

# Alameda County & Telecare Corporation



## Innovative Approaches to Address Changing Needs

SUPPORTING ALAMEDA COUNTY IN MAXIMIZING RESOURCES AND IMPROVING CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

### SAVING MONEY

- Cost-effective solutions
- Program savings are returned to Alameda County

### SOLVING PROBLEMS

- Reduce burden on limited County resources
- Interagency collaboration to close service gaps
- Flexible approaches to changing client and system needs

### SUPPORTING RECOVERY

- Delivering professional services that are consumer-centered
- Developing a Recovery-Centered Clinical System that is effective
- Actively involving consumers in design of recovery services

### LOOKING AHEAD

- Transforming system with MHSA funding
- Ensuring appropriate use of limited resources
- Documenting/improving outcomes using information to enhance services



# Partnership Solutions & System Benefits

## 1970s & 1980s — Strategic Responses: Create robust inpatient subacute programs in local communities.

In the late 1970s, usage of state hospital beds was high; people were treated far from home in highly restrictive settings. Alameda County attempted to reduce its state hospital use but was unsuccessful. To force a reduction in use, the State planned to decrease the County's funding for state hospital care. A reduction in funding would have adversely impacted the local system of care.

Alameda County negotiated a settlement with the State to preserve this funding and then partnered with Telecare to open two inpatient subacute facilities — Garfield Geropsychiatric Center in 1980 (now Morton Bakar Center) and Villa Fairmont in 1981. This step helped develop local capacity for high-risk, high-cost, severely disabled individuals. Compared to the cost of the state hospital, **the ongoing savings since 1982 has averaged approximately \$7 million annually for these two programs.**

## 1990s — Strategic Responses: Expand local array of services and best practices aligned with recovery approaches.

In the 1990s, Alameda County wanted to decrease its reliance on out-of-county institutions to provide services to its residents, while continuing reductions in state hospital use. The County partnered with Telecare to expand and adapt its local inpatient programs to simultaneously meet changing consumer and community needs. For example, the Garfield geropsychiatric program was relocated to Morton Bakar Center. Garfield then transitioned into a longer-term subacute inpatient service returning out-of-county clients to their home communities. In the mid-1990s, to further broaden less-restrictive options, the Garfield site was reconfigured to become a regional neurobehavioral program. Garfield clients were transitioned to the new ACT programs being developed by Telecare and Alameda County (Alameda STRIDES).

Alameda STRIDES was the first Assertive Community Treatment (ACT) program in the state specifically focused on individuals who were high-utilizers of inpatient services. The ACT program cost \$50,000 less per year, per client. **This generated an overall net savings to Alameda County of \$2.1 million during the first four years. These system changes also created over 300 local jobs.**

## 2000s & Beyond — Strategic Responses: Expand and infuse local systems of care with recovery philosophy and design models.

Alameda County wanted to expand its ability to support clients in recovery, while continuing to address critical system problems. They sought solutions that would help people recover their life roles vs. solely stabilize and maintain their current level of functioning.

Formally established in 1997, Telecare's recovery continued to expand in the early 2000s. Telecare began transforming its programs to be "power-with" vs. "power over" environments. An indicator of this shift: between 1998 and 2008, there has been an 83% reduction in seclusions, an 87% reduction in restraints and a 68% reduction in assaults in Telecare's sub-acute programs.

Concurrently, Telecare also worked with the County to bring cost-effective, recovery-focused services to underserved, high-intensity populations including people experiencing a mental health crisis (Sausal Creek), individuals with serious mental illness in the jail system (Project Change, North County Jail Acute Forensic Program), and adolescents (Willow Rock Center).

These programs help alleviate strain on highly taxed County resources, including law enforcement, medical/surgical hospitals, etc. by using existing funds in innovative ways.



## Telecare's Current Spectrum of Services

★ Since 1965, Telecare and Alameda County have jointly operated programs in these categories.

Inpatient Acute	Inpatient Non-Acute	Crisis	ACT	Case Management	Residential	Outpatient	Administrative Services
Within Medical Hospital	★ Recovery Centered 16-Bed	★ 23-Hour Facility-Based Crisis	PACT	★ Intensive	★ Residential Treatment	Outpatient Clinic	Service Access
★ Free Standing Psychiatric	★ Subacute	Mobile Services	★ Enhanced CARF ACT	★ Transitional	Transitional Community Living		Payment Authorization
	★ Extended	Crisis Residential	★ CARF ACT				Appeals
		Telephone Support					

### ABOUT TELECARE:

Based in Alameda, California, Telecare specializes in providing services and supports for individuals with serious mental illness (SMI). In FY07-08, Telecare served over 22,500 individuals through 60 programs in five states with the support of more than 2,100 employees. We are committed to the use of evidence-based practices and continual innovation in meeting client, customer, families and community needs. We offer an array of services that can be tailored to the needs of targeted clients and systems of care.

### WHO WE SERVE

Telecare provides services to adults with serious mental illness and complex needs, as well as adolescents and transitional age youth (18-25) with serious emotional disturbances. Telecare clients have often experienced long-term stays in institutional settings, repeated cycling through psychiatric emergency services, and/or histories of homelessness and criminal justice involvement.

Telecare's Recovery Centered Clinical System (RCCS) has been implemented in all current Alameda County programs.

All of Telecare's Alameda County programs have received CARF or JCAHO accreditations. CARF awarded commendations for ACT model, recovery practices, and consumer involvement practices.

# Alameda County & Telecare

Decade	1960s	1970s
Treatment Era	<b>Institutional</b> Long-term hospitalization	<b>Community Psych</b> Move from state hospitals to local locked settings
System Challenges	State-funded hospitalizations. Unfunded deinstitutionalization begins.	Reliance on state hospitals and local medical/surgical hospitals.
Strategic County Responses	Begin community mental health development. Civil rights for people with SMI.	Continue development of local community mental health system of care.
Funding Structure	Services for people with SMI are primarily state-funded. <b>1957 Short-Doyle Act</b> implemented. <b>1968 Lanterman-Petris-Short Act</b> implemented.	State increases local funding, but fails to distribute much of savings from state hospital closures. <b>1971 Short-Doyle/Medi-Cal</b> pilot project begins. 50% federal Medi-Cal match.

**Alameda County/  
Telecare  
Partnership  
Solutions**

**System Benefits**

**Open First Freestanding  
Acute Psych Program  
in Northern CA**

Provided local acute services for high-risk, high-cost, severely disabled individuals

**Develop Day-Treatment  
Outpatient Services**

Provided local community-based supports for high-risk, severely disabled individuals

# Partnership: Partnering to Solve System-Wide

## 1980s

### Psychiatric Rehabilitation

Transitioning people out of locked settings with skill-building and supports

Deinstitutionalization is moving slowly;  
few services available closer to home.

Create robust inpatient subacute programs  
in local communities.

Mental health system continues to experience erosion of funding based on population growth and cost of providing services.  
In 1988, **AB3777** established reforms and three integrated service agencies piloted them.

## 1990s

### Rehab to Recovery

Consumer literature begins to define recovery

Over-reliance on out-of-county  
institutional care.

Expand local array of services  
with best practices aligned with  
recovery approaches.

**Bronzan and McCorquodale Act** realigns fiscal and administrative responsibility under County, and defines priority populations.  
Revenues are funded from increase in sales tax and vehicle license fees.  
**1995-1998 Medi-Cal** mental health managed care consolidation.

### Establish Inpatient, Subacute Secure Programs for Adults and Older Adults

Brought individuals — and jobs — back to the local community, while incorporating a rehab and skill-building approach philosophy into a home-like setting. Villa Fairmont & Morton Bakar Center average \$7M in annual savings to Alameda County.

### Open First Assertive Community Treatment (ACT) Program in CA for High-utilizing Population; Open Neurobehavioral, Social Detox, and Expand Subacute

Produced longer community-tenure and lowered unnecessary inpatient use. Controlled study of ACT showed savings of \$2.2M in four years.

1980 Garfield Geropsychiatric SNF; 1981 Villa Fairmont MHRC

1992 Garfield Sub-Acute Adult 1992 Morton Bakar Center; 1994 Alameda STRIDES; 1996 Garfield Neurobehavioral (Redesign); 1997 Vida Nueva (closed 2001); 1997 Alameda STAGES; 1997 Gladman MHRC (Redesign)

# Side Challenges Over Time

## 2000s

### Recovery

Recovery is possible; people can reclaim life roles

Serve greater number of individuals; prevent unnecessary hospitalizations; instill hope.

Expand and infuse local system of care with recovery philosophy and design models.

Beginning in 1999, **AB34/2034** homeless outreach legislation.

**2004 Mental Health Services Act (Proposition 63)**

infuses \$1B+ in new money into the MH system annually, with emphasis on recovery, education, training, infrastructure and measurement.

## Future

### Recovery & Beyond

More fully exploring what recovery means for consumers, families and communities

Push transformation into new areas of system of care, while managing fiscal challenges.

Expand local system of care with innovative, culturally-competent cutting edge approaches.

#### Funding Structure Uncertain

**Budget Deficit:** Record deficits erode base system, while MHSA-funding system expands. **Nationally-driven issues** such as parity, universal health care, and integration of behavioral and physical health care.

## Develop/Implement Nine New Programs to Creatively Meet Specialized Population Needs

Provided new array of services in local community by redistributing existing funds: 23-hour crisis; voluntary short-stay inpatient; acute adolescent services; private pay acute services; and dual recovery for SMI/SA and SMI/DD. These help reduce burden on over-taxed Alameda County resources; recovery model yields 87% reduction in assaults.

## Currently Developing New Mental Health Rehabilitation Center for Individuals with SMI/DD

Creative and collaborative partnership with Regional Centers will bring new subacute resources for SMI/DD population into Alameda County. Continue to find opportunities to partner with the County developing SMI/DD, forensic and PEI services.