



## **Impacts of Realignment of Substance Use Disorder Services 2020 Report to the Legislature**

Submitted by the Department of Health Care Services  
Pursuant to the Requirements of  
Health and Safety Code Section 11756.8

## Table of Contents

Overview.....	1
Background.....	1
Data Considerations.....	1
Findings.....	3
Appendix A – Statewide Treatment Expenditures and Unique Drug Medi-Cal Service Recipients Summary - Fiscal Years 2011-2016.....	5
Appendix B – Treatment Expenditures by County and California - Fiscal Years 2014-2016 .....	6
Appendix C –Unique Drug Medi-Cal Service Recipients by County and California – Fiscal Years 2014-2016.....	7
Appendix D – Treatment Service Recipient Outcomes: Outpatient Drug Free and Future Findings.....	8
Appendix E – Updated Data Quality Considerations for Treatment Outcomes.....	10
Appendix F – Definitions.....	11

## Overview

The annual Impacts of Realignment of Substance Use Disorder (SUD) Services 2020 report from the Department of Health Care Services (DHCS) provides an overview of the impact of the 2011 Public Safety Realignment (2011 Realignment) of SUD program services. This report illustrates 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. Note that cost report data utilized for the purposes of this report is prior to implementation of the DMC Organized Delivery System (ODS) waiver. The intent of this report is to assist in monitoring changes over time and the degree to which programs are meeting state- and county-defined outcome measures. Outcome measures are based on data from three sources:

1. County reported treatment expenditures from cost reports (Substance Abuse Prevention and Treatment Block Grant [SABG] funding and DMC funding);
2. Data from the Short-Doyle Medi-Cal Remediation Technology (SMART) system; and
3. Service recipient data reported through the California Outcomes Measurement System Treatment (CalOMS Tx).

## Background

Enactment of the 2011 Realignment marked a significant shift in the state's role in administering programs and functions related to SUD services. Prior to the 2011 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 these programs to the counties. It is the intent of this report to provide information to the Legislature, the public, and SUD services stakeholders regarding the impact of the 2011 Realignment over the period of time it has been in effect.

## Data Considerations

### Treatment Expenditure Data

Expenditures reflect funding for treatment services from both 2011 Realignment, including Women's and Children's Residential Treatment Services Subaccount expenditures, and federal funding, including the SABG, and DMC funding. The expenditure data is based on cost reports for actual treatment services claims submitted by counties for FY 2015-16. This report provides the most current cost report data, which was finalized in November 2020.

Appendix A provides a summary of statewide treatment expenditures and unique drug Medi-Cal service recipients between FY 2011-12 and FY 2015-16. SUD treatment

includes the following treatment services (see Appendix F for definitions of funding sources and service types):

- 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
- Rehabilitative Ambulatory Detox (non-methadone)
- Free Standing Residential Detox
- Perinatal and other 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 DMC Treatment Service Recipients

The unique DMC client data for FY 2015-16 was collected from the SMART system. “Unique” service recipient counts in Appendix C 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 B and Appendix C.

#### CalOMS Tx: Service Recipient Outcomes

The CalOMS Tx system collects outcome data measures, at the time of the recipient’s admission and discharge from publicly funded SUD treatment services and/or licensed NTPs. 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 the impact 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 multiple 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 2016-17. Outcomes are only reported at the statewide level. The historical outcomes reporting methodology did not accurately reflect all recipients’ actual outcomes, because counties vary substantially in the number of discharges reported that do not contain client data regarding level of functioning. The discharge data is necessary to provide generalizable and comparable outcomes across counties. See Appendix D for details.

## Findings

### Treatment Expenditures

The summary treatment expenditures data from FY 2011-12 to FY 2015-2016 increased by \$58,871,958 at the statewide level; an increase of 17.75 percent. Treatment expenditures statewide in FY 2011-12 were \$331,717,082 compared to \$390,589,040 in FY 2015-2016 (see Appendix A). Comparing FY 2014-15 to 2015-16, approximately 41% percent of counties showed an increase in treatment expenditures, with eight counties increasing \$1 million or more in expenditures from FY 2014-15 to FY 2015-16. The counties experiencing the greatest increase in treatment expenditures were Los Angeles County increasing by \$5,205,115, San Francisco County increasing by \$2,931,527, and Alameda County increasing by \$2,530,593. Treatment expenditures for 20 of the 57 counties increased ten percent or more from FY 2014-15 to FY 2015-16, with three counties showing an increase of more than 50 percent (see Appendix A). This increase in expenditures may be due to an overall increase in client counts and DHCS' effort to increase county participation in DMC.

### Counties Administering DMC and Unique DMC Client Counts

The number of counties administering the DMC program increased from 42 counties in FY 2011-2012 to 57 counties in FY 2015-2016. Of the 57 counties administering the DMC program in FY 2015-16, only 46 of the counties reported unique DMC service recipient counts. Of the 46 counties, six of the counties reported decreases in unique counts of DMC service recipients: Inyo County, Mariposa County, Modoc County, Napa County, Sonoma County, and Tulare County. Conversely, 16 counties had substantial increases (10 percent or more) in unique counts of DMC service recipients, with three counties increasing by 100 percent or more. The unique drug Medi-Cal service recipient count from FY 2011-2012 to FY 2015-2016 increased by 31,463 at the statewide level; an increase of 56.56 percent. Recipients statewide in FY 2011-12 were 55,622 compared to 87,085 in FY 2015-2016 (see Appendices B and C.)

### Treatment Service Recipient Outcomes

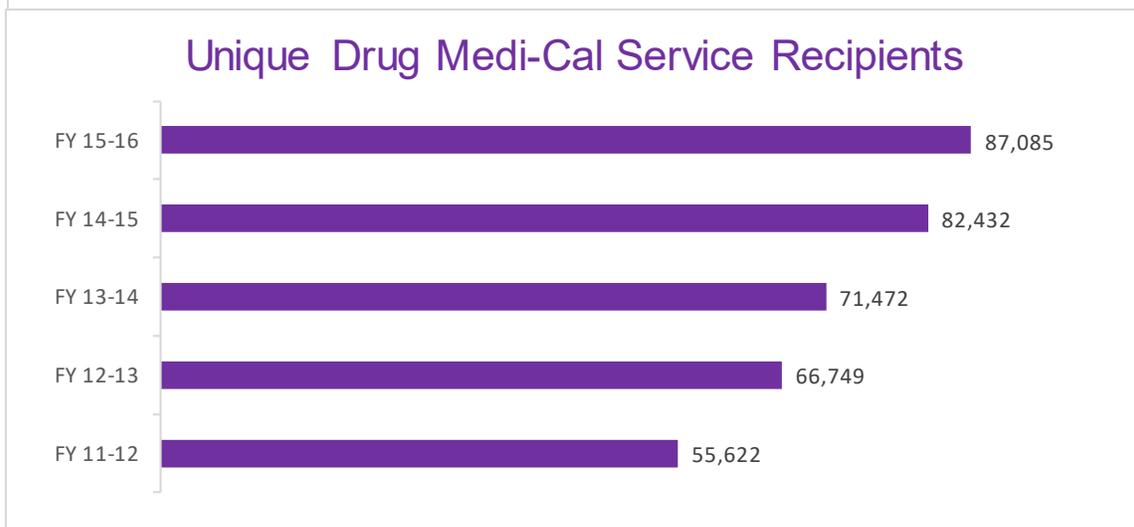
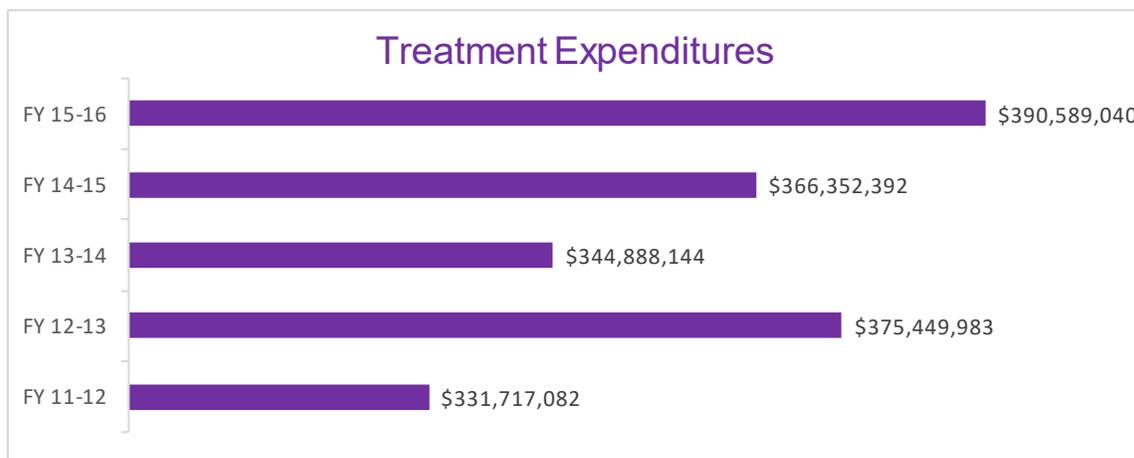
Treatment service recipient data included in this report are for ODF services. This service type represents the largest proportion of treatment admissions to publicly-monitored treatment programs. In addition, ODF is typically the last service type in an episode of treatment (i.e., when a service recipient progresses from more intensive to less intensive treatment services). The five key measures for outcomes in the chart in Appendix D provide service recipient outcomes by year for ODF services. From FY 2010-2011 through FY 2016-2017, CalOMS Tx data indicated that ODF service recipient outcomes showed improvement in employment, whereas no improvement was made for the remaining outcome measures (No Arrests, Not Homeless, No Alcohol and Other Drug (AOD) Use, and Four or More Days Social Support).

While percentages for the "Four or More Days Social Support" outcome have remained relatively stable across fiscal years, and the number of clients reporting sustainable employment improved, the data outcome measures collected for "No Arrests," "Not Homeless" and "No AOD Use" are slightly worsening over time. In detail, ODF service

recipients with no arrests decreased by 3.8 percent from 54.7 in FY 2010-2011 to 50.9 in FY 2016-17 (outcome measure reported as “No Arrests”). The percentage of clients experiencing homelessness decreased by 5.9 percent from 53.5 percent in FY 2010-2011 to 47.6 percent in FY 2016-2017 (outcome measure reported as “Not Homeless”). However, this is in the context of a severely worsening homelessness problem in California. According to the Homeless Policy Institute at the University of Southern California, homelessness has grown 22% over the last decade. Additionally, Homelessness increased another 16% between 2018 and 2019, so we may continue to see worsening trends in future reports, as clients in drug treatment often experience challenges with employment and housing security. While the data doesn’t allow this level of analysis, worsening arrest rates could be linked to the increase in homelessness, as homelessness highly increases the risk of criminal justice involvement. AOD Use by ODF service recipients also decreased by over 5 percent, from 43.1 percent in FY 2010-2011 to 37.4 percent in FY 2016-2017 (outcome measure reported as “No AOD Use”). It is important to note with these data that the main challenge in analyzing, measuring and reporting these trends completely and accurately is the continually increasing percentage of missing outcome data reported in CalOMS Tx (refer to Appendix E).

**Appendix A  
Statewide Treatment Expenditures and Unique Drug Medi-Cal Service Recipients Summary FYs 2011-2016**

	Treatment Expenditures	Unique Drug Medi-Cal Service Recipients
FY 11-12	\$331,717,082	55,622
FY 12-13	\$375,449,983	66,749
FY 13-14	\$344,888,144	71,472
FY 14-15	\$366,352,392	82,432
FY 15-16	\$390,589,040	87,085
Difference FY 11-12 & FY 15-16	\$58,871,958	31,463
Percentage Change FY 11-12 & FY 15-16	17.75%	56.56%



**Appendix B**  
**Treatment Expenditures by County FY 2014-15 and FY 2015-16**

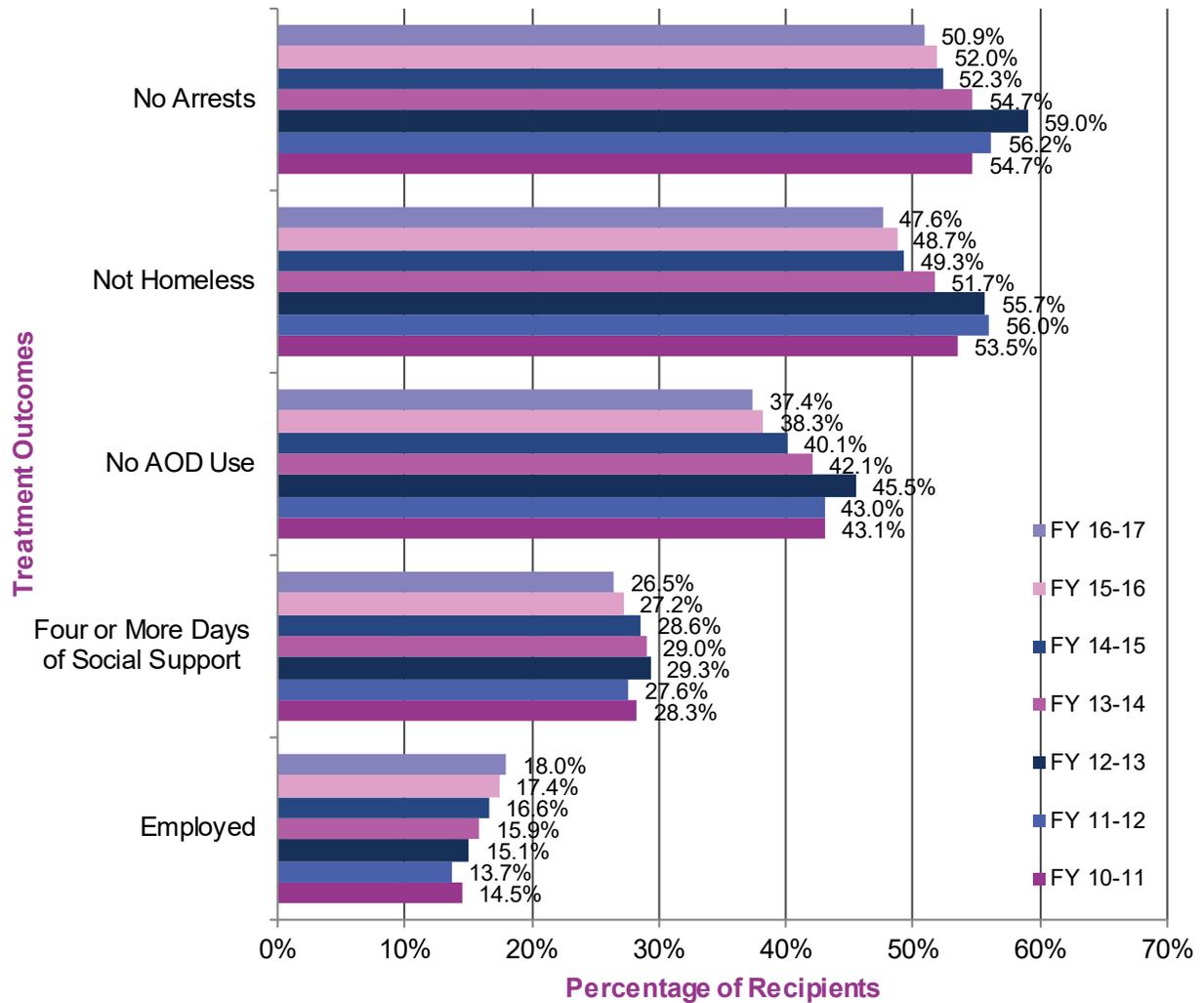
County	Totals		County	Totals	
	FY 14-15	FY 15-16		FY 14-15	FY 15-16
Alameda	\$17,934,388	\$20,464,981	Orange	\$17,597,608	\$18,739,502
Alpine	\$53,036	\$56,944	Placer	\$2,878,432	\$3,312,312
Amador	\$150,189	\$121,503	Plumas	\$41,307	\$124,510
Butte	\$3,532,814	\$4,112,734	Riverside	\$11,833,882	\$12,741,949
Calaveras	\$121,818	\$56,309	Sacramento	\$18,370,836	\$20,026,006
Colusa	\$232,748	\$238,514	San Benito	\$526,129	\$535,914
Contra Costa	\$11,970,376	\$12,611,237	San Bernardino	\$14,913,474	\$15,911,369
Del Norte	\$114,083	\$164,028	San Diego	\$16,985,278	\$16,613,118
El Dorado	\$1,065,168	\$1,339,125	San Francisco	\$21,610,009	\$24,541,536
Fresno	\$17,715,730	\$18,932,505	San Joaquin	\$13,424,404	\$13,615,277
Glenn	\$156,944	\$191,029	San Luis Obispo	\$4,158,235	\$4,912,436
Humboldt	\$1,092,455	\$1,333,730	San Mateo	\$6,893,726	\$6,521,280
Imperial	\$686,791	\$103,177	Santa Barbara	\$6,210,781	\$6,761,437
Inyo	\$92,755	\$59,598	Santa Clara	\$9,514,440	\$9,822,367
Kern	\$11,129,502	\$11,496,068	Santa Cruz	\$4,967,093	\$5,664,655
Kings	\$986,988	\$1,034,581	Shasta	\$1,401,044	\$1,023,465
Lake	\$712,239	\$757,915	Sierra	\$39,746	\$66,806
Lassen	\$189,546	\$121,735	Siskiyou	\$372,827	\$379,325
Los Angeles	\$103,148,887	\$108,354,002	Solano	\$2,964,423	\$3,178,785
Madera	\$814,404	\$833,963	Sonoma	\$4,838,467	\$4,798,620
Marin	\$2,180,273	\$2,580,612	Stanislaus	\$6,231,183	\$7,800,541
Mariposa	\$60,320	\$91,004	Sutter/Yuba	\$913,821	\$1,025,440
Mendocino	\$744,000	\$846,521	Tehama	\$408,121	\$295,205
Merced	\$3,899,242	\$4,079,971	Trinity	\$126,218	\$79,435
Modoc	\$299,507	\$144,109	Tulare	\$5,398,522	\$6,119,092
Mono	\$258,119	\$258,119	Tuolumne	\$405,749	\$211,164
Monterey	\$3,233,232	\$3,466,325	Ventura	\$8,252,382	\$9,277,777
Napa	\$1,003,299	\$1,380,170	Yolo	\$794,963	\$634,330
Nevada	\$700,442	\$624,878	<b>Statewide</b>	<b>\$366,352,392</b>	<b>\$390,589,040</b>

**Appendix C**  
**Unique Drug Medi-Cal Service Recipients by County FY 2014-15 & 2015-16**

County	Totals		County	Totals	
	FY 14-15	FY 15-16		FY 14-15	FY 15-16
Alameda	3,936	4,049	Orange	1,940	2,374
Butte	1,286	1,567	Placer	1,050	1,203
Contra Costa	1,588	1,772	Riverside	4,205	4,396
El Dorado	317	338	Sacramento	5,609	5,893
Fresno	5,273	5,709	San Benito	195	218
Glenn	85	82	San Bernardino	4,101	4,156
Humboldt	330	335	San Diego	6,617	7,138
Imperial	823	791	San Francisco	3,382	3,502
Inyo	47	*	San Joaquin	2,954	3,149
Kern	2,995	3,120	San Luis Obispo	1,202	1,314
Kings	342	381	San Mateo	502	597
Lake	326	318	Santa Barbara	2,631	2,624
Lassen	92	85	Santa Clara	2,222	2,591
Los Angeles	14,978	15,824	Santa Cruz	679	845
Madera	252	321	Shasta	942	969
Marin	215	274	Solano	1,022	1,126
Mariposa	84	62	Sonoma	1,604	1,465
Mendocino	134	179	Stanislaus	1,209	1,426
Merced	835	878	Sutter-Yuba	582	700
Modoc	530	*	Trinity	42	88
Monterey	254	699	Tulare	1,643	799
Napa	467	262	Ventura	2,755	2,728
Nevada		449	Yolo	197	249
			<b>Statewide</b>	<b>82,474</b>	<b>87,085</b>

\*Indicates a count less than 11 masked to protect confidentiality.

### Appendix D Treatment Service Recipient Outcomes: Outpatient Drug Free for all Counties for FYs 2010-2016



#### Future Updates

Future reports will continue to include updates to the summary treatment expenditure and service recipient outcomes to support the ongoing monitoring of 2011 Realignment impacts. The next report will include FY 2016-17 cost report data, which will include first year expenditures for DMC-ODS.

## **Appendix E**

### **Data Quality Considerations for Treatment Outcomes**

Historically, SUD treatment outcomes 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: at admission to treatment and at discharge. Changes in service recipient functioning were determined by comparing admission and discharge data, through the different responses at the two points in time, and then quantifying the changes (e.g., percent change) in responses. 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).

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 by the percent change between data captured 30 days prior to admission and 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, which does not accurately reflect their true drug utilization. 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). Similar to data collection regarding drug use at admission, some service recipients also report little to no participation in social support recovery activities at the beginning of treatment. Therefore, measuring social support recovery activity participation is more appropriately measured in the month prior to discharge.

An “administrative discharge” is a type of discharge that is used when a service recipient leaves the treatment program and the provider is unable to contact them (in person or by phone). Minimal data is required to “administratively” report the close of the corresponding CalOMS Tx admission record, which would indicate that the service recipient is no longer in the program. Since the service recipient cannot be located, no outcome (i.e., service recipient functioning) data is 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 which contains all the necessary service recipient functioning data to measure outcomes.

There are substantial variations in the percentage of “administrative” discharges found across years, counties, and specific treatment service types. 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 a larger percent 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 is factored into comparisons across years and between counties or providers. Based on these findings, 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 Appendix D).

Example:

*During a given time period, County A has 1,200 total discharge records. Of those 1,200 records, 10.5 percent (or 126) are missing data. The 1,074 discharge records (1,200 minus 126) with data show that 201 clients are employed and 873 are not. Dividing 201 by 1074 equals approximately 19 percent who are 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 employed. Dividing 5 by 15 equals approximately 33 percent employed. Since the records with missing data are excluded from the denominator when calculating percentages, these comparative statistics erroneously show that County B has better employment outcomes than County A.*

*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 1,200 total discharge records with 201 of them documenting employment at discharge. Therefore, County A shows 16.7 percent employed at discharge (201 divided by 1,200). County B had 83 total discharges, with 5 documenting employment. Therefore, County B shows 6 percent employed at discharge (5 divided by 83).*

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 and minimize the number of administrative discharges.

## Appendix F 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 the 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 (Committee on Budget and Fiscal Review, 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):** 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 57 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, intensive outpatient treatment, narcotic treatment program, naltrexone treatment (oral tablets) and perinatal residential treatment.

**Hospital Inpatient Detox (24 hours):** 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 to 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. Provides narcotic withdrawal treatment to service recipients undergoing a period of planned withdrawal from narcotic dependence.

**Intensive Outpatient:** 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 Only):** 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 needs are determined and available.

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

**Non-DMC:** 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 or recovery services provided in an outpatient setting. SUD treatment services include individual and/or group counseling that 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 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 that provide narcotic withdrawal treatment to service recipients who are undergoing a period of planned withdrawal from narcotic dependence.

**Outpatient Narcotic Treatment Program (NTP) Maintenance/NTP Narcotic Replacement Therapy (NRT):** Outpatient treatment and recovery services that include the provision of NRT medication, such as methadone or naltrexone 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).

**Perinatal and Other Residential Treatment:** Short-term (<30 days) and long-term (>30 days) treatment services provided in a residential setting. Services may include the following elements: personal recovery and treatment planning, educational sessions, social and recreational activities, individual and group sessions, and assistance in obtaining health, social, vocational, or other community services.

**Women's and Children's Residential Treatment Services (WCRTS):** One of the funding sources within the Behavioral Health Services subaccount is the WCRTS special account. 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.