



**ASSEMBLY BILL 75
ANNUAL REPORT TO THE LEGISLATURE**

**Transfer of Administrative and Programmatic
Functions of the Department of Alcohol and Drug
Programs to the Department of Health Care Services**

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Transfer of Administrative and Programmatic Functions of the Department of Alcohol and Drug Programs to the Department of Health Care Services

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I. Overview

Background

Enactment of the 2011 Public Safety Realignment marked a significant shift in the State's role in administering programs and functions related to substance use disorder (SUD) services. Realignment also redirected funding for the Drug Medi-Cal (DMC) Treatment Program and discretionary SUD programs to the counties. Reflecting this shift, the Administration announced its intent in the Fiscal Year (FY) 2011-12 May Revision, and then proposed in the FY 2012-13 Governor's Budget, to reorganize the Department of Alcohol and Drug Programs (ADP). As part of the FY 2013-14 budget process, Governor Brown signed Assembly Bill (AB) 75 (Committee on Budget, Chapter 22, Statutes of 2013), which enacted law to eliminate ADP and transfer all remaining administrative and programmatic functions from ADP to the Department of Health Care Services (DHCS), with the exception of the Office of Problem Gambling which transferred to the California Department of Public Health. Previously, in FY 2011-12, Governor Brown signed Assembly Bill (AB) 106 (Committee on Budget, Chapter 32, Statutes of 2011), which enacted law to transfer the administration of the DMC Treatment Program from ADP to DHCS, effective July 1, 2012.

Consolidating responsibility for SUD services and community mental health services into DHCS aligned the State of California with its federal, state, and county counterparts. Nearly all community mental health programs from the former Department of Mental Health (DMH) transferred to DHCS with the enactment of the FY 2012-13 Budget, effective July 1, 2012.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has been moving towards administrative integration in the application for its block grant by encouraging states to submit one combined application. As of January 2013, more than 30 other states had SUD and mental health (MH) services combined in one department and 56 of California's 58 counties had also combined these areas.

DHCS and ADP began collaborating on transitions in early 2011, when they began the planning for the transfer of the DMC Treatment Program. For the transfer of the remaining administrative and programmatic functions of ADP, both departments built upon that infrastructure.

The two departments had a joint Executive Steering Committee, which included senior staff from both DHCS and ADP. They also had a joint Transition Team, which consisted of unit-level managers from the departments. Each department identified a Project Manager and created a work plan for the transition. A Project Manager for DHCS and a Project Manager for ADP each participated in the Transition Team, and were focused on implementing the transition work plans of each department.

Department Overview

DHCS' mission is to preserve and improve the health status of all Californians by providing residents with access to affordable, high-quality health care, including medical, dental, Mental Health, SUD, and long-term services and supports. DHCS' vision is to preserve and improve the physical and Mental Health of all Californians. DHCS works closely with federal officials, health care professionals and organizations, county governments and health plans in the administration of health care programs and services. DHCS plays a critical role in supporting a health care safety net for California's low-income and disabled persons.

As of June 2015, the programs administered by DHCS serve over 12.5 million Californians. One in three Californians receives health care services financed or organized by DHCS, making DHCS the largest health care purchaser in the State. DHCS invests over \$70 billion in public funds to provide health care services. DHCS provides access to comprehensive health services and emphasizes prevention-oriented health care that promotes human health, well-being and individual choice. DHCS ensures appropriate and effective expenditure of public resources to serve those with the greatest health care needs. The health care programs and services administered by and financed through DHCS help maintain the health care delivery safety net by providing California's low-income persons and families, children, pregnant women, seniors and persons with disabilities with access to critical health care.

DHCS programs are designed to:

- Deliver health care services to low-income persons and families who meet defined eligibility requirements;
- Emphasize prevention-oriented health care measures that promote health and well-being;
- Ensure access to comprehensive health services through the use of public and private resources; and,
- Ensure appropriate and effective expenditure of public resources to serve those with the greatest health care needs.

The transfer of administrative and programmatic functions from ADP provides the opportunity for improved efficiencies, maximization of resources, and improved coordination and integration of physical health care services. These opportunities align with the commitment strategies and actions outlined in the [DHCS Strategic Plan](#). (Note that underlined texts in this report are links to information on the DHCS website.)

Purpose of the Report

AB 75 directs DHCS to report annually to the Joint Legislative Budget Committee and the appropriate budget subcommittees and policy committees of the Legislature on the SUD services programs. The report addresses impacts of the transition of ADP programs to DHCS and establishes a baseline for evaluating, on an ongoing basis, how

and why alcohol and other drug prevention and treatment service delivery has improved, or otherwise changed, as a result of this transition.

Note: Updates to this report since its last publication are shown in *italics*.

II. Continuity of Care

There have been no reported disruptions in treatment services reported to DHCS since the transfer of administrative and programmatic functions from ADP.

III. Savings (or Costs) to State and Local Government

In the first years, all costs for transferring the administrative and programmatic functions from ADP to DHCS were absorbed within existing resources of ADP and DHCS. No additional budget authority was authorized. The primary costs to transfer the functions were associated with the transfer of information technology (IT) systems and relocation of staff. Additional costs were incurred due to investment of significant staff time in planning, tracking and operationalizing the transfer.

DHCS received *six* complex IT systems from ADP and more than 200 additional staff with computing needs, as a part of the transfer. This is an update to the 2015 report, and the number of 42 systems reported in the 2014 report (42) was incorrect. The goal of the IT transition activities was to ensure the transition of these systems and meet staff computing needs while avoiding infrastructure and security risks to the DHCS network. *DHCS' Enterprise Innovation Technology Services Division (EITSD)* (formerly named Information Technology Services Division), worked with ADP staff to assess ADP's existing IT systems. It was determined that ADP's servers, hardware, and software were not compatible with *DHCS'* IT infrastructure. DHCS procured DHCS-compatible hardware, including servers, to reduce the risk of future system failures once ADP IT application systems were transitioned into *DHCS'* environment. Additionally, DHCS procured DHCS-compatible software, such as anti-virus, data backup, and storage management software. The costs of migration of ADP's IT systems and network servers and to procure DHCS-compatible hardware and software for transferring employees were absorbed by DHCS. DHCS entered into one-time consulting contracts with technical experts to migrate ADP's IT systems, infrastructure, and network servers. DHCS *EITSD* invested significant staff time in the migration effort.

DHCS *EITSD* continues to work collaboratively with the *SUD* Divisions to identify business needs, prioritize IT efforts (projects, enhancements, upgrades), consolidating functionality of the IT systems where applicable, and provide improvements through process re-engineering.

In early 2014, a significant number of administrative staff from human resources, legal services, accounting, IT, etc., was relocated to the East End Complex. Program staff was relocated to the East End Complex in December 2014. The costs for relocation of staff were absorbed.

DHCS partners and stakeholders have indicated that the transfer has resulted in increased costs related to contract and payment delays, staff time related to the recertification process for the DMC Treatment Program, and processing contract amendments with counties, vendors and service providers. In 2013, transitioning federal authority for [SAMHSA's Substance Abuse Prevention and Treatment Block Grant \(SAPT BG\)](#), [Strategic Prevention Framework State Incentive Grant \(SPF SIG\)](#) and CARE grants delayed payments to the State *which resulted* in late payments to counties and providers.

IV. Improved Efficiency and Maximization of Resources

The transfer of the remaining SUD administrative and programmatic functions from ADP to DHCS reunited the State administration of the DMC Treatment Program with the rest of SUD programs. This consolidated the SUD programs within DHCS to: foster coordination of SUD programs with community mental health and primary care; improve efficiencies in the administration of the programs; and maximize resources. The reorganization offered numerous benefits to the SUD system, including:

- Alignment with federal and county partners;
- Promotes opportunities for improvement of health care delivery;
- SUD, MH and primary care programmatic expertise coordinating within DHCS;
- Enhances oversight of SUD programs; and
- Reflects realignment.

In anticipation of the transfer of programs from the former DMH and the DMC Treatment Program from ADP, DHCS began an effort in early 2011 to identify key business processes transferring from the departments to conduct risk assessments and to identify opportunities for process improvement. The Business Process Reengineering (BPR) effort provided collaboration between DHCS, DMH, and ADP subject matter experts and stakeholders. The BPR identified key business processes to be examined and assessed for ease of transfer to DHCS, identification of efficiencies that could be operationalized at transfer, and/or any potential risks. The BPR Team identified seven ADP business processes to document. This effort, led by *DHCS'* Internal Audits Branch of the Audits and Investigations Division, worked with ADP subject matter experts, and flow-charted the processes. Claims processing and payments, cost report and settlement, and financial audits and appeals were selected and additional stakeholder input was gathered. *DHCS'* Internal Audits Branch conducted a risk assessment on the remaining four processes and gathered the related statutory language. As a result, *EITSD* worked with the Short Doyle system to ensure system improvement to more accurately improve the system processes, a contract was secured with *the* Office of Audits and Appeals to conduct hearings for ADP and support and training was provided to transitioning staff. *DHCS'* Internal Audits Branch continues to provide information to DHCS on historical perspectives of the processes in place prior to the transition of ADP. Once ADP transitioned into DHCS, business processes were taken over by SUD Services, and improvements are made as needed.

DHCS Contracts Management Unit worked with ADP contract staff prior to the transfer to determine the most efficient means to transfer county contracts. The team developed an efficient and expeditious method to amend and extend existing county and direct-provider contracts, transitioning authority to DHCS. This method was effective in eliminating potential service disruptions.

As the July 1, 2013, date approached to transfer the remaining ADP programs and funding sources, DHCS issued amendments to the State-county contracts and DMC Treatment Program direct-provider contracts to extend the contracts for one additional year, through June 30, 2014. The contracts covered the DMC Treatment Program, as well as other programs, including the SAPT BG, and Parolee Services Network funds. *Extending contracts an additional year eased the transition and avoided greater disruption of payments to counties.*

Information Technology (IT) and Data Management

DHCS' IT infrastructure provides an opportunity to improve some longstanding issues with California Outcomes Measurement System-Treatment (CalOMS Tx). For example, one vision in early stages of CalOMS Tx development under ADP was for an online reporting system into which counties and providers could directly enter CalOMS Tx data. However, ADP did not have the IT infrastructure to support such an online platform. As a result, counties and providers built local systems and submitted data in monthly batches. *The greater capacity of DHCS' IT infrastructure may provide an opportunity to move toward an alternative reporting platform that improves local reporting of CalOMS Tx data.*

Since SUD services systems are now under DHCS, there are opportunities to streamline data systems, data reporting requirements, and data collection. As DHCS implements the federal Affordable Care Act (ACA), there is opportunity to take a holistic approach to data reporting systems across primary care, MH and SUD service delivery systems while reducing the data-reporting burden of counties, providers, and health plans. A possible long-term outcome of the transfer is increased capacity to simplify data collection and reporting across service systems; analyze individual system performance as well as performance in areas of service integration; and implement, support, and maintain continuous quality improvement in both service delivery and data quality.

Public Reporting of Treatment Statistics

While the transfer to DHCS has impacted public reporting of treatment statistics, the transfer also provides opportunity to improve in this area. The SUD Office of Applied Research and Analysis (OARA), DHCS' specialized SUD research branch, may have access to additional data and analysis tools and resources. *Where research/evaluation were historically focused primarily on treatment data, there may be opportunities in the future to look at service recipients across treatment services.* Such research and

evaluation could provide a greater understanding of all services accessed and utilized, service outcomes, program performance, and long-term health outcomes of SUD service recipients.

In addition, there is opportunity to align and streamline policies and practices related to Health Insurance Portability and Accountability Act (HIPAA) and *42 Code of Federal Regulations*, Part 2, as they pertain to public reporting of treatment statistics. Though public reporting of treatment statistics has been limited since the transfer, reviewing policies and practices will ultimately lead to clarification of what aggregate statistics can be provided, simplification of review, and reduced turnaround time. This, in turn, may help shift resources (currently used to study and discuss what can be released and make possible changes to policies) to potentially new research and valuation functions and/or focus in SUD populations.

V. Improved Coordination and Integration of Physical Health Care Services

The transfer of programs from ADP to DHCS has resulted in improved coordination and integration of physical health care services with SUD treatment services, both at the State and local level.

The DHCS Deputy Director of Mental Health and Substance Use Disorder Services (MHSUDS) oversees the *two* SUD Divisions and Mental Health Services Division (MHSD) within DHCS. By law, this position is appointed by the Governor and confirmed by the Senate. The Deputy Director reports directly to the Director of DHCS.

Through the establishment of MHSUDS, SUD programs are easily and efficiently able to collaborate with multiple DHCS divisions involved in physical health care (*e.g. Managed Care Quality and Monitoring, Benefits, Provider Enrollment, Audits and Investigations, Pharmacy Benefits*). This newly expanded and collaborative approach has increased integration of SUD programs with MH and other health programs to improve health outcomes for beneficiaries receiving services via multiple delivery systems (*e.g. managed care, fee-for-service, and county delivery systems*). *DHCS staff from various divisions meet internally and externally with stakeholders on a regular basis to ensure crosscutting issues are addressed appropriately.* As a result, the transfer of SUD programs into DHCS directly connects those programs to the physical health care issues, policies and delivery systems in a way that had never occurred previously.

The transfer of SUD programs to DHCS has supported increased communication and collaboration between the physical and behavioral health components of managed care and county delivery systems. *This increased communication and collaboration has also been seen and supported in the Coordinated Care Demonstration Project also known as [Cal MediConnect](#).*

Staff in SUD Divisions work with counterparts from *MHSD* to ensure improved coordination and integration of physical health care through attendance at *DHCS* meetings with Medical Directors from Managed Care and Mental Health Plans.

Additionally, DHCS hosted a forum for managed care plan representatives and Mental Health Plan Directors. The forum provided SUD staff an opportunity to discuss the issues and challenges with SUD service delivery in an integrated setting with administrative leaders of these key delivery systems.

VI. Access and Effectiveness of Substance Use Disorder Prevention and Treatment Services

Prevention Services

Prevention of Substance Use Disorders (SUD)

Substance use is a behavior that begins as experimental and can lead to various negative consequences, including later onset of a SUD, which is a chronic, clinical condition. According to SAMHSA, SUD prevention is defined as activities directed at individuals who do not require treatment for an SUD. Such activities may include education, counseling, or changes to the social/community environment that reduce risk factors and increase protective factors, thereby reducing the risk of individuals developing a SUD.

The major federal funding source for SUD prevention services in California is the Substance Abuse Prevention and Treatment Block Grant ([SAPT BG 20 percent Primary Prevention Set-Aside](#).) The Primary Prevention Set-Aside is distributed through a population-based formula allocation for SUD prevention services to all counties. The annual allocation has remained relatively constant since 2012 providing approximately \$45 million to \$47 million dollars.

Prevention Services Data Sources

Each of California's 58 counties is required by contract to develop a Strategic Prevention Plan, with measurable goals and objectives, using [SAMHSA's Strategic Prevention Framework \(SPF\)](#). The SPF consists of five phases: needs assessment, capacity building, planning, implementation, and evaluation. The needs assessment includes looking at local data to determine the major contributing factors associated with SUD use locally, and an assessment of local capacity and resources to reduce and/or prevent SUD use. Examples of data sources used by counties are:

- Surveys such as the California Healthy Kids Survey and the Youth Development Survey;
- Motor vehicle accidents and fatalities associated with SUD;
- Hospitalizations and deaths related to SUD;
- Crimes/arrests associated with SUD; and
- SUD treatment admissions.

Counties prioritize identified areas of focus, develop goals and objectives for identified areas of focus to be funded, and select strategies from SAMHSA's approved Center for

Substance Abuse Prevention (CSAP) strategies to meet the goals. The CSAP strategies for allowable use of SAPT BG funding are:

- **Information Dissemination** to provide awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. This dissemination is usually a one-way communication from a source to an audience, with limited contact between the two (e.g., printed materials, websites).
- **Education** is two-way communication between an educator/facilitator and the participants (e.g., classroom curriculum). Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systematic judgment abilities.
- **Alternatives** provide opportunities to participate in activities that exclude substance use. Activities must contain an SUD component and provide for youth leadership opportunities (e.g., youth involvement in a local coalition focusing on preventing excessive alcohol consumption at annual community events).
- **Problem Identification and Referral** involves identifying those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. This strategy does not include any activity designed to diagnose if a person is in need of treatment.
- **Community-Based Process** enhances the ability of the community to more effectively provide prevention services for SUD. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implemented, interagency collaboration, coalition building, and networking.
- **Environmental** efforts establish or change community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives (e.g., social host ordinances, establishing policies) and those that relate to the service and action-oriented initiatives (e.g., law enforcement and retailer education, media campaigns).

Statewide SUD prevention information in California is collected using the California Outcomes Measurement System for Prevention (CalOMS Pv). The DHCS Resource Center Inventory System is used for tracking the number of publications disseminated, and the number and type of inquiries received for SUD information and treatment referrals. FYs 2011-12 and 2012-13 are included in this report. FY 2011-12 is the most current and completed year of CalOMS Pv data available; FY 2013-14 and 2014-15 CalOMS Pv data are preliminary until year end cost reports are received and reconciled.

Access to Prevention Services

SUD Prevention Services are provided at the individual and population levels. Individual-level prevention services are characterized as one-on-one or group sessions that are interactive and engage participants in structured SUD prevention services. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviors that ultimately prevent SUD use. Individual-level services allow for demographic information to be collected.

Population-level prevention focuses on settings such as neighborhoods. Prevention services at this level are typically designed to impact the climate, community processes, and policies in a given system. Social norm and marketing campaigns are often used to foster neighborhood climates that promote healthy relationships. Because population-level prevention is delivered to the community at large, demographic data is not collected.

This comprehensive prevention service delivery structure allows counties to provide the maximum benefit for the largest number of people, thereby mitigating service access issues.

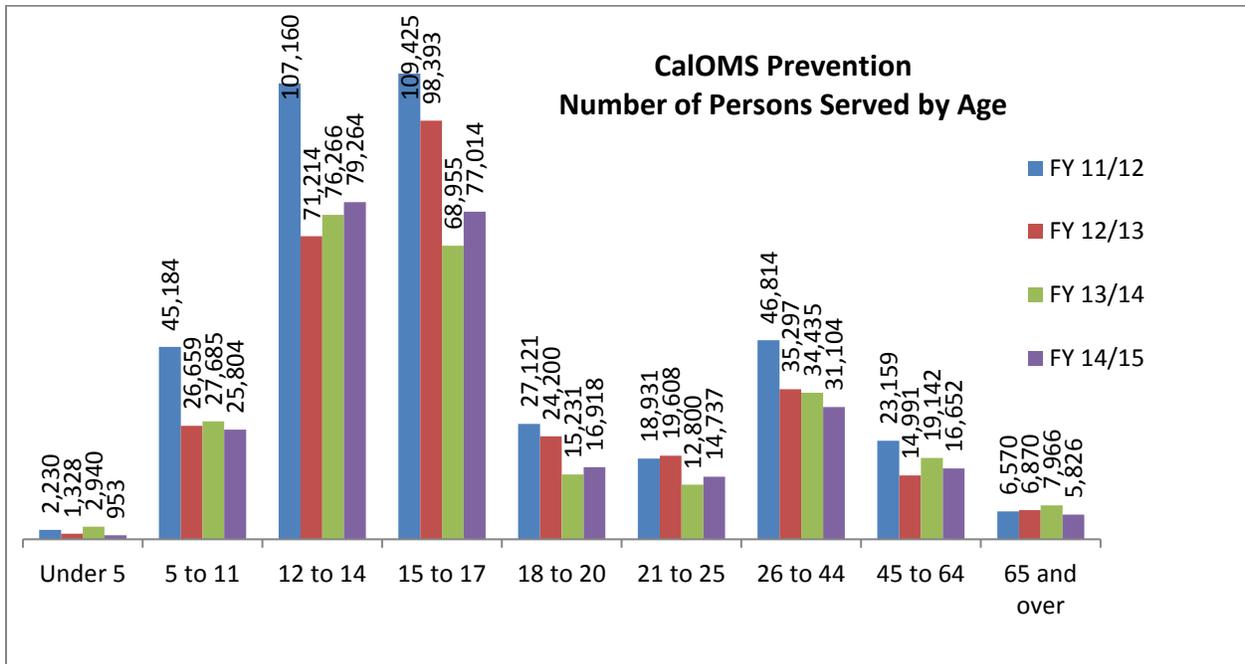
In FY 2011-12, a total of 386,594 persons received an individual-level service. The following demographic information was collected:

- 79.6 percent of the total number of persons served was youth and young adults (11.7 percent aged 5-11, 27.7 percent aged 12-14, 28.3 percent aged 15-17, and 11.9 percent aged 18-25).
- Slightly more than half (53.4 percent) of persons served were female.
- Nearly 40 percent of the persons served identified their race/ethnicity as Hispanic/Latino, while one third (33.3 percent) identified as White, Not Hispanic. African Americans represented the third largest group (10.2 percent) and Asian Americans represented the fourth largest group (7.4 percent).

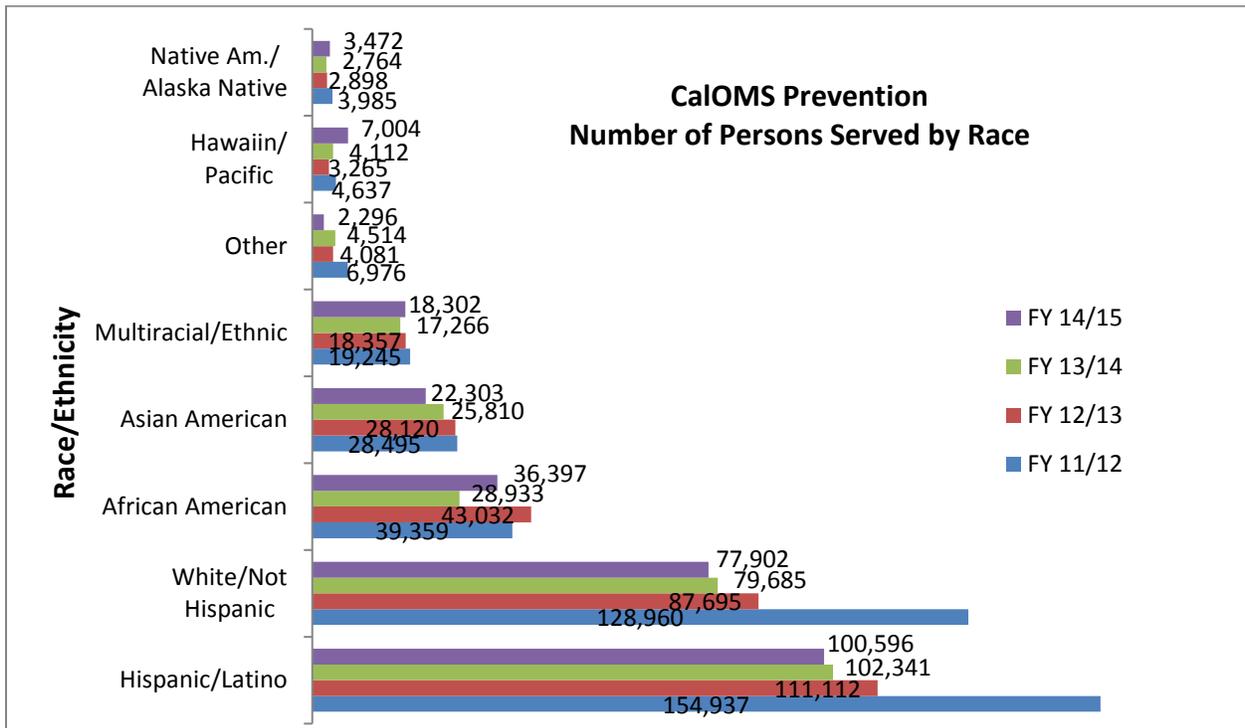
In FY 2012-13, a total of 298,560 persons received an individual-level service, in FY 2013-14, a total of 265,420 persons received an individual-level service and in FY 2014-15 237,168 persons received an individual-level service where demographic information is collected. Please note that the total number of persons served for FY 2014-15 is based on preliminary data. Updated figures will be reported in the 2016 AB 75 Transition Report. The steady decline in total number of persons served from FY 2011-12 is attributable to the growing number of counties reporting services that align with the Community-Based Process strategy which does not collect demographic data. Counties and providers often use this strategy to report weekly aggregated entries of indirect and/or administrative duties.

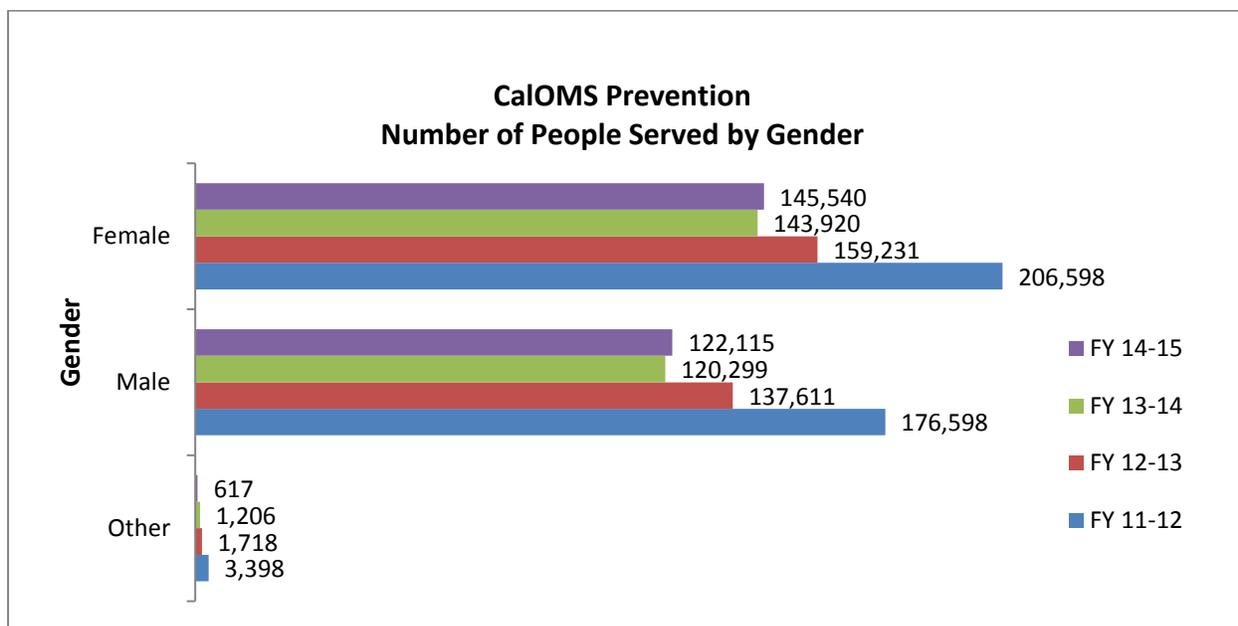
The following charts depict data on age, race and gender collected in CalOMS Pv. Note that counties are only required to report services in CalOMS Pv that are funded with SAPT BG dollars; services provided with other funds are not reflected. Also, the FY

2013-14 CalOMS Pv data are preliminary until year end cost reports are received and reconciled.



*CalOMS Pv Data Retrieved 7/28/15, FY 13/14 and 14/15 data are preliminary





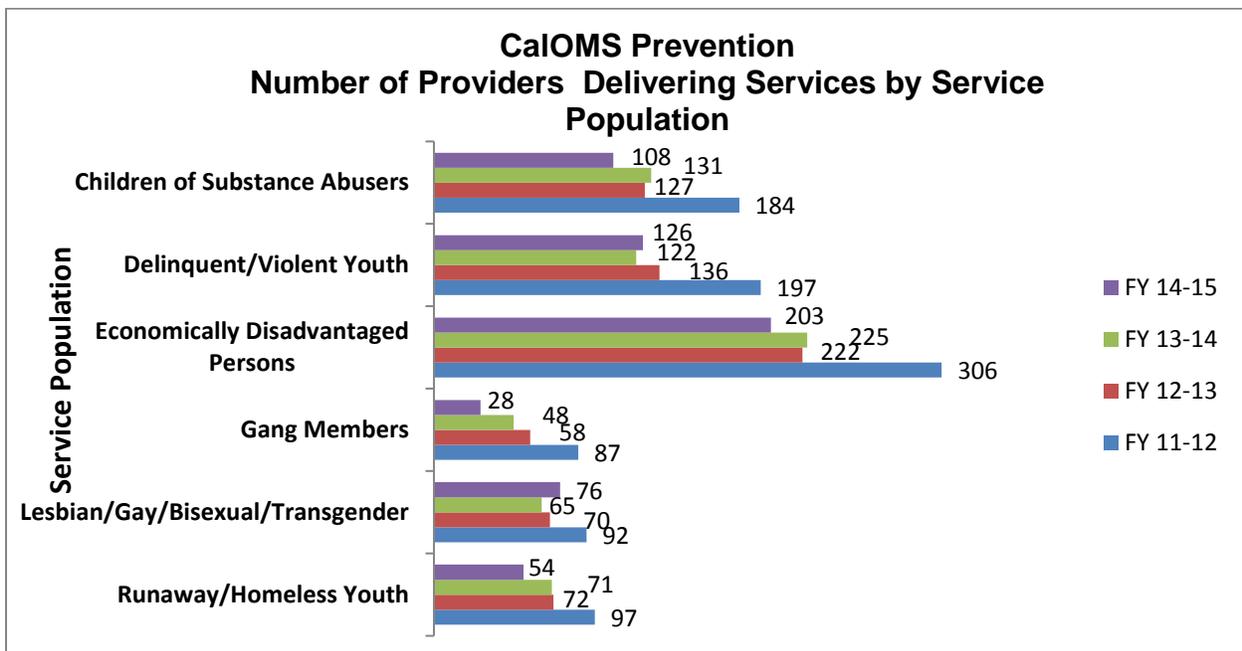
Access to Prevention Services for Vulnerable and Underserved Populations

At the State level, the SUD Resource Center (RC) provided SUD information and resources through telephone inquiries and referrals, clearinghouse publications, lending and conference services, and social media. This service *provided* information to the general public, often to persons in crisis or in need of access to services in their communities. *As well, many* of these services were available in multiple languages (e.g., Spanish, Chinese, Ukrainian, and Vietnamese).

In FY 2011-12, the RC received 1,136 individual orders and distributed 299,936 publications. In FY 2012-13, the RC received 1,203 individual orders and distributed 246,389 publications. Of the publication orders, 588 (257 in FY 2011-12 and 331 in FY 2012-13) were to incarcerated persons. *As well, a total of 112,481 publications were disseminated in FY 2013-14.*

One of the most important roles of the RC was the toll-free telephone line which *provided* information and referrals to the public, both in English and in Spanish. In FY 2011-12, 12,509 calls were received. Of those calls, 493 were to Spanish speaking individuals. In FY 2012-13, the RC fielded 14,709 calls; 410 were to Spanish speaking individuals. *In FY 2013-14, the RC fielded 16,931 calls; 383 were to Spanish speaking individuals.*

At the local level, while many counties serve vulnerable and underserved populations, these populations are seldom reported as specific targeted populations for SUD prevention services. As mentioned previously, counties are required to engage in a strategic planning process that identifies specific local needs. Through this process, counties may identify gaps in service to specific underserved and vulnerable populations and contract with providers to address those specific populations. The CalOMS Pv data collection system allows service providers to identify the underserved/vulnerable populations they serve, but it is not a requirement for the submission of data. Note that CalOMS Pv does not have the capacity to capture specific individual level demographics for underserved/vulnerable populations but rather the number of providers that deliver services to these populations. The chart below represents the most frequently identified service populations considered to be underserved and/or vulnerable. Per the federal grant application, *economically disadvantaged persons are defined as persons with net income less than 130 percent of the poverty level. This aligns with other federal requirements for free school lunches, WIC, etc. The terminology Economically Disadvantaged Persons aligns with the terminology used by the federal Center for Substance Abuse Prevention.*



*CalOMS Pv Data Retrieved 7/28/15, FY 13/14 and 14/15 data are preliminary

Prevention Services System Capacity and Infrastructure

The SUD Policy and Prevention Branch (PPB) develops and maintains a comprehensive, statewide prevention system that aims to avert and reduce substance use to improve the health, safety, and economic conditions of California residents. The PPB provides technical assistance and guidance to the counties and their providers, as well as oversight to ensure the requirements for the SAPT BG funds are being met. As

previously stated, the SAPT BG 20 percent Primary Prevention Set-Aside is the primary funding for SUD prevention efforts in California, the majority of which is allocated to the counties, making SUD prevention in California county-driven but guided by the *counties'* [Strategic Prevention Framework \(SPF\)](#). Counties determine the focus of their prevention efforts and identify any gaps in services. This process allows for expanded county-level service capacity.

Performance Management and Accountability

Strategic Planning

As previously stated, each of California's 58 counties are required by contract to have a Strategic Prevention Plan, with measurable goals and objectives, developed using SAMHSA's SPF. The county submits the strategic plan to DHCS for review and feedback, enters the identified priorities, goals and objectives into CalOMS Pv, and assigns each objective to one or more providers.

Service Delivery

When the providers report SUD prevention services in CalOMS Pv, each service is linked to an objective. This allows both the county and DHCS to ensure the services, strategies, goals and objectives align with the county's priorities. Over time, progress toward meeting the goals can be tracked and modifications can be made as necessary.

Technical Assistance

Technical assistance is available at no cost to counties and providers that require assistance with strategic plan development, meeting reporting requirements, understanding the fiscal reconciliation process, and selecting and implementing appropriate strategies including evidence-based programs.

When counties incorporate SPF into their everyday business practices and utilize available technical assistance and training, it allows for expanded local system capacity. One phase of the SPF is to build local capacity. This includes ensuring a county has the resources and readiness to support the prevention programs and practices they choose. Programs and practices that are well-supported are more likely to succeed and to be sustained over time.

Performance Tracking and Indicators

The PPB participated in the departmental statewide needs assessment priority setting and planning, prior to transfer of ADP. Since the transfer, PPB has continued priority development and strategic planning with *the* DHCS Office of the State Medical Director. The following PPB goals have been included in the [DHCS Strategy for Quality Improvement in Health Care](#) that outlines DHCS' seven quality strategy priorities:

Quality Strategy Priority 5: Advance Prevention: The PPB's goals are related to building the knowledge and capacity of the prevention workforce, statewide

prevention outcomes, and *Screening, Brief Intervention and Referral to Treatment (SBIRT)* services; and

Quality Strategy Priority 6: Foster Healthy Communities: The PPB's goals relate to SPF SIG which addresses underage and excessive drinking by utilizing evidence-based programs, and increasing Friday Night Live (FNL) program fidelity. FNL is a statewide youth development program.

The ways in which the PPB has strategized to meet these goals include: 1) developing and implementing professional competencies for the prevention field; 2) building a core staff of competent prevention trainers; 3) piloting statewide outcomes in ten counties; 4) collaborating with [DHCS' Managed Care Quality and Monitoring Division](#) to include [SBIRT](#) services for all Medi-Cal beneficiaries; 5) implementing the SPF SIG goals in twelve communities; and 6) developing and implementing the FNL Roadmap, in all counties that administer FNL programs.

Fiscal Reconciliation Process

To ensure accountability and full expenditure of the SAPT BG prevention dollars, DHCS engages in a reconciliation process in which budget and cost data are compared to the services reported in CalOMS Pv.

The chart below indicates the number of prevention providers in the *state* engaging in each CSAP strategy. *Note:* Providers that engage in more than one strategy may be counted in more than one strategy.

Number of SUD Primary Prevention Providers Reporting per CSAP Strategy

| Service Modality | FY 2011-12 | FY 2012-13 | FY 2013-14 | FY 2014-15 |
|-------------------------------------|-------------------|-------------------|-------------------|-------------------|
| Information Dissemination | 241 | 209 | 222 | 204 |
| Education | 227 | 178 | 181 | 163 |
| Alternatives | 165 | 140 | 149 | 127 |
| Problem Identification and Referral | 71 | 55 | 48 | 46 |
| Community-Based Process | 246 | 220 | 240 | 223 |
| Environmental | 150 | 154 | 170 | 164 |

*CalOMS Pv Data Retrieved 7/28/15, FY 13/14 and 14/15 data are preliminary

Prevention Services System Outcomes

PPB, in collaboration with the SAPT + Prevention Subcommittee of the *County Behavioral Health Directors Association (CBHDA)*, has been working to identify priorities and associated goals to collect prevention outcomes statewide.

Based on a keyword analysis conducted in FY 2012/13 of State- and county-level needs assessment data, underage alcohol use was identified as the top priority. Research

shows that the early onset of alcohol use, frequency of drinking, and intensity of drinking among youth are predictors of later substance abuse and other risky behaviors *or* harmful consequences.

The three priority areas identified to address underage and excessive drinking are:

1. *Reduce* the percent of youth ages 12-16 who report the initiation of alcohol use by age 15 (Too Early);
2. *Reduce* the percent of youth between 9th and 11th grades who report drinking three or more of the past 30 days (Too Often); and
3. *Reduce* the percent of youth between 9th and 11th grades who report engagement in binge drinking within the past 30 days (Too Much).

Although these outcomes were approved by CBHDA in September 2012, implementation at a statewide level has been met with some barriers.

- Many counties are in the middle of implementing three to five year strategic prevention plans and may be locked into contracts with providers.
- Some counties may have identified other priorities based on their local needs assessment.
- Many counties rely on the [California Healthy Kids Survey](#) – the largest youth survey in the nation on substance use, school climate, and student health – for local data to use as a baseline and measurement for outcomes. With the loss of Title IV funding (Safe and Drug Free Schools and Communities), and its requirement to collect school-level data, many schools lack the resources to continue administering the survey.

Despite these challenges, DHCS is committed to increasing the number of counties addressing statewide priorities. It is anticipated that changes will first be measureable at the intervention/community level (on an annual basis), then at the county level (within three to five years), and then eventually at the State level (within five to seven years).

PPB is also using the SPF SIG to pilot a study using evidence-based programs and practices. *In September 2010*, ADP was awarded SAMHSA's SPF SIG to streamline existing SPF processes at the county and community level, and demonstrate effective implementation of research-based prevention strategies in communities.

In following the SPF five-phase process, the SPF SIG Workgroup conducted a statewide needs assessment, the results of which identified underage and excessive drinking among 12- to 25-year-olds as the priority of the California SPF SIG project.

Environmental prevention strategies will be implemented in 12 communities in California. Results will be compared to 12 control communities that have been matched with the SPF SIG communities. The SPF SIG implementation communities were selected based on local AOD use and consequence data. The communities are: Livermore (Alameda County); Antioch (Contra Costa County); Walnut Creek (Contra Costa County); Santa Monica (Los Angeles County); San Rafael (Marin County); Merced (Merced County); Huntington Beach (Orange County); Folsom (Sacramento County); Redlands (San Bernardino County); Santa Barbara (Santa Barbara County); Santa Rosa (Sonoma County); and Ventura (Ventura County).

These communities focus on underage and binge drinking and employ evidence-based strategies that fall into three primary strategies: 1) Retail access; 2) Social access; and 3) drinking and driving. To date, the following strategies have been used: *Driving Under the Influence* (DUI) roadside checkpoints, DUI saturation patrols, responsible beverage service training, party patrols, downtown foot patrols, compliance checks, Remind and Reward Programs, conditional use permits, deemed approved ordinances, social host liability, keg registration, neighborhood watch, place-of-last-drink surveys, alcohol use permits, entertainment permits, minor decoy operations, and visibility messaging on both compliance and enforcement operations.

Process and outcomes evaluations will be completed at the end of the project (September 2016). Archival data from various sources will be used to evaluate intervention effects on community-level outcomes, such as alcohol-related motor vehicle crashes, assaults, injuries, and underage drinking. Baseline and follow-up surveys of 2,400 18 to 30-year-olds (~100 per city) and 1,500 adolescents (~60 per city) will be conducted in 2013 and 2015. The process evaluation will help to understand the paths to success and why initiatives in some communities may have worked better than initiatives in other communities. All findings will be disseminated to county behavioral health directors, county prevention coordinators, and will be available on the DHCS website (www.dhcs.ca.gov/provgovpart/Pages/SPFSIG.aspx). Information, tools and techniques from the project also will be incorporated into the workshops and trainings of the Community Prevention Initiative technical assistance contract.

Treatment Services

Treatment Services Data Sources

Data on SUD treatment services and service recipients come from *the* California Outcomes Measurement System for Treatment (CalOMS Tx). CalOMS Tx collects SUD treatment admission and discharge data from publicly funded treatment services and/or licensed Narcotic Treatment Programs (*NTP*) in California. For future reference, these are called “publically monitored treatment services.” Pursuant to AB 75, FY 2011-12 data are included as baseline data. FY 2012-13 and *FY 2013-14* are included for *trend analyses*. *FY 2013-14* is the most current and completed fiscal year of CalOMS Tx data available.

Treatment data include the following treatment service modalities:

- Outpatient Drug Free - individual and/or group counseling provided in an outpatient setting;
- *NTP* Maintenance – provision of narcotic replacement medications such as methadone or buprenorphine in an outpatient setting and includes individual and/or group counseling;
- Intensive Outpatient Treatment – provision of three hours of counseling and rehabilitation services three days per week;

- Outpatient Detoxification - rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting. Services are designed to support and assist participants undergoing a period of planned withdrawal from SUD dependence and explore/develop plans for continued service. Administration of prescribed medication may be included in this type of service;
- NTP Detoxification - rendered in less than 24 hours and provide narcotic withdrawal treatment to clients undergoing a period of planned withdrawal from narcotic dependence;
- Residential Detoxification – includes hospital and non-hospital detoxification services. Hospital detoxification services are provided in a licensed hospital where participants are hospitalized for medical support during the planned SUD withdrawal period. Non-hospital detoxification services are provided in a residential facility which support and assist the participant during a planned SUD withdrawal period; and
- Residential Treatment – includes short-term (less than 30 days) and long-term (more than 30 days) treatment services provided in a residential setting. Services may include the following elements: personal recovery/treatment planning; educational sessions; social/recreational activities; individual and group sessions ; and information about/assistance in obtaining, health, social, vocational, and other community services.

Access to Treatment Services

CalOMS Tx collects data on individuals admitted to publically monitored treatment services. This data does not include those seeking but not receiving publically monitored treatment.

The following (see Appendix 1) provides CalOMS Tx based demographic information on persons admitted into SUD treatment. These statistics provide counts of all admissions for all service types. (Note: An individual treatment service recipient may be admitted to multiple service types in a given year *or be admitted to the same service type multiple times*; so admissions will not *equal* the number of unique treatment service recipients.)

The following summary of CalOMS Tx admissions is for FY 2013-14. *Most of this service recipient information has remained relatively stable compared with the FY 2011-12 and FY 2012-13 figures except where noted.*

- Over one-fourth of admissions into SUD treatment (29.2 percent) are for service recipients 26 to 35 years old. The 36 to 45 year-old *category represents 18.9 percent of the total followed by the 18-25 year-old category (17.8 percent) and the 46 to 55 year-old category (17.2 percent)*. Those under 18 years of age represent 9.7 percent and those 56 and older represent 7.2 percent. *Since FY 2011-12 there has been an annual decrease in the percent of service recipients who are under 18 years of age.*
- 62.9 percent of the admissions were males and 37.0 percent were females.
- Most admissions are for service recipients identifying their race-ethnicity as either White (44.1 percent) or Hispanic (35.9 percent). *In FY 2013-14, the percent of*

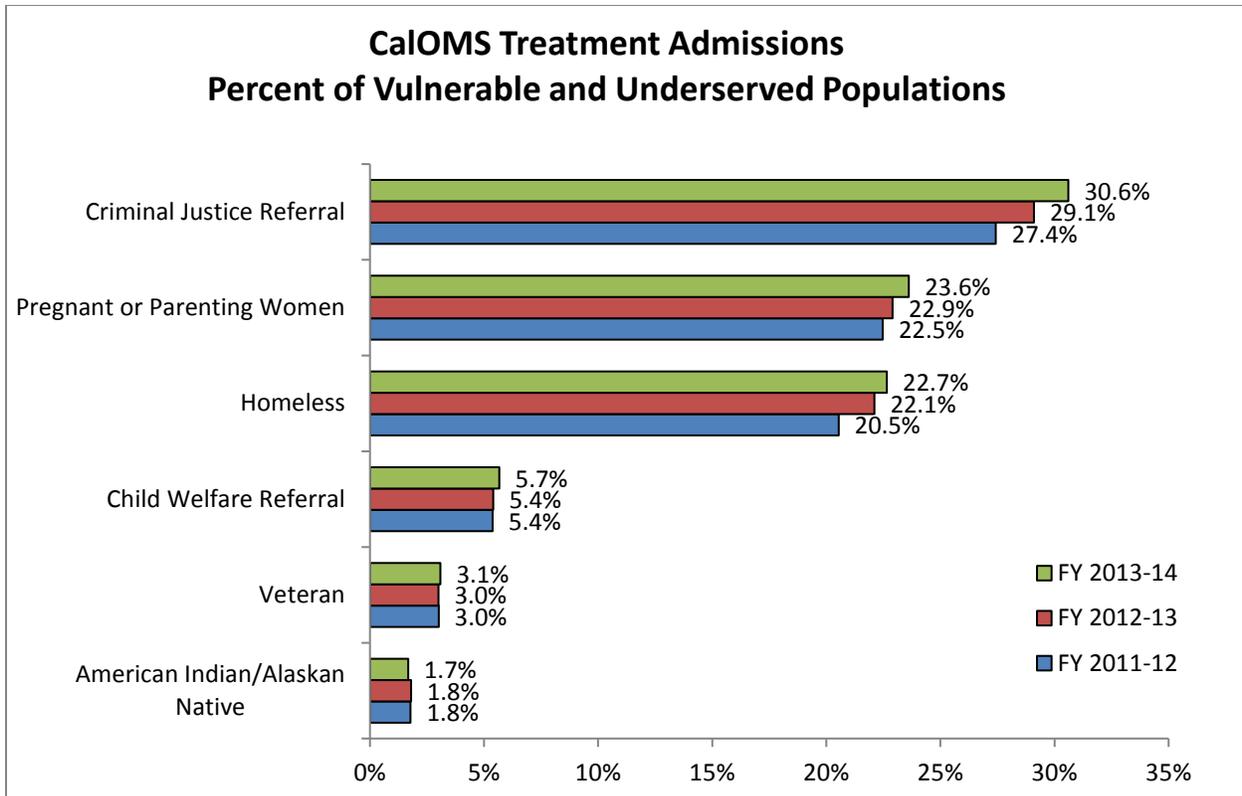
African Americans slightly decreased compared to the percentages in FY 2011-12 and FY 2012-13.

- 42.8 percent of admissions are service recipients who referred themselves to treatment or are referred by a relative or a friend. 30.6 percent are referred from the criminal justice system, and 8.5 percent from other community referrals. While only 2.4 percent are presently referred from other health care providers, this source of referral may become more common as health care coverage reform and integration of primary care and SUD services occur. The remaining 15.7 percent are referred from other SUD programs, schools, etc.
- The most commonly reported primary drug *used* at admission is methamphetamine (29.4 percent), *heroin* is second (24.0 percent), followed by alcohol (19.3 percent), marijuana (16.0 percent), and cocaine/crack (4.3 percent). The remaining percentage is comprised of a variety of other drugs. *The percent of service recipients reporting heroin as the primary drug has gradually increased since FY 2011-12, with the greatest increase between FY 2012-13 and FY 2013-14.*
- 27.3 percent of admissions are service recipients reporting intravenous drug use in the past year. *This percent has risen in the same manner as the increase in the percent of service recipients reporting heroin as their primary drug since the most common route of administration of heroin is by injection.*

Note that drug trends for those in treatment are not necessarily reflective of drug use trends in the general population. For instance, *while alcohol is the most commonly used and abused drug in the general population, it is not the most prevalent in the treatment population.*

Access to Treatment Services for Vulnerable and Underserved Populations

CalOMS Tx collects information on the following vulnerable and underserved populations (*see Appendix 2*). Service recipients may be included in more than one of these populations. This graph shows *the vulnerable and underserved populations have remained relatively stable since FY 2011-12. Criminal justice referred service recipients comprise the largest percentage of the populations shown. There are small and steady increases in the percent of criminal justice referrals from 27.4 percent in FY 2011-12 to 29.1 percent in FY 2012-13 to 30.6 percent in FY 2013-14.*



Treatment Services System Capacity and Infrastructure

The following provides CalOMS Tx based information on persons served in SUD treatment. “Served” counts provide information on all “active” service recipients during a given period (e.g., FY 2013-14). *This includes service recipients admitted during the year plus those admitted in prior years but still received treatment services during the year. Each admission is counted for service recipients who have multiple admissions.*

The treatment “served” counts remained *relatively stable* with approximately 271,000 in FY 2013-14 compared with about 273,000 in the baseline FY 2011-12 and about 276,000 in FY 2012-13. The following provides more specific information by service type (see Appendix 3).

- Outpatient Drug Free – This service type has the largest percent of total served. *Service recipients served in this service type decreased slightly each year from 49.0 percent in FY 2011-12 to 47.3 percent in FY 2012-13 to 44.1 percent in FY 2013-14.*
- Narcotic Treatment Program (NTP) Maintenance – Service recipients served in this service type *were stable between FY 2011-12 (20.1 percent) and FY 2012-13 (20.8 percent), but increased slightly to 24.7 percent in FY 2013-14.*
- Intensive Outpatient Treatment (IOT) – Service recipients served in this service type remained stable over the three years making up between 4 to 5 percent of all those served.

- NTP Detoxification – The percent of service recipients served in this treatment type *remained stable in each of the three years, about 3 percent.*
- Residential Detoxification – Service recipients served in this service type remained stable in *each of the three years making up between 8 to 9 percent of all those served.*
- *Long Term Residential – (>30 Days) – The percent served in this treatment type remained stable in each of the three years making up nearly 15 percent of all those served.*
- Short Term Residential (<31 Days) and Outpatient Detoxification (non-NTP) each comprised less than one percent of all service recipients served in *each of the three years.*

In addition to examining “served” counts, waiting list information also provide insights about treatment system capacity. Out of all treatment admissions during FY 2013-14 (170,742), about 22.7 percent of service recipients reported waiting at least one day to gain admission to treatment services. This is relatively stable compared with FY 2012-13 (22.9 percent) and a slight decrease compared with FY 2011-12 (24.3 percent). The percent that reported waiting varies by service type. Service recipients seeking residential services had the largest percentages having to wait for treatment admission.

There were small annual decreases in the percent of service recipients who waited at least one day to receive long term (>30 days) residential services, from 52.4 percent in FY 2011-12 to 50.2 percent in FY 2012-13 to 49.2 percent in FY 2013-14.

VII. Contribution to Discussions of Delivery of Healthcare Services

The transfer of ADP administrative and programmatic functions to DHCS provides SUD issues a greater and more prominent platform for public policy discussions related to the delivery of health care services in California. There is increased recognition of the relationship between high costs and poor outcomes for individuals with co-occurring SUD, mental illness, and chronic health conditions. State-level integration of the administration of SUD and MH programs and primary care facilitate coordination of health care to benefit health outcomes for individuals with SUD and co-occurring disorders. The consolidation of MH and SUD services under one directorate in DHCS demonstrates the commitment to integration of physical and behavioral health. Substantive discussions of behavioral health programs in the delivery of health care services within DHCS, with federal and county partners and stakeholders, and with prominent trade associations such as the CBHDA are enriched through this integration.

SUD program staff *now* work directly in collaboration with multiple DHCS divisions involved in physical health care (e.g. Managed Care *Quality and Monitoring*, Benefits, Provider Enrollment, Audits and Investigations, Pharmacy and *others* as needed). Staff from these divisions meets *internally and externally* with stakeholders *on a regular basis* to ensure crosscutting issues are addressed appropriately. As a result, the transfer of SUD programs to DHCS directly connects those programs to the physical health care issues, policies and delivery systems in a way that had never occurred previously. This

has improved integration of SUD programs with other health programs as part of the enhanced and expanded benefits provided to beneficiaries receiving services via multiple delivery systems overseen by DHCS (e.g. managed care, *fee-for-service* and county delivery systems).

SUD program staff are key DHCS participants in the implementation of the ACA, [Cal MediConnect](#) duals demonstration project, and the expansion of Medi-Cal managed care to rural counties. SUD program staff were instrumental in developing support for inclusion of the SBIRT benefit in the Managed Care system. The outcomes of new and more effective involvement of SUD program staff reflect a positive impact on the delivery of health care in California.

The transfer of ADP has contributed to broader and deeper discussions related to the delivery of health care services.

VIII. Stakeholder Involvement

To ensure continued engagement with stakeholders on improving SUD programs, DHCS has maintained, and continued working with the advisory groups that ADP convened prior to the transfer.

DHCS maintains engagement with:

- County Behavioral Health Directors Association (CBHDA)
- Interagency Prevention Advisory Council
- Counselor Certification Advisory Committee
- NTP Advisory Committee
- *DUI* Advisory Group

Beyond maintaining the advisory groups from ADP, opportunities for stakeholder involvement have both changed and enhanced as a result of the transition. SUD stakeholders *now* have direct access to DHCS leadership and the extensive resources of DHCS regarding SUD program and policy issues. The implementation, strengthening and expansion of SUD benefits for newly eligible Medi-Cal beneficiaries has benefited greatly with regular stakeholder engagement. *These* stakeholder discussions are ongoing as the State, county partners, and providers continue the hard work to provide sufficient capacity for as broad a range as possible of quality services.

Senate Bill X1 1 Hernandez, (Chapter 4, Statutes of 2013) authorized the expansion of available services under the DMC Treatment Program to include residential and *IOT* services commencing on January 1, 2014. This expansion represents a significant change in available services for current and optional expansion Medi-Cal populations. In response to the legislation, DHCS held DMC Treatment Program Expansion meetings with representatives from the former County Alcohol and Drug Program *Administrators* Association of California and several county SUD program administrators and has held several teleconferences with SUD services stakeholders to

provide regular updates. The teleconferences provided an opportunity for stakeholders to ask questions and/or provide comments.

DHCS continues to regularly provide updates to stakeholders. *With the establishment of the Behavioral Health Forum (BHF), these meetings provide multiple and varied opportunities for stakeholder involvement for state and county leaders and to ensure stakeholder engagement with DHCS.*

DHCS is committed to ongoing, active engagement with its SUD partners and stakeholders. DHCS continues to use existing forums such as CBHDA meetings, to solicit and discuss stakeholder recommendations and concerns about SUD *programs*. DHCS has also met with provider groups and associations and *will continue* to have regular check-in meetings to *maintain* ongoing communication.

IX. Appendix 1 – Statewide Treatment Admissions Data

| California Outcomes Measurement System- Treatment (CalOMS-Tx) Statewide Admission Data for Fiscal Years (FY) 2011-12 and 2013-14 | | | |
|---|-------------------|-------------------|-------------------|
| Total Admissions | FY 2011-12 | FY 2012-13 | FY 2013-14 |
| | 169,875 | 175,114 | 170,742 |
| Client and Service Characteristics | | | |
| Age | | | |
| Under 18 years | 14.9% | 13.5% | 9.7% |
| 18-25 years | 18.0% | 18.2% | 17.8% |
| 26-35 years | 25.7% | 27.1% | 29.2% |
| 36-45 years | 18.6% | 18.2% | 18.9% |
| 46-55 years | 16.6% | 16.4% | 17.2% |
| 56-65 years | 5.5% | 5.8% | 6.5% |
| 66 and older | 0.7% | 0.8% | 0.7% |
| Gender | | | |
| Male | 61.9% | 62.6% | 63.0% |
| Female | 38.1% | 37.4% | 37.0% |
| Race/Ethnicity | | | |
| African American | 14.4% | 14.5% | 12.8% |
| American Indian/Alaskan Native | 1.3% | 1.3% | 1.2% |
| Asian/Pacific Islander | 2.2% | 2.3% | 2.2% |
| Hispanic | 35.2% | 35.4% | 35.9% |
| Multiracial | 2.0% | 2.0% | 2.2% |
| Other | 1.9% | 1.8% | 1.6% |
| White | 43.0% | 42.7% | 44.1% |
| Primary Drug Used | | | |
| Alcohol | 22.5% | 21.8% | 19.2% |
| Cocaine/Crack | 5.9% | 5.1% | 4.3% |
| Heroin | 17.9% | 19.1% | 24.0% |
| Marijuana/Hashish | 20.2% | 19.4% | 16.0% |
| Methamphetamine | 25.8% | 27.5% | 29.4% |
| Other | 7.7% | 7.1% | 7.1% |
| Route | | | |
| Oral | 29.5% | 28.6% | 26.1% |
| Smoking | 47.3% | 47.0% | 44.7% |
| Inhalation | 4.6% | 4.9% | 5.2% |
| Injection | 18.2% | 19.2% | 23.5% |
| Other | 0.4% | 0.3% | 0.5% |
| Used Needles (in past 12 mos.) | | | |
| Yes | 21.7% | 22.9% | 27.3% |
| No | 78.3% | 77.1% | 72.7% |
| Referral Source | | | |
| 12 Step Mutual Aid | 0.1% | 0.1% | 0.1% |
| SUD Program | 5.8% | 5.9% | 6.9% |
| Child Protective Services | 5.4% | 5.4% | 5.7% |
| Criminal Justice | 27.4% | 29.1% | 30.6% |
| Employer/EAP | 0.2% | 0.1% | 0.1% |
| Individual | 42.1% | 40.7% | 42.8% |
| Other Community Referral | 11.4% | 11.5 | 8.5% |
| Other Health Provider | 2.2% | 2.4% | 2.4% |
| School/Educational | 5.4% | 4.8% | 2.9% |

X. Appendix 2 – Special or Vulnerable Populations Admissions

**California Outcomes Measurement System-Treatment (CalOMS-Tx)
Special or Vulnerable Populations Admission Information
Statewide Data for Fiscal Years (FY) 2011-12 Through 2013-14**

| Total Admissions | FY 2011-12 | | FY 2012-13 | | FY 2013-14 | |
|--|-----------------|------------------|-----------------|------------------|-----------------|------------------|
| | 169,875 | | 175,114 | | 170,742 | |
| | Yes | No | Yes | No | Yes | No |
| Special or Vulnerable Population (Number/Percent) | | | | | | |
| Criminal Justice Referral | 46,602 27.4% | 123,273 72.6% | 50,961 29.1% | 124,153 70.9% | 52,259 30.6% | 118,483 69.4% |
| Pregnant or Parenting Women | 14,533 22.5% | 50,157 77.5% | 14,998 22.9% | 50,573 77.1% | 14,923 23.6% | 48,260 76.4% |
| Homeless | 34,895 20.5% | 134,980 79.5% | 38,610 22.1% | 136,504 77.9% | 38,681 22.6% | 132,061 77.4% |
| Child Welfare Referral | 9,142 5.4% | 160,733 94.6% | 9,395 5.4% | 165,719 94.6% | 9,686 5.7% | 161,056 94.3% |
| Veteran | 5,108 3.0% | 164,767 97.0% | 5,238 3.0% | 169,876 97.0% | 5,269 3.1% | 165,473 96.9% |
| American Indian/Alaskan Native | 3,016 1.8% | 166,859 98.2% | 3,089 1.8% | 172,025 98.2% | 2,857 1.7% | 167,885 98.3% |

XI. Appendix 3 – Statewide Treatment Services

| | FY 2011-12 | FY 2012-13 | FY 2013-14 |
|--|---------------------------------|---------------------------------|---------------------------------|
| Service Type | Frequency/Percent | Frequency/Percent | Frequency/Percent |
| Outpatient Drug Free | 134,072 49.0% | 130,369 47.3% | 119,617 44.1% |
| Narcotic Treatment Program (NTP) Maintenance | 55,064 20.1% | 57,464 20.8% | 66,894 24.7% |
| Intensive Day Care | 11,019 4.0% | 12,629 4.6% | 11,093 4.1% |
| Outpatient Detoxification | 153 0.1% | 228 0.1% | 227 0.1% |
| NTP Detoxification | 8,411 3.1% | 8,651 3.1% | 8,072 3.0% |
| Residential Detoxification | 22,899 8.4% | 24,392 8.9% | 23,358 8.6% |
| Short-Term Residential (<31 Days) | 1,791 0.7% | 1,410 0.5% | 1,334 0.5% |
| Long-Term Residential (>30 Days) | 39,871 14.6% | 40,433 14.7% | 40,412 14.9% |
| Total | 273,280 100.0% | 275,576 100.0% | 271,007 100.0% |

*Served counts include service recipients admitted into treatment during the year plus those admitted in prior years but are still receiving treatment services during the year. Each admission is counted for service recipients who have multiple admissions during the year.