to capture greater capacity within the RCFE market for the identified, vulnerable populations. Any “patch” or bridging payments should ideally correspond with the acuity of care needs and expenses for individual residents. As noted previously in this study, many of the 6,400 vacant and underutilized beds that could serve seniors experiencing homelessness in Los Angeles County were observed within the RCFE license class.

Many RCFE owners and operators not currently serving the population have expressed willingness to do more to house seniors from vulnerable populations, but they have four major needs to be fulfilled to maximize placements in the RCFE Market segment:

1) Avoidance of an "first available placement" approach for RCFEs, to ensure that senior individuals are placed in RCFEs which are comprehensively appropriate for their specific needs, and do not enable individuals to pose dangers to other vulnerable members of resident communities;

2) A need for transitional programs and assistance to socially integrate seniors who have experienced long-term homelessness, incarceration, or substance abuse/misuse into RCFE communities, both before and after placement;

3) Active, post-placement management and care via highly-integrated wraparound services for the special needs of seniors placed from vulnerable populations into RCFEs; and,

4) Financial incentivization in the form of bridging funding between the rates provided from standard governmental benefits (such as SSI, SSDI, or ALW program rates) and the reasonable range of rates provided to facilities from low- to mid-range privately-funded or self-funded residents.

Improving Market User Information about Facility Capabilities

In addressing the needs of a vast number of Market Users that find it difficult to locate, assess the suitability of, or place vulnerable individuals with a specific mix of needs in Market ARFs and RCFEs, consideration should be provided by the market regulator, CCLD, to reorganize facility licensing categories or subclassify facilities within existing license classes based on their enhanced capabilities to serve more specific, vulnerable populations.

CCLD stakeholders indicated that the regulator formerly possessed more detailed descriptions and information about the composition of vulnerable populations served by ARF and RCFE facilities. As a matter of policy, with valid intentions to protect residents from neighbors in communities with biases against specific, vulnerable populations, the practice of collecting or distributing this information was abandoned. Based on feedback from senior leaders and Market Users from across the many systems of care that make use of ARFs and RCFEs, it is recommended that this policy and/or change should be reconsidered. To address the relevant, historical concerns of CCLD stakeholders regarding the potential misuse of such information, this critical resource of information could be resurrected in an access-controlled environment for exclusive reference by verified Market Users serving in critical navigation roles with Counties, or other governmental agencies.

If CCLD is unwilling or unable to reconsider furnishing this information to a limited number of reliable, governmental Market Users who will keep the primary source for this information in-confidence, the role of generating and serving as custodian for this data should fall to a Los Angeles County agency that is also willing to not only actively manage this resource internally, but on behalf of all other governmental, nonprofit, and community Market Users. It is not advisable to vest this information with a nonprofit or commercial entity, due to issues of potential disruption(s) from continuation of funding, reduced cooperation from facilities in the collection and provision of this information due to concerns about how the data could be misused by a non-governmental entity, and/or enhanced costs to Market Users from commercial maintenance or secure access to this information. As the market regulator, CCLD has better means by which to collect this information (and resident demographic / census data) than any other entity, as part of rolling, facility re-licensure processes.

Another approach to maintaining specialization of facilities information is found in the parallel market of facilities serving those living with developmental disability, which requires exclusivity for the majority of its facilities serving the population. Multiple Regional Center stakeholders shared that they have strict guidelines regarding mixed usage of facilities due to specific issues relating to potential vulnerabilities for the population they serve, also identifying the high degree of information and knowledge that they possess regarding the specific capabilities of every facility that provides services to their clients. This function is driven by the California Welfare and Institutions Code (WIC) for Regional Center-affiliated facilities under the aegis of the Department of Developmental Services[22]. The key drawback of the approach taken by the Regional Centers is the potential for other Market Users serving differing groups of vulnerable populations not having transparency

[22] Section 4418.25 (b) (1 - 4), of the California Welfare and Institutions Code (WIC): https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=4.1.&title=&part=1.&chapter=&article=

into the utilization rates of facilities dedicated to a single channel of services. Further, when service models for any particular channel of service to a specific vulnerable population experiences change, coordination and interface efforts are required to preserve and reoptimize the total capacity of facilities across multiple markets, for potential use by other vulnerable populations that may continue to be underserved by available ARF and RCFE housing.

Whatever solutions are deployed to provide Market Users with additional information about the specialization of facilities, via any agency or stakeholder group, this feature is an asymmetric gap in information that leads Market Users to place residents from vulnerable populations in less optimal Market facilities than those that could deliver more of their specific needs, which leads to additional churn and lateral movements amongst ARFs and RCFEs, and outwards to higher levels of care in other systems. The current, siloed operational practices reported by Market Users of having personal knowledge, familiarity, and existing relationships to place clients from their systems of care with specific facilities reduces the net benefit and value of the Market for all users.

12.0

Image: www.dreamstime.com

Estimated Costs of Care to Taxpayers

Econometric research was undertaken to establish comparative understanding of the costs of care to Los Angeles County taxpayers for Market ARFs and RCFEs against the cost of delivering in-situ services to people experiencing homelessness. The estimations of comparative costs of care for taxpayers have been developed from the analysis of governmental data, literature review of prior studies into costs generated by people experiencing homelessness and other less optimal settings where residents would be if not housed within the Market.

Econometric Summary

- According to the LAHSA's January 2022 Homeless Count, there were 60,111 individuals defined as not permanently housed during the point-in-time count[23]. For the purposes of the analysis, this figure is utilized as a basis for the entire 2022 calendar year[24].

- **Based on the published budgets of Los Angeles County-based public agencies and a literature review of recent research, it is estimated that providing services and care to people experiencing homelessness in Los Angeles County came at a direct cost to local taxpayers of more than $2.05 billion for calendar year 2022.** This estimated cost to taxpayers is inclusive of cost expenditures by County of Los Angeles Departments, all 88 cities and municipalities located within Los Angeles County, the Los Angeles Homeless Services Authority (a joint powers authority), and the California Department of Transportation.

- **Estimated costs to taxpayers presented herein do not duplicate pass-through funds disbursed to local agencies from State and Federal sources[25],** business improvement districts, nonprofits and charities, or ancillary costs of public agencies not directly attributable to people experiencing homelessness.

- **This study utilized a "full time homeless individual", or FTHI basis. FTHI estimates the equivalent costs of supporting an individual experiencing a period of uninterrupted homelessness (on the street, in a vehicle, in temporary/crisis/bridge accommodation, or otherwise without permanent address or abode) for the duration of a calendar year.** Utilizing FTHI helps to account for services to individuals that experienced homelessness for only a portion of 2022.

- **The estimated cost to Los Angeles County taxpayers of providing homelessness services and care during the 2022 year was $34,194, per FTHI.** Many of the previous studies reviewed in preparation for this analysis identified that the most expensive 5% of services came at a cost to taxpayers of 40% or more of overall homelessness services costs for the total, unhoused population. On this basis, the top 5% of homelessness services users in Los Angeles County in 2022 (3,457 individuals) attracted an average services cost of $273,553 per FTHI. Previous studies also documented individuals experiencing homelessness utilizing over $1 million in taxpayer-funded services in a single year.

- In comparison to the average costs of residents receiving services at Market ARFs and RCFEs and in consideration of findings and insights presented in the study, coupled with reference to prior research into the types of service utilization required by people experiencing homelessness, up to 90% of people experiencing homeless would require a much lower cost mix of services funded by government if housed at Los Angeles County ARFs and RCFEs (Non-Medical Out-of-Home Care), **which at lowest-funded levels, the cost per resident cost to taxpayers was approximately $15,500 in 2022.**

- **Based on estimated utilization levels of government funding across the identified, vulnerable resident population, the weighted average cost per resident, per year across all government-funded Market ARF and RCFE beds in Los Angeles County for 2022 was $20,713.** This equates to a 39.4% reduction in costs compared to the costs to taxpayers of providing services to people experiencing homelessness over the calendar year.

- **On a comparative basis, Los Angeles County taxpayers could have hypothetically saved up to $810 million in government expenditure in 2022 if Market ARF and RCFE housing were funded to directly house all 60,111 people experiencing homelessness instead of serving them in other, in-situ settings, under a hypothetical assumption that Market possessed bed capacity levels to house all individuals experiencing homelessness during that year.** This extreme, hypothetical estimate excludes one-time costs to expand Market capacity to enable housing and service delivery.

[23] https://www.lahsa.org/documents?id=5201-homelessness-statistics-by-city.pdf
[24] At time of analysis, the 2023 LAHSA point-in-time count of people experiencing homelessness was not yet available.
[25] De-duplication of State and Federal funding also applies to Medi-Cal and Medicare reimbursements to County agencies.

Literature Review Relating to County Homelessness Services Expenses

The research team examined more than 20 prior research papers and studies, before determining that 5 were principally-relevant, Los Angeles County-based studies with insights and findings that could deeply inform the study's econometric analysis. The consensus finding across these studies suggests that supportive housing ("broadly" analogous to the provision of Market ARF and RCFE housing and care) is likely to reduce the frequency and use of public services, such as emergency room visits, in-patient care, and reliance on General Relief, especially in comparison to the potential expenses generated from in-situ service delivery to people experiencing homelessness on the street, in vehicles, in shelters or temporary accommodation, or without other permanent abode.

The Flaming, Burns, and Matsunaga (2009) study[26] found that governmental costs for individuals receiving General Relief who had experienced periods of homelessness decreased by about half when these individuals were not experiencing homelessness. The authors reported that public service costs were lower in the group receiving housing, even after taking into account the service costs of supportive housing itself. The authors found that average public service savings was $2,300 per month ($27,600/year) and $1,200 per month ($14,400/year) after including supportive housing costs. A 79% reduction in public service costs was identified, largely attributed to reduced health care service needs.

Toros, Stevens, and Moreno (2012)[27] estimated a 38-percent reduction in public service costs resulting in the $3,400 per month ($40,800/year) average public service costs per individual one year prior to housing falling to $2,100 per month ($25,200/year) for the year after being housed. This identified an overall net savings of approximately $4,800 per individual, over the first two years of the program. A study of frequent users of hospital services by Flaming, et. al. (2013)[28], found that health care costs were estimated to have declined 72 percent, from $58,962 to $16,474 on average, per person, for an estimated net savings of $31,736.

There were two studies that relied almost exclusively on Los Angeles County service utilization data procured from the Los Angeles County Executive Office (CEO). Wu and Stevens (2016)[29] identified the County resources directly associated with services to people experiencing homelessness, serving as the County's official report on these costs. This report was considered as a baseline for further analysis. With additional review, there were indications that information was missing or incomplete, such as that one-third of the participants did not have any Emergency Room or County hospital visits in the year prior. Without eliciting additional information, it was hypothesized that either these individuals either received no care, or the data set did not contain information on utilization of private hospitals or health care services provided by non-governmental entities.

Hunter, et. al. (2017) [30], on behalf of the Rand Corporation, conducted a study regarding cost savings on the effects of permanent supportive housing on the costs of delivery of services utilizing a pre-post methodology. The authors found an overall 60% reduction in County expenditures when comparing costs incurred during the year prior to supportive housing and for the year after. With a greater than 80% in reduction in jail expenses alone, when the cost of housing was included, there was a net 20% reduction in overall costs to the County.

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[26] Flaming, Daniel, Burns, Patrick and Matsunaga, Michael. "Where We Sleep: Costs when Homeless and Housed in Los Angeles." Economic Roundtable (2009).
[27] Toros, Halil, Stevens, Max, and Moreno, Manuel. "Project 50: The Cost Effectiveness of the Permanent Supportive Housing Model in the Skid Row Section of Los Angeles County." County of Los Angeles, Chief Executive Office–Service Integration Branch, (June 2012).
[28] Flaming, Daniel, Lee, Susan, Burns, Patrick, and Sumner, Gerald. "Getting Home: Outcomes from Housing High-Cost Homeless Hospital Patients." Conrad N. Hilton Foundation, UniHealth Foundation, CSH, the Corporation for National and Community Service, and the Economic Roundtable (2013).
[29] Wu, Fei and Stevens, Max. "The Services Homeless Single Adults Use and their Associated Costs: An Examination of Utilization Patterns and Expenditures in Los Angeles County over One Fiscal Year." County of Los Angeles, Chief Executive Office–Service Integration Branch, (January 2016)
[30] Hunter, Sarah B., Harvey, Melody, Briscombe, Brian and Cefalu, Matthew. "Evaluation of Housing for Health Permanent Supportive Housing Program." Rand Corporation (2017)

Estimated Los Angeles County Agency Direct Expenditures on Homelessness Services

Excluding the Los Angeles County Sheriff's Department (to be examined alongside other County-based law enforcement jurisdictions), there are five other, principal Los Angeles County departments[31] that have direct interaction with people experiencing homelessness and bear direct costs for taxpayers from homelessness services delivery:

Table 12.1: Los Angeles County Department Budgets and Homelessness Expenditure, FY2022 estimates			
Los Angeles County Department	FY2022 County Agency Total Budgets	Est. % of FY2022 Budget for Homelessness Services	Est. FY2022 Budget for Homelessness Services
Department of Health Services (DHS)	$ 8,866,753,000	5.61%	$497,424,843
Department of Mental Health (DMH)	$ 2,994,157,000	14.29%	$427,865,035
Department of Public Social Services (DPSS)	$ 4,822,736,000	8.53%	$411,379,381
Department of Public Health (DPH)	$ 1,868,337,000	3.50%	$65,391,795
Los Angeles County Probation Department	$ 1,025,224,000	1.42%	$14,558,181

This analysis considered the prior referenced research by Wu and Stevens (2016), undertaken directly with the County of Los Angeles regarding total expenditures for people experiencing homelessness as a percentage of the 2015 total departmental budgets. After review and correlation with contemporary budget figures and sources, a base proportion was interpolated. Using this proportions, there was an estimated $1,554,998,665 spent by Los Angeles County Departments on individuals experiencing homeless for the year 2022-2023. For the purposes of this analysis, it is a reasonable assumption that this is a low-range estimate, as utilizing the $964,200,000 total from Wu and Stevens study and accounting for the 36% growth in the homeless population whilst adjusting for CPI[32], the total projected costs for the year re-calculate to $1,678,121,844[33].

While the overall combined Los Angeles County budgets estimated above is for 2022-2023 more than a 59% increase over 2015 expenditure levels, it only nominally exceeds the rate of inflation and growth in population. While the total population in the Wu study are far greater than the reported number in 2022, the Wu study included the number of individuals utilizing the service for the year under review and not the average number of individuals that are unhoused at any given time as they clearly state in their study. There were 148,815 individuals in 2014-2015 who used county services as a homeless person, but there was only a full time equivalent of 44,359 according to LAHSA.

As such, even though the finding was that the total cost per homeless individual was $6,481 for 148,815 individuals, the total cost per individual per year is $21,742 ($27,925 in 2023 Dollars) when normalizing the average cost (#people/#daily population) in the Wu and Stevens study based on the LAHSA reporting. This number is less than the average of $38,146 per individual documented by Hunter et al a year later which focused exclusively on the costs of 980 individuals of one year before they went into permanent supportive housing and the full cost of year in Permanent Supportive Housing afterwards. The Wu and Stevens study found that the costliest 5% (7,441) averaged $51,227 in annual costs.

The total budget of the six, Los Angeles County departments associated with direct service delivery to the homeless population is more than $23.5 billion for the 2022-2023 fiscal year, compared to $14.8 billion for these six departments in 2015: an increase of more than $8.75 billion. This study estimates that the County spent at least $1.55 billion on the homeless during the 2022-2023 year which is significantly more than the

[31] Department-Breakdown.v2.pdf (lacounty.gov)
[32] CPI Inflation Calculator (bls.gov)
[33] County of Los Angeles (lahsa.org)

$590 million more spent in 2015. If adjusted for inflation, the County Departments are servicing an additional 11,719 FTHI by spending the equivalent of $316 million more in funding when adjusted for inflation. This would be a $123 million shortfall of the expected total cost, if the yearly cost per FTHI were the same as 2015 when adjusted for inflation.

Estimated City/Municipal and JPA Direct Expenditures on Homelessness Services (excluding Law Enforcement)

A key area of inquiry excluded from many prior studies were the costs for homelessness services within the County of Los Angeles directly generated by its 88 cities and municipalities. The expenditures for the City of Los Angeles and LAHSA were derived from their joint budget proposal for funding for services directly for Homelessness for FY 2020-2021[34]. The City of Long Beach provided an accounting of $13,113,000[35] for 2022-2023 in its published budget.

Most of the remaining 87 cities of Los Angeles County do not provide specific budget figures for their municipal expenditures on services to people experiencing homelessness. A working model was developed based on localized, self-reported counts of populations experiencing homelessness and annual budget figures sourced from data contained in local jurisdictional profiles published by the Southern California Association of Governments (SCAG)[36]. Culver City provided a figure of more than $1.34 million[37] in non-law enforcement homelessness services expenditure for FY 2022-2023. With a population of 40,779, a reported homeless population of 328, and a total annual budget of more than $91.8 million, Culver City is a relatively median-sized municipality within Los Angeles County and the 0.00446% of its annual budget expended per FTHI was utilized for estimation of average, non-law enforcement expenditures by municipalities across Los Angeles County.

An estimate of $47.2 million of non-law enforcement related expenditure relating to homelessness was estimated across 87 municipalities (excluding the City of Los Angeles), with total, combined municipal budgets of more than $4.06 billion in 2022.

Estimated Law Enforcement Agency Direct Expenditures on Homelessness Services

This study assumes a median cost for policing across Los Angeles County. From data analysis, the agency with the largest proportion of law enforcement service delivery hours in Los Angeles County is the jurisdiction of the Los Angeles Police Department. In 2019, the Los Angeles Police Department handled 979,592 calls for service during the year. The five-year annual average of calls for service from 2014 through 2018 was 929,176. It is estimated that about 140,000 of these calls were related to homelessness (roughly 14%). The LAPD 2022-2023 proposed budget allocated $909,657,128 for its Field Forces. Attributing 14% of the deployments, time, effort and cost of LAPD's Field Forces in situations involving people experiencing homelessness would generate expense of $130,000,000 annually. According to LAHSA 2022 point-in-time count, there were 36,332 unhoused in the City of Los Angeles. This equates to $3,578 spent on average, per full-time homeless individual (FTHI), for LAPD Field Services.

These costs do not include booking, local detention, and auxiliary services (replicated by the Los Angeles County Sheriff's Department). Adding the median cost of Sheriff's jail services at $1,390, the cost per FTHI is $4,968. When normalized for the percentage of all individuals with arrests to the number of occurrences per arrest, the cost averages $6,557 per arrest. Considering inflation and other factors, this is reasonably close to the relative costs for law enforcement engagement with people experiencing homelessness identified by Wu and Stevens (2016) which was $5,781 per individual, with a cost per arrest of $5,396. This equates to an average cost increase of 22% over a period of eight years.

[34] Proposed_Budget-Homelessness.pdf (lacity.org)
[35] Microsoft PowerPoint - 5_Homeless Emergency Response Update 5.3.23.pptx (legistar.com)
[36] https://scag.ca.gov/data-tools-local-profiles
[37] homelessprogrammingfactshe.pdf (culvercity.org)

Table 12.2: Los Angeles County Law Enforcement Agency Direct Homelessness Expenditures, FY2022		
Divisions and/or Jurisdiction(s)	Est. FY2023 Homelessness Service Expenditures	Est. FY2023 Cost Per FTHI
Los Angeles County Sheriff - Jail	$83,540,309	$1,390
Los Angeles County Sheriff – Administration	$3,554,377	$59
Los Angeles County Sheriff's Department – Other	$9,982,812	$166
Los Angeles Police Department	$130,005,143	$3,578
Other L.A. County Local Law Enforcement Jurisdictions	$215,089,750	$3,578[38]
Total of All County Law Enforcement Jurisdictions	$312,167,248	$5,193

Estimated California Department of Transportation (Caltrans) Direct Expenditures on Homelessness Services

There is no recent data regarding the exact costs that the California Department of Transportation expends relating to costs of remediation from the presence of people experiencing homelessness on State-owned properties. It is estimated that Caltrans expended $8,143,000 maintaining its property in Los Angeles County during 2022-2023 based on projections of past data and reports of the number of encampments cleared within the County in its most recent reports. This produces an estimated cost per FTHI of $197 per year[39,40].

Estimated Public Funding of Market ARFs and RCFEs as Direct Expenditures

Adult Residential Facilities and Residential Care Facilities for the Elderly have a range of resources available based on identified acuity and nature of resident needs. The base costs are the Supplemental Security Income (SSI) which is $914.00 and State Supplementary Payment (SSP) which is $578.82[41]. All other types of housing are based on these costs and additional services can be acquired when the individual has specialized mental and/or physical health needs.

Market ARFs and RCFEs can access additional services through funding from the Los Angeles County Department of Mental Health (DMH) and Department of Health Services (DHS). DHS has a tiered system of payment to facilities for housing under its -Enhanced Residential Care program based on resident (client) needs and acuity. ARF operators can receive $1,000 per month additional funding for housing individuals with mental health needs[42]. The DMH ERC can link residents to additional mental health services. The DHS ERC provides additional funding with rates that range from $2,000 to as much as $5,000 for room, board, care coordination, plus Medi-Cal expenses. For individuals with physical and/or mental health needs that require specialized living arrangements, Assisted Living Waiver provides licensed facilities with the means to provide such either in an ARF or RCFE setting that matriculate from Skilled Nursing Facilities (SNFs). These individuals are also Medi-Cal / Medi-Care Long Term Care eligible[43].

The State of California also operates an elder care program named the Program of All-inclusive Care for the Elderly (PACE)[44] which provides Medicare and Medi-Cal covered benefits including, but not limited to, primary

[38] This estimate comes with a caveat, as it utilizes mean LAPD costs per FTHI as a baseline, as reporting on law enforcement expenditure from the majority of other jurisdictions within the County segmented for homelessness service response was not available.
[39] Unsheltered population change as reflected on HHAP-4 applications
[40] Cost To Clean Up Homeless Camps Climbs
[41] SSI/SSP Payment Standards Effective January 1, 2022 Appendix C (ca.gov)
[42] 1120630_MHSAAnnualUpdateFY2022-23.pdf (lacounty.gov)
[43] Assisted Living Waiver Reimbursement Rates (ca.gov)
[44] https://calpace.org/wp-content/uploads/2018/04/PACE_Cost_Effective_Fact_Sheet_02.21.2018.pdf

and specialty medical care, room, board, adult day care, in-home services, home care, prescription drugs, laboratory and diagnostic services, physical and occupational therapies, meals, transportation, and as necessary, hospital and nursing home care. The study was unable to determine any consistency in the proportion of funds utilized by PACE for cost reimbursement of room, board, and non-medical care furnished by Market RCFEs.

Table 12.3: Los Angeles County Market ARF / RCFE Public Funding Levels by Program, 2022		
Funding Source of Care	Existing Resources	Annual Cost
Non-Medical Out-of-Home Care (NMOHC)	SSI/SSDI =$1,492.82/Month	$15,514
ARF- DMH Enriched Residential Care (ERC)	$1,000 plus SSI/SSDI = $2,292.82	$27,514
ARF- DMH ERC & Full-Service Partnership (FSP)	$1,000 plus SSI/SSDI + $14,642/Yearly average costs	$42,156
ARF-DMH ERC & Outpatient Fee for Service Behavioral Health Services-Medi-Cal billing (Short Doyle Medi-Cal)	$1,000 plus SSI/SSDI + average of $3,861/Resident	$31,375
ARF/RCFE- DHS ERC & Medi-Cal Billing for Health/Mental Health	Between $2,000-$5,000 per month (plus Medi-Cal)	$24,000 - $60,000
ARF-DMH Enriched Residential Services programs (formerly "IMD step-downs")	$1,000 plus SSI/SSDI + average $35,500/Resident	~$63,014
ARF-RCFE & Assisted Living Waiver (ALW) rates	SSI/SSDI+ between $84-$200 per day	$46,174 - $88,513

The weighted mean cost per individual resident across all of the listed programs is estimated to be $20,713 per year. This calculation is not based on current utilization rates, rather, it is on the basis of capacity.

Hypothetical Savings Scenario for County Taxpayers

- Funding public-private partnerships to construct new, purpose-built ARFs and RCFEs to specifically serve people experiencing homelessness was an alternative shared by many Market Users, alongside facility owners and operators, as their preferred method for the Market to leverage its capabilities to better address the crisis of homelessness in Los Angeles County.
- At an estimated mean savings of $13,481 per individual served, per year, there are significant differences in the annual costs to Los Angeles County taxpayers from serving individuals through public funding of Market ARFs and RCFEs in comparison to the provision of in-situ services to people experiencing homelessness from a range of governmental and contracted, nonprofit entities in Los Angeles County (at an annual cost of $20,713 per FTHI).
- By maximizing utilization of SSI/SSDI funds alongside other homelessness services funding allocated whilst enabling housing, access to care, and better living conditions for people experiencing homelessness, the County and State of California can reduce the number of individuals experiencing homelessness while enhancing the overall quality and outcomes from services delivered.
- If all 65,111 people experiencing homelessness from LAHSA's January 2022 point-in-time count were housed and funded by a hypothetical, mass-scale expansion of new and existing Market ARFs and RCFEs (more than 250% of the current number of Market facilities and beds), the taxpayers, government agencies, and systems of Los Angeles County could save a projected (2023) $810 million dollars per year in expenses from in-situ homeless services costs[45].

[45] This illustrative but extreme, hypothetical scenario would require significant, one-time public investment(s) and/or private investment(s) for mass-scale construction and/or acquisition of new ARFs and RCFEs (licensed, congregate facilities), not accounted for in the projected annual cost savings for housing, care, and service delivery, outside of the scope of exploration for the study.

13.0

Image by Eduardo Barrios on Unsplash

Recommended Actions

The following recommended actions relating to the Market and prospective policy changes, program development, funding allocation, quality improvement, advocacy activities, and service delivery are presented for ARF and RCFE owners and operators alongside Market Users, such as decision makers serving municipal, Los Angeles County, and California government agencies and nonprofits serving a range of missions and vulnerable population groups, the residents of facilities and their families, elected officials at all levels, advocates for change, and members of the public. Recommended actions were developed through use of an evidence-based methodology, connecting directly to insights and findings presented elsewhere in the study.

Market Facility Owners and Operators

Make use of the evidence, findings, and insights presented in this study to communicate clearly with external stakeholders about the Market of facilities and its value, making note of how identified, vulnerable residents of Market ARFs and RCFEs generally express high levels of satisfaction and trust from their experiences, and how many residents view Market facilities as permanent homes and communities that enhance their stability to have access to a range of care services; also consider utilizing this study to inspire continuous improvement in service delivery and practices across the Market.

Reconsider any Market biases and/or facility perceptions related to directly serving people with experiences of homelessness as residents of ARFs and RCFEs; many facility owners and operators inadvertently already provide service to this vulnerable population without awareness of the histories that many current residents possess in having experiences of homelessness as an adult.

Enable business processes to rapidly identify resident vacancies and underutilized bed capacity to government agencies and nonprofit organizations serving vulnerable populations, increasing the sustainability and profitability of Market ARF and RCFE operations for business owners.

Work more closely with Market Users to better understand the specific care needs of residents from vulnerable populations, to reduce the unnecessary movement of residents among ARFs, RCFEs, or other systems of care that can occur when a facility cannot deliver what residents need; owners and operators also need to communicate with residents in new ways to better understand the unmet needs of their existing populations, such as the conduct of routine surveys, structured interviews, or resident roundtables.

Develop service quality plans that include a focus on residents from vulnerable populations to ensure that the needs of these residents are fully met, and that facilities continue to deliver increased levels of net public value to maintain the support of external advocates, funders, and decision makers.

Maximize the levels of staff knowledge and connections to organizations delivering services and programs that can serve the current or future needs of vulnerable residents at low- or no-cost, such as re-entry services, substance abuse treatment, mental health services, adult day care, job programs, and other, publicly-funded services providers that deliver care to residents in need.

Develop formal plans to preserve and maintain the physical assets of facilities before failures in building systems, reductions in asset value occur, or resident service quality erodes; seek participation in government and nonprofit programs that can provide facilities with advice on how to enact preventative maintenance practices, plan for these expenses, and access low-interest loans and/or grants to address existing issues before they interrupt business and resident service continuity.

Seek direct engagement with homelessness services organizations, especially for facilities with high vacancy rates, as many serve vulnerable individuals with the capability to be immediately placed within facilities that already have access to County and nonprofit services and programs.

Connect with external programs that develop skills and capabilities for residents that can enable them to move on, or graduate, to other forms of housing and independent living, whenever practicable, ensuring that Market facilities continue to maintain focus on residents for whom other forms of housing are not an option; this can be aided by ensuring that facilities have connections with nonprofits and agencies delivering affordable or permanent supportive housing - a particularly urgent, unmet need for many Market residents at ARFs.

Formalize connections and cooperation with other owners and operators in the Market and wider industry, to assert a collective voice with government to improve facility survival and sustainability, reform regulations, increase funding, and increase the public profile of ARFs and RCFEs; consider joining existing organizations with this expressed purpose (such as the **Los Angeles Residential Care Association, or LARCA**[46]).

[46] https://www.larca.org

Provide better incentivization and career definition to staff serving within the Market of ARFs and RCFEs, whenever practicable, as the labor and knowledge required to serve the Market into the future is threatened by low levels of confidence to remain in the industry on a 10-year forward timeframe; communicate the potential of a progressive, career pathway to all staff, potentially leading some to consider ownership one day, and meet these expectations by upskilling high-performing staff to serve in vital roles to ensure a sustainable, professional workforce to serve the Market into the future and minimize labor shortages.

Persuade owners of larger facilities, namely RCFEs, not currently serving any members of identified, vulnerable populations, to take on at least one publicly-funded resident to enhance the policy and business case to government to increase funding and service rates, as well as increase benefits delivered to communities.

Reach out to government agencies and nonprofits if a facility is in danger of closure, sale, or business failure, ensuring that if traditional facility partners are no longer able to provide placement of residents or funding, that new relationships are sought with other agencies and partners are attempted before making a decision to leave the Market, as there is greater demand than ever for beds to serve vulnerable individuals who might otherwise experience homelessness or live without access to care.

The 88 Cities / Municipalities of Los Angeles County

Engage owners and operators of Market facilities directly with government and key stakeholders, assuring Market owners and operators are given an opportunity to a voice commensurate with the net public benefit and value delivered to cities and municipalities based on the service they provide to vulnerable populations.

Undertake public communications with communities to advocate for the role and importance of ARFs and RCFEs, to reduce unjustifiable stigma and fear of facilities that may be experienced by neighboring community members.

Improve the customer service quality, communications quality, and responsiveness of city and municipal stakeholders in interactions with Market facility owners and operators, with a significant proportion of facilities indicating that the efficiency and effectiveness of their interactions with local government has imposed unnecessary burdens on their capabilities to open, manage, and continue to operate their facilities.

Improve the interface and relationships of local law enforcement and emergency services with Market facilities, clearly identifying liaison with a senior officer or commander within local area commands and service areas to conduct outreach with facilities to improve delivery of interactions with facilities housing members of vulnerable populations; additionally, many facility owners and operators have identified and recommended improvements in the responsiveness, sufficiency, and/or supportiveness of 911, police, fire, ambulance, and other emergency services.

Improve the consistency of and access to local initiatives relating to mental health emergency services experienced by Market facilities, assuring integration and interface of such efforts with local law enforcement and other first responders; consider enhancement of staff knowledge to improve alignment and interface with Los Angeles County Department of Mental Health (DMH) services, such as the Psychiatric Mobile Response Team (PMRT).

Connect Market owners and operators to city and municipal services, agencies, nonprofits, and community advocates to initiate new conversations and introductions so that facilities have comprehensive knowledge and understanding of additional resources that can serve to benefit resident populations; proactively identify and connect Market facilities to sources of additional local or charitable funding before facilities are in danger of closure due to asset condition, age, or improvements due to updates in local building codes and/or ordinance(s).

Improve the efficiency of zoning and planning processes to enable the development and deployment of additional Market facilities, in particular, ARFs, which face substantive barriers from low government service optimality and persistent complexity delivered by city planning authorities, coupled

with challenging community engagement processes that do not advocate for net public benefit as a primary focus - highlighted by Market facilities and stakeholders as a particularly pressing need within the City of Los Angeles.

Ensure genuine, effective collaboration with other cities, municipalities, Los Angeles County agencies, nonprofits, and their programs serving vulnerable populations across the Market of ARFs and RCFEs, contributing to an environment of shared philosophy and accountability that directs cohesive coverage and deployment of whole-of-region government strategies to maintain the Market and its benefits without competition or refusal to participate amongst local government entities, promoting improved outcomes and quality services across all County cities.

Understand that overall satisfaction levels with local government from Market facility owners and operators are relatively positive, but these stakeholders have identified a genuine need for improvement across the aforementioned areas of service delivery from all of Los Angeles County's 88 cities / municipalities.

Los Angeles County Government Agencies

Prioritize the Market's integration across policy development, planning, data, and systems of care to house people experiencing homelessness with LAHSA, Coordinated Entry System providers, nonprofits, Los Angeles County service agencies, and local government services, ensuring that ARFs and RCFEs serving the Market are viewed as a genuine housing resource by all stakeholders, regardless of perspectives on the permanence of the resource, Federal (HUD) definitions of housing, and restrictions on funding streams, as to not allow thousands of available housing placements in Market ARFs and RCFEs to go underutilized and/or underfunded each year.

Take immediate action to fill vacancies in facilities and expand County service networks by conducting a fresh round of highly-publicized, whole-of-County government coordinated outreach and planning across the Market, to reset customary paradigms and inconsistent communications with the owners and operators of ARFs and RCFEs; actively work to overcome the Market's collective experience of maintaining separate relationships and interactions across a large and reportedly-confusing range of County agency acronyms, programs, stakeholders, funding sources, and services.

Enhance public communications with communities to advocate for the role and importance of ARFs and RCFEs, to reduce unjustifiable stigma and fear of these facilities from neighboring community members across the County.

Undertake coordinated outreach to the collective leadership of Los Angeles County-based Regional Center agencies to identify any underutilized ARFs that may be available to serve other vulnerable populations if they no longer operating at full capacity to serve people living with developmental disabilities, or are at risk of closure relating to changes in Regional Center preferred service models that have occurred over recent years.

Reduce service inefficiency from any siloed, single-agency interactions with residents at Market ARFs and RCFEs receiving services across multiple agencies, programs, and channels by integrating and sharing data between any isolated County government systems, increasing collaborative service delivery approaches, and prioritizing capabilities to develop and deliver effective, whole-person care with reduced points of interface with County administrative stakeholders as a primary service model for the Los Angeles County Market of ARF and RCFE residents.

Take well-considered steps to better ensure the equitable and balanced delivery of services and programs access for facilities and residents across all Los Angeles County Service Planning Areas (SPAs), by undertaking internal review of program design, service delivery models, distribution of budgets, staffing, resources, and access for ARFs and RCFEs serving the Market, to enable continuous improvement in service distribution in all catchments.

Centralize all public navigation services for Market ARFs and RCFEs within a single public entity or agency, for use as a resource by all Los Angeles County Market Users, public and nonprofit, to ensure

that vacant beds at facilities are maximally utilized, eliminating competition for placements within facilities between Market Users.

Develop and deliver new wraparound programs and services to enhance the living skills and capabilities of more residents, enabling more to graduate and/or move to lower levels of care, such as affordable and/or permanent supportive housing, to enable greater total capacity across Market facilities to serve greater numbers of the identified, vulnerable populations.

Identify and actively reduce the bureaucratic burden on Market facility owners and operators by streamlining documentation for participation in resident programs and funding channels, as this reduces the capability and time of staff at facilities to manage quality and deliver resident services; this could also be accomplished with more online systems and integration across a unified service focused on delivery to Market ARFs and RCFEs to consolidate facility interface with County agencies.

Improve the interface and relationships of the Los Angeles County Sherrif's Department with Market facilities, clearly identifying liaison with a senior officer or commander within (sub)stations to conduct outreach with facilities and improve delivery of Department interactions with facilities housing members of vulnerable populations; in addition, many facility owners and operators have recommended improvement in the responsiveness, sufficiency, and/or supportiveness of 911, police, fire, ambulance, and other emergency services, particularly applicable to Los Angeles County contract service cities and unincorporated communities.

Investigate claims that members of vulnerable populations are being moved into Los Angeles County Market facilities under arrangements with ownership groups of facilities that have locations across other County jurisdictions; discuss this phenomenon with stakeholders representing agencies in other California counties to find a reasonable resolution that does not adversely impact the capacity of the Market to serve the extended population of individuals from vulnerable populations already present in Los Angeles County.

(If not actioned by CCLD) **Provide and maintain a centralized source of information about the Market's service capabilities,** accessible to all bona fide Market Users, including information about public benefits acceptance and capacity to house individuals from vulnerable populations, to maximize service capacity, to enhance optimality of placements, and to ensure sustainability and survivability for facility business owners.

Understand that overall satisfaction levels with Los Angeles County Agencies from Market facility owners and operators are generally positive, but these stakeholders have identified genuine needs for improvement across the aforementioned areas of service delivery from County programs and services.

Community Care Licensing Division (CCLD / CDSS)

Consider agency-level, policy and/or structural changes to enhance CCLD's current mission, enabling more action to preserve and increase the number of licensed facilities delivering service to those reliant on public benefit, and delivering standardization of understanding across government; this can be accomplished through greater engagement with elected officials, legislators, and other public agency leaders to "de-genericize" the abstracted public value delivered by facilities in service to vulnerable populations, working to eliminate the excessively vague terminology of "board and care" in continued use by peer agencies at the State-level, and committing to a policy for active promotion of acceptance of residents reliant on public benefit to both new and existing facility owners, and actively promoting expansion of the number of new facilities serving the Market, especially ARFs.

Consider re-enactment of greater specificity or definition across ARF and RCFE license classes (or readily-identifiable subclasses), creating better clarity for the Market Users of both privately-funded and publicly-funded facilities with specific needs to more optimally utilize the resource.

Provide and maintain a reliable, centralized source of information about the Market's service capabilities, accessible only to bona fide Market Users to prevent misuse of the resource, including information about public benefits acceptance and capabilities to house specific vulnerable

populations, to maximize service capacity, enhance optimality of placements, and to promote sustainability and survivability for Market business owners.

Improve the quality of information collected and maintained in CCLD licensing databases, establishing greater standards for data hygiene, enabling improved efficiency in communications with licensees, better recognition of facilities owned or operated by groups, supporting regulatory and enforcement efforts; regularly validate accurate licensee contact information as a business process; develop business processes to validate delivery of these functions at a high level of quality due to their implications for many other factors of Market regulation.

Collect and produce detailed information about the demography of residents within licensed facilities, for regulated access by valid Market Users to maximize the utilization of facilities by optimizing navigation of residents to the right facilities for their needs, as well as to help assure equity, diversity, and inclusion of representation across resident populations, in line with State / government service policies and objectives.

Ensure that CCLD staff deliver a greater appearance of consistency across audit and enforcement activities; communicate more clearly, consistently, and frequently with owners and operators, as well as delivering all interactions with facilities without appearance of unreasonable biases, preconceptions, and/or attitudinal differences amongst staff or between service regions.

Consider additional differentiation(s) in licensure fees for Market facilities that serve a strong majority of publicly-funded residents, also considering methods to clearly identify additional State-sponsored business benefits from other California agencies to Market facilities serving a strong majority of publicly-funded residents.

Undertake passive innovation and research activity with CCLD staff to deliver thought leadership to facility owners and operators regarding better and best practices, communicate new and progressive methods and practices to inspire continuous improvement from licensed facilities with consideration to operating costs; recognize innovation and best practices when encountered at facilities by seeking consent to identify and share their value across the regulated industry of licensed facility owners and operators.

Increase the successful delivery of existing CCLD activities to identify and eliminate unlicensed facilities, which reduce community trust and enable public confusion about the quality and nature of care in licensed facilities, as well as endangering the well-being of vulnerable populations, with stories of unlicensed facilities significantly contributing to public mistrust of the industry.

Continue the successful delivery of the core CCLD mission in protecting the interests of residents and the prevention of unacceptable quality and/or safety issues in licensed facilities, which erodes the overall service quality, reputation, and capabilities of ARFs and RCFEs in the Market to serve vulnerable populations and communities, also contributing to public mistrust and apprehension regarding the industry.

Understand that overall satisfaction levels with CCLD from Market facility owners and operators are positive, but these stakeholders have identified a genuine need for improvement across the aforementioned areas of service delivery from CCLD.

Elected Officials (Local, County, and State)

Elected officials need to know and communicate the value and importance of ARFs and RCFEs to the public, cultivating connection with the public to address the needs of owners and operators serving the Market, as well as cultivating knowledge relating to the benefits and net public value delivered to vulnerable populations, communities, and constituents from the very existence of Market facilities; present levels of public discourse and media from elected officials relating to the services of ARFs and RCFEs in efforts to reduce homelessness are almost non-existent, not just in Los Angeles County, but across California.

Leadership and bravery are required to integrate ARFs and RCFEs into public policy discussions, across all levels of government, relating to solutions to comprehensively reduce homelessness, ensuring that facilities are seen by legislators, government agencies, nonprofits, the Continuum(s) of Care, and the public as significant contributors to reducing and preventing current and future homelessness across all communities, whenever and wherever they are enabled to do so by governments.

More funding is required to sustain and increase service capacity from ARFs and RCFEs serving the needs of individuals, families, communities, and government in providing transitional and permanent housing for the vulnerable individuals in Los Angeles County (and across California), with many businesses subsisting on providing services to vulnerable individuals with public benefit rates far below those found in comparable systems of care and services while simultaneously experiencing the effects of extraordinary inflation on operating costs; as the Market is in direct competition at the legislative level with funds allocated for the development and creation of new housing units to reduce homelessness across communities, the Market resource of ARFs and RCFEs has not been funded comparably to sustainably provide the public value and benefits it already delivers.

Greater public incentives are required for the creation and development of new ARFs, which almost exclusively serve individuals completely reliant on public benefit, such as people with experience of homelessness, yet exist in the Market without a rational business case for many new players to consider development of new ARFs to serve identified, vulnerable populations; mandating reductions in taxation, fees, and the costs of insurance for ARFs, as well as increasing rates reimbursed for care provided for ARF residents could make a better business case for potential Market entry by additional, rational players, and increase the number of ARFs serving the needs of vulnerable populations.

Reform of regulations relating to ARFs and RCFEs is needed across all levels of government, ensuring balance between fundamental needs to protect residents and their rights, community needs to have effective housing resources to serve the specific care needs of vulnerable populations, a need for procedural fairness in enabling facility business owners to deliver what government requires of them without bias or undue burden, and a need to assure that any administrative or bureaucratic requirements of government are appropriately minimized and sustainable to the scale of operations for facilities, without affecting the survivability of businesses in the Market or the industry at-large.

Although this study did not ask Market owners or operators to evaluate their satisfaction with elected officials, many recommendations sought by these constituents structurally require active participation from elected officials; should the Market of ARFs and RCFEs be unable or unwilling to continue delivering service to vulnerable populations due to economic or regulatory concerns, a good proportion of the vulnerable individuals served by Market will likely experience homelessness (with some residents experiencing homelessness again) as a result.

There is political risk in not being seen by constituents, the media, and community advocates to identify and utilize every asset, advantage, or capability in overcoming the issue of people experiencing homelessness across Los Angeles County and California's many communities, including not being seen to utilize and fund existing beds and underutilized resources of the Market's ARFs and RCFEs to their maximum capacity or potential to address the crisis of homelessness.

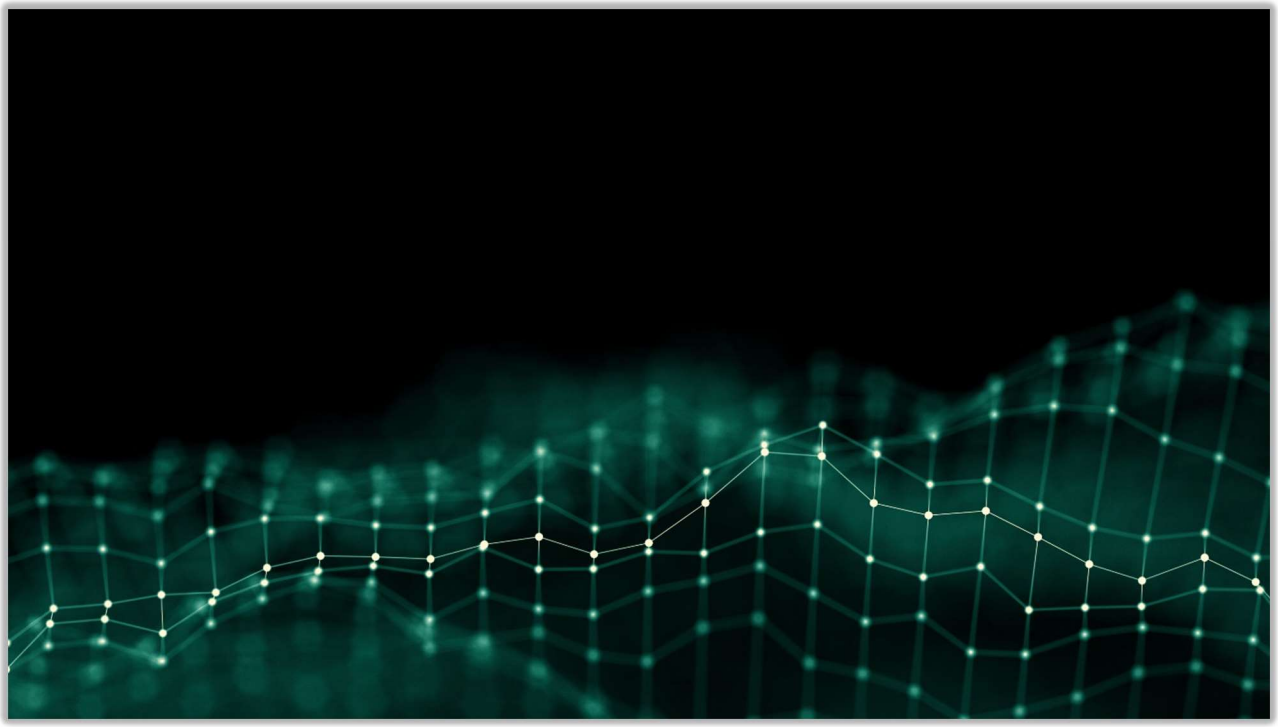

Image: www.dreamstime.com

Appendices

Research Standards

The Future Organization (TFO) delivered the research study incorporating the following standards:

- TFO utilized standardized research design, sample sizing, statistical methods (descriptive, parametric, and non-parametric), and fieldwork methods commonly deployed and accepted in the fields of market and social science research, dependent on research subject identity (facility owner or operator, resident, or external stakeholder)

- TFO staff possessed the requisite training and experience in leading and conducting research with vulnerable and at-risk populations, conduct of difficult conversations, anti-bias education, and maintained currency of knowledge in best practice for research and community engagement

- TFO ensured ethical research engagement by adherence to statutory and ethical guidelines, regulations, and best practice for human subjects belonging to vulnerable and/or at-risk populations wherever and whenever applicable, including:

    - U.S. 45 CFR 46 – Protection of Human Subjects (HHS)
    - U.S. "Common Rule" Specifications and Exemptions (NSF)
    - ISO 20252:2019 (Market, opinion and social research, including insights and data analytics)
    - HIPAA (to guide avoidance of collection of any personally-identifiable health information)

- TFO carefully considered impacts from research activities and processes, as well as the potential impacts on individuals and groups, from the reporting and insights produced from the research study.

- TFO actively advises clients against research practice(s) that could produce unreasonably adverse and/or biased research outcomes.

Given the sensitivity of the research subject matter and the need to deploy an expanded fieldwork team for the research study that had capability to sensitively interact with a diverse resident population of vulnerable individuals with distinctive needs, TFO trained and deployed a team of 8 graduate students from Los Angeles County-based university graduate studies programs to assist with the conduct of on-site surveys, including California State University Los Angeles (CSULA), California State University Long Beach (CSULB), Pepperdine University, and University of California Los Angeles (UCLA).

All graduate student Field Researchers were enrolled (or had recently completed) degrees across Masters- or Doctoral-level programs in Social Work, Public Administration, Clinical Psychology, or International Development. All graduate students undertook specific training with TFO to prepare them for independent engagement with members of vulnerable populations prior to field studies, were provided with safety training to exceed government standards and practices for engagement during the COVID-19 pandemic, received guided supervision during the pilot phase of the study, and received regular supervision, evaluation, and detailed feedback regarding research standards and data quality throughout the conduct of field studies.

TFO also engaged the services of additional, temporary staff who were not affiliated with university programs to coordinate outreach and booking of site visits and interviews with facilities. These additional coordination staff did not engage with individuals belonging to vulnerable populations at any point during research activities.

TFO sought advisement from members of the Initiative's Advisory Committee in regard to engagement with prospective Institutional Review Boards (IRBs) for the conduct of this research, but it was determined that as the research study would be undertaken exclusively by The Future Organization LLC, and was not directly funded by any governmental or research entity with an active IRB with direct accountability for oversight, that the research was not subject to review by an IRB.

Participation incentives were provided to research participants after the completion of interviews, for facility owner/operator respondents and resident respondents. Advance consideration was given to attempt to avoid and prevent individually-adverse impact(s) from the provision of research participant incentives.

Definitions and Links

ACCESS – **Access Transit Services**: the Los Angeles County Consolidated Transportation Services Agency ("CTSA") that administers the Los Angeles County Coordinated Paratransit Plan, provides transportation services to the functionally disabled and aging community https://accessla.org/

ADLs - Activities of Daily Living: a term used to collectively describe fundamental skills required to independently care for oneself, such as getting out of bed, bathing, dressing, eating, walking, and using toilet facilities

ALW – **Assisted Living Waiver Program:** a Home and Community-Based Services (HCBS) waiver program administered by the California Department of Health Care Services (DHCS) the program funds Medi-Cal-eligible seniors and persons with disabilities to live in an ARF, or RCFE, or public housing

APS – **Adult Protective Services**: a program under the Workforce, Development, Aging and Community Services Agency of Los Angeles County responsible for the investigation into the abuse of elders and dependent adults https://wdacs.lacounty.gov/services/older-dependent-adult-services/adult-protective-services-aps/

ARF – **Adult Residential Facility**: a facility licensed to provide housing, support, and care for a range of vulnerable populations, generally (not exclusively) serving populations aged between 18 and 61 years of age

"Board & Care" – an informal, generic term utilized frequently by members of the public and Market Users to refer to ARFs and RCFEs, based on perceptions of the basic nature of services provided by licensed facilities, without detailed knowledge of the range of services delivered or vulnerable populations served

Brilliant Corners – Nonprofit organization delivering affordable and permanent housing services and programs across California, including Los Angeles County: principal sponsor of this research study https://www.brilliantcorners.org/

CAPI – **Cash Assistance Payments to Immigrants**: a public aid program administered by the California Department of Social Services (CDSS) for new arrivals and undocumented residents

CA DHCS – **California Department of Health Care Services**: state-level agency accountable for the provision of health care services and programs for Medi-Cal beneficiaries, among other service functions https://www.dhcs.ca.gov/

CCLD –**Community Care Licensing Division**: part of the California Department of Social Services (CDSS): serves as regulator and licensor for all ARFs and RCFEs in the State of California, responsible for evaluating training offerings for continuing education and service delivery to assist owners and operators of licensed facilities https://www.cdss.ca.gov/inforesources/community-care-licensing

CDSS - California Department of Social Services: state agency responsible for delivery of a range of social service programs to aid diverse members of communities and their needs as well as manage safety and compliance activities: parent agency of the Community Care Licensing Division (CCLD) https://www.dcss.ca.gov

CEC – **Continuing Education Credit(s)**: a requirement for individual licensure by state agencies for staff at ARFs and RCFEs, managed by the Community Care Licensing Division (CCLD)

CES –**Coordinated Entry System**: an organized network of homeless service providers, system funders, and other partners from across Los Angeles County that coordinate resources and services according to a set of common principles and shared procedures

CoC –Continuum of Care: a term identifying an integrated system of care that guides and tracks homeless individuals and families through housing and services: also refers to the regional or local planning body that coordinates housing and services funding for homeless families and individuals

Conservatorship – managed by the Los Angeles Public Guardian, there are two types of conservatorship: Lanterman-Petris Short (LPS) Conservatorships for gravely disabled individuals, and Probate Conservatorships for aging individuals who cannot provide for their own financial, safety, health, food, clothing, and care needs; conservatorship is sought to protect their rights, arrange care and manage their financial resources

COVID-19: the general designation for multiple coronavirus variant(s) identified as the primary cause of the 2020 - 2023 global pandemic

CPP– Community Placement Plan: a program to de-institutionalize individuals living with a developmental disability funded through the California Department of Developmental Services https://www.dds.ca.gov/services/cpp/

CRDP – Community Resource Development Plan: a program to enhance the service delivery system and reduce reliance on the use of developmental centers and other restrictive living environments for the developmentally disabled, funded through the California Department of Developmental Services https://www.dds.ca.gov/services/cpp/

DMH – Los Angeles County Department of Mental Health: the Los Angeles County agency serving the needs of people living with mental illness across County communities in multiple settings. Special emphasis is placed on addressing co-occurring mental health disorders and other health problems such as addiction https://dmh.lacounty.gov/

DHS – Los Angeles County Department of Health Services: the Los Angeles County agency serving the needs of low-income individuals requiring primary care, specialty care and resources; administrator of Housing for Health and Integrated Case Management programs funded under Measure H https://dhs.lacounty.gov

DHS ODR – Los Angeles County Department of Health Services, Office of Diversion and Re-entry: develops and implements programs to divert people with serious mental, physical and/or behavioral health needs away from the LA County Jail and into community-based care https://dhs.lacounty.gov/office-of-diversion-and-reentry/

DPH – Los Angeles County Department of Public Health: protects health, prevents the spread of communicable diseases, and provides health education programs for all persons in Los Angeles County through a variety of programs http://dph.lacounty.gov

ERC –Enriched Residential Care: DMH and DHS programs that facilitate placement of clients who require 24-hour care and supervision into licensed, residential facilities to help them achieve housing stability via the provision of a housing subsidy to the facility

ERS – Enriched Residential Services (formerly known as **"IMD step-downs"**): a DMH program that provides a per diem rate for higher acuity clients who need 24-hour care, supervision, and mental health treatment, in order to transition out of an Institution for Mental Disease (IMD)

FIRST MENTION – research term indicating that a respondent was limited to only one initial answer to a question to enable accurate insight into their "top-of-mind" or first preference

FY – Fiscal Year: also referenced as the financial year, used in government accounting, and for budget purposes.

FSP – Full-Service Partnership: a program funded through the Department of Mental Health for wraparound services to vulnerable individuals with high rates of incarceration, homelessness, and conservatorship https://dmh.lacounty.gov/our-services/outpatient-services/fsp/

FQHC – **Federally Qualified Health Center**s, community-based clinics delivering comprehensive health care services, under regulation by Health Resources and Services Administration (HRSA) and qualify for funding under section 330 of the Public Health Services Act

FTE- full-time equivalent basis: an employee's scheduled hours divided by the employer's hours for a full-time workweek

HIPAA – Health Information Portability and Accountability Act: U.S. Federal law identifying protocols for the security and transmission of potentially-identifiable health information, enabling patient and client protections

HOME Team – **Homeless Outreach Mobile Engagement Program**: funded through the Department of Mental Health is a multi-disciplinary team designed to serve severely disabled individuals directly on the street in order to transition them to housing https://dmh.lacounty.gov/our-services/countywide-services/home/

H4H – **Housing for Health**: a program and system of care within the LA County Department of Health Services that serves unhoused and housed individuals with complex healthcare needs, funded by Measure H https://dhs.lacounty.gov/housing-for-health

HUD – **United States Department of Housing and Urban Development**: Federal-level department of the United States government with oversight of American housing practices, amongst other functions

ICMS –**Integrated Case Management Services**: a DHS Housing for Health program, funded by Measure H

IMD – **Institutions for Mental Disease**: IMDs are facilities with 16 or more beds where people get diagnosis, treatment, and care (including medical and nursing care) for a mental health disability

Interim housing –Temporary accommodations for people that have nowhere else to spend the night; considered alongside crisis or bridge housing as non-permanent forms of housing

LAHSA – **Los Angeles Homeless Services Authority**: a joint powers authority formed by the City and County of Los Angeles; lead agency for the homelessness Continuum of Care across Los Angeles County, with the exceptions of the City of Long Beach and the City of Pasadena http://www.lahsa.org

LAPG – **Los Angeles Public Guardian**: unit within the Department of Mental Health that provides services through a legal process known as conservatorship for those who are physically or mentally disabled to the point where they cannot utilize community services and resources https://dmh.lacounty.gov/our-services/public-guardian/

LARCA – **Los Angeles Residential Care Association**: a nonprofit advocacy organization formed in 2021 to represent the interests of the owners and operators of Los Angeles County Adult Residential Facilities and Residential Care Facilities for the Elderly https://www.larcala.org

Likert scale – A common survey methodology where respondents are asked to evaluate a feeling or quality of experience for a factor utilizing a scale with descriptives, such as an absolute 0-10 scale, which enables quantitative analysis and comparison of perceptions and sentiment across the population subgroups

LTC – **Long Term Care**: under CA Department of Health Care Services provides benefits for individuals who are eligible for both Medicare and Medi-Cal based on age, disability, and income levels

LTCO - **Long Term Care Ombudsman**: managed under the California Department of Aging and providing residents in long-term care facilities with resolving issues related to care, health, safety, and preferences https://aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/

Market Users – Governmental, nonprofit, private, and commercial stakeholders that seek to place individuals into ARFs and/or RCFEs for the purposes of receiving room, board, and care

MHHU – Mental Health Hookup: a nonprofit that delivers mental health resources to the community, also serving as an advocate for ARF and RCFE owners and operators https://www.mhhu.org

MHSA – Mental Health Services Act (California) addresses a broad continuum of prevention, early intervention, and service needs making access to treatment easier, improving the effectiveness of services, reducing the use of out-of-home and institutional care, as well as expansion of the necessary infrastructure, technology, and training elements that effectively support the public behavioral health system

MPOX – Refers to the virus formerly known as "monkeypox", identified in a communicable disease outbreak affecting Los Angeles County in 2022

(MR), or **multiple response**– indicates analysis featuring an open-ended qualitative question posed to a respondent; responses for these questions are recoded in summary form to produce a quantitative measurement that can sum to greater than 100% of the total responses, as each respondent can provide more than one answer to the question in their response

N.B. – abbreviation of the Latin phrase 'nota bene': an instruction to a reader to "make note of" an item

N.E.C. – abbreviation for "not elsewhere classified"

PACE – Programs of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, elderly people (participants) still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. PACE service providers are typically Health Management Organizations (HMOs) and nonprofits https://www.dhcs.ca.gov/provgovpart/Pages/PACE.aspx

PEH – an acronym for "people experiencing homelessness"

PH2 – **Prevent Homelessness, Promote Health**: a DMH/DHS program that provides services for individuals or families at risk of eviction https://file.lacounty.gov/SDSInter/dmh/1068543_Brochure1.23.2020_002_.pdf

PMRT – **Psychiatric Mobile Response Team**: a Los Angeles County Department of Mental Health program that provides non-law enforcement-based mobile crisis response for clients experiencing a psychiatric emergency in the community https://dmh.lacounty.gov/our-services/countywide-services/eotd/pmrt/

PPP – **Paycheck Protection Program**: a federal government program operated by the Small Business Administration (SBA) to provide emergency loans and grants to business owners during the COVID-19 pandemic

PROMPTED – indicates a list of identifiers that were provided, exactly and verbatim, to every respondent answering a particular question: can also indicate that a respondent was asked to provide multiple answers to sum to a mathematical total (such as 100%) to ensure consistency in data collection across all surveys

PSH, or permanent supportive housing: affordable/subsidized housing with service-enriched resources such as case management, mental health, and substance use services

RCFE – **Residential Care Facility for the Elderly**: a facility licensed to provide housing, support, and care to aged individuals, generally (but not exclusively) over the age of 61

Recuperative Care – Interim housing: with transitional medical care for unhoused individuals discharged from hospitals, funded through DHS Housing for Health

REIT - a real; estate investment trust is a company that owns, operates, or finances income-generating real estate, modeled after mutual funds, REITs pool the capital of numerous investors

Regional Center Agencies - Funded through the California Department of Developmental Services, to support clients with developmental disabilities https://www.dds.ca.gov/

SNF– **skilled nursing facility**: medical facilities for individuals with long-term health needs who are discharged from hospitals

SPA – **Service Planning Area**: geographic regions utilized by Los Angeles County agencies for service planning, delivery, and analysis of health and social services

SSI – **Social Security Insurance** payments based on Age (65+) OR blindness (any age) OR disability (any age) and limited/no income and resources https://www.ssa.gov/

SSDI – **Social Security Disability Insurance** payments based pm disability and sufficient work credits through own/family employment https://www.ssa.gov/

VA – **United States Department of Veterans Affairs:** federal agency responsible for providing benefits and care to veterans and families affiliated with service in the United States Armed Forces https://www.va.gov/

Based in Southern California, The Future Organization LLC is a consultancy specializing in the delivery of evidence-based change and directed research for nonprofits, public agencies, and other organizations seeking to improve the efficiency, effectiveness, and quality of service delivery, often for diverse and vulnerable populations, in support of clients with high-complexity, strategic planning and implementation service needs. We partner with and serve organizations of all sizes, from startups to enterprise-level.

Our people utilize a range of quantitative, qualitative, and facilitative techniques, developed through years of operational, research, and consulting experience, to deliver insights and rational alternatives, with dedicated focus to ensuring that all organizations have the opportunity to build a better future.

TFO's mission is to deliver efficient and effective service, insights, and assistance, providing clear and coherent evidence to guide clients and communities to realize objectives, implement change, and achieve measurable outcomes.

The Future Organization stands ready to help you and your community to move forward.

Connect with your Future. A better tomorrow begins today.

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