alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW, Director

- MEMORANDUM -

DATE: May 18, 2023

TO: Alameda County Residents and Providers

FROM: Kate Jones, RN, MS, MSN, Adult and Older Adult System of Care Director

SUBJECT: **Adult and Older Adult System of Care Update (May 2023)**

Dear Alameda County Residents and Providers:

In the last year, Mental Health Plans and Managed Care Plans across the State have undergone many changes related to California Advancing and Innovating Medi-Cal (CalAIM). Alameda County Behavioral Health Care Services (ACBHCS), the Mental Health Plan for Medi-Cal beneficiaries and eligible, is no exception. All systems within ACBHCS have been engaged in rolling out those changes and will continue to implement them over the next several years. During the last year of CalAIM implementation, the Adult and Older Adult System of Care (AOASOC) has also been engaged in other changes as we continue to strive for serving our community more efficiently and effectively.

The purpose of this Memo is to make you aware of several important Adult and Older Adult System of Care initiatives and priorities that are underway:

1. **Sub-acute Inpatient Hospital Quality Management Pilot**
2. **Washington Hospital and Fremont Engagement Pilot**
3. **Health Equity at The Forefront**
4. **Quality and Collaboration**

Subacute Inpatient Hospital Utilization Management Pilot:

ACBHCS has made subacute inpatient beds available to our beneficiaries for over 30 years. While we are not required to provide this level of care by the Department of Health Care Services as the County Mental Health Plan, we are committed to providing this critical service to our community. That said, we continue to face challenges of subacute inpatient beds being readily available to serve the demand and to support our treatment first, jails last efforts. As our entire system changes to divert people to treatment and to meet potential increasing demand related to the implementation of CARE Courts, we feel it is urgent to work smarter and be more efficient with the resources we have.

Prior to 2020 the AOASOC began working in collaboration with the providers of subacute mental health inpatient services to create utilization management for this level of care, which was put on hold due to the declaration of the public health emergency. At the beginning of this fiscal year, we picked that work back up to plan and implement a utilization review pilot at three of our four inpatient hospitals. At its most basic, the goal of utilization review is to make sure a healthcare service is necessary, appropriate, effective, and efficient. Villa Fairmont MHRC,

Gladman MHRC, and Morton Bakar MHRC will participate in the pilot. Some additional details about the pilot are below:

WHAT this looks like in practice:

- ACBHCS staff will review documentation to determine if someone needs inpatient services
- Determine if the provider is doing what is necessary and making best efforts to support the individual to reengage in the community in a timely manner
- Determine if the person needs a continued stay or is ready for discharge

WHY this pilot is happening:

- to provide greater access to this level of care for those who need it
- to manage a finite and expensive resource
- to provide care first and jails last for persons with serious mental health conditions
- to ensure that beneficiaries are not kept in the most restrictive settings once they are ready for discharge

WHEN the pilot will start:

- Villa Fairmont MHRC will begin the pilot on July 1, 2023
- Both Gladman and Morton Bakar MHRC will implement the pilot on January 2, 2024

Each Mental Health Rehabilitation Center will have an average length of stay (ALOS) goal based on the population that they serve. In addition, our System of Care is working with our outpatient providers to participate in monthly treatment plan meetings and provide in person follow up within seven days of discharge from an inpatient hospital stay.

Some of you may wonder if the beneficiary you serve or your loved one will discharge to the community based on the ALOS set for the program in which s/he/they are in. Those concerns are figured into this pilot in that we recognize that each person is unique and moves towards community reengagement at a different pace.

In addition to the pilot, the Adult/Older Adult System of Care is creating a Transition of Care Team (TCT) that will work with hospital settings and providers to ensure engagement and follow up post discharge including appointments with prescribers and connection to services. We strive to make this team operatational starting in early 2024.

We are excited to work with our provider community to institute this pilot and hope to decrease lengths of stay, provide more beneficiaries care who need it, and discharge individuals in a timely way.

Washington Hospital and Fremont Engagement Pilot:

The Adult and Older Adult System of Care is working in collaboration with Washington Hospital to institute a unique pilot program. The pilot program will focus on persons with serious mental health conditions and who may also have substance use conditions, who are identified as using Emergency Department resources for non-emergent needs with great frequency, known as Familiar Faces.

The community-based organization (CBO) that wins this request for proposal (RFP) will perform in-reach into the emergency department (ED) to begin engagement immediately upon referral to the program from ED staff. CBO staff will work to engage individuals to identify both wants and needs that can served outside of an Emergency

Department setting. Furthermore, those individuals that are identified as having a very high number of non-emergent emergency department visits will receive intensive outreach and engagement efforts by the community provider to connect them directly to the most appropriate services. In addition, others will be able to refer individuals, through our ACCESS line, who reside in Fremont (housed or unhoused) to the team who may need treatment and support but are disinclined to accept support.

All our communities have individuals that are reluctant to receive services and seek supports that may not match their current need. ACBHS provides services throughout the county and had a unique opportunity to partner with Washington Hospital and the Fremont community for this pilot.

Lastly, the RFP is due to be posted this Summer/Fall with a planned program start in late Fall.

Health Equity at the forefront:

In the last two years, the Adult and Older Adult System of Care has made strides to engage both internally and externally on encouraging culturally affirming practices among our providers and understanding health equity. In our continued efforts to forward this work, our system is working with the ACBHCS Health Equity Division to ensure that health equity and culturally affirming practices are at the foundation of each new RFP that serves the adult and older adult population. The first RFP to come out with this commitment is the Washington Hospital pilot program highlighted above. Future program development will include greater outreach to community stakeholders to assist in formulating populations served, defining culturally affirming practices for the population served, and outcome measures.

Quality and Collaboration:

During the last year, the Adult and Older Adult System has made several internal changes to increase our collaboration, technical assistance, and have more contact with our community providers. Our providers are challenged by hiring and retention of employees and our goal is to support them as well as collaborate on the quality and effectiveness of the services that are provided.

The Adult and Older Adult System of Care meets regularly with providers and has developed reports that assist all of us to review how often a service is provided, where the service was provided, and what kind of service is provided. The reports assist both the provider and our system of care to determine if both contractual obligations and outcomes are being met in a timely way. It is also an opportunity to problem solve barriers and provide technical assistance to ensure beneficiaries are being well served. There are instances when that does not occur, and our system of care may place a provider on a corrective action plan (CAP) to improve the provision of services. Our belief is to support our providers to the best of our ability so they can support the beneficiaries to the best of their ability.

As the Adult and Older Adult System of Care looks ahead to the next two fiscal years, we will engage in CARE_Court planning and implementation, implementing the projects detailed above, and focusing on transitions of care. Lastly, we look forward to increasing opportunities to partner with providers and community members to help shape our work ahead.