Impacts of Realignment of Substance Use Disorder Services 2015 Report to the Legislature

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Overview

This annual report provides an overview of the initial impacts of the 2011 realignment of Substance Use Disorder (SUD) program services with data illustrating the amount of realigned funds expended for SUD treatment services, unique counts of Drug Medi-Cal (DMC) service recipients, and the treatment outcomes of service recipients, based on data from three sources:

1. County reported treatment expenditures from cost reports
2. Data from the Short-Doyle Medi-Cal Remediation Technology (SMART) system
3. Service recipient data reported through the California Outcomes Measurement System Treatment (CalOMS Tx)

Background

Enactment of the 2011 Public Safety Realignment marked a significant shift in the State's role in administering programs and functions related to SUD services. Prior to realignment, many public SUD programs and services were provided locally by counties with the program policy authority and funding responsibilities residing with the State. The Fiscal Year (FY) 2011-12 Budget Act, through Senate Bill (SB) 1020 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2011) and Proposition 30 of November 2012, resulted in the realignment of the funding for these programs to the county. It is the intent of this report to provide information to the Legislature, the public, and SUD services stakeholders regarding the impact of 2011 Realignment, initially and over a period of time.

Data Considerations

Treatment Expenditure Data

Expenditures reflect funding for treatment services from both 2011 Realignment and federal funding, including Substance Abuse Prevention and Treatment Block Grant, and Drug Medi-Cal funding. The expenditure data are based on treatment services reported on cost reports submitted by counties for FY 2010-11 through FY 2012-13, which is the last year for which final settled costs are available for 2015 reporting purposes. These data do not separately track each individual funding source that was established by the 2011 Realignment in the Behavioral Health Services Account (i.e., Women's and Children's Residential Treatment Services, Drug Courts, DMC and non-DMC), as these subaccounts existed for one fiscal year and were then combined in 2012 into a broader Behavioral Health Subaccount. Therefore, all expenditure data included in this report are in aggregate.

Appendix A provides treatment expenditures for each county and statewide. Refer to Appendix D for definitions of the funding sources and service types. SUD treatment includes the following range of treatment services:

- Outpatient Methadone Detoxification (Detox)
- Inpatient Methadone Detox

- Naltrexone Treatment
- Outpatient Narcotic Treatment Program (NTP) Maintenance
- Outpatient Drug Free (ODF) Detox
- Interim Treatment Services
- NTP Narcotic Replacement Therapy
- Intensive Outpatient/Day Care Rehabilitative
- Rehabilitative Ambulatory Detox (non-methadone)
- Free Standing Residential Detox
- Residential Treatment -- Short Term and Long Term Residential Treatment
- Hospital Inpatient Detox (24 hours)
- Hospital Inpatient Residential (24 hours)
- Chemical Dependency Recovery Hospital
- Drug Court and Other Treatment Related Services

SMART: Unique Counts of Drug Medi-Cal Treatment Service Recipients

The unique DMC client data for FY 2010-11 through FY 2012-13 was collected from the SMART system. "Unique" service recipient counts in Appendix B are defined as the number of individuals who received a DMC treatment service as opposed to the total DMC services provided. Data for Sutter and Yuba Counties are combined and displayed as one county in both Appendix A and Appendix B.

CalOMS Tx: Service Recipient Outcomes

The CalOMS Tx system collects outcomes data measures, at the time of the recipient's admission and discharge from publicly-funded SUD treatment services, and/or licensed narcotic treatment programs. CalOMS Tx collects a variety of treatment service recipient outcome measures in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. Outcome measures collected in these areas indicate impacts of treatment services. These CalOMS Tx measures, along with the percentage of administrative discharges (i.e., the service recipient left treatment prior to their planned discharge and could not be reached for discharge data collection), can be used to measure and compare service recipient outcomes across years. CalOMS Tx does not track data on the specific funds used to provide services, but for purposes of consistency, the CalOMS Tx data are included for FY 2010-11 through FY 2012-13. The outcome measures are only reported for the state. County data is not shown due to data quality issues explained in Appendix C.

Findings

Treatment Expenditures

From FY 2010-11 to FY 2012-13, treatment expenditures increased by $76.6 million at the statewide level; this represents an increase of 25 percent (25.4 percent). Approximately 73 percent of counties showed an increase in treatment expenditures, with treatment

expenditures more than doubling for five counties from FY 2010-11 to FY 2012-13. Treatment expenditures statewide in FY 2010-11 were $302,279,078 compared to $378,951,175 in FY 2012-13. Treatment expenditures for ten of the 57 counties decreased ten percent or more from FY 2010-11 to FY 2012-13 (see Appendix A).

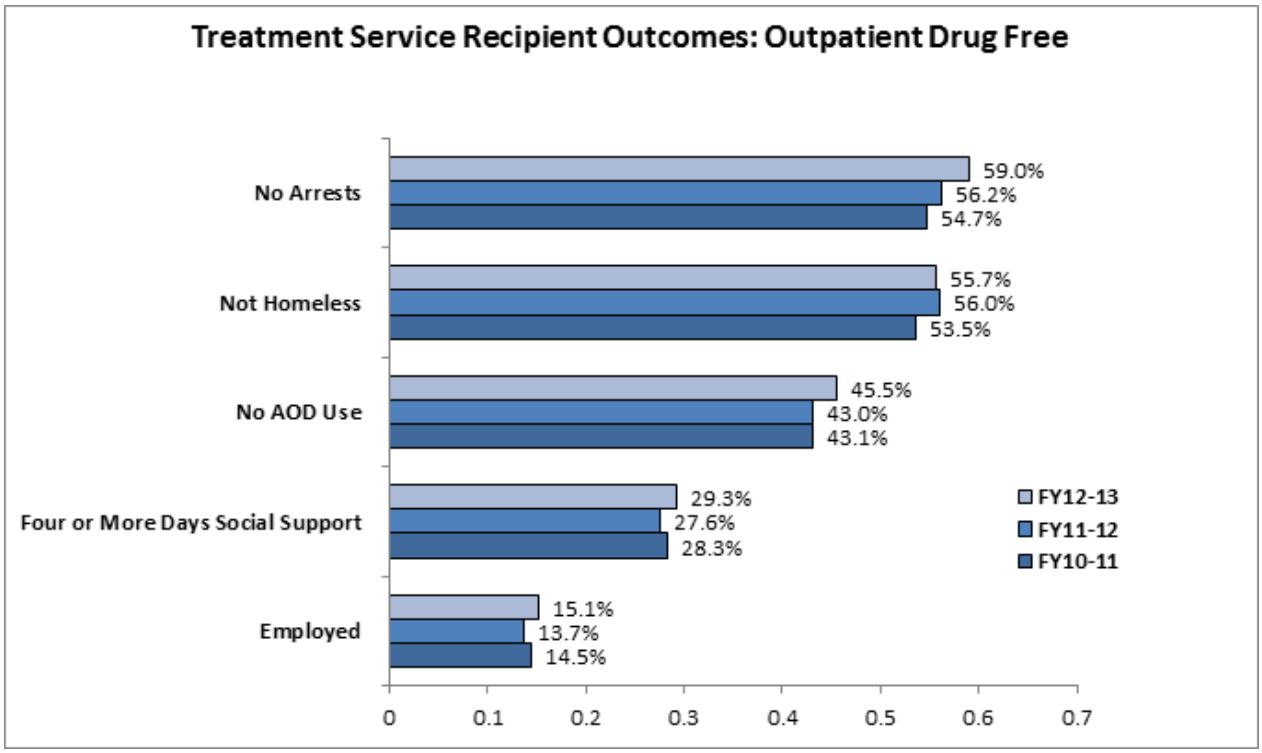
Counties Administering DMC and Unique DMC Client Counts

The number of counties administering the DMC program increased from 41 counties in FY 2010-11 to 44 counties in FY 2012-13. Of the 44 counties administering the DMC program in FY 2012-13, 12 had substantial decreases (ten percent or more) in unique counts of DMC service recipients between FY 2010-11 and FY 2012-13. However, the overall number of unique DMC service recipients increased by 4.8 percent from 62,580 in FY 2010-11 to 65,575 in FY 2012-13 (see Appendix B).

Treatment Service Recipient Outcomes

Treatment service recipient data included in this report are for ODF services. This service type represents the largest proportion of treatment admissions to publicly-monitored treatment programs. In addition, ODF is usually the last service type in an episode of treatment (i.e., when a service recipient progresses from more intensive to less intensive treatment services). From FY 2010-11 through FY 2012-13, the CalOMS Tx data indicated that ODF service recipient outcomes remained stable in four of the following five outcome measures: No Arrests, Not Homeless, No Alcohol and Other Drug Use, Four or More Days Social Support, and Employed.

The five key measures for outcomes in the chart below provide service recipient outcomes by year for ODF services. While percentages for each outcome have remained stable across fiscal years, the one measure that shows a slight increase from FY 2010-11 to FY 2012-13 is “No Arrests”, with an increase of about four percentage points. Outcomes for other treatment service types may be included in future reports (e.g., residential treatment) as the development of treatment outcome criteria and measures continues.



Future Updates

Future reports will include updates to the summary treatment expenditure and service recipient outcomes to support ongoing monitoring of 2011 Realignment impacts.

Appendix A
Treatment Expenditures by County and California FYs 2010-11 through 2012-13

County	A FY 10-11	B FY 11-12	C FY 12-13	Difference A - C	Percent Change A
Alpine*	$4,388	$1,262		-$4,388	-100.0%
Trinity	$403,616	$292,099	$203,999	-$199,617	-49.5%
Sierra	$91,998	$43,006	$47,418	-$44,580	-48.5%
Lassen	$312,841	$590,753	$170,514	-$142,327	-45.5%
Mendocino	$716,784	$535,172	$413,901	-$302,883	-42.3%
Imperial	$816,876	$386,911	$482,589	-$334,287	-40.9%
Modoc	$377,755	$347,234	$266,718	-$111,037	-29.4%
Inyo	$113,643	$93,742	$85,646	-$27,997	-24.6%
Mariposa	$80,259	$351,112	$64,642	-$15,617	-19.5%
Humboldt	$749,361	$672,989	$647,740	-$101,621	-13.6%
Riverside	$12,380,379	$12,950,925	$11,915,880	-$464,499	-3.8%
Calaveras	$238,985	$263,944	$230,126	-$8,859	-3.7%
Kings	$592,894	$653,559	$573,066	-$19,828	-3.3%
Solano	$2,130,593	$1,819,671	$2,077,823	-$52,770	-2.5%
Shasta	$952,480	$939,171	$934,920	-$17,560	-1.8%
Sonoma	$4,415,146	$3,950,975	$4,446,891	$31,745	0.7%
Madera	$576,713	$546,863	$582,910	$6,197	1.1%
Contra Costa	$8,648,809	$8,011,991	$8,858,797	$209,988	2.4%
Santa Cruz	$3,097,945	$2,789,831	$3,183,055	$85,110	2.7%
Tulare	$4,070,768	$4,020,558	$4,203,176	$132,408	3.3%
Mono	$244,617	$253,179	$258,119	$13,502	5.5%
Monterey	$2,750,005	$1,937,774	$2,979,892	$229,887	8.4%
Glenn	$172,735	$203,987	$188,172	$15,437	8.9%
Merced	$2,054,695	$1,830,808	$2,239,343	$184,648	9.0%
Colusa	$223,802	$147,110	$245,973	$22,171	9.9%
Kern	$6,556,416	$7,783,448	$7,211,902	$655,486	10.0%
Sacramento	$13,730,298	$14,723,723	$15,115,966	$1,385,668	10.1%
San Mateo	$5,132,143	$4,551,280	$5,810,536	$678,393	13.2%
Lake	$531,511	$415,841	$606,544	$75,033	14.1%
Napa	$1,003,154	$1,172,504	$1,152,187	$149,033	14.9%
San Francisco	$15,337,301	$16,310,123	$18,064,098	$2,726,797	17.8%
Amador**	$44,992		$53,104	$8,112	18.0%
Alameda	$13,796,557	$14,041,122	$16,605,029	$2,808,472	20.4%
Ventura	$5,222,441	$5,308,612	$6,286,887	$1,064,446	20.4%
Sutter/Yuba	$1,086,888	$1,219,656	$1,317,754	$230,866	21.2%
Orange	$14,657,296	$15,085,673	$17,874,245	$3,216,949	21.9%
San Bernardino	$9,120,799	$9,963,431	$11,384,523	$2,263,724	24.8%
Santa Barbara	$4,262,806	$4,892,130	$5,338,377	$1,075,571	25.2%
California	**$302,279,078**	**$327,357,659**	**$378,951,175**	**$76,672,101**	**25.4%**
Nevada	$574,930	$640,287	$729,495	$154,565	26.9%
Los Angeles	$115,320,352	$130,247,381	$148,651,257	$33,330,905	28.9%
Yolo	$573,925	$526,120	$750,445	$176,520	30.8%
Tuolumne	$218,323	$271,811	$287,706	$69,383	31.8%
Fresno	$12,836,314	$15,005,794	$17,107,658	$4,271,344	33.3%
San Diego	$14,237,234	$15,933,073	$19,540,425	$5,303,191	37.2%
Placer	$2,047,250	$2,328,481	$3,012,672	$965,422	47.2%
Santa Clara	$8,245,810	$8,045,291	$12,800,498	$4,554,688	55.2%

Marin	$1,564,440	$2,494,073	$2,472,083	$907,643	58.0%
San Luis Obispo	$1,209,830	$1,290,070	$2,097,635	$887,805	73.4%
Stanislaus	$2,441,671	$4,643,345	$4,681,688	$2,240,017	91.7%
El Dorado	$489,008	$490,174	$955,790	$466,782	95.5%
Tehama	$160,296	$288,902	$319,051	$158,755	99.0%
San Benito	$196,156	$274,504	$393,574	$197,418	100.6%
Siskiyou	$108,673	$155,080	$236,688	$128,015	117.8%
Butte	$1,263,502	$1,781,668	$2,865,954	$1,602,452	126.8%
Del Norte	$88,412	$193,385	$200,875	$112,463	127.2%
San Joaquin	$4,002,263	$3,646,051	$9,593,657	$5,591,394	139.7%
Plumas**			$131,566	$131,566	

*Small numbers result in increased differences (i.e. percent change)

**The county did not indicate expenditures for treatment services in one or more fiscal years

Appendix B
Unique Drug Medi-Cal Service Recipients by County and California
FYs 2010-11 through 2012-13

County	A FY 10-11	B FY 11-12	C FY 12-13	Difference A - C	Percent Change A
Napa	291	293	67	-224	-77.0%
El Dorado	321	264	139	-182	-56.7%
Lake	408	266	231	-177	-43.4%
Humboldt	258	189	150	-108	-41.9%
Santa Cruz	555	584	323	-232	-41.8%
Marin	151	121	89	-62	-41.1%
Mendocino	149	130	98	-51	-34.2%
Imperial	861	814	613	-248	-28.8%
Lassen	141	118	115	-26	-18.4%
Sonoma	1,076	960	920	-156	-14.5%
Shasta	422	413	364	-58	-13.7%
Mariposa	60	40	52	-8	-13.3%
Tulare	1,216	1,194	1,136	-80	-6.6%
Riverside	2,837	3,543	2,668	-169	-6.0%
Kern	1,701	1,665	1,623	-78	-4.6%
San Bernardino	2,108	2,097	2,056	-52	-2.5%
Santa Barbara	1,862	1,783	1,829	-33	-1.8%
Butte	663	789	656	-7	-1.1%
Ventura	1,445	1,516	1,431	-14	-1.0%
Santa Clara	1,440	1,694	1,446	6	0.4%
San Francisco	1,973	1,977	1,989	16	0.8%
Contra Costa	889	911	899	10	1.1%
San Joaquin	1,560	1,575	1,581	21	1.3%
Alameda	2,155	2,073	2,233	78	3.6%
California	**62,580**	**65,670**	**65,575**	**2,995**	**4.8%**
Monterey	302	344	318	16	5.3%
Solano	486	540	518	32	6.6%
Los Angeles	25,330	25,868	27,016	1,686	6.7%
Kings	68	75	73	5	7.4%
Yuba/Sutter	327	359	353	26	8.0%
Sacramento	3,887	4,481	4,293	406	10.4%
Nevada	253	331	284	31	12.3%
Orange	659	713	742	83	12.6%
Placer	446	447	506	60	13.5%
Stanislaus	655	751	754	99	15.1%
Fresno	4,233	4,829	5,261	1,028	24.3%
San Mateo	173	170	221	48	27.7%
San Diego	1,962	2,114	2,531	569	29.0%
Madera	80	96	104	24	30.0%
Merced	191	333	396	205	107.3%
San Luis Obispo	174	315	377	203	116.7%
Yolo*	23	90	138	115	500.0%
Glenn**			61		
Inyo**			19		
San Benito**		55	76		

Note: Service-recipients may have received service from more than one county: so, there may be some individuals counted more than once.

*Small numbers result in increased difference (i.e. percent change)

**Numerator or denominator missing, cannot calculate percentage change

Appendix C
Data Quality Considerations for Treatment Outcomes

SUD treatment outcomes historically referred to measured changes in service recipient functioning in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. The same measures of service recipient functioning (e.g., frequency of primary drug use in the past 30 days) are collected at two points in time: once at admission to treatment and then again at discharge. Changes in service recipient functioning were determined by merging admission and discharge data, comparing the responses at the two different points in time, and quantifying changes (e.g., percent change) in response. For simplicity, responses were often categorized into two groups: "positive" actions (e.g., no drug use) and "negative" actions (e.g., used drugs one or more times). These measured changes in service recipient functioning were referred to as "service recipient outcomes."

This outcome measurement method was historically used to develop all basic outcome statistics for a given time period (e.g., a fiscal year), county, or a specific SUD treatment service type (e.g., residential, outpatient). For certain comparisons (e.g., between year comparisons), other methodologies are more valid.

Collaboration with the former County Alcohol & Drug Program Administrators Association of California, Treatment Data/Outcomes Subcommittee, and other stakeholders led to the conclusion that for some CalOMS Tx recipient outcome measures, functioning in the 30 days prior to treatment discharge offers a better indication of service recipient functioning; rather than the quantified change between admission and discharge, as calculated as the percentage change from 30 days prior to admission to 30 days prior to discharge. For example, since many service recipients are coming from controlled environments (e.g., jail, prison) or other SUD treatment services, many service recipients report not using drugs in the month prior to admission thus rendering any calculation measuring the percentage change in functioning moot. Additionally, social support recovery activity participation is more important during the 30-day period prior to discharge from treatment, when the service recipient is moving in the continuum of care from treatment to longer term recovery (e.g., disease management) that follows. Some service recipients report little to no participation in social support recovery activities at admission. Therefore, measuring social support recovery activity participation in the month prior to discharge, provides a better indicator of functioning in this domain than quantifying the difference in such participation from admission to discharge. This methodology of examining the desired level of client functioning in the 30 days prior to discharge is used for the five outcome measures shown in this report (see page 4).

There are substantial variations in the percentage of "administrative" discharges found across years, counties, and specific treatment service types. This type of discharge is used when the service recipient leaves the treatment program abruptly, and the provider is unable to contact them (in person or by phone). Therefore, minimal data is reported to "administratively" close the corresponding CalOMS Tx admission record, indicating the service recipient is no longer in the program. Because the service recipient cannot be

located, no outcome (i.e., service recipient functioning) data are collected. In contrast, when a service recipient remains in treatment as planned, and is available for discharge interview (in person or by phone), a standard discharge report is completed and contains all the necessary service recipient functioning data to measure outcomes.

In general, it is reasonable to assume that the outcomes for service recipients discharged administratively would be worse than for those with planned discharges. Thus, generalizing outcomes of all treatment service recipients from the outcome data collected in the standard discharges (from the service recipients with planned discharges) creates a positive bias. Counties (or fiscal years) with larger percentages of administrative discharges may appear to produce more positive outcomes since the outcomes would be generated from service recipients with completed standard discharge reports. Outcome measurement bias and variability are reduced, when the administrative/missing discharge data are factored into comparisons across years and between counties or providers.

Example:
During FY 2012-13 County A has 1,331 total discharge records. Of those 1,331 records, 12.6 percent (or 167) are missing data. The 1,164 discharge records (1,331 minus 167) with data show that 261 clients are employed and 903 are not. Dividing 261 by 1164 equals approximately 22 percent employed. County B has 83 total discharge records with 81.9 percent (or 68) of the discharge records missing data. The 15 discharge records (83 minus 68) with data show that five clients are employed and ten are not. Dividing five by 15 equals approximately 33 percent employed. These comparative statistics would erroneously show that County B has better employment outcomes than County A, if the records with missing data are excluded from the denominator when calculating percentages.

If the records with the missing data are included in the denominator, then more objective outcome comparisons across counties can be made. For example, County A had 1,331 total discharge records with 261 of them documenting employment at discharge. Therefore, County A shows 19.6 percent (261 divided by 1,331) employed at discharge. County B had 83 total discharges with five documenting employment. Therefore, County B shows six percent (5 divided by 83) employed at discharge.

This example underscores the importance of ongoing data quality monitoring and management. The State must continue to work with the counties and direct service providers to improve data quality.

Appendix D
Definitions

Chemical Dependency Recovery Hospital (CDRH): treatment programs located in a CDRH facility licensed by the California Department of Public Health.

Drug Courts: a permissible use of funding in the Behavioral Health Services Subaccount. "Drug courts" or "drug court operations" refers to provision of intensive drug treatment services, and close supervision to promptly address relapses for individuals whose involvement in the court system is a result of substance abuse. Drug court program administration was realigned under SB 1014 (Chapter 36, Statutes of 2011) and historically included the following programs: Comprehensive Drug Court Implementation Act, Drug Court Partnership, and Dependency Drug Court services.

Drug Medi-Cal (DMC): refers to SUD treatment services provided as a carve-out from other standard Medi-Cal services. These SUD treatment services are provided to Medi-Cal beneficiaries through the statewide DMC program. The DMC program is currently administered in 44 counties through contracts between DHCS and the county SUD administration office or between DHCS and a DMC certified provider. DMC SUD treatment services include the following SUD treatment service types: outpatient drug free, nonresidential/outpatient NTP maintenance, intensive outpatient treatment, and residential treatment.

Hospital Inpatient Detox (24 hours): includes hospital and non-hospital detoxification services. Hospital detoxification services (Hospital Inpatient Detoxification – 24 Hours) are provided in a licensed hospital where participants are hospitalized for medical support during the planned SUD withdrawal period. Non-hospital detoxification services (Free-Standing Residential Detoxification) are provided in a residential facility and support and assist the participant during a planned SUD withdrawal period.

Hospital Inpatient Residential (24 hours): non-detoxification medical care provided in a hospital facility in conjunction with treatment services for substance use disorders.

Inpatient Methadone Detox: rendered in a controlled, 24-hour hospital setting and provides narcotic withdrawal treatment to service recipients undergoing a period of planned withdrawal from narcotic dependence.

Intensive Outpatient/Day Care Rehabilitative: provision of counseling and rehabilitation services that last two or more hours, but less than 24 hours per day, three days per week.

Interim Treatment Services (CalWORKS): services designed to determine need for more intensive SUD treatment. This includes provision of up to eight weeks of group and/or individual counseling sessions, in a nonresidential/outpatient setting until such time SUD treatment service need is determined and services are available.

Naltrexone Treatment: use of Naltrexone (Trexon) to block effects of heroin and other narcotics or opiates. Services include medication, medical direction, medically necessary urine screens for substance use, counseling, and other appropriate activities and services.

Non-DMC: refers to SUD treatment programs and services funded with sources other than DMC, such as Substance Abuse Prevention and Treatment Block Grant dollars from the federal Substance Abuse and Mental Health Services Administration.

Outpatient Drug Free (ODF): treatment/recovery services provided in an outpatient setting. SUD treatment services include individual and/or group counseling and may or may not include medication.

ODF Detox: 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.

Outpatient Methadone Detox: rendered in less than 24 hours and provide narcotic withdrawal treatment to service recipients, undergoing a period of planned withdrawal from narcotic dependence.

Outpatient Narcotic Treatment Program (NTP) Maintenance/NTP Narcotic Replacement Therapy (NRT): outpatient treatment/recovery services that include provision of NRT medication, such as methadone or buprenorphine in an outpatient setting and include individual and/or group counseling.

Rehabilitative Ambulatory Detox (non-methadone): outpatient treatment services rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

Residential Treatment: includes short-term (<30 days) and long-term (>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 assistance in obtaining health, social, vocational, and other community services.

Women's and Children's Residential Treatment Services (WCRTS): one of the funding sources in the Behavioral Health Services Subaccount. The term refers to the funding source as well as the WCRTS program. WCRTS includes women's treatment programs, perinatal certified programs, women's and children's programs (services for both mother and child), family services, and comprehensive family-centered treatment programs.