

DHCS



California Department of  
**HealthCareServices**

2017

STATEWIDE NEEDS  
ASSESSMENT &  
PLANNING REPORT

CALIFORNIA DEPARTMENT OF  
HEALTH CARE SERVICES

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MENTAL HEALTH AND  
SUBSTANCE USE DISORDER  
SERVICES

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## Executive Summary

The Department of Health Care Services (DHCS) Statewide Needs and Assessment Planning (SNAP) report is a biannual needs assessment required of all single state agencies receiving Substance Abuse Block Grant (SABG) funds. This SNAP report summarizes the statewide patterns of SUD, and describes current prevention, treatment, and recovery activities, and gaps in services. This SNAP report also lays out DHCS' strategic initiatives for federal fiscal year (FFY) 2018-19, aligning state-specific goals with Substance Abuse and Mental Health Services Administration's (SAMHSA's) strategic initiatives found in SAMHSA's report *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018*<sup>1</sup> and DHCS' strategic plan *DHCS 2017 Strategy for Quality Improvement in Health Care*.<sup>2</sup>

### 45 CFR § 96.133(a)(1): Incidence and Prevalence of Substance Use<sup>3</sup>

**Alcohol:** In combined calendar years (CYs) 2014-15, 6.6% of Californians ages 12+ had an alcohol use disorder in the past year, compared with 6.7% in CYs 2013-14. In CYs 2014-15, 3.5% of Californians ages 12+ suffered from an alcohol dependence disorder in the past year, compared with 3.3% for CYs 2013-14.

**Illicit Drugs:** In CYs 2013-14, 11.5% of Californians ages 12+ used an illicit drug in the past month. In CYs 2013-14, 8.3% of Californians ages 12+ reported dependence on or abuse of an illicit drug in the past year.

**Marijuana:** In CYs 2014-15, 9.7% of Californians ages 12+ used marijuana in the past month, compared with 14.5% in CYs 2013-14.

**Youth:** The 2013-15 California Health Kids Survey reported alcohol use in the past 30 days among 8.2% of seventh graders, 18.6% of ninth graders, and 29.1% of eleventh graders. Rates decreased from 2011-13 with 11.2%, 20.2%, and 33.0%, respectively.

**Deaths and Emergency Department Visits:** In CY 2013, individuals using any type of opioid (i.e., including pharmaceuticals, heroin, and illicit narcotics<sup>4</sup>) had the highest fatality rate (5.1 per 100,000). In CY 2014, the rate of alcohol-related ED visits (310.5 visits per 100,000 individuals) was more than twice as high as other drug-related ED visits (144.9 visits per 100,000 individuals).

**Hepatitis C:** In CY 2013, the California Department of Public Health received 24,268 new reports of chronic Hepatitis C infections. The rate of newly-reported chronic Hepatitis C infections in California decreased 48% between CY 2009 and CY 2013, from 121.4 to 63.3 per 100,000 population.

### 45 CFR § 96.133(a)(2): SUD Prevention and Treatment Activities

#### California Outcomes Measurement System - Prevention Data

The total number of beneficiaries served steadily decreased across state fiscal year (SFY) 2011-12 (386,594), SFY 2012-13 (298,560) and SFY 2013-14 (265,420), but increased slightly in SFY

<sup>1</sup><http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2>

<sup>2</sup> [http://www.dhcs.ca.gov/services/Documents/DHCS\\_Quality\\_Strategy\\_2017.pdf](http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2017.pdf)

<sup>3</sup> Incidence and prevalence data is limited to results in tables and reports published by SAMHSA as of January 2017.

<sup>4</sup> The term "illicit drugs" is commonly used to describe drugs which are under international control (and which may or may not have licit medical purposes) but which are produced, trafficked and/or consumed illicitly.

2014-15 (268,749 beneficiaries).<sup>5</sup>

### **Prevention Strategies**

- **Information Dissemination** strategies reached 268,750 beneficiaries.
- **Education** strategies served 110,126 beneficiaries.
- Strategies related to **Alternatives** served 101,650 beneficiaries.
- **Problem Identification and Referral** strategies were provided to 12,246 beneficiaries.
- **Community-Based Process** strategies were provided to 31,395 beneficiaries.
- **Environmental** strategies assist with reducing alcohol access to underage youth.

### **California Outcomes Measurement System – Treatment Data for SFY 2014-15**

- Approximately 195,000 unique beneficiaries were served, a 3.9% decrease from 2012-13.
- Over 92,000 beneficiaries were in treatment on April 1, 2015 (one-day count).
- There were over 166,000 admissions to treatment for all services, representing 126,000 unique beneficiaries.
- There were over 161,000 treatment discharges for over 129,000 beneficiaries.
- Outpatient Drug-Free treatment had the largest admission percentage with 43%, while 20% were for residential treatment, 16% for narcotic replacement therapy maintenance services, 4% for intensive outpatient treatment, and 18% for Detoxification.

### **45 CFR § 96.133(a)(4): Goals and Objectives**

**Strategic Initiative #1: Prevention of Substance Use:** Focuses on preventing substance use by maximizing opportunities to create environments where youth, adults, families, communities, and systems are empowered to manage their overall emotional, behavioral, and physical health.

**Strategic Initiative #2: Recovery Support Services:** Focuses on expanding the availability of recovery support services by linking individuals in SUD recovery with community resources.

**Strategic Initiative #3: Workforce Development:** An adequate supply of a well-trained SUD workforce is the foundation of an effective service delivery system.

### **45 CFR § 96.133(a)(5): Needing but Not Receiving Treatment**

National Survey on Drug Use and Health estimates for individuals needing but not receiving treatment are as follows:

- For CYs 2013-14, an estimated 2.5% of Californians ages 12+ reported needing but not receiving treatment for illicit drug use in the past year, compared to 2.6% in CYs 2012-13.
- For CYs 2013-14, an estimated 6.4% of Californians ages 12+ reported needing but not receiving treatment for alcohol use in the past year, compared to 6.8% in CYs 2012-13.

<sup>5</sup> Please note that the total number of beneficiaries served for SFY 2014-15 is based on preliminary data.

# Statewide Needs Assessment and Planning

## Introduction

Analyzing substance use disorder (SUD) data on prevention and treatment services requires examining intricate relationships, patterns, and trends to draw a cohesive picture of how the California Department of Health Care Services (DHCS) provides SUD services to low-income and Medi-Cal beneficiaries. The 2017 Statewide Needs Assessment and Planning (SNAP) report describes DHCS' financing system of its low-income SUD services using a blend of Medi-Cal (California's Medicaid program), federal block grant, and other state funding.

The goal of the SNAP report is to measure California's SUD incidence and prevalence rate among its low-income beneficiaries, measure related service utilization and beneficiary outcomes and program performance, and identify their unmet prevention, treatment, and recovery service needs. Using the needs assessment results, this report identifies federal fiscal year (FFY) 2018-2019 priorities for California's use of the Substance Abuse Prevention and Treatment Block Grant (SABG) funds to fill in service gaps not funded by other federal or state sources. DHCS' priorities align with the federal strategic initiatives in the Substance Abuse and Mental Health Services Administration's (SAMHSA) report *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018* with the state's strategic plan, *DHCS 2017 Strategy for Quality Improvement in Health Care*. DHCS circulates the SNAP report in draft form to health care stakeholders and beneficiaries for feedback. DHCS conducts the needs assessment to provide stakeholders with a better understanding of how to provide or access effective and high-quality SUD services.

DHCS is the single state agency tasked with providing Medi-Cal, SABG, and other state-funded services to California's beneficiaries in need of SUD services. As a condition of receiving SABG funding, DHCS is required to complete this biannual needs assessment as a tool to improve the quality of SUD services. The 2017 SNAP report then becomes a critical component of federal, state, and community health care planning, and clarifies the needs of state residents while encouraging policy makers to make the best decisions to shape healthcare policy and allot resources.

In accordance with statute and regulation, this SNAP report summarizes the statewide patterns of SUD, describes current prevention and treatment activities, and outlines DHCS' strategic initiatives for FFY 2018-2019 that align state-specific goals with SAMHSA's federal strategic initiatives. The DHCS strategic plan advances the following three goals:

1. Improve the health of all Californians.
2. Enhance health care quality, including the patient care experience in DHCS programs.
3. Reduce DHCS per-capita health care program costs.

## DHCS SUD Services and Programs

DHCS is the backbone of California's health care safety net, helping millions of low-income and disabled beneficiaries daily. The mission of DHCS is to provide Californians with access to affordable, integrated, and high-quality health care, including medical, dental, mental health, SUD prevention and treatment services, and long-term care. The vision of DHCS is to preserve and improve the overall health and well-being of all Californians.

DHCS funds health care services for approximately 13.5 million Medi-Cal beneficiaries, and additional low-income individuals who do not qualify for Medi-Cal. About one-third of Californians receive health care services financed or organized by DHCS, making DHCS the largest health care provider in California. The success of DHCS is only possible through collaboration and cooperation with other state agencies, counties, and stakeholders. DHCS invests more than \$93 billion annually in public funds for the care of low-income families, children, pregnant women, seniors, and persons with disabilities.

Two divisions within DHCS Mental Health and Substance Use Disorder Services oversee the SUD system of care: the SUD Program, Policy, and Fiscal Division (SUDPPFD), and the SUD Compliance Division (SUDCD). While both divisions have similar and overlapping roles in overseeing the SUD system of care, SUDPPFD is responsible for providing leadership and coordination in the planning, development, implementation, and evaluation of a comprehensive and statewide SUD service system. SUDCD is responsible for ensuring that licensed and certified SUD providers are compliant with state and federal laws, regulations, and other governing requirements. SUDCD also oversees licensing and certification functions, including approval of initial applications, submissions and renewals, assessing licensing and certification fines and fees, monitoring, site visits, technical assistance, complaint investigations, death investigations, narcotic treatment programs, and driving-under-the-influence programs. Both divisions are involved with reviewing, approving, and monitoring providers in the Drug Medi-Cal Program and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

DHCS endeavors to help individuals understand that SUD is not a moral issue or an affliction caused by a lack of willpower; rather, it is a chronic medical disease that must be treated with adequate SUD services and other health care and recovery support over a lifetime.

The 2017 DHCS SNAP report not only describes the results of the biannual needs assessment required of all single state agencies receiving SABG funds, but also provides information on the effectiveness of SUD prevention and treatment services in California. DHCS also intends the SNAP report to assist DHCS and its stakeholders in making informed decisions on allocating resources to meet the SUD prevention and treatment needs of individuals, families, and communities.

## 45 CFR §96.133(a)(1): State Incidence and Prevalence of Drug and Alcohol Use

As determined by statute, the first section of this report fulfills the requirements of 45 CFR §96.133(a)(1) to provide data and information to measure the incidence and prevalence of SUD. “Incidence” refers to the number of new cases that emerge within a given time period. “Prevalence” refers to the total number of cases at any given moment in time. This report focuses on four main areas to provide a snapshot of the impact of SUD on individuals, including:

- SUD-related consumption
- SUD-related health consequences
- SUD-related motor vehicle incidents
- Criminal justice SUD-related arrests

Analyzing data from these four areas facilitates a comprehensive and accurate understanding of the incidence and prevalence of substance use and abuse in California. These categories capture a point-in-time picture of statewide trends across prevention, treatment, and recovery services in California’s SUD delivery system.

The needs assessment data generally includes the most current information available. Depending upon the source, data may cover multiple time spans. For example, sections of this report may compare data from the most recent calendar years (CYs) available, versus data based on the state fiscal year (SFY).

In preparing the SNAP report, DHCS made the best effort to be transparent about the weaknesses and biases in the data from which conclusions were reached. By critically reviewing data reliability and validity, DHCS is mindful about developing strategies to improve the data and resulting information to inform program policies and services in the future. DHCS outlines the strategies for improvement in the strategic initiatives articulated in this report, along with requests for federal technical assistance to leverage the quality of system data reporting. By following a quality improvement process, DHCS can improve services and make future needs assessments more accurate, complete, and meaningful.

### National Survey on Drug Use and Health – Substance Use Prevalence and Incidence

The following estimates from the SAMHSA National Survey on Drug Use and Health (NSDUH) are regarded as conservative because they are based on a household, face-to-face interview sample, and because it excludes some populations (e.g., homeless, incarcerated) who likely use substances at higher levels than individuals living in the household population.

SAMHSA published the NSDUH state estimates of past month substance use among individuals ages 12+ for CYs 2014-15.<sup>6</sup> To generate accurate state-level estimates, SAMHSA combines two years of NSDUH data. In its most recent report, SAMHSA compares CYs 2014-15 data with CYs

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<sup>6</sup><https://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2015/NSDUHsaeShortTermCHG2015.htm>

2013-14 data to examine changes over time.

Please note that this section is limited to a discussion of the results in tables and reports published by SAMHSA as of January 2017.

### **Alcohol Use**

- In CYs 2014-15, 6.6% of Californians ages 12+ reported an alcohol use disorder, down slightly from 6.7% in CYs 2013-14.
- In CYs 2014-15, 3.5% of Californians ages 12+ reported an alcohol dependence disorder in the past year, up slightly from 3.3% in CYs 2013-14.<sup>7</sup>

### **Illicit Drug Use**

Illicit drugs included under this category include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and prescription-type drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives) used non-medically.

- In California, there was no statistically significant change in illicit drug use, slightly increasing from 11.2% in CYs 2012-13 to 11.5% in CYs 2013-14.

### **Marijuana Use**

Data estimates on marijuana use revealed no significant change.

- In CYs 2014-15, 15.3% of Californians ages 12+ used marijuana in the past year, an increase from 14.5% in CYs 2013-14.
- There was no significant change in marijuana past month usage in California between CYs 2014-15 and CYs 2013-14, decreasing slightly from 9.7% to 9.2%.

### **Other Illicit Drugs**

The review of NSDUH California data covering CYs 2014-2015 and CYs 2013-2014 revealed no significant overall changes in use of other illicit drugs, including cocaine or non-medical use of pain relievers.

- In CYs 2014-15, 2.2% of Californians reported using cocaine in the past year, compared with 2.1% in CYs 2013-14.
- In CYs 2014-15 and CYs 2013-14, 0.2% of Californians ages 12+ reported using heroin.
- In CYs 2013-14, estimated non-medical use of pain relievers among Californians ages 12+ was 4.3% (CYs 2014-15 data was not available).

### **Age Group Differences**

DHCS found positive news in the data related to the 12-17 age group, as there were significant

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<sup>7</sup> The two different alcohol disorder categories in these NSDUH estimates use the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-4th edition (DSM-IV) criteria of 'alcohol abuse' and 'dependence'. Under DSM-IV, anyone meeting one or more of the "abuse" criteria within a 12-month period would receive the "abuse" diagnosis. Anyone with three or more of the "dependence" criteria during the same 12-month period would receive a "dependence" diagnosis. NSDUH uses the term "alcohol use disorder" for the 'alcohol abuse' level. For more understanding of the two levels and specific criteria, see page 2 of the following document: <https://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.pdf>.

decreases in children and teen substance use. For example:

- Past month alcohol use (13.1% to 11.6%)
- Past year alcohol dependence or abuse (4.2% to 3.1%)
- Past month illicit drug use (11.2% to 9.8%)
- Past year illicit drug dependence or abuse (5.4% to 4.2%)
- Past year cocaine use (1.1% to 0.8%)
- Past month cigarette use (5.4% to 4.3%)

It is important to note that while “significant” statistical use decreases were found among children ages 12–17, “significance” here means that the differences between years are unlikely to be due to chance, not that they are necessarily substantial. While the decreases are relatively small, they suggest SUD prevention activities may be making an impact. However, many children are still starting to use drugs, indicating that increased and improved prevention efforts are needed. The decreases reported here are clearly significant, but other differences may also exist that are not discussed in this report.

On these measures, there were no significant recent decreases in SUD in California among other age groups. There was a significant increase in illicit drug use other than marijuana among adults ages 26+ (2.7% to 3.4%). The same increase was also true nationally (2.5% to 2.8%).

There was a “marginally” significant trend toward the higher use of non-prescription pain relievers in the past year among individuals ages 18+ in California (4.7% to 5.2%), but not nationally (4.5% for both periods).

### **Alcohol Use – By Gender and Age Group**

Research shows that males and females begin drinking at similar rates, but that males report higher drinking rates later in life, and have greater illicit drug use throughout life. This pattern may indicate that prevention efforts need to target males who experiment and abuse drugs more at later stages in life.

The following national information from the NSDUH 2014 report supports the conclusion that both sexes start out with similar drinking rates (based on past month data), but male drinking becomes more prevalent with age.

- Ages 12+
  - In CY 2014, an estimated 57.3% of males ages 12+ were current drinkers, while the rate for females was 48.4%.
- Ages 12-17
  - In CY 2014, among youth ages 12-17, the percentage of males who were current drinkers (10.8%) was lower than for females (12.3%).
  - The CY 2014 percentage (11.2%) for males and females ages 12-17 was similar to CY 2013 (11.9%).
- Ages 18-25

- Among young adults ages 18–25, an estimated 61.6% of males and 57.6% of females were past-month drinkers in CY 2014.
- Ages 26+
  - Among individuals ages 26+, an estimated 62.5% of males and 51.0% of females reported current drinking in CY 2014.
  - In this age group, the frequency of binge drinking for males was more than twice the rate for females (30.7% vs. 15.1%).

### **Illicit Drug Use**<sup>8</sup>

NSDUH CY 2014 data also shows that illicit drug use is higher for males than females, as reported in prior years as well.

- In CY 2014, the rate of current illicit drug use among individuals ages 12+ was higher for males (12.8%) than females (7.7%), which are both increases from CY 2013 rates (11.5% and 7.3%, respectively).
- In CY 2014, the rate of illicit drug use in the past month was higher for males than females ages 12-17 (9.6% vs. 9.1%, respectively). This represents a change from CY 2013 when the rates of current illicit drug use were higher among males than females (9.6% and 8.0%, respectively), and reflects an increase in the rate of current illicit drug use among females while male stayed the same from CY 2013 to CY 2014.

Males were more likely than females to be current users of several different illicit drugs in CY 2014, including:

- Marijuana (10.9% vs. 6.0%, respectively)
- The rate of marijuana use in the past month was higher for males than females ages 12-17 (7.9% vs. 6.8%, respectively), which reflects an increase from CY 2013 among females while males stayed the same (7.9% and 6.2%, respectively)
- Cocaine (0.8% vs. 0.4%, respectively)
- Hallucinogens (0.6% vs. 0.3%, respectively)
- Methamphetamine (0.3% vs 0.1%, respectively)

## **Substance Use among Pregnant and Postpartum Women**

In the United States, drug overdose is the leading cause of accidental death, with opioid use being the leading cause of this epidemic.<sup>9</sup> Consequently, opioid-specific SUD is a growing epidemic among women. Between 1999 and 2010, prescription drug overdoses (including those from

<sup>8</sup> For methamphetamine use prior to 2015, questions on methamphetamine use were asked in the context of misuse of prescription stimulants because methamphetamine is legally available by prescription. For 2015, NSDUH asked a new set of questions specific to methamphetamine that were not specific to prescription stimulants. Since comparable 2014 data on methamphetamines is not available, reliable estimates for methamphetamine use in California or the U.S. are not included in this report.

<sup>9</sup> Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*. MMWR Morbidity and Mortality Weekly Report, 2016;65: 1445–1452. DOI: <http://dx.doi.org/10.15585/mmwr.mm655051e1>

opioids) among women increased by 400%.<sup>6</sup>

Specifically, ensuring treatment services for pregnant and postpartum women with SUD is especially important due to the increased risk of adverse outcomes for both mother and child. Children of substance-using mothers are at risk for a host of health issues, including neonatal abstinence syndrome, birth defects, and premature births.<sup>10</sup> Many women who are pregnant or have young children either do not seek treatment or drop out of treatment early because they are unable to care for their children and may also fear that authorities will remove their children from their care.<sup>11,12</sup> Furthermore, individuals who do seek and attend treatment frequently may be overwhelmed with the burden of child care and other responsibilities.<sup>9,10</sup>

Similar to national statistics, the incidence of drug overdose in California continues to be on the rise. According to the California Office of Statewide Health Planning and Development (OSHPD), between 2010 and 2014 there has been a continuous increase in emergency department (ED) visits for opioid use. For women of childbearing age (ages 15 to 44), the number of opioid-related ED visits has also seen a steady increase from 2010 to 2014.

**Table 1: Emergency Department Visits Related to Selected Drugs in California, Females and Males, All Ages**

Data Year	Opioids	Amphetamines	Cannabis
2010	21.8	16.4	8.1
2011	24.2	17.4	10.0
2012	26.2	22.2	10.2
2013	28.1	27.2	9.3
2014	30.3	33.8	10.9

**Source:** OSHPD Emergency Department Data. Prepared by CDPH Safe and Active Communities Branch. Report generated from <http://epicenter.cdph.ca.gov> on May 25, 2017.

\*Rates are calculated per 100,000 population.

**Table 2: ED Visits Related to Selected Drugs among Females Ages 15-44**

Data Year	Opioids	Amphetamines	Cannabis
2010	24.3	21.9	10.0
2011	26.3	23.3	12.8
2012	28.7	28.2	12.7
2013	30.4	33.9	12.1
2014	33.0	41.2	14.5

**Source:** OSHPD ED Data Prepared by CDPH Safe and Active Communities Branch. Report generated from <http://epicenter.cdph.ca.gov> on May 25, 2017.

\*Rates are calculated per 100,000 population.

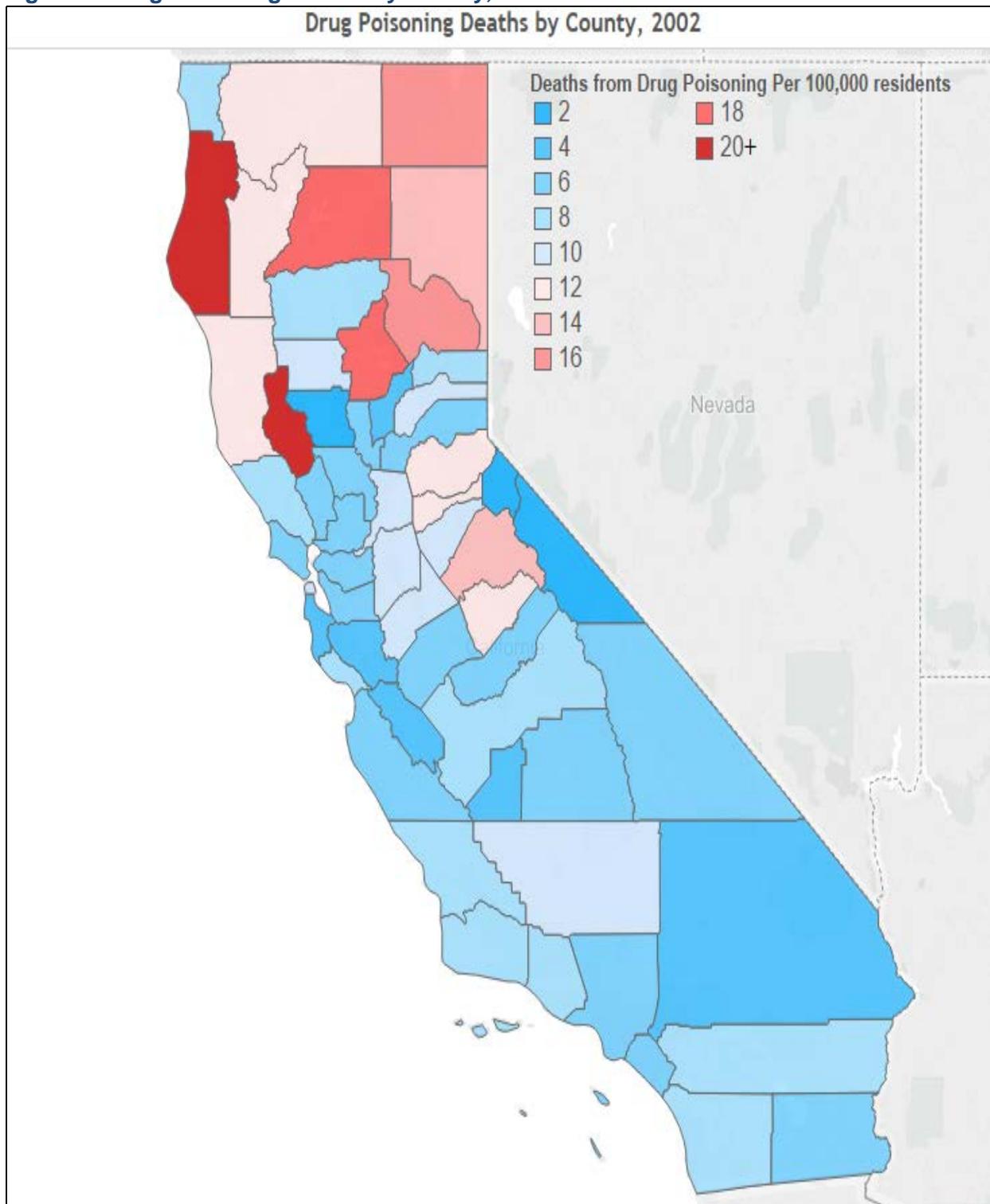
<sup>10</sup> <http://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx>

<sup>11</sup> <https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/sex-gender-differences-in-substance-use-disorder-treatment>

<sup>12</sup> <https://www.ncbi.nlm.nih.gov/books/NBK64083/#A89609>

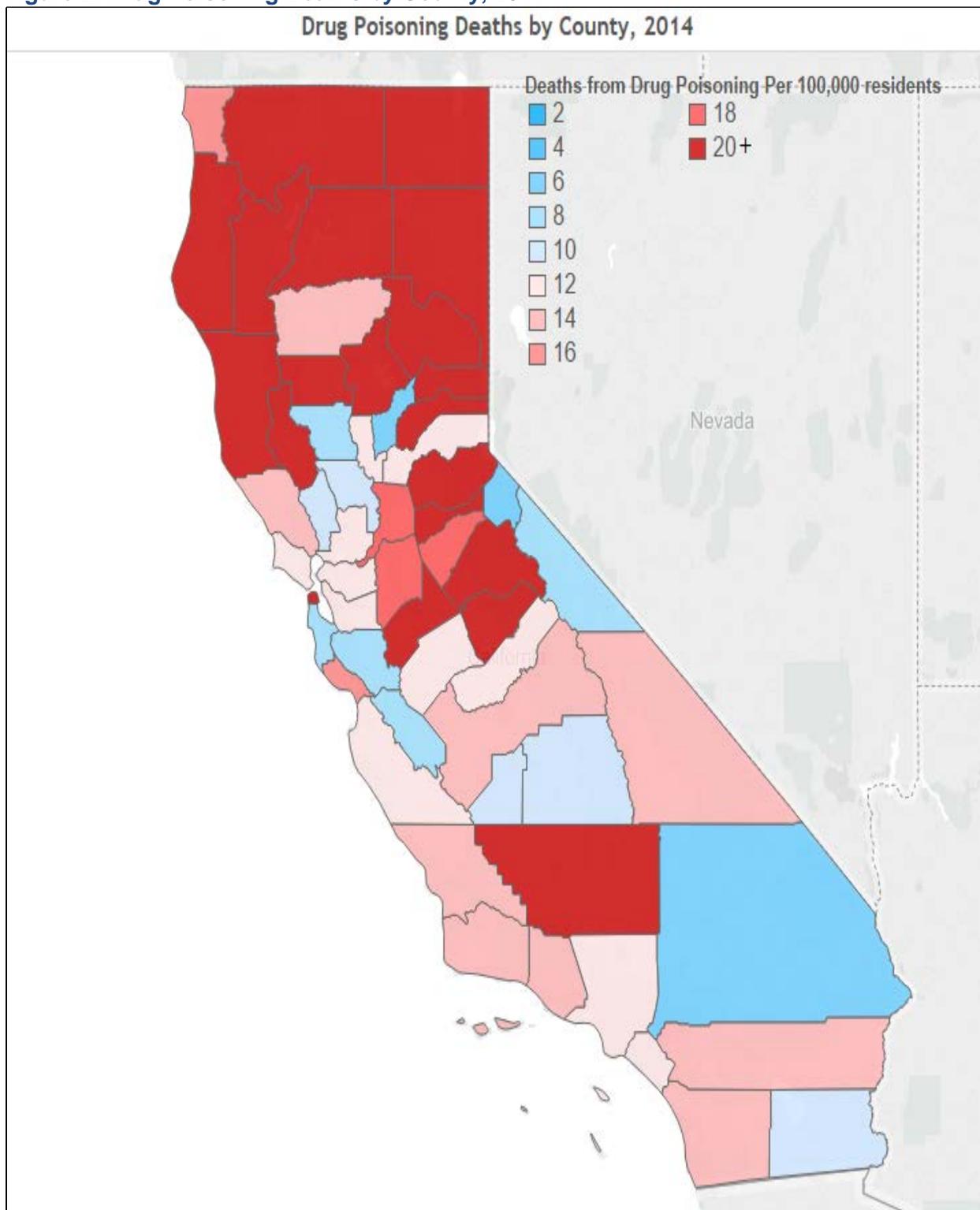
Furthermore, the following heat maps (Figures 1 and 2) illustrate the prevalence of drug poisoning deaths in each county. Between 2002 and 2014, 56 out of 58 counties have seen an upsurge in death rates resulting from drug poisoning.

**Figure 1: Drug Poisoning Deaths by County, 2002**



**Source:** Centers for Disease Control and Prevention

Figure 2: Drug Poisoning Deaths by County, 2014



Source: Centers for Disease Control and Prevention

## **Substance Use Estimates From the California Healthy Kids Survey**

The following review of the California Healthy Kids Survey (CHKS) survey data provides estimates gathered from this statewide survey of youth patterns tracking current substance use in the past 30 days. CHKS is a large statewide survey generally used by service providers and educators as a powerful tool to help identify strengths, weaknesses, needs, resiliency, protective factors, and risky behaviors occurring among children in grades 7, 9, and 11. DHCS collected the following data from the CHKS 2013-2015 combined sample of over 36,000 secondary school students. The survey results help guide statewide efforts to improve school climates, increase availability of learning supports, and engage students in healthier lifestyle behaviors. CHKS helps individuals working with children and adolescents to identify and increase the quality of health, prevention, and youth development programs. In the CHKS 2013-2015 report:

- Alcohol use in the past 30 days was reported by 8.2% of seventh graders, 18.6% of ninth graders, and 29.1% of eleventh graders, which were all decreases from 2011-13 (11.2%, 20.2%, and 33.0%, respectively).
- Binge drinking (five drinks or more on the same occasion) among youth was a common practice, occurring among 9.6% of ninth graders, and 17.6% of eleventh graders.
- Marijuana use in the past 30 days was the second most frequently consumed substance by youth, with 13.4% of ninth graders and 20.1% of eleventh graders reporting consuming marijuana in the past month.

## **California Behavioral Risk Factor Surveillance System**

The Behavioral Risk Factor Surveillance System (BRFSS) is funded by the U.S. Centers for Disease Control and Prevention, and is the world's largest ongoing telephone health survey system. BRFSS was developed to enable state health agencies to better capture and interpret data and target resources to reduce behavioral risks and their consequent illnesses. National data may not be applicable to the conditions found in any given state. However, achieving national health goals through monitoring data and targeting behavioral change interventions requires state and local agency participation. Monitoring data helps inform and facilitate efforts to improve lifespan, health, and longevity. The basic philosophy of the survey is to collect data with a specific focus on actual behaviors related to disease and injury, rather than surveying attitudes or knowledge. Understanding a population's actions and habits is instrumental in facilitating efforts to plan, initiate, support, and evaluate health promotion and disease prevention programs.

BRFSS includes the Cell Phone Survey. By including cell phones in the survey, BRFSS is able to reach segments of the population that were previously inaccessible—individuals who have a cell phone but not a landline—and results in a more representative sample and higher quality data. Cell Phone Surveys were included in the public release data set beginning in 2011.<sup>13</sup>

BRFSS is conducted by California Department of Public Health (CDPH) and the Public Health Institute. The emphasis of the survey is on health-related behaviors in the adult population, with

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<sup>13</sup> In 2011, a new weighting methodology—raking, or iterative proportional fitting—replaced the post stratification weighting method that were used with previous BRFSS data sets. In addition to age, gender, and race/ethnicity, raking permits more demographic variables to be included in weighting such as education attainment, marital status, tenure (property ownership), and telephone ownership. Details on this methodology are provided in the June 8, 2012, issue of the Morbidity and Mortality Weekly Report, which highlights weighting effects on trend lines. <http://www.cdc.gov/surveillancepractice/reports/brfss/brfss.html>

a focus on behaviors related to disease and injury. BRFSS prevalence estimates for 2015 shows:

- The percentage of heavy drinkers<sup>14</sup> was lower in California (5.7%) than the nation (5.9%).
- In California, the population groups with the highest rates of heavy drinking were males, individuals ages 25-34, and non-Hispanic Whites.
- The percentage of binge drinkers<sup>15</sup> was higher in California (16.5%) than the nation (16.3%).
- In California, the population groups with the highest rates of binge drinking were among males, individuals ages 25-34, and Hispanics.

### **Maternal Infant Health Assessment**

The Maternal Infant Health Assessment (MIHA) is an annual, statewide survey of women who participated in California’s Women, Infants, and Children Program during pregnancy with a recent live birth in California. MIHA collects information on maternal and infant experiences before, during, and shortly after pregnancy. DHCS uses MIHA data to help inform programs and services, and improve the health of substance-using mothers and their infants.

The following statistics on alcohol use and cigarette smoking are from the SFY 2013-14 MIHA survey of 13,963 women who recently gave birth to a live infant in California (see Tables 3-6).

- 15.1% reported binge drinking three months before pregnancy.
- 7.6% reported any alcohol use during the third trimester.
- 11.6% reported smoking cigarettes in the three months before pregnancy.
- 2.9% reported smoking cigarettes during the third trimester.
- 5.6% reported smoking cigarettes at the time of the post-birth survey.

The age group data in Table 3 shows:

- Women ages 20-34 had the highest percentage of binge drinking in the three months before pregnancy, smoking cigarettes in the three months before pregnancy, and smoking in the third trimester.
- Women ages 35+ had the highest percentage of any alcohol use in the third trimester.

**Table 3: Percent of Females in California Who Report Binge Drinking Three Months before Pregnancy, or Any Alcohol Use during the Third Trimester, by Maternal Age, 2013-14**

<b>Maternal Age</b>	<b>Binge Drinking Three Months before Pregnancy</b>	<b>Any Alcohol Use in Third Trimester</b>
15-19	9.5%	0.3%
20-34	16.3%	7.2%
35+	11.9%	11.1%

**Source:** MIHA Survey Data Snapshots, 2013-2014. CDPH, 2016.

<sup>14</sup> Heavy drinking is defined as adult males having more than 14 drinks per week and adult females having more than 7 drinks per week

<sup>15</sup> Binge drinking is defined as males having five or more drinks on one occasion and females having four or more drinks on one occasion in the past month

- White females had the highest percentages of binge drinking in the three months before pregnancy, and any alcohol use in the third trimester (Table 4).

**Table 4: Percent of Females in California Who Report Binge Drinking Three Months before Pregnancy, or Any Alcohol Use during the Third Trimester, by Race/Ethnicity, SFY 2013-14**

Race/Ethnicity	Binge Drinking Three Months before Pregnancy	Any Alcohol Use in Third Trimester
Hispanic	14.3%	3.9%
African American	13.2%	6.7%
White	20.5%	15.7%
Asian/Pacific Islander	7.1%	4.6%
Other <sup>a</sup>	N/A	N/A
<b>Statewide<sup>b</sup></b>	15.1%	7.6%

a. Estimates not provided for “Other” Race. “Other” Race refers to all individuals identifying as one of the remaining race definitions adopted by the Office of Management and Budget (2008).

b. Total includes records with missing race/ethnicity.

Source: MIHA Survey Data Snapshots, 2013-14. CDPH, 2016.

- Females ages 15-19 had the highest percentage of postpartum smoking (Table 5).

**Table 5: Percent of Females in California Who Report Smoking Three Months before Pregnancy, or Any Smoking during the Third Trimester or Postpartum, by Maternal Age, SFY 2013-14**

Maternal Age	Smoking Three Months before Pregnancy	Any Smoking in Third Trimester	Any Smoking Postpartum
15-29	12.1%	2.1%	7.6%
20-34	12.6%	3.4%	6.1%
35+	7.7%	1.2%	3.3%

Source: MIHA Survey Data Snapshots, 2013-14. CDPH, 2016.

- African Americans had the highest percentages of smoking cigarettes across all three smoking categories (see Table 6).

**Table 6: Percent of Females in California Who Report Smoking Three Months before Pregnancy, or Any Smoking during the Third Trimester or Postpartum, by Race/Ethnicity, 2013-14**

Race/Ethnicity	Smoking Three Months before Pregnancy	Any Smoking in Third Trimester	Any Smoking Postpartum
Hispanic	8.9%	1.6%	3.4%
African American	18.6%	5.9%	12.3%

White	17.3%	5.0%	9.3%
Asian/Pacific Islander	6.7%	1.8%	2.7%
Other <sup>a</sup>	N/A	N/A	N/A
<b>Statewide<sup>b</sup></b>	11.6%	2.9%	5.6%

a. Estimates not provided for "Other" Race. "Other" Race refers to all individuals identifying as one of the remaining race definitions adopted by the Office of Management and Budget, 2008.

b. Total includes records with missing race/ethnicity.

**Source:** MIHA Survey Data Snapshots, SFY 2013-14. CDPH, 2016.

## Health Consequences Related to Substance Use Disorder

DHCS collaborates with the CDPH Safe and Active Communities Branch to analyze administrative data on deaths, hospital discharges, and ED encounters to track the numbers and rates of SUD-related health consequences. Currently, data strongly indicates that there is an increased need statewide for prevention, treatment, education, and provider training in opioid use and overdose avoidance.

### Deaths

The rate of SUD-related deaths in California has been relatively stable over the past few years.<sup>16</sup> Alcohol-related death rates were consistently higher than all other drug-related death rates.

- In CY 2013, the rate of alcohol-related deaths was 11.9 per 100,000 population.
- For all other drug-related deaths in CY 2013, the rate was 8.5 per 100,000 population.

Among the deaths in CY 2013 where drugs were a contributing cause:

- Individuals using any type of opioid (i.e. including opioid pharmaceuticals, heroin, and illicit narcotics) had the highest fatality rate (5.1 per 100,000).
- After opioid-related deaths, the next highest rates were for amphetamines (2.7 per 100,000), sedatives (1.6 per 100,000), and cocaine (0.6 per 100,000).

### Hospitalizations

As with deaths, the rates of hospitalizations for alcohol- and other drug-related health consequences in California were relatively stable.<sup>17</sup> The rates of alcohol-related hospitalizations are consistently higher than the rates of other drug-related hospitalizations. For CY 2014:

<sup>16</sup> Death data comes from the CDPH Center for Health Statistics and Informatics (CHSI), who is responsible for registering all death certificates for California through the Electronic Death Registration System: <https://www.cdph.ca.gov/Programs/CHSI/Pages/Program-Landing1.aspx>. With assistance from the National Center for Health Statistics, CHSI annually produces Death Statistical Master and Multiple Cause of Death files that use the ICD-10 codes to classify the cause and manner of deaths.

<sup>17</sup> Hospitalization and ED data are collected by OSHPD: <http://www.oshpd.ca.gov>. OSHPD collects inpatient and ED data from all licensed hospitals and EDs in California, including general acute care, acute psychiatric care, chemical dependency recovery, psychiatric health facilities, and produces annual hospital patient discharge and ED files. The annual hospital file includes a record for each hospital discharge; therefore the file may contain multiple records for the same individual if they were hospitalized more than once during the year. The same is true for the ED files.

- The rate of alcohol-related hospitalizations was 88.3 per 100,000.
- The rate for other drugs was 55.9 per 100,000.
- Specifically, opioid-related hospitalizations had the highest rate (18.2 per 100,000), followed by sedatives (11.0 per 100,000), and amphetamines (2.1 per 100,000).

Future public health efforts should observe and address that, according to the federal government, the high rate of opioid prescriptions poses an increasing threat of death or illness from drug overdoses and birth defects.

### **Emergency Department Visits**

As with deaths and hospitalizations, the rate of alcohol-related ED visits in California is higher than the rate of other drug-related ED visits.<sup>12</sup>

- The rate of alcohol-related ED visits is more than twice as high as the rate of other drug-related ED visits (310.5 vs. 144.9 per 100,000 in 2014, respectively).
- Unlike the rates of deaths and hospitalizations, the rates of SUD-related ED visits have steadily increased over the past several years.
- Amphetamine-related ED visits in CY 2014 had the highest rate at 33.8 per 100,000 population, closely followed by opioids (30.3 per 100,000), and sedatives (20.8 per 100,000).

## **Other Health Consequences Related to Substance Use Disorder**

### **Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome**

Over 220,000 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) cases were reported in California through June 30, 2014. Of those cases, 8.8% identified injection drug use (IDU) as the exposure category. Another 8.8% identified Men who have Sex with Men/ Bisexual Male & IDU as the exposure category. Thus, nearly 18% of all HIV/AIDS cases were related to injection drug use.

### **HIV Early Intervention and Services Survey of Block Grant Providers**

During SFY 2015-16, federal HIV Early Intervention Services block grant funding was provided to 51 (counting the Sutter and Yuba counties as one county) out of 58 counties. Six counties declined these funds due to minimal need. DHCS distributed at least \$7,500 to each participating county to test over 31,000 individuals for HIV and/or Hepatitis C. A total of 116 SAPT HIV EIS programs were funded in SFY 2015-16, with over 23,439 individuals tested.<sup>18</sup>

### **Hepatitis C**

Hepatitis C is a serious liver disease caused by the Hepatitis C virus. Exposure to Hepatitis C through needle sharing, or other injection equipment, during injection drug use is a predominant transmission method. The infection spreads when blood contaminated with the virus enters the bloodstream of an uninfected person.

In 2013, CDPH received 24,268 new reports of chronic Hepatitis C infections. The rate of newly-

<sup>18</sup> Data on HIV EIS testing was self-reported by counties.

reported chronic Hepatitis C infection in California decreased 48% between 2009 and 2013, from 121.4 to 63.3 per 100,000 population. However, chronic Hepatitis C remains one of the most frequently reported communicable diseases. The occurrence of chronic Hepatitis C infections among individuals ages 30 and younger is most likely due to sharing injection equipment. Individuals who inject drugs are more likely to be out of care and thus more likely to be undiagnosed and unreported, except when they are incarcerated in state prisons.

### **Tuberculosis-Intravenous Drug Use**

In 2015, there were 2,133 cases of Tuberculosis diagnosed in California. Twenty-seven (1.3%) of those cases were within the IDU population. This is a decrease from the 42 (1.9%) cases within the IDU population, as well as a decrease of the 2,189 total Tuberculosis cases for 2012.<sup>19</sup>

### **Motor Vehicle Incidents**

Substance use contributes to the rate of injuries and deaths resulting from traffic crashes. Therefore, data on motor vehicle collisions and impaired drivers provides a valid indicator of substance use consumption and consequences. The data used in this report comes from the Statewide Integrated Traffic Records System (SWITRS).

### **Statewide Integrated Traffic Records System**

SWITRS is operated by the California Highway Patrol in partnership with the California Department of Motor Vehicles. The SWITRS database includes all property damage and injury crashes investigated by police in all California jurisdictions. In the 2013 SWITRS report, the California Highway Patrol reported 1,075 alcohol-involved fatal collisions with 1,197 individuals killed statewide. Additionally, there were 16,060 alcohol-involved injury collisions, with 23,178 individuals injured.

### **Criminal Justice and Substance Use-Related Arrests**

Substance use-related arrests occur when individuals are taken into custody because authorities determine if they have violated alcohol or other drug laws. Alcohol law violations include driving-under-the-influence, public drunkenness, and liquor law infractions. Drug law violations include arrests for possession of narcotics (heroin, opium, etc.), marijuana, dangerous drugs (barbiturates, phencyclidine, etc.), and other drugs. Although arrest data is only one indicator of the underlying incidence and prevalence of the substance use problem, the information gleaned from tracking this data also reflects the level of resources (e.g., funding and building of jails/prisons and correctional personnel costs) and attention (e.g., governmental priority) invested by the public and private sectors to address consequences.

### **Monthly Arrest and Citation Register**

The Monthly Arrest and Citation Register (MACR) database, kept by the California Department of Justice, contains statewide information on arrests of juveniles ages 10-17, and adults ages 18+. In 2015, MACR reported:

- 429,166 felony and misdemeanor arrests for substance use-related violations (221,464 for alcohol and 207,702 for other drugs) out of 1,150,118 arrests (37.3%).

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<sup>19</sup> [https://archive.cdph.ca.gov/programs/tb/Documents/TBCB\\_Report\\_2015.pdf](https://archive.cdph.ca.gov/programs/tb/Documents/TBCB_Report_2015.pdf)

- Of this population, 420,827 were adults and 8,339 were juveniles.
- Among adults, 219,837 arrests were for alcohol and 200,990 arrests were for other drugs.
- Among juveniles, there were 1,627 arrests for alcohol and 6,712 arrests for other drugs.
- Cumulatively, there were 44,629 felony arrests for other drugs, and 4,927 were for alcohol. There were 216,537 misdemeanor arrests for alcohol, and 163,073 misdemeanor arrests for other drugs.

This data highlights the need for collaboration between SUD policy planners and the criminal justice system. It should be noted that in November 2014, California voters passed Proposition 47 that reduced some felony offenses (such as drug offenses) to misdemeanors. These changes affected the number of felony offenses reported. Caution should be used when comparing felony and misdemeanor arrest data to prior years.

## 45 CFR §96.133(a)(2): Current Substance Use Disorder Prevention and Treatment Activities in California

This section fulfills the legislative mandate of 45 CFR §96.133(a)(2) that requires the single state agency receiving SABG funds to describe the state's SUD prevention, treatment, and recovery support services. In addition, this section provides a description of DHCS' intended use of SABG funds relating to prevention and treatment, as well as SUD treatment system capacity.

DHCS uses current research and knowledge advances to equip health care providers, communities, policymakers, law enforcement, and others with the evidence, tools, and information needed to create effective healthcare policy and services. DHCS recognizes that a rare opportunity of timing exists within the health care reform movement for integration of SUD into the physical and mental health system and that parity laws equally apply to SUD treatment. SUD prevention services must prioritize early intervention strategies directed at youth. Prevention efforts are crucial as early use of psychoactive alcohol or drugs predicts SUD later in life, psychopathology, deficits in social and occupational functioning, and a wide range of other adult health problems.

The first part of this section describes DHCS' prevention activities and strategies. The overview includes recent innovations and improvements in SUD treatment services. The second part of this section describes strategic initiatives that prioritize specific goals to improve services for individuals needing SUD prevention or treatment. Identities of the entities are included that provide a list of the services and a description of their services.

### Prevention Data

#### Data

The prevention data collection system used by DHCS is the California Outcome Measurement System for Prevention (CalOMS Pv).<sup>20</sup> This system is designed to help effectively manage and improve the provision of publicly-funded SUD prevention services at the state, county, and provider levels. Prevention services are provided for populations at three levels of risk:

1. Universal for the general public
2. Selective for sub-populations at higher than average risk for substance abuse
3. Individuals presenting with indicators for using alcohol or other drugs, or engaging in other high-risk behaviors but are not yet defined as in need of treatment

CalOMS Pv collects data on participants engaged in prevention activities. All prevention services funded with SABG funding must be reported to CalOMS Pv. All of the following data is for SFY 2014-15.

All 58 counties have a current strategic prevention plan. Nineteen counties referred individuals for additional services from primary prevention service settings.

Twenty-four counties conducted primary prevention screenings. Screenings were provided by

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<sup>20</sup> See: <https://caprev.onmosaix.com/caprevent2016/pLogin.aspx> to view DHCS CalOMS Pv data submission web site.

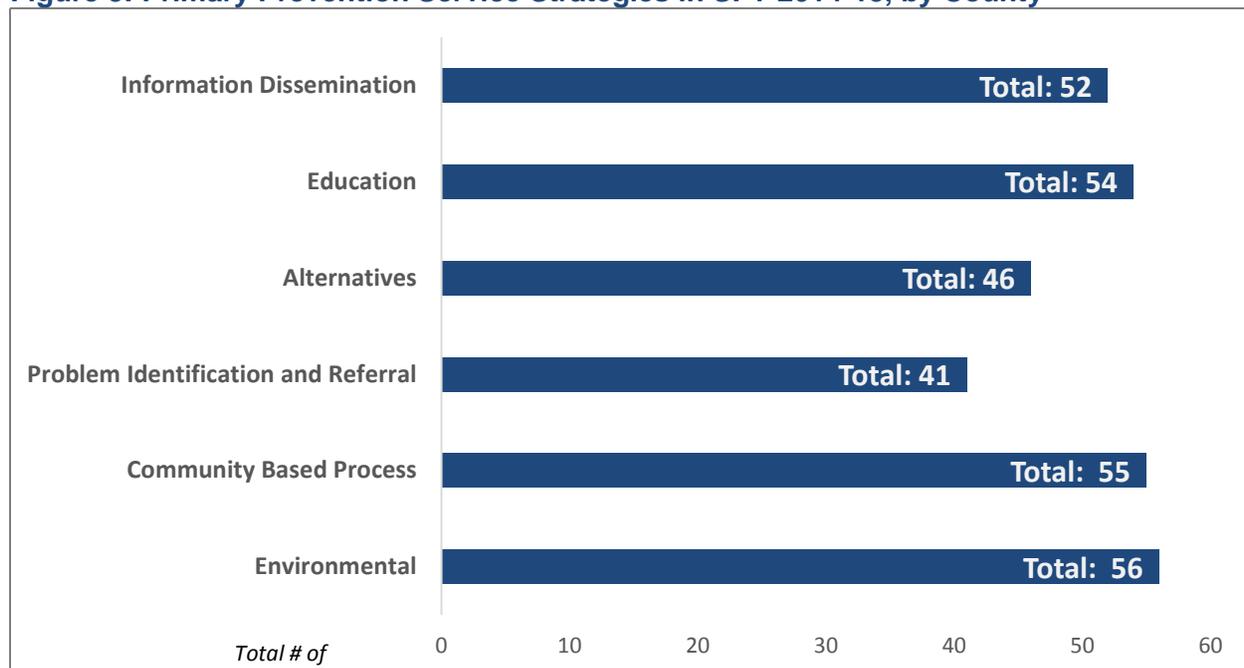
counties in the following settings:

- Other County Offices: 5 counties
- Student Health Centers: 3 counties
- County AOD Offices: 6 counties
- Other Settings: 21 counties

## Prevention Strategies

The six prevention service strategies as defined by SAMHSA's Center for Substance Abuse Prevention are Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental. Each of these strategies has multiple related services/activities that are quantifiably reported into CalOMS Pv by counties and prevention service providers (see Figure 3). With the exception of Information Dissemination, five strategies capture demographic data on participants that includes gender, age, and race/ethnicity.

**Figure 3: Primary Prevention Service Strategies in SFY 2014-15, by County**



Source: CalOMS Pv

### Information Dissemination

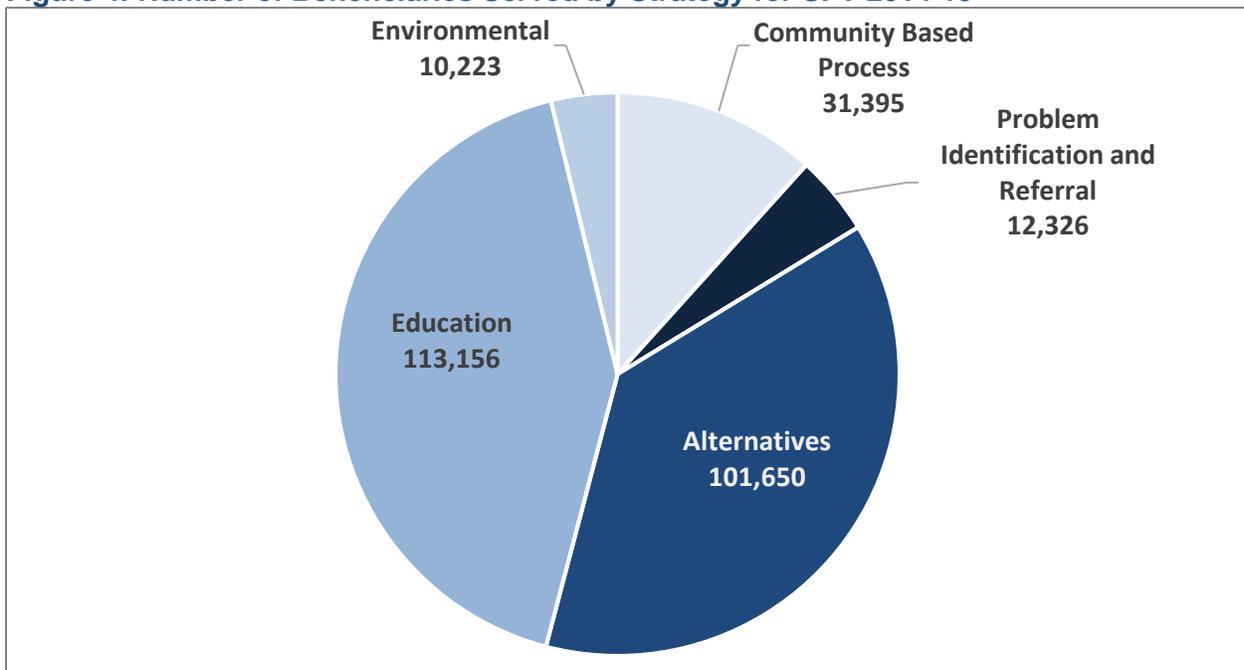
Information Dissemination activities reported into CalOMS Pv include audio and visual material development and dissemination, conference/fair planning and attendance, media campaign development and implementation, resource directory development and dissemination, speaking engagements, and similar multi-media generating activities. Demographic data for information dissemination activities is not available by age groups, race, or gender. In SFY 2014-15, the highest totals reported by service frequency activity statewide were as follows (number of individuals served is not captured in these strategy descriptions):

- Printed Materials Disseminated = 6,885

- Printed Materials Developed = 4,159
- Speaking Engagements = 3,612
- Brochures/Pamphlets Disseminated = 3,179
- Health Fair/Promotion Planning = 1,471

Figure 4 below displays the total individuals served by each strategy, with the exception of Information Dissemination. Publicly-funded providers reported that 268,750 Californians received some type of SUD prevention service. Education and Alternatives strategies are provided to the largest number of prevention recipients, while Environmental strategies serve the fewest individuals. Environmental and Community-Based Process strategies capture some individuals-served data. However, many activities in these strategies are planning/coordination and occur at an organizational level, rather than involving direct prevention services to individuals, as reflected in the other strategies' data.

**Figure 4: Number of Beneficiaries Served by Strategy for SFY 2014-15**



Source: CalOMS Pv

### Education

Prevention service activities reported as Education include SUD prevention classroom and educational services for youth and adult groups, mentoring, parenting and family management services, peer leader and preschool prevention programs, theatre troupes, and groups for children of substance abusers. The five activities with the highest number of individuals served were:

- Classroom Educational Services = 56,398
- Small Group Sessions = 15,793
- Educational Services for Youth Groups = 14,373
- Educational Services for Adult Groups = 12,843

- Parenting/Family Management Services = 10,719

### **Alternatives**

Activities reported within Alternatives in CalOMS Pv include community center activities and operation, substance use-free social events, community service, youth and adult leadership, and Outward Bound. The highest numbers of individuals served through alternative activities are:

- Substance Use-Free Social/Recreational Events = 44,344
- Youth/Adult Leadership Activities = 43,642
- Community Service Activities = 6,831
- Community Drop-in Center Activities = 4,457
- Recreational Activities = 2,376

### **Problem Identification and Referral**

This strategy contains the fewest types of activities ranging from Alternatives to Violence to Student Assistant Programs.

- Prevention Screening and Referral Services = 9,109
- Student Assistance Programs = 3,137

### **Community-Based Process**

This strategy predominantly reflects activities in planning and coordination of prevention services along with technical assistance and training. The community-based process strategy includes serving and providing guidance to individuals who are “Intermediaries” (social workers, beverage servers, policy makers, law enforcement, etc.). The secondary impact on these participants is delivered through later actions of their agencies/services; however, the quantity/demographics of these actions are outside the view of a prevention data system and are not captured in CalOMS Pv. The data below reflects the three activities that report individuals served.

- Technical Assistance = 15,549
- Community/Volunteer Training = 8,188
- Training Services = 7,658

Not all of the activities under this strategy capture the number of individuals served, as many are indirect services rather than services provided to individuals. The remaining Community-Based Process activities are reported as count-of-service types or the frequency of occurrence. The most reported activities are as follows:

- Multi-Agency Coordination/Collaboration = 23,807 services
- Assessing Community Needs/Assets = 4,404 services
- Evaluation Services = 2,909 services

### **Environmental**

As with the Community-Based Process strategy, service frequency is reported for all environmental activities, but not all environmental activities collect data for individuals served. The

Compliance Training sub-categories report the most individuals served as follows:

- Compliance: Training – Commercial Host and Management = 4,083
- Compliance: Training – Social Host and Management = 3,198
- Compliance: Retailer/Vendor Education = 1,406

The highest service frequencies reported for this strategy are:

- Environmental Other = 6,537 services
- Policies and Regulations = 3,082 services
- Media Strategies = 2,297 services
- Efforts with City and/or County Officials = 1,980 services

## Prevention Demographics

### Gender

More females than males were served in SFY 2014-15 (see Table 7). The general population of California contains fewer males than females while individuals self-identifying as “other” is not reported in the larger population by California Department of Finance demographic sources. However, as mentioned previously there are gender differences that may require future targeted planning efforts. It is generally known that while males develop SUD more than females as they age. In addition, males and females in general start out drinking at similar rates, but males exhibit higher drinking rates later in life and demonstrate greater illicit drug use throughout life. From the NSDUH 2013 Report, data shows that while both sexes start out with similar drinking rates (past month), male drinking becomes more prevalent as they age. This observation leads DHCS researchers to ask: Should California have more prevention efforts focused on males who experiment more and have higher rates of drug usage later in life?

**Table 7: Individuals Served in SFY 2014-15, by Gender**

Gender	Beneficiaries Served	California Population	Rate per 1,000 Population
Female	145,850	19,194,857	7.6
Male	122,118	19,007,349	6.4

Source: CalOMS Pv

### Age

Prevention services are primarily provided to youth under age 25 (see Table 8). Youth ages 12-17 were the largest group of recipients of prevention activities, even though this group makes up only 8.1% of California’s population. However, the fewest number of individuals served occurred in the 65+ age group, which makes up 12.6% of the general population. Rates per 1,000 allows for comparison between subgroups and are as follows: there are 6,014,930 individuals ages 0-11 living in California, and for every 1,000 of the general population in that age group, a little over four are participating in some kind of publicly-funded Prevention service activity.

**Table 8: Individuals Served in SFY 2014-15, by Age Group**

Age Group	Beneficiaries Served	California Population	Rate per 1,000 Population	Age Group % of Total CA Population
0-11	26,653	6,014,930	4.4	15.7
12-17	155,839	3,089,930	50.4	8.1
18-25	31,874	4,553,582	7	11.9
26-44	31,702	10,081,041	3.1	26.4
45-64	16,743	9,658,364	1.7	25.3
65+	5,938	4,804,159	1.2	12.6

Source: CalOMS Pv

### Race/Ethnicity

The Race/Ethnicity demographic in CalOMS Pv data is categorized by non-Hispanic White, Asian American, Hispanic/Latino, American Indian/Alaska Native, African American, Multiracial/Ethnic, Hawaiian/Pacific Islander, and Other. As displayed in the following tables and charts, Multiracial/Ethnic is combined with Other in CalOMS Pv data. For comparison, the category of Other was used in the California population data from the California Department of Finance for 2013.

Table 9 provides a brief summary of all prevention services delivered in SFY 2014-15 by race/ethnicity group. To control for the wide variations in the total numbers of each race/ethnic group in the general California population, rates per 1,000 are utilized. This method allows more valid comparisons of the proportions of each group who are receiving some type of prevention service. The Pacific Islander group received the highest proportion (50.4 per 1,000) followed by the Other/Multiracial group (21 per 1000), the American Indian group (20.4 per 1,000), and the African-American group (16.4 per 1,000). The race/ethnic groupings receiving the least prevention services as a proportion of their varying population numbers are Asian (4.4 per 1,000), followed by non-Hispanic White (5.2 per 1,000), and Hispanic (6.9 per 1,000) groups.

**Table 9: Beneficiaries Served in SFY 2014-15, by Race/Ethnicity**

Race/Ethnicity	Beneficiaries Served	California Population	Rate per 1,000 Population	Race/Ethnicity % of Total CA Population
American Indian	3,480	170,198	20.4	0.4
Asian	22,175	4,996,700	4.4	13.1
African American	36,399	2,215,348	16.4	5.8
Hispanic	101,005	14,692,509	6.9	38.5

Pacific Islander	6,992	138,815	50.4	0.4
White	77,837	14,994,349	5.2	39.2
Other/ Multiracial	20,862	994,287	21	2.6

Source: CalOMS Pv

## Prevention Activities and Strategies (45 CFR §96.133[a][2])

The SUD Policy and Prevention Branch (PPB) provides statewide leadership and support to the 58 counties and approximately 300 SUD primary prevention providers. SUD PPB aims to achieve quality substance abuse prevention services through: effective planning, development, and delivery of systems; application of current research and technology; ongoing needs assessment and data collection; continuing collaboration and coordination with other entities providing prevention services; and provision of quality improvement and quality assurance activities.

Over the last two years, California continued strengthening its SUD prevention infrastructure that supports the local implementation of the Strategic Prevention Framework (SPF) by creating a coordinated prevention system led by the Interagency Prevention Advisory Council (IPAC).

## Interagency Prevention Advisory Council

IPAC operates utilizing a Collective Impact model where multiple state agencies and local organizations come together to achieve a common agenda with mutually reinforcing activities. Through the IPAC planning process, IPAC's Executive Leadership Team (ELT) identified six priority areas as follows:

- Underage marijuana use
- Underage alcohol use
- Access to care (with higher education as the target population)
- Prescription drug misuse (strategic partnering area)
- Impaired driving (strategic partnering area)
- Suicide and depression (strategic partnering area)

Workgroups were established to address issues related to the identified priority areas. Strategic partnering areas were established to align with existing statewide workgroups. This allows IPAC to maximize its coordinated effort while reducing redundancies.

## State Epidemiological Workgroup

The vision of California's State Epidemiological Workgroup (SEW) is to enhance statewide analytical capacity by functioning as an expert data advisory group that recognizes the importance of regular statewide evaluations to monitor and track outcomes. SEW provides support for SABG, current and future federal discretionary grants, as well as provides data advisory group support to multiple state-level efforts. An ELT functions as the core of the SEW, and plans, organizes, and

leads efforts related to the following:

- Peer review data, data analysis, and evaluation methodologies and reports.
- Provide guidance to data collection efforts and encourage data-informed decision making to IPAC prevention priorities, multiple state departments, state indicator reports, the SNAP report, etc.
- Review, analyze and report trends related to substance use and mental health issues and disorders that cause harm.
- Support IPAC efforts to annually update the Annual Prevention Priorities and Strategies Report.
- Plan for continuous data quality improvement.
- Continue to support the Epi-Center and other data collection efforts.
- Respond to ad hoc data queries from federal, state, and local stakeholders.

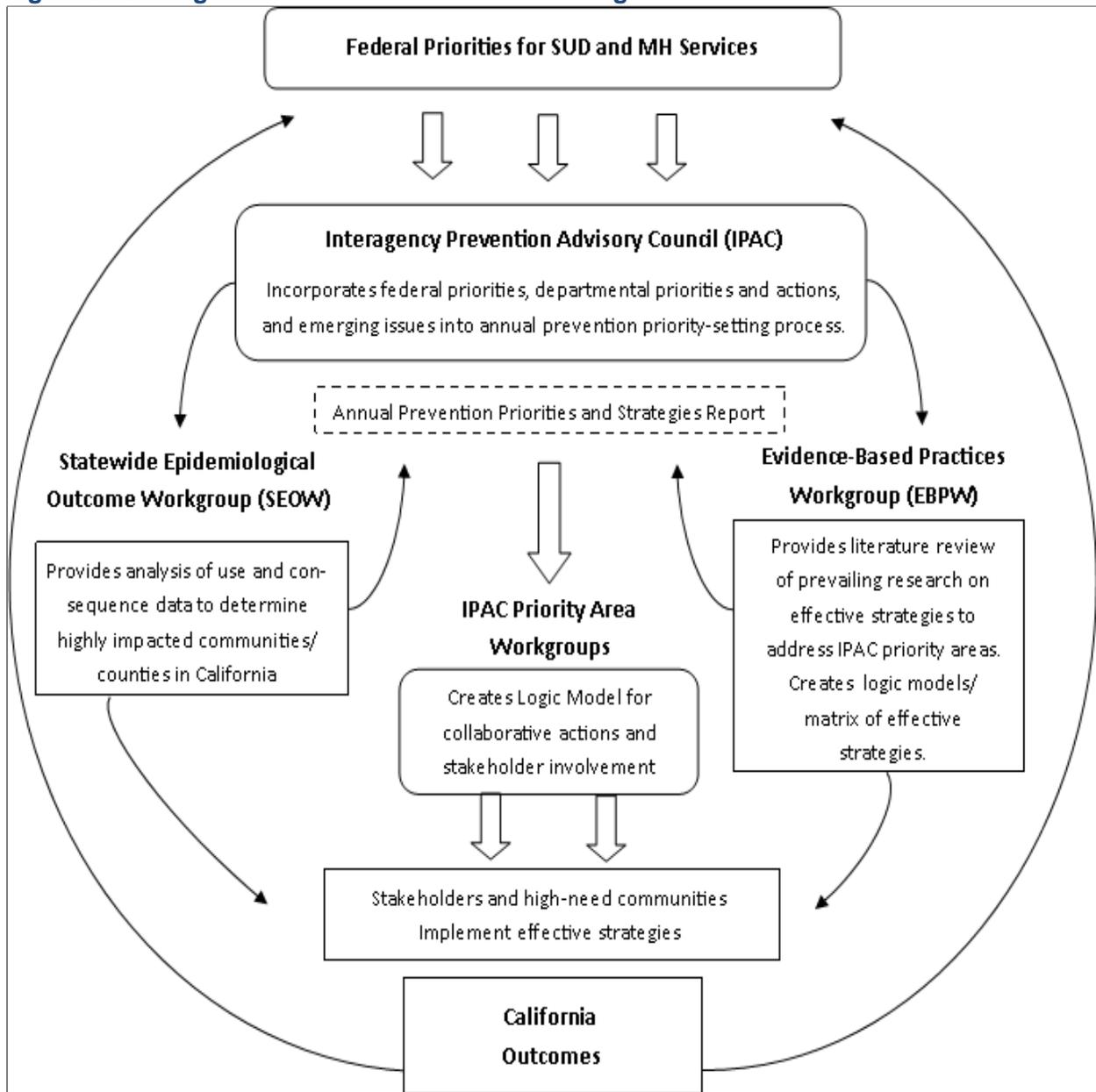
### **Evidence-Based Practices Workgroup**

The vision of the Evidence-Based Practices Workgroup (EBPW) for Primary Prevention is to expand the statewide use of evidence-based practices (EBP), programs, policies, and strategies to positively impact statewide outcomes. The EBPW provides support for SABG, current and future federal discretionary grants, and provides input and support to multiple state, county, and provider efforts. EBPW works to streamline the process of moving from problem identification to achieving changes in outcomes. The methodology used will include the most efficient and effective methods to change behaviors, perceptions, attitudes, and policies related to consumption, consequences, and contributing factors of substance misuse and abuse. Currently, California uses a very narrow definition of EBPs that is limited to those listed on SAMHSA's National Registry of Evidence-Based Programs and Practices. In the coming two years, the EBPW plans to:

- Create a definition of EBPs to fit California's diverse needs.
- Develop a "menu" of common SUD-related consequences, consumption, contributing factors and indicators, and their related evidence-based policies, programs, interventions, promising practices, and best practices.
- Encourage the development of local innovative programs by creating criteria that will allow acknowledgement of developed and implemented programs not yet having outcomes.
- Work collaboratively with DHCS SUD prevention planning, IPAC prevention priorities, and the SEW to create a model that incorporates the problem, supporting data, and possible solutions.

Creation of the SEW and EBPW followed the Strategic Prevention Framework planning process and uses a project management methodology to monitor and track progress.

**Figure 5: Strategic Prevention Framework Planning Process**



For SABG Primary Prevention-funded programs, each of the 58 counties are required by contract to develop a Strategic Prevention Plan, with measurable goals and objectives, using SAMHSA’s SPF. Over the last several years, PPB has developed numerous tools to support counties with data-informed decision-making, evidence-based strategy selection, and program evaluation.

California’s youth development model known as Friday Night Live is the most commonly-implemented SABG-funded program. Statewide technical assistance and training is available at no cost to all counties. Counties must maintain a Member in Good Standing status to receive the Friday Night Live stipend, a subset of the SABG Primary Prevention Set-Aside.

However, California’s prevention infrastructure supports both individual- and population-based

programs. 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. Demographic data is not collected because population-level prevention is delivered to the community at large.

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

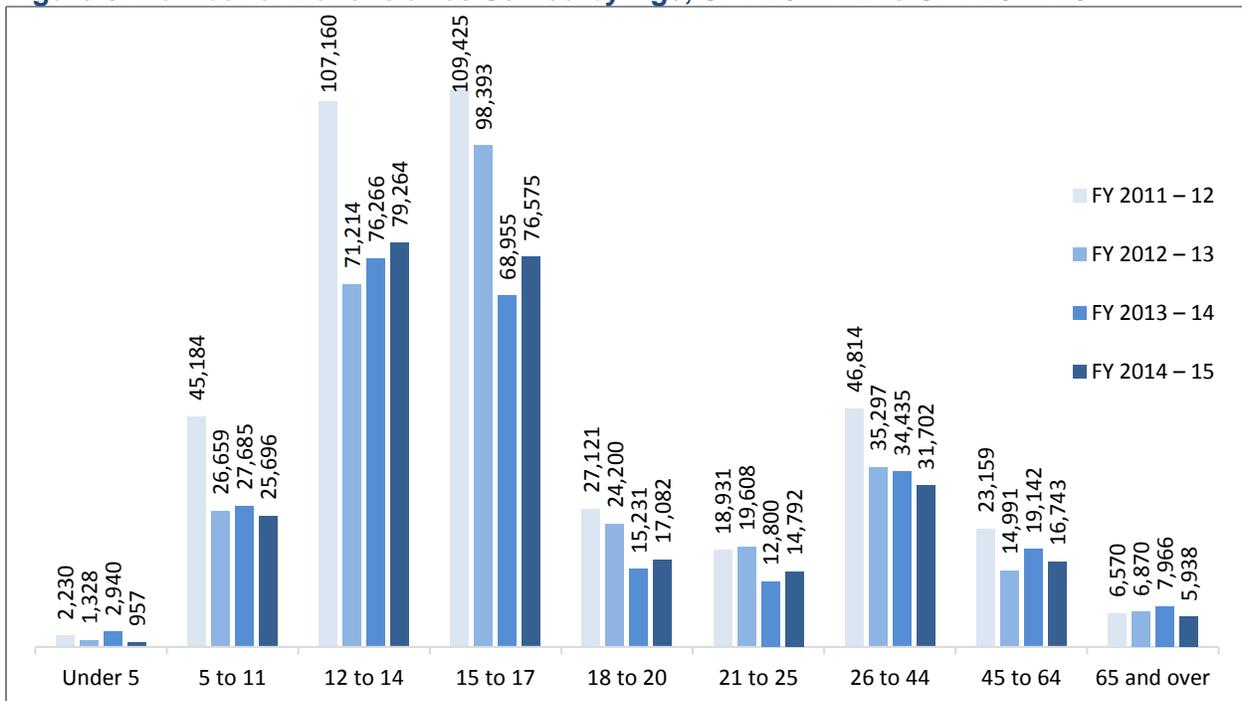
In SFY 2011-12, 386,594 beneficiaries received an individual-level service. The following demographic information was collected:

- 79.6% of the total number of beneficiaries served was youth and young adults, with 11.7% ages 5-11, 27.7% ages 12-14, 28.3% ages 15-17, and 11.9% ages 18-25.
- Slightly more than half (53.4%) of beneficiaries were female.
- Nearly 40% of the beneficiaries served identified their race/ethnicity as Hispanic/Latino, while one-third (33.3%) identified as Non-Hispanic Whites. African Americans represented the third largest group (10.2%), and Asian Americans represented the fourth largest group (7.4%).

The total number of beneficiaries served has steadily decreased across SFY 2011-12 (386,594), SFY 2012-13 (298,560) and SFY 2013-14 (265,420), but increased slightly in SFY 2014-15 (268,749 beneficiaries). Please note that the total number of beneficiaries served for SFY 2014-15 is based on preliminary data.

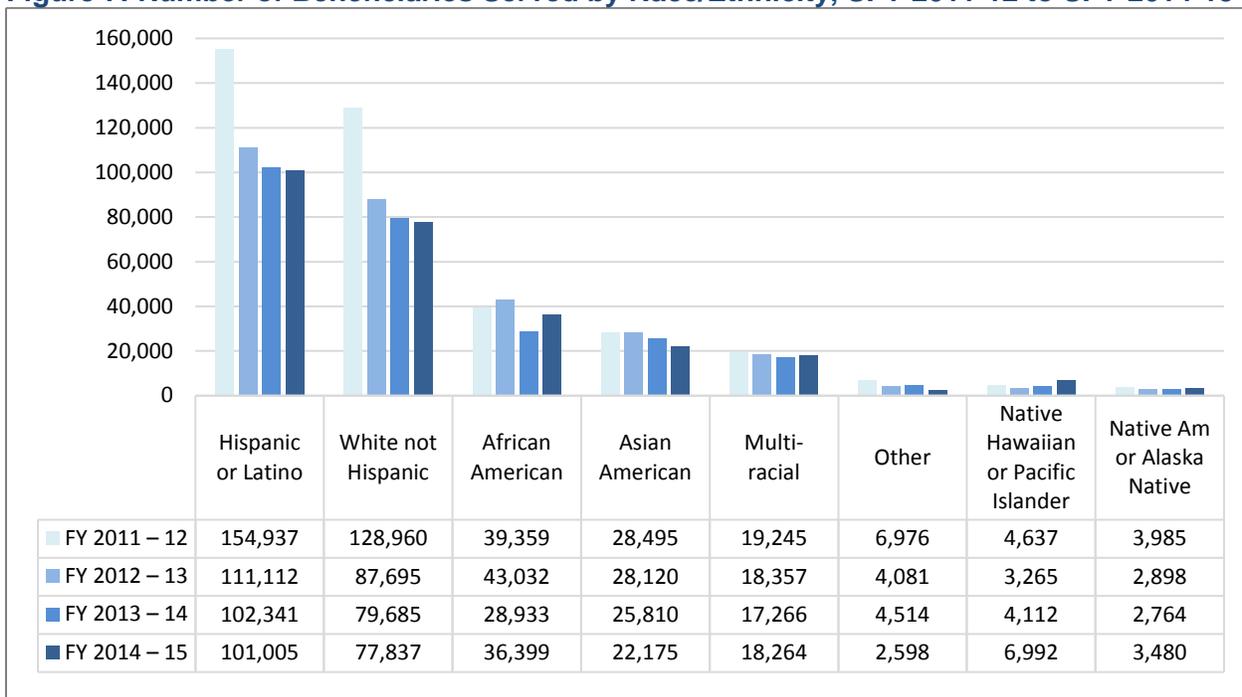
Figures 6-9 depict trend data on age, race, and gender collected in CalOMS Pv. Note that counties are only required to report services in CalOMS Pv that are funded with SABG funds; services provided with other funds are not reflected. In addition, the SFY 2014-15 CalOMS Pv data are preliminary until year-end cost reports are received and reconciled.

**Figure 6: Number of Beneficiaries Served by Age, SFY 2011-12 to SFY 2014-15**



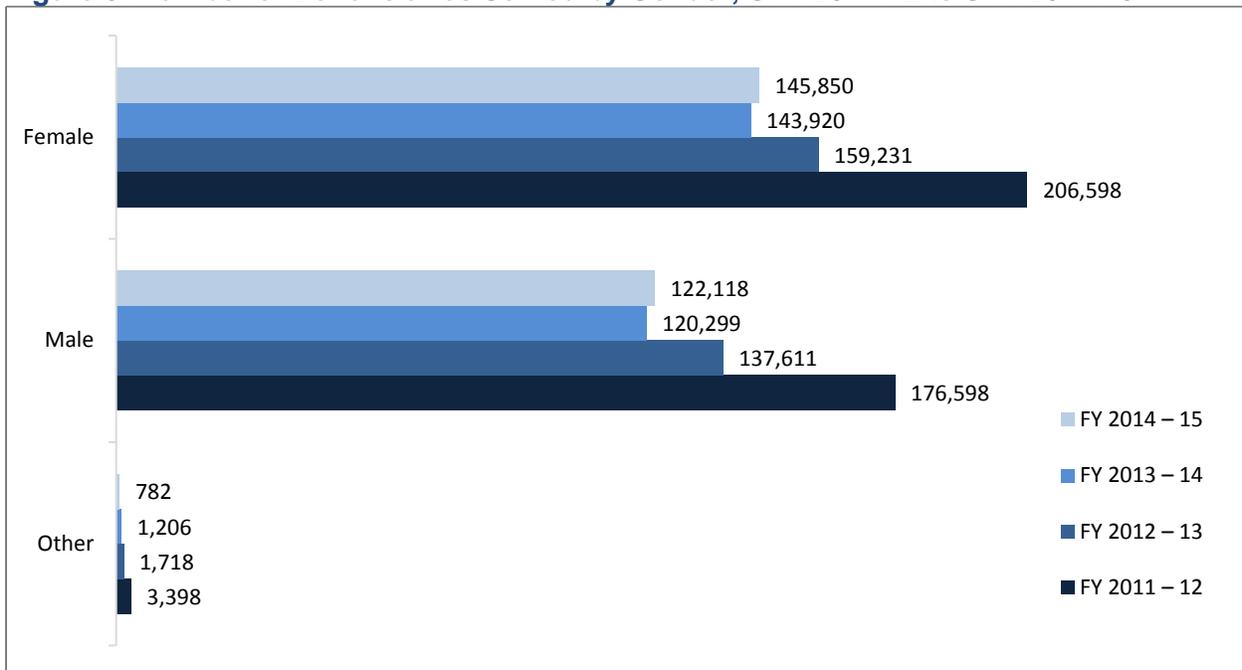
Source: CalOMS Pv data retrieved 10/10/16, SFY 2014-15 data is preliminary

**Figure 7: Number of Beneficiaries Served by Race/Ethnicity, SFY 2011-12 to SFY 2014-15**



Source: CalOMS Pv data retrieved 10/10/16, SFY 2014-15 data is preliminary.

**Figure 8: Number of Beneficiaries Served by Gender, SFY 2011-12 to SFY 2014-15**

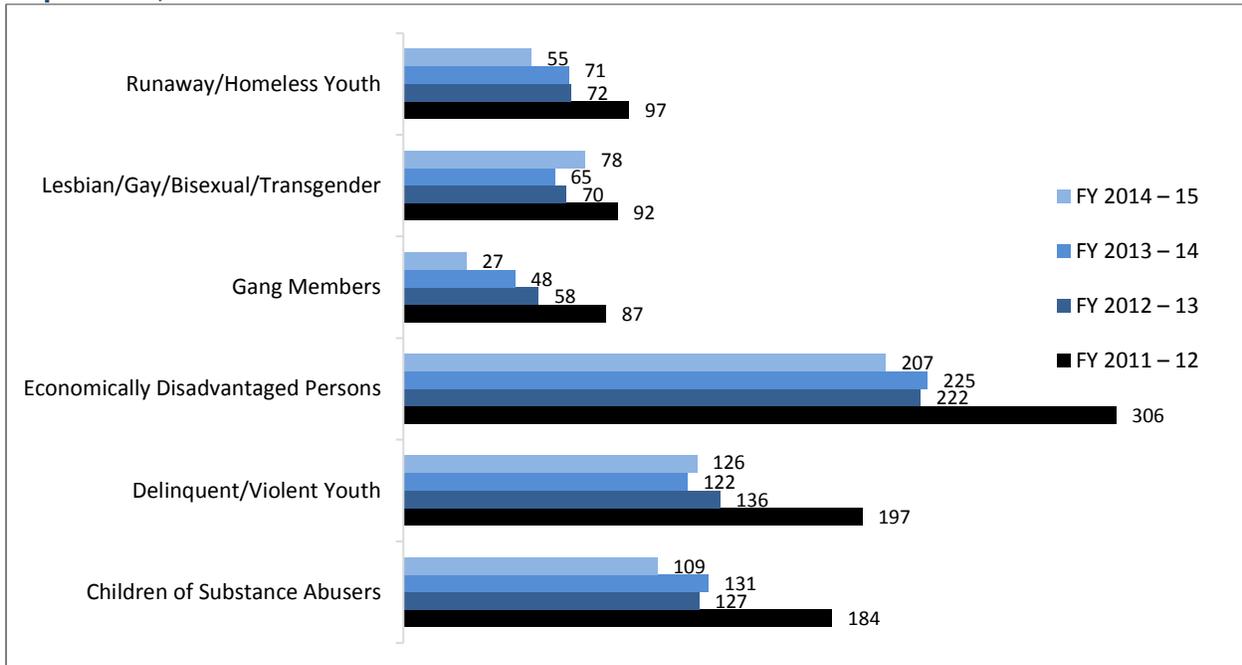


Note: "Other" refers to beneficiaries who did not specify a gender.

Source: CalOMS Pv data retrieved 10/10/16, SFY 2015-16 data is preliminary.

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 needs for specific underserved and vulnerable populations and contract with providers to address those specific populations. CalOMS Pv allows service providers to identify the underserved and 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 or vulnerable populations but rather the number of providers that deliver services to these populations. Figure 9 represents the most frequently identified service populations considered underserved or vulnerable.

**Figure 9: Number of Providers Delivering Primary Prevention Services by Service Population, SFY 2011-12 to SFY 2014-15**



**Source:** CalOMS PV data retrieved 10/10/16, SFY 2015-16 data is preliminary

Efforts to address social determinants of health will remain a priority. Ongoing technical assistance and training tools will be developed and implemented on topics related to social determinants such as social norms and attitudes, culture, and socioeconomic conditions.

## Statewide Initiatives

### Prescription Drugs

According to the Centers for Disease Control and Prevention, prescription medication misuse and overdose is a national epidemic. The long-term health consequences are severe and can lead to limitations in daily activity, impaired driving, mental health problems, SUD, overdose, and death. When it comes to unintentional injury deaths in the U.S., more people die from prescription medication overdoses than motor vehicle crashes. In 2014, more than 28,000 people died from opioid overdoses, with 14,000 of those deaths involving prescription opioids.

To combat this problem, California formed a Statewide Prescription Opioid Misuse and Overdose Workgroup led by CDPH. DHCS actively participates in the workgroup. The workgroup formed task forces to focus on areas such as health policy, public communication, data collection, and treatment. CDPH, DHCS, and the California Health Care Foundation have provided grants to communities of high need to build local capacity to address problems associated with prescription drug misuse. The work to implement services at the community level will be a priority for DHCS over the next few years.

### Marijuana

In November 2016, voters passed Proposition 64, the Adult Use of Marijuana Act. This law specifies funding for SUD services for both prevention and treatment for youth. This funding

provides an opportunity to fill the longstanding gaps and leverage funding for SUD services, especially early intervention and treatment services for youth that are largely underfunded. In the coming months, CDPH, DHCS, California Department of Education, and its respective stakeholders will need to work collectively to develop a comprehensive SUD gap analysis and create a long-term plan for meeting the identified needs.

### **Screening, Brief Intervention, and Referral to Treatment**

Effective January 1, 2014, California began offering the Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit to adult Medi-Cal beneficiaries. SBIRT is a comprehensive health promotion approach for delivering early intervention and treatment services to adults with, or at risk for, developing alcohol use disorders. SBIRT screening for alcohol misuse is used to identify individuals engaging in risky or hazardous drinking.

Medi-Cal managed care plans are required to cover and pay for an expanded alcohol screening for members ages 18+ who answer “yes” to the alcohol question in the DHCS Staying Healthy Assessment (considered a “pre-screen”), or at any time the primary care physician identifies a potential alcohol misuse problem. Also, managed care plans shall cover and pay for up to three brief interventions per year for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder. Any member screened positive should be referred to the SUD program in the county where the member resides for evaluation and treatment. Medi-Cal reimburses SBIRT services in connection with adult alcohol abuse only and not for drug-related services.

See <http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx> for more information.

## **SUD Treatment and Recovery Services**

SAMHSA administers and distributes SABG funds by formula to all U.S. states and territories. DHCS is California’s single state agency responsible for administering SABG funding, which serves as a cornerstone of California’s SUD prevention, treatment, and recovery services. DHCS is also the state agency responsible for administrative and fiscal oversight of DMC, administered as a fee-for-service Medi-Cal program, for SUD treatment services. DHCS now administers the expanded SUD services pilot program, the DMC-ODS waiver. SABG serves as a critical safety net program, acting as the “payment of last resort,” filling in gaps when DMC and other funding for SUD services are unavailable.

### **Purposes of SABG Funding**

State grantees use SABG funding for SUD programs providing prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, state funding, and private insurance. SAMHSA requires SABG recipients to use the award for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short time periods.
- Fund those priority treatment and support services that demonstrate success in improving outcomes or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention

activities and services for individuals not identified as needing treatment.

- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

DHCS is responsible for allocating and monitoring the use of SABG funds by all 58 counties that oversee delivery of SUD services. Counties use SABG funds to support and fill gaps in county-level services including primary prevention, SUD treatment, services to pregnant and parenting women, and services to adolescents and youth. All counties receiving SABG funding are required to contract with DHCS through a state-county contract that outlines agreements pursuant to federal rules, state laws and regulations, safety codes, and other SUD delivery requirements. Counties provide services directly to beneficiaries or enter into agreements with sub-contractors to deliver SUD services. Additionally, DHCS oversees the federal Anti-Drug Abuse Act of 1988 requirement that, for the fiscal year for which the grant is provided, no less than five percent of the providers receiving SABG funds be reviewed by peers independent from the funding source. This process, otherwise known as the Independent Peer Review (IPR), assesses the quality, appropriateness, and effectiveness of treatment and recovery services.

### **County Performance Unit**

The DHCS SUD County Performance Unit (CPU) measures and monitors county performance to improve the SUD continuum of care throughout California. CPU duties and responsibilities include monitoring compliance with the SABG and DMC state-county contracts by collecting qualitative information and reviewing county documents through an annual monitoring instrument. CPU conducts annual county site and desk reviews based on the results of the risk assessment.

After each annual county monitoring review and follow up, CPU issues a report documenting any deficiencies, recommendations, and required follow-up actions. If deficiencies exist, CPU requires the county to submit a corrective action plan for approval and implementation. The report serves as a record of compliance to the terms and conditions set forth in the state-county contracts. These county reports are posted on the DHCS website.<sup>21</sup>

### **California Outcomes Measurement System for Prevention and Treatment**

The California Outcomes Measurement System for Prevention (CalOMS Pv) and Treatment (CalOMS Tx) together comprise California's data collection and reporting system for SUD services. Each month, treatment providers submit beneficiary treatment data to DHCS through CalOMS Tx. This data builds a comprehensive picture of beneficiary behavior including alcohol and drug use, employment, education, legal and criminal justice involvement, medical and physical health, mental health, and social and family life. CMU analyzes CalOMS Tx service and activity data submitted by each county and their sub-contracted prevention providers to help counties and communities identify substance use trends, risks, and local needs. CMU also sets priorities, allocates resources, and demonstrates the effectiveness of services and their associated costs. CMU creates reports consisting of treatment outcome data to improve understanding of counties' provision of SUD services. CMU shares the reports with the counties.

<sup>21</sup> [http://www.dhcs.ca.gov/services/Pages/County\\_Monitoring\\_Reports.aspx](http://www.dhcs.ca.gov/services/Pages/County_Monitoring_Reports.aspx)

## **Women's Services**

California continues to work to improve the service delivery to the pregnant and parenting women (PPW) population. As part of this continuous improvement, DHCS annually updates the county monitoring tool used to ensure counties are meeting the requirements for SABG-funded treatment programs for PPW.

### **Monitoring Tool-Pregnant and Postpartum Women**

DHCS annually monitors counties to ensure they are meeting the requirements in the state-county contract that governs SABG-funded activities. The section of the monitoring instrument that addresses the PPW population addresses specific requirements in the Perinatal Services Network Guidelines. These requirements are based on the requirements set forth in section 45 CFR §96. Over the next two years, the following priority areas for PPW will be addressed in the monitoring instrument:

- Capacity management
- Referral
- Interim services

Through the monitoring of these areas, DHCS will identify where the gaps in service occur for the PPW population, and will work to close these gaps by providing technical assistance to the counties.

### **Community SUD Provider Directory-Pregnant and Postpartum Women**

In an effort to ensure counties and providers have additional tools to help them effectively and efficiently refer PPW to SUD treatment, DHCS will update the directory for publicly-funded SUD programs. Once updated, DHCS will prioritize sharing this information with counties and encourage counties to share this directory with providers and other SUD partners, such as Juvenile Justice, schools, etc.

## **Youth Services**

California is working to build a state-level infrastructure for a coordinated system of care for youth SUD services. This work will be done through stakeholder involvement of key state departments, county behavioral health representatives, foundations, and providers that work directly with youth across the continuum of care.

### **Youth Advisory Group**

The vision of California's Youth Advisory Group (YAG) is to build a coordinated, statewide system of care for youth SUD services. YAG serves as the advisory body for youth early intervention, treatment, and recovery services. In addition, YAG provides feedback and recommendations used to guide SABG and DMC policy decisions specific to youth services.

The state continues to collaborate with YAG to revise the draft Youth Services Policy Manual (YSPM). In the next two years, the state will incorporate YAG feedback and recommendations and finalize the draft YSPM, creating a statewide standard for youth SUD services.

### **Gaps and Priority Areas**

In an effort to understand where the gaps are for youth SUD services, California has completed

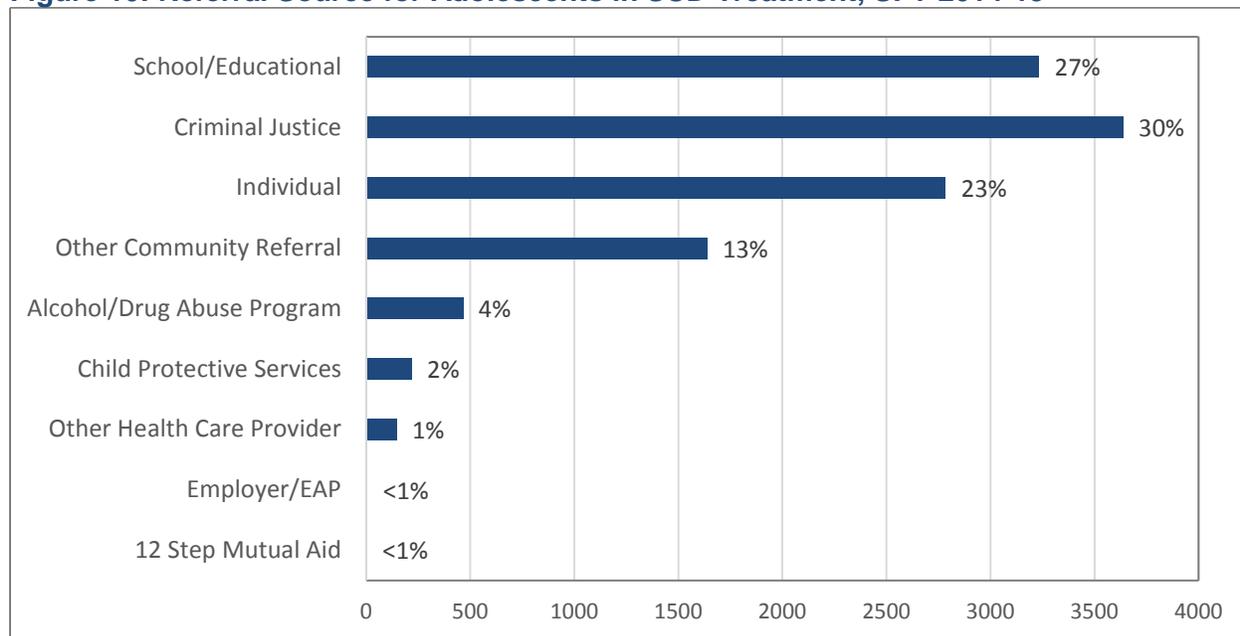
a Youth SUD Treatment Needs Assessment incorporating feedback from YAG, quantitative data from CalOMS Tx, and other datasets. The needs assessment has identified the main gaps that impact youth SUD services. Workgroups are being established on the following priority areas as YAG provides recommended strategies to fill these gaps:

- Standardized assessments
- Workforce development
- Access to care

The goal of the workgroups will be to prioritize and recommend their top three strategies. DHCS will compile these strategies into a larger statewide strategy to build the infrastructure for youth SUD services.

The workgroup involvement in building the infrastructure for youth is a key component to building an effective infrastructure for youth SUD services. Workgroup members are from counties and other state departments impacted by, or are referral sources for, youth SUD services. The number of adolescents admitted to SUD treatment has decreased from approximately 15,000 in SFY 2013-14 to approximately 12,000 in SFY 2014-15. As shown in Figure 10, although the number of adolescents admitted to treatment has decreased, the main referral sources stay the same. The majority of the adolescents admitted to SUD treatment in SFY 2014-15 were referred to treatment from the criminal justice system (30%), and from schools and education sources (27%). Figure 10 depicts the percent of adolescents referred to treatment by referral source as reported in CalOMS Tx.

**Figure 10: Referral Source for Adolescents in SUD Treatment, SFY 2014-15<sup>22</sup>**



Source: CalOMS Tx

<sup>22</sup> Percentages in some figures and tables throughout this report may not add to 100% due to rounding.

## Strengthening the Effect of Using SABG Funds in the Drug Medi-Cal Organized Delivery System Waiver

The most recent and dynamic innovation in California's publicly-funded SUD treatment program is the implementation of the DMC-ODS waiver and its effect on strengthening the use of SABG funds by bolstering the system with new quality standards, evidence-based practices, oversight, and the creation of a more robust continuum of care. DMC-ODS finances an expanded menu of SUD treatment services. This expansion allows counties and providers to draw down Medi-Cal Federal Financial Participation (FFP) reimbursement for services not previously covered under California's existing DMC treatment program, as detailed in California's State Plan. DMC-ODS is a five-year pilot program designed to make quality improvements to the existing DMC service delivery system and to expand the continuum of care.

Not all counties will opt-in to the DMC-ODS waiver at this time, but almost half will. Three counties have executed DMC-ODS contracts, while DHCS has also approved 12 county implementation plans as of July 2017, with four draft plans under review. For the counties that do not opt-in to DMC-ODS, the DMC State Plan system continues to apply.

DHCS will rigorously evaluate on a yearly basis, and report to the Centers for Medicare & Medicaid Services (CMS), critical elements measuring the effect of DMC-ODS and its impact on repurposing the use of SABG funds. The key elements of evaluation will include:

- Access to care
- Quality of care
- Integration and coordination of SUD care
- Cost analysis

DHCS has contracted with UCLA's Integrated Substance Abuse Program (ISAP) team to perform the evaluation of the DMC-ODS waiver. The research team has released the initial evaluation of the pilot describing the baseline against which to evaluate the future success of DMC-ODS.<sup>23</sup> The focus of the ISAP team will be to evaluate treatment access, quality, coordination and integration, and the facilitate discussions with stakeholders regarding the improvement of evaluation and data collection methods. Due to a phased rollout, baseline data is still being gathered and UCLA expects to gain access to additional data sources.

SABG previously paid for some services that will be now be funded by DMC-ODS. Therefore, DMC-ODS waiver opt-in counties can repurpose the use of SABG funds to fill in remaining service gaps.

However, it should be noted that certain requirements regarding SABG funds are still in effect. SABG funds are a payer of last resort for services authorized under §300x-22(b), and §300x-24. Section 300x-22(b) pertains to services to pregnant women and women with dependent children. Section 300x-24 pertains to HIV Early Intervention Services and Tuberculosis Services. For other services, SABG funds are intended to be used for prevention, treatment, recovery support, and other services to supplement Medi-Cal, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

<sup>23</sup> <http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf>

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

The following section “New DMC-ODS Benefits” describes specifically how this will occur.

### New DMC-ODS Benefits

The State Plan DMC program covers SUD outpatient, intensive outpatient, perinatal residential, and narcotic treatment program (NTP) services. In contrast, the DMC-ODS waiver expands this menu of services and tests a new paradigm of SUD care by creating an organized delivery system assisting Medi-Cal beneficiaries. DMC-ODS opt-in counties must provide a fuller, more robust continuum of SUD services modeled after the American Society of Addiction Medicine (ASAM) Criteria. DMC-ODS requires opt-in counties to create a network of providers offering coordinated services to the beneficiary for which DHCS holds the counties clinically and fiscally accountable to improve health outcomes. The organization of DMC-ODS expands local networks of high-quality providers using selective contracting. DMC-ODS opt-in counties will improve coordination between systems of care to more effectively integrate with physical and mental health services, and expand quality assurance and utilization controls.

Counties choosing to participate in DMC-ODS receive FFP reimbursement for an expanded array of SUD services for Medi-Cal enrollees compared to the existing DMC State Plan system. These are outlined below.

<b>DMC-ODS Benefits</b>	<b>DMC State Plan Benefits</b>
Outpatient Drug-Free Services	Outpatient Drug-Free Services
Intensive Outpatient Treatment Services	Intensive Outpatient Treatment Services
Residential Treatment (multiple levels of care for all enrollees with no bed number limitation)	Perinatal Residential Treatment (perinatal only with 16 bed limitation)
Withdrawal Management (ASAM continuum)	Inpatient Hospital Detoxification
Narcotic Treatment Program Services	Narcotic Treatment Program Services
Recovery Services	
Case Management	

Physician Consultation	
Additional Medication Assisted Treatment (optional)	
Partial Hospitalization (optional)	

**Highlights of DMC-ODS Expanded Services**

**Medication-Assisted Treatment, NTP Services, and Buprenorphine**

Medication-assisted treatment is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person SUD treatment recovery approach. MAT is required for DMC-ODS counties. MAT includes NTP services with expanded access to buprenorphine, naloxone, disulfiram, and methadone within an NTP setting with rates set by DHCS. Previously, beneficiaries seeking buprenorphine treatment found it difficult to access because the California State Plan limits NTP services to only providing methadone and Levacetylmethadol (also known as LAAM). With the DMC-ODS waiver, buprenorphine can now be administered in an NTP setting without a physician-to-patient limitation.

**Case Management and Recovery Services**

The DMC-ODS waiver reimburses Case Management and Recovery Services, encouraging opt-in counties to pull-down FFP to provide these supportive services to beneficiaries. Previously, counties providing SUD recovery services could only finance these services using SABG funds or other state and county funds. Medi-Cal did not reimburse case management or recovery services. Now, the DMC-ODS waiver continuum of care requires counties to provide case management and recovery support services to strengthen the beneficiaries’ support system and counties receive FFP reimbursement for providing them.

**Case Management**

Counties will coordinate case management services during treatment and these services can be provided at DMC provider sites, county locations, and regional centers or as outlined by the county in their implementation plan. However, the county will be responsible for determining which entity monitors their case management activities. A Licensed Practitioner of the Healing Arts or certified counselor may provide services.

Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community. Case management services include:

- i. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services.
- ii. Transition to a higher or lower level SUD of care.

- iii. Development and periodic revision of a client plan that includes service activities.
- iv. Communication, coordination, referral and related activities.
- v. Monitoring service delivery to ensure beneficiary access to service and the service delivery system.
- vi. Monitoring the beneficiary's progress.
- vii. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.
- viii. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

### Recovery Services

Recovery services are provided post-treatment and are important to the beneficiary's recovery and wellness. These services are part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and occur during the transfer/transition planning process linking beneficiaries to applicable recovery services. The treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health and health care. Treatment emphasizes the patient's central role in managing their health, use of effective self-management support strategies, and organization of the internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community. The components of recovery services are:

- i. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.
- ii. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
- iii. Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
- iv. Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
- v. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education.
- vi. Support Groups: Linkages to self-help and support, spiritual and faith based support.
- vii. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

An example highlighting the importance of recovery services is peer-to-peer services. These are services eligible for FFP reimbursement in the DMC-ODS waiver when provided as SUD assistance services or as a component of recovery services. The term "peer" refers to all individuals who share the experience of SUD and recovery, either directly, as family members, or as significant others. In a peer-helping-peer service alliance, a peer leader in stable recovery

provides social support services to a beneficiary who is seeking help in establishing or maintaining recovery. Both parties are helped by the interaction and their recovery is strengthened. For counties that offer peer support services through DMC-ODS, the county must first submit a SUD Peer Support Training Plan to DHCS for approval prior to providing billable peer support services. Counties are also responsible for ensuring that only peer providers eligible for participation in the Medi-Cal program deliver covered services.

## **SABG-Funded Room and Board for Transitional Housing, Recovery Residences, and Residential Treatment Services**

SAMHSA encourages states to use SABG funding for the provision of short-term (up to 24 months) support services and linkages to housing, including the payment of room and board, for beneficiaries in transitional housing, recovery residences, and DMC-ODS residential treatment. SAMHSA specifically gives permission to California allowing use of SABG funds for payment of the room and board component for beneficiaries to provide them with a safe and clean environment to support recovery efforts. SAMHSA allows counties to use a portion of their SABG discretionary funds to cover the cost of room and board for beneficiary SUD housing-related services. This authorization allows counties to use SABG funds for expanded recovery opportunities. Counties can repurpose their use of SABG to cover this needed housing service. An explanation of room and board use follows:

1. **Transitional Housing:** Counties contracting with the state to provide DMC State Plan or SABG-funded SUD services may use SABG funding to pay beneficiary room and board in transitional housing as an essential support service. SUD services cannot be provided in transitional housing, but all residents must be actively engaged in SUD treatment services provided off-site. The residence does not require licensure by DHCS, but each county should develop guidelines for contracted transitional housing providers, and conduct monitoring and oversight.
2. **Recovery Residences:** DMC-ODS counties may use SABG funding to pay beneficiary room and board in recovery residences, as an ancillary component of DMC-ODS SUD treatment, with adherence to the following guidance. SUD services cannot be provided in recovery residences, but all residents must be actively engaged in medically necessary recovery support services off-site. Recovery residences are not licensed by DHCS but each county should develop guidelines for contracted recovery residence providers, and provide monitoring and oversight.
3. **DMC-ODS Residential Treatment:** DMC-ODS counties are required to provide at least one ASAM level of residential treatment. The county implementation plan must also demonstrate provision of ASAM levels of Residential Treatment levels 3.1, 3.3, and 3.5 within three years of CMS approval of the county implementation plan, and the intergovernmental agreement with counties. The county must also describe future coordination for ASAM levels 3.7 and 4.0. In DMC-ODS, paying room and board for a beneficiary in residential treatment is for a non-institutional, 24-hour, non-medical, and short-term residential program providing rehabilitation services to individuals with a SUD diagnosis. A Medical Director or Licensed Practitioner of the Healing Arts must determine the residential treatment to be medically necessary and in accordance with the beneficiary's individualized treatment plan.

## **Mental Health Parity and Addiction Equity Act**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on Mental Health or SUD (MH/SUD) benefits are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

During SFY 2016-17, DHCS conducted a mandatory assessment of Medi-Cal benefits across all managed care delivery systems to ensure the state's compliance with the Federal Parity rule. In an effort to assess existing practices in key areas, DHCS is surveying the managed care organizations, mental health plans, DMC-ODS county plans, and counties providing DMC State Plan services. DHCS will incorporate the analysis into an overall DHCS parity compliance plan, including a comparative analysis of MH/SUD and medical/surgical benefits, an annual monitoring plan, contract changes and amendments, and other communications with counties and plans. The compliance plan and associated materials will be submitted to CMS by the deadline of October 2, 2017.

## **45 CFR § 96.133(a)(3): Technical Assistance Needs, Including Collection of Incidence and Prevalence Data**

In accordance with 45 CFR § 96.133 (a)(3), the following is DHCS' description of the state's need for technical assistance to carry out SABG-funded activities, including activities relating to the collection of incidence and prevalence data identified in §96.133(a)(1). The priorities in both §96.133(a)(3) and (a)(4) (identification of improvement goals and objectives) are interrelated.

The state does not collect SUD population incidence and prevalence data, instead relying on SAMHSA's state-level NSDUH reports. If the state pursued its own collection of SUD disease epidemiology data, efforts would require extensive technical assistance and resources. However, state-led collection would not be the most efficient method of acquiring accurate data. Instead, it would be more accurate to add state-focused questions to an existing survey done by an outside entity.

Rather than expand data collection efforts on measuring incidence and prevalence, DHCS intends to prioritize creating better estimates of treatment need, which is both a downstream result of incidence and prevalence of SUD, and the most relevant estimate for treatment planning. Such estimates should include information focusing on individuals with mild, moderate, or more severe (e.g., DSM 5) co-occurring mental health conditions. The state could benefit from federal technical assistance on the use of synthetic estimation methods for this purpose.<sup>24</sup> Similarly, the state could benefit from federal technical assistance on developing improved methods to estimate treatment capacity. Technical assistance could take the form of training or providing access to information on successful models from other state or federal efforts. The state also needs training for computer programmers at the state level to upgrade data systems.

The counties have requested training for county and provider entities on correctly entering data for the purposes of CalOMS treatment tracking. In response, the state has provided more of these trainings, and implemented additional regional training opportunities.

## **UCLA Evaluation of DMC-ODS and SABG-Technical Assistance Request**

Researchers from UCLA ISAP have released their initial baseline DMC-ODS study, "FY 2015-2016 Report, Evaluation for California's Section 1115 Demonstration Waiver." In the report, researchers measured data prior to DMC-ODS implementation to describe the "starting point," measuring SUD baseline services for future comparisons against DMC-ODS and SABG-funded services. UCLA ISAP will circulate evaluation data to gather stakeholder feedback on future study methods and measures, and will continue yearly data collection efforts, analysis, and evaluation as the DMC-ODS waiver becomes operational. DHCS asks that SAMHSA review the use of SABG funds, taking into account the changes made by the DMC-ODS in strengthening the continuum of care.

The UCLA evaluation addresses three key areas of focus: (1) access to care, (2) quality of care,

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<sup>24</sup> Synthetic estimation involves matching people who have the same demographic characteristics and using information on the matched individual (e.g., need for treatment) to generate estimates at the local level while ignoring the original geographic location of the matched individual. This would potentially enable DHCS to estimate need and penetration rates at the county level, for example, even if sufficient data at that level does not exist to produce such estimates directly.

and (3) the integration and coordination of SUD care. Cost will be addressed in future reports after additional DMC and Medi-Cal data becomes available for cost analysis. UCLA defines the data sources examined in each key area, presents the results of baseline measurements, summarizes preliminary findings, and describes plans to improve future evaluations.

UCLA's current and future DMC-ODS evaluations and provider surveys will include questions on how counties and administrators repurpose use of SABG funds to take advantage of the ability for DMC-ODS to provide services previously only covered by other funding sources. Included in the 2015 UCLA survey of County Administrators are questions about which priorities, if any, each county is currently targeting with public SUD funds, (i.e., DMC, SABG). The surveys include questions on county administrator plans to shift the use of SABG funds, after implementation of the DMC-ODS waiver, to target previously unmet needs and other priorities, including prevention of substance abuse and mental illness, health care and health systems integration, trauma and justice, recovery support, health information technology, housing, and workforce development.

Annual DMC-ODS evaluations by UCLA will help DHCS gather valuable incidence and prevalence data to help better target SABG activities and services. DHCS asks SAMHSA for continued federal assistance to design repurposed uses of SABG funding to fill in current gaps in services for beneficiaries.

## 45 CFR §96.133(A)(4): Goals And Objectives & Activities Taken In Furtherance

This section requires the state to establish goals and objectives for improving SUD treatment and prevention activities, and to report on activities taken in support of these goals and objectives.

### Strategic Initiatives

In this section, DHCS aligned strategic initiatives for SUD services with the federal initiatives announced in SAMHSA's *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018* and the state's strategic plan, *DHCS 2017 Strategy for Quality Improvement in Health Care*. DHCS harmonizes federal and state strategic priorities to leverage opportunities for service improvement preventing or minimizing the harmful consequences of SUD.

SAMHSA's 2015-2018 strategic plan initiatives guiding state use of SABG funds includes the following federal priorities that DHCS is focusing on for FFY 2018-2019:

- Strategic Initiative #1: Prevention of Substance Use
- Strategic Initiative #2: Recovery Support
- Strategic Initiative #3: Workforce Development

#### Strategic Initiative #1: Prevention of Substance Use

Strategic Initiative #1 focuses on preventing substance use by maximizing opportunities to create environments where youth, adults, families, and communities are motivated and empowered to manage their overall emotional, behavioral, and physical health. Special focus is placed on several high-risk diverse populations, including college students and transition-age youth, American Indian/Alaska Natives, ethnic minorities experiencing health and behavioral health disparities, service members, veterans and their families, and lesbian, gay, bisexual, transgender, and questioning LGBTQ individuals.

#### *Disparities*

Significant behavioral health disparities persist in diverse communities across the nation. Various subpopulations face elevated levels of mental illness and SUD, and experience higher rates of suicide, poverty, domestic violence, childhood and historical trauma, and involvement in the foster care and criminal justice systems. Historically, these diverse populations tend to have less access to care, or experience disrupted service use, and poorer behavioral health outcomes. Through Strategic Initiative #1, DHCS commits to addressing these disparities by improving cultural competence and access to prevention programs that serve all of these diverse groups and communities.

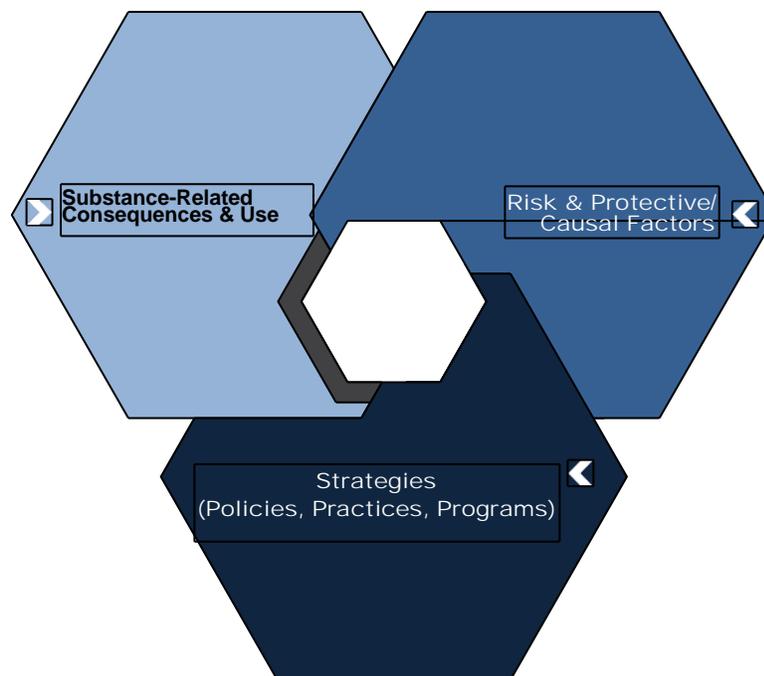
#### *Prevention Priorities*

The needs assessment performed in Part 1 of the SNAP report leads to the conclusion that DHCS must continue to prioritize three prevention goals:

1. Improved data collection and review;
2. Planning for continuous quality improvement; and,
3. Building statewide capacity (organizational and field)

Initiative #1 prevention priorities are developed that closely follow SAMHSA’s SPF, a five-step planning process guiding the selection, implementation, and evaluation of evidence-based, culturally-appropriate, and sustainable prevention activities.<sup>1</sup> The effectiveness of the SPF is enhanced by a clear understanding of community needs and depends on the involvement of community members in all stages of the planning and implementation process. DHCS uses a data-informed, outcomes-based approach throughout the SPF planning process, beginning with assessment of the negative consequences or outcomes that result from SUD. This approach allows DHCS to identify priority problems and recommend strategies that address these priorities. Based on the SUD and behavioral outcomes identified, risk and protective factors related to these outcomes are established and strategies are created and aligned to impact these factors (see Figure 11).

**Figure 11: Outcome-Based Strategic Prevention Framework**



**Source:** SAMHSA

Although only a limited summary of data sources and data findings are presented in this SNAP report, DHCS based its ongoing assessments on a variety of data. The State Epidemiological Workgroup with guidance from DHCS assist with efforts to assess trends and current conditions. Though the availability of thorough data on risk and protective factors has proven difficult to attain, DHCS approaches this issue from a behavioral health perspective by identifying common or shared risk and protective factors across the life span and full socio-ecological spectrum from individual, family, community, and societal domains.

**Strategic Initiative #2: Recovery Support**

SAMHSA promotes the priority that states use SABG funding for linkages of beneficiaries to recovery support services offered by the health care system, community and faith-based

organizations, and services financed by other sources. According to SAMHSA, state efforts to prioritize recovery support services promotes a public health care policy recognizing that beneficiaries need additional assistance beyond SUD treatment. SAMHSA makes it clear that federal policy does not relegate recovery support services to a subordinate role within a treatment system predominantly focused on clinical services. Recovery services, formally categorized as “adjunct” and “ancillary” to clinical treatment and previously under-funded, must be promoted for their ability to support a person’s unique recovery journey over a lifetime. Recovery support services have secured a permanent place in the continuum of care for low-income individuals with SUD.

The ASAM Criteria, adopted by DHCS for uniform placement decisions, incorporates recovery services into the beneficiary’s recovery and wellness plan. ASAM includes an assessment of recovery support treatment needs, categorized as Dimension 6, Recovery Environment, which is primarily operational during the post-treatment, transfer/transition planning process. In Dimension 6, an assessment is conducted to plan beneficiary linkages to appropriate long-term recovery services.

Both SAMHSA and the ASAM Criteria placement continuum recognize that the treatment community is a therapeutic agent through which patients are empowered to manage their own health and recovery beyond treatment. DHCS recognizes that state SUD treatment priorities must emphasize the patient’s central role in managing their own health by using effective self-management support strategies.

In accordance with the policy of emphasizing recovery support services, the DMC-ODS waiver also incorporates the requirement that counties provide recovery services in their continuum of care as a Medi-Cal fee-for-service benefit. Adding recovery support services as a DMC-ODS benefit will have a downstream positive effect on SABG use by financing services that were previously paid for only by SABG funding. Therefore, DMC-ODS will free up SABG funding for other uses, such as providing wrap-around care in opt-in counties and beneficiary room and board for all counties.

The goal of DMC-ODS is to demonstrate how an organized SUD system of care improves beneficiary health outcomes, while decreasing system-wide health care costs. The DMC-ODS structure reinforces use of recovery services, giving them an important role in providing beneficiaries with access to a full continuum care and benefits modeled after the ASAM Criteria. DHCS expects this approach to provide eligible enrollees with access to the care and services they need for a sustainable and lifelong successful recovery.

In DMC-ODS counties, beneficiaries may access recovery services after completing their course of treatment, whether they are triggered to relapse, have relapsed, or as a preventative measure to avoid relapse. Recovery services may be provided to the beneficiary face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community.

The components of Recovery Services are:

1. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if further care is needed.
2. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
3. Substance Abuse Assistance: Peer-to-peer services in and out of the clinic, and relapse

prevention.

4. Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
5. Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education.
6. Support Groups: Linkages to self-help and support, spiritual, and faith-based support.
7. Ancillary Services: Linkages to housing assistance, transportation, case management, and individual services coordination.

In conclusion, the above menu of services now provided by DMC-ODS counties will enable counties to finance services that were only previously paid for by SABG funding. SABG funding will now be available for innovative uses by counties, such as payment of room and board in short-term transitional residences, and other services.

### **Strategic Initiative #3: Workforce Development**

An adequate supply of well-trained SUD workforce employees is the foundation of an effective service delivery system. California is facing SUD workforce development challenges while integrating several changes in the federal health care system into our SUD system of care. The federal changes to the SUD health care system include parity regulations, health reform legislation, the Affordable Care Act enrollment growth, and increased competition for providers between private insurance, Medi-Cal, and SABG. Other ongoing challenges include replacing an aging workforce, geographic and cultural differences between provider and member distribution, and a long workforce educational “pipeline” for training SUD professionals. To achieve better outcomes, California must make its SUD provider workforce further integrated and effectively trained to coordinate across the physical and mental health landscape. Following SAMHSA’s lead, California seeks to enhance and support its SUD workforce to attract and employ skilled and culturally competent employees.

SAMHSA promotes workforce development through Strategic Initiative #6 from *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018*. Initiative #6 supports SABG funding of strategies to strengthen and expand the SUD workforce and improve service provider’s SUD treatment knowledge and skills. SAMHSA recognizes that expanding the workforce enhances the availability of prevention and treatment services for SUD, strengthens the capabilities of behavioral health professionals, and promotes a health system infrastructure that delivers competent and organized services. SAMHSA commits to support each state’s use of SABG funding to monitor and assess a workforce able to meet the needs of youth, provide services targeted to specific communities, deliver culturally competent services, and meet SUD health care needs.

### **Peer Support Services**

SAMHSA also recognizes the value of boosting a peer support provider workforce to assist with beneficiary engagement and recovery. SAMHSA prioritizes increasing the peer and paraprofessional workforce, and increasing the evidence-based research for best uses of their services. The federal government understands that the effort to expand peer services will require states to invest in expanding the reach of professional treatment and support professionals.

The DMC-ODS waiver's inclusion of recovery services will leverage use of peer services for beneficiaries. Expanded use of peer support services in DMC-ODS leverages workforce expansion.

A substantial number of studies demonstrate that peer support specialists improve patient functioning, increase patient satisfaction, reduce family burden, alleviate depression, minimize hospitalizations and hospital days, increase patient activation, and enhance patient self-advocacy. There is a direct secondary benefit to the individual peer support specialist as well; enhancing their recovery when sharing lived experience in recovery to beneficiaries. Peer support specialists are used in a majority of states and throughout the Veterans Health Administration. Expanded use of peer providers in the DMC-ODS and SABG-funded SUD service system integrates peers into a care team to improve patient care coordination between behavioral and physical health care systems. Peers help patients navigate coordinated patient care management, leading to a reduction of high-cost care and better management of chronic conditions, hospitalizations, and ED visits.

SUD peer support specialist services are Medi-Cal reimbursable under DMC-ODS when provided as SUD assistance services as a component of recovery services. Under DMC-ODS, "peer" refers to all individuals who share the experiences of SUD and recovery with the beneficiary, either directly, or as family members or significant others. In a peer-helping-peer service alliance, a peer leader in stable recovery provides social support services to a beneficiary seeking help in establishing or maintaining their recovery. Both parties are helped by the interaction and the recovery of each is strengthened. For counties that offer peer support services through DMC-ODS, the county must submit a SUD Peer Support Training Plan to DHCS and receive approval prior to providing billable peer support services. Counties are also responsible for ensuring that eligible peers participating in the Medi-Cal program responsibly provide covered services.

#### Additional DMC-ODS and SABG Workforce Expansion Efforts

DMC-ODS also promises to expand the SUD workforce by including LPHAs as providers able to assess beneficiaries and perform other functions within their scope of licensing. This DMC-ODS workforce expansion will have a downstream effect on the SABG-funded SUD workforce as it leverages and increases the number of trained SUD treatment professionals throughout the state. The initial DMC-ODS beneficiary eligibility determination can now be performed through an expanded variety of professionals at expanded entrance points. Settings for eligibility determination includes review via telehealth with a Medical Director, licensed physician, or LPHA. The list of professionals able to provide SUD services under DMC-ODS or supervise unlicensed counselors includes the following: physician, nurse practitioners, physician assistants, registered nurses, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, and licensed-eligible practitioners working under the supervision of licensed clinicians.

After establishing a diagnosis, professionals apply the ASAM Criteria to determine placement into a level of care. DHCS has leveraged ASAM trainings to expand the workforce by overseeing and providing criteria training that enhances the skills of the entire SUD workforce. Using face-to-face trainings, webinars, and technical assistance, DHCS has ensured the consistent use of the placement-oriented ASAM criteria that will become the standard used throughout the SUD treatment system.

#### SUD Primary Prevention Workforce

California has trouble in retaining staff with SUD primary prevention experience. Individuals choose to leave the prevention field because of low wages, a lack of standardized prevention services in various health care and community settings, a general lack of career opportunities, and a lack of relevant training opportunities.

During the past year, DHCS launched an initial collaborative effort to create a standard and consistent prevention body of knowledge. The intention was to add credibility to the prevention field and to increase the validity of the SUD primary prevention work performed statewide. The statewide credentialing organization, California Consortium of Addiction Programs and Professionals, offered individuals a one-time open enrollment period to apply for a California Certified Prevention Specialist (CCPS) certification, consistent with the International Credentialing and Reciprocity Consortium standards. Since August 2016, the statewide number of CCPS-certified individuals increased from eight to seventy-one.

Based on the high level of interest to pursue this credentialing opportunity, DHCS will continue efforts to establish statewide standards for consistent delivery of prevention services and to promote the development of a statewide infrastructure. State, county, and provider prevention staff recognize the need to find creative ways to encourage individuals to enter the prevention field and to create justification to remain in the field.

To meet the ongoing challenge to expand the role of CCPS-certified individuals, a potential next step is to assess the prevention field's readiness to acknowledge and accept prevention roles that converge on health care and community-setting boundaries. Employing CCPS-certified individuals within their communities builds community trust that can lead to reducing health disparities at the local level.

Linked to improving workforce skills in the community is the need to explore the feasibility of creating a career ladder and the viability of offering primary prevention training in non-traditional locations, such as community college settings or as a collaborative effort between education and local business partners.

DHCS plans to expand the number of training opportunities that align with each of the required domains of the International Certification and Reciprocity for Prevention. DHCS plans to expand trainings offered through the Community Prevention Initiative on social determinants of health, prevention ethics and cultural competency.

## **2015-16 Independent Peer Review Project**

The federal Anti-Drug Abuse Act of 1988 requires that for the fiscal year for which the grant is provided, no less than five percent of the providers receiving SABG funds from the state are reviewed by peers who are independent from the funding source. This process, known as the Independent Peer Review (IPR), assesses quality, appropriateness, and efficacy of recovery and treatment services. The programs reviewed are to be representative of the total population of such entities. The IPR process focuses solely on the treatment programs and SUD service system, rather than on individual practitioners. The purpose of the IPR is to inform the state in a manner that contributes to the continuous improvement of SUD services.

The IPR must adhere to specific statutory and regulatory guidelines. Title 42 CFR, Section 96.136, defines "Quality" as the provision of treatment services, which within the constraints of technology, resources, and beneficiary circumstances, meets accepted standards and practices to improve

beneficiary health and safety, in the context of recovery. “Appropriateness,” for purposes of this section means the provision of treatment services consistent with the beneficiary’s identified clinical needs and level of functioning. “Efficacy” in this context is the ability of treatment to produce a desired or intended result for the beneficiary.

DHCS selects independent peer reviewers for their expertise in the field of alcohol and drug use treatment. They must be representative of the various disciplines used by the program under review, be knowledgeable about the modality under review, and understand the program’s theoretical approach to SUD treatment. Reviewers must also be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

### **Report Summary**

To comply with these requirements, DHCS entered into a three-year contract with the California Consortium of Addiction Programs and Professionals (CCAPP) to administer the peer review process and produce the SFY 2015-16, Project Year 18, IPR Report.

DHCS randomly selected 40 programs to review in northern counties, including Alameda, Butte, Contra Costa, El Dorado, Humboldt, Marin, Napa, Sacramento, San Francisco, San Mateo, Santa Clara, Santa Rosa, Siskiyou, Sonoma, Sutter, Yolo, and Yuba Counties. CCAPP completed 39 reviews, which is within the five percent range. Programs reviewed included licensed or certified SUD treatment programs, NTPs, county outpatient, detoxification, and perinatal residential services.

CCAPP sent recruitment letters to programs in the counties being reviewed announcing the Peer Review Project and enclosing an application for consultants. Each application received in response to that mailing was reviewed for the appropriate experience and qualifications specified by DHCS. Sixteen reviewers made the final selection process. CCAPP conducted a training and orientation session at the CCAPP office in Sacramento, CA, prior to beginning the reviews. During this orientation session, the peer review instruments were thoroughly explained as well as the process of the on-site peer reviews.

### **Summary of IPR Findings, Conclusions, and Recommendations**

#### **Design and Approach**

- Reviewers found that 100% of the programs reviewed had a clearly defined target population and provide services appropriate to the needs of that population.
- 90% were observed to impact parents, spouses, siblings and significant others as appropriate.
- 90% of the programs seem to be initiating some innovative approaches and utilizing various resources and networks to accomplish this goal.

#### **Staff**

- 100% of the programs reported that staff turnover is not a factor for their facility.
- 90% of facilities were staffed by individuals with the appropriate credentials, training, and ratio for clients served.

#### **Client Records/Assessments**

- Reviewers found that an assessment was conducted prior to and/or on the day of admission in 100% of the facilities reviewed.
- 100% of programs found the assessment provided sufficient information on which to base a recovery and treatment plan.

#### **Client Records/Recovery and Treatment Planning**

- In 90% of programs reviewed the files were complete and the recovery/treatment plans were appropriate. Goals and objectives were clearly stated and progress towards said goal was charted.

#### **Client Records/Program Notes**

- 90% of program notes show that goals and objectives identified in the recovery/treatment plan are being addressed.
- 90% of the programs are reported to document group notes in such a way that notations for an individual are recorded if necessary.

#### **Client Records (Discharge and Aftercare Planning)**

- 90% of the discharge plans appear to be individualized and to address identified client needs at discharge.
- Accordingly, 90% of the programs suggest that planning begins before discharge and there is evidence of post-discharge follow up in 80% of the programs.
- 100% of programs reviewed provide relapse prevention counseling.

#### **Case Management/Ancillary Services**

- The programs appear to devote adequate resources to reviewing the clients' progress in 99% of the reviews, while records indicate appropriate referrals for client and family in 90%, and family services appear to be a vital part in 90% of the programs.

#### **Quality Assurance Improvement**

- 90% of programs reported formal quality assurance/improvement plans or procedures.
- 90% of the programs have an adequate system for tracking the progress of clients through various program levels. 100% of the programs monitor themselves to determine a need for program changes.

#### **Physical Environment**

- 100% of the programs are reported to have an ambience that is conducive to a positive and supportive recovery/treatment environment.
- 100% of the reviewers found the environment safe and secure for staff and clients.

#### **Recovery/Treatment Environment**

- Reviewers reported that 100% of the programs reviewed appear to be actively and effectively engaging clients in recovery/treatment.
- Clients appear to progress in the program environment in 100% of the programs.

- This year 100% of programs have a policy in place to determine client satisfaction.

### **Network, Continuum, Diversity of Funding**

- 90% of the programs were reported to have linkages and good relationships within the community and with other social service programs.
- 90% have a variety of funding sources.

### **Feedback from IPR Reviewers**

The review teams solicited feedback from the programs on the IPR project process. The observations conveyed that reviewers were respectful, courteous, and professional throughout. Reviewers were valued for their skills, knowledge, and insight. In short, programs reported that the IPR process itself was useful and helpful for program development. Technical assistance recommendations made to beneficiary programs included training on:

- Trainings for Drug Medi-Cal compliance
- Grant writing assistance
- Family and group training
- Trauma-informed care
- Training on DSM to International Classification of Diseases, 10th Edition (ICD-10)
- On-site training for staff to obtain CEUs
- File management and documentation
- Education for parenting and family wellness
- Facilitator trainings of evidence-based practicum
- Evidence-based curriculum and group therapy

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<sup>1</sup> <http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework>

## **45 CFR § 96.133(A)(5): The Extent To Which The Availability Of Prevention And Treatment Activities Is Insufficient To Meet The Need for Services, and Availability of Interim Services**

In accordance with 45 CFR §96.133(a)(5), this needs assessment includes a description of the extent to which the availability of prevention and treatment activities is insufficient to meet beneficiary need and the availability of interim services provided to triage beneficiaries into treatment. As to prevention activities, this report also includes a description of the populations at risk of becoming substance users that need intervention.

Regarding 45 CFR §96.133(a)(5), DHCS uses the NSDUH estimates data on individuals needing but not receiving SUD treatment to monitor treatment capacity. Approximately three million Californians are estimated to be in need but not receiving SUD treatment. The Affordable Care Act and the emphasis on reducing health care disparities between populations for SUD and other mental health disorder services provides opportunities to increase service capacity to attain parity in providing substance use services.

NSDUH estimates for individuals needing but not receiving treatment for California (using CY 2013 and 2014 combined data) are:

- An estimated 2.5% of Californians ages 12+ were in need of SUD treatment for illicit drug use in the past year, compared with 2.6% in CY 2012-13
- An estimated 6.4% of Californians ages 12+ were in need of SUD treatment for alcohol use in the past year, compared with 6.8% in CY 2012-13.

Pregnant women and individuals in need of treatment for intravenous drug use receive priority for admission to SUD treatment services. The availability of residential perinatal treatment providers has been decreasing in California. Given the number of women with SUD, the availability of residential treatment services are severely lacking.

Tracking assessed level of care and actual placement is not possible for DHCS to accomplish at this time. Measuring treatment service capacity is a complex task requiring extensive, timely, complete, and accurate data collection. Obviously, capacity fluctuates in relation to available funding. Definitions of capacity also vary in relation to residential versus outpatient service types, and the number of services for individual versus group counseling available at treatment providers. Often treatment recipients may receive a lower level of care (e.g., outpatient instead of residential), or an interim service, when the appropriate level of care is not available. Moreover, while shorter lengths of stay can increase the numbers of individuals seen during the year (thereby increasing system capacity), research indicates that longer lengths of stay are related to more positive treatment outcomes.

Types of funding affect criminal justice capacity. For many years, California provided large amounts of SUD treatment service funding for lower-level criminal justice offenders as diversion from incarceration. During this time, many criminal justice offenders had access to robust SUD treatment. When that funding source was eliminated, there was a corresponding reduction in the numbers of criminal justice referred beneficiaries seeking and being admitted to treatment, even though the need for treatment had not decreased.

## Interim Services

The Public Health Services Act (42 USC 300x-21 through 300x-66) authorizes SABG funding and requires provision of interim services to Intravenous Drug Users (IVDU) and pregnant women or injection drug-using women seeking SUD treatment who cannot be immediately admitted to a program due to capacity limitations. These federal-mandated interim services are provided through a county-based system and are operationalized through state-county contracts between DHCS and the 58 counties. Interim SUD services are provided until an individual is admitted into a SUD treatment program. The purposes of these services are to reduce the adverse health effects on the individual, and reduce the risk of transmissions of disease. At a minimum, interim services include counseling and education about health risks and, for pregnant women, include referral for prenatal care, sources for housing, food, legal aid, case management, children's services, Temporary Assistance for Needy Families, and Medi-Cal services.

## 45 CFR § 96.133(A)(6): State Information Management System

Part §96.133(a)(6) requires DHCS to provide documentation describing how DHCS uses the state management information system for tracking treatment capacity. The key capacity factors that were tracked included treatment admissions and discharges. Prevention activities play a central role in this tracking effort by documenting which populations are at risk for SUD. DHCS uses the Drug and Alcohol Treatment Access Report (DATAR) and CalOMS Tx systems to collect the data used in measuring SUD treatment capacity.

### Drug and Alcohol Treatment Access Report

DATAR is intended to provide essential information about the capacity of California's publicly-funded SUD treatment system to meet the demand for services. Treatment providers that receive state or federal funding through the state or county, as well as all licensed NTP providers, are required to send DATAR information to DHCS each month. The system is intended to retain information on each program's capacity to provide different types of SUD treatment to beneficiaries and assess how much capacity was utilized in a given month. DHCS is working with providers to improve the timeliness, reliability, and accuracy of the DATAR system to better meet beneficiary service needs.

### CalOMS Tx

DHCS maintains the CalOMS Tx data system as the statewide database that provides data regarding all beneficiaries receiving SUD treatment services from publicly-monitored treatment programs, including DMC, SABG, and all NTP programs, regardless of funding source and the outcomes achieved at the time of discharge from treatment. CalOMS Tx is used to report many facets of treatment including: treatment utilization, beneficiary admission and discharge information, length of stay, beneficiary outcome measures, and program performance measures.

### Treatment Capacity

DHCS develops annual "served" counts using our CalOMS Tx database. This data allows DHCS to use the state management information system to track treatment capacity and service utilization.

#### Unique Beneficiaries Served

Unique beneficiaries served means all beneficiaries admitted during the year and beneficiaries admitted prior to the current year that continue to receive treatment services during the year. Using CalOMS Tx data submitted to DHCS, there was a slight decrease in the last several years in the counts of beneficiaries served.

- During SFY 2014-15, approximately 195,000 unique beneficiaries were served (an approximate 3.9% decrease from 203,000 beneficiaries served in SFY 2012-13).

#### Total Served

The term "total served" means all admissions to all service types (e.g., Detoxification, Residential, and Outpatient) during the year plus all admissions prior to the current year that continued to receive treatment services during the year. Each admission is counted for beneficiaries who have

multiple admissions during the year. DHCS uses these “served” counts to estimate the number of admissions in which the beneficiary is still participating in treatment to estimate current “active” treatment participation.

- During SFY 2014-15, the total served count was approximately 249,000 (an approximate 2.0%, a decrease from approximately 250,000 in SFY 2013-14, and 254,000 in SFY 2012-13).

For SFY 2014-15 the following are the percentages served in each major service type:

- ODF: 39.2%
- NTP Maintenance: 29.8%
- Residential: 15.8%
- Residential Detoxification: 9.4%
- Intensive Outpatient Treatment (IOT): 3.1%
- NTP Detoxification: 2.6%

Examination of the various service types shows the following trends from SFY 2012-13 through SFY 2014-15:

- There were decreases in ODF, IOT, and NTP Detoxification.
- There was an increase in NTP Maintenance.
- Non-NTP Detoxification and Residential Services showed relatively stable trends.

### One-Day Counts

DHCS calculates one-day counts using CalOMS Tx data as a method to estimate SUD service capacity. For instance, over 92,000 beneficiaries were in treatment on April 1, 2015. A sample of one-day counts throughout the year or over multiple years would show that one-day counts vary. Still, one-day counts provide an estimate of capacity on a given day. The one-day count uses a similar methodology as the “served” count to estimate the number of beneficiaries enrolled in treatment on a given day, regardless if the admission was opened during the current or prior fiscal year.

The distribution of the one-day capacity count among the service types was as follows:

- NTP Maintenance: 56.5%
- ODF: 32.1%
- Residential: 8.1%
- IOT: 2.1%
- Residential Detoxification: 0.7%
- NTP Detoxification: 0.6%

## Treatment Beneficiary Admission and Discharge Information

DHCS analyzes CalOMS Tx data on beneficiaries receiving SUD treatment services in publicly-funded treatment programs and all private, for-profit NTP programs, regardless of funding source. The following summarizes information from the analysis of SFY 2014-15 data.

- There were about 166,000 admissions to treatment during SFY 2014-15. This includes admissions to publicly-monitored SUD detoxification, residential, and outpatient services.
- There were about 126,000 unique beneficiaries admitted to treatment during the year.

Beneficiaries having multiple admissions to treatment during a year account for the difference between the number of admissions and the number of beneficiaries. Admission counts can provide more current information on service utilization and more current trends since served counts also include beneficiaries admitted prior to the year (some many years ago) that are still in treatment.

Regarding treatment service type, the approximate admission-based percentages were as follows:

- ODF: 43%
- Residential (short- and long-term): 20%
- NTP Maintenance: 16%
- IOT: 4%
- Detoxification: 18%

Detoxification by itself does not constitute complete SUD treatment. It is considered a precursor to treatment and designed to treat the physiological or medical effects of SUD. Detoxification is often short term and repeated numerous times over a person's lifetime, given the chronicity of SUD, a disease that is characterized by patterns of repeated relapse leading to stability.

Since 18% of the admissions in CalOMS Tx were for detoxification during SFY 2014-15, including them in the analyses would distort the beneficiary characteristic statistics. Thus, for the summary below, detoxification admission data were not included. The figures in this section reflect admission data for over 136,000 non-detoxification admissions.

## Beneficiary Characteristics

### Gender

- Males: 61%
- Females: 39%

### Race/Ethnicity

Race/ethnic proportions for SFY 2014-15 were about the same as for SFY 2012-13. Admissions by race/ethnicity were as follows:

- Non-Hispanic Whites: 42%

- Hispanics: 39%
- African Americans: 11%
- Asian/Pacific Islanders, American Indians/Alaskan Natives, Multi-Racial, and Other: 8%

### Age at Admission

Compared with SFY 2012-13, SFY 2014-15 admissions among beneficiaries ages 18 and younger declined from 16% to 10%, ages 18-24 admissions were stable, ages 26-35 admissions increased from 27% to 32%. Beneficiary admissions among beneficiaries ages 36+ were also stable.

- Under 18: 10%
- 18-25: 18%
- 26-35: 32%
- 36-45: 19%
- 46-54: 14%
- 55+: 7%

### Primary Drug Reported at Admission

The primary drug reported at treatment admission is defined as the drug causing the greatest dysfunction to the beneficiary at the time of admission.

- Methamphetamine: 32%
- Heroin: 23%
- Alcohol: 18%
- Marijuana: 17%
- Other opiates and opiate synthetics: 3%
- Cocaine: 3%
- Oxycodone/Oxycontin: 2%
- Other drugs: 2%

The main changes from SFY 2012-13 to SFY 2014-15 are a rise in heroin-related admissions from 16% to 23%, and drops in marijuana-related admissions from 23% to 17%, and cocaine-related admissions from 5% to 3%. The percentage of use of other opiates and opiate synthetics is now about the same as for cocaine.

## Discharge Statistics

During SFY 2014-15, there were over 155,000 discharges from treatment services (i.e., detoxification, residential, outpatient) for about 122,000 unique beneficiaries. Like admissions,

beneficiaries may have multiple discharges in a given year since a discharge is submitted at the end of each treatment service to which they were admitted. This accounts for the difference between discharge counts and beneficiary counts. Detoxification services are short in duration, often repeated multiple times a year, and therefore excluded from the analyses in this section so as not to bias the discharge statistics.

- There were over 126,000 non-detoxification discharges in SFY 2014-15.

There are two main types of discharges from treatment:

- Standard discharge: The beneficiary is asked all the CalOMS Tx discharge questions that are used to measure beneficiary outcomes.
- Administrative discharge: The beneficiary is not available to answer the CalOMS Tx questions at discharge (i.e., stopped attending treatment sessions, died, or was incarcerated). The provider completes a minimum set of questions (e.g., discharge date, discharge status).

During SFY 2014-15, the percentages of discharges were as follows:

- 56% were standard discharges
- 44% were administrative discharges

It is necessary to increase the number of standard discharges to obtain more information about beneficiary outcomes. This will improve services and treatment.

Upon examination of several years of CalOMS Tx discharge data, it was determined that there was a lack of agreement by treatment providers as to what constitutes “treatment completion.” In 2010, the following criteria was adopted for any discharges coded as “completed treatment:”

- The beneficiary must reduce drug use or be abstinent.
- The beneficiary must participate in social support recovery activities.
- The beneficiary must stay in treatment for a sufficient length of time to obtain the maximum benefit from participation in the treatment program.

Until all treatment providers consistently use these criteria to measure “completed treatment,” DHCS will not use specific discharge statuses to measure this concept.

## Length of Stay

The length of stay is the number of days a beneficiary stays in treatment from admission to discharge. Research verifies that longer stays in treatment are associated with positive outcomes. Conversely, shorter lengths of stay (e.g., fewer than 30 days), especially for ODF services, are related to a lack of engagement in treatment and poor treatment outcomes.

The length of treatment varies depending on the type of service and beneficiary needs (e.g., severity of SUD problem, family issues, etc.). Also, some treatment services have time limitations. For example, most residential treatment services do not exceed 90 days. Treatment often consists of several service types, progressing from more-intensive to less-intensive services (e.g., residential to outpatient). This “step down” continuum of care is often needed because of the

severe nature of the illness at treatment admission and potential for relapse. The analyses in this summary are based on the length of beneficiary service stays (e.g., residential treatment) rather than the combined length of multiple service stays. Only treatment services that may last more than 30 days are described.

- The longest stays occur in NTP maintenance services, with 22% of the beneficiaries receiving services for over one year.
- Nearly half (47%) of the beneficiaries receiving ODF services, and almost 39% in intensive day-care programs, stayed 90 or more days.
- Conversely, about 26% of ODF stays were 30 or fewer days.

This last statistic indicates an opportunity to improve treatment engagement strategies for treatment providers with higher rates of short stays.

## **Beneficiary Outcome Measures**

Historically, SUD treatment beneficiary outcomes measurements referred to changes in beneficiary functioning in seven life domains:

- Alcohol Use
- Other Drug Use
- Employment/Education
- Legal/Criminal Justice
- Medical/Physical Health
- Mental Health
- Social/Family

DHCS asks the same beneficiary functioning questions (e.g., frequency of primary drug use in the past 30 days) at two points in time:

- Upon admission to treatment
- Upon discharge from treatment

DHCS determined changes in beneficiary functioning by matching the admission to the discharge record and comparing the responses to the same question at these two times. For simplicity, DHCS categorized responses into two groups: “positive” actions (e.g., no drug use) and “negative” actions (e.g., used drugs one or more times). DHCS referred to the changes in beneficiary functioning resulting from SUD treatment as “beneficiary outcomes.”

DHCS has worked with various subcommittees to reach the conclusion that it is often better to use beneficiary functioning at discharge to measure outcomes, instead of comparing admission and discharge data. For instance, it is a more objective outcome measure to count the percent abstinent in the 30 days prior to treatment discharge rather than the change in abstinence from 30 days prior to admission to 30 days prior to discharge. One would expect that almost all

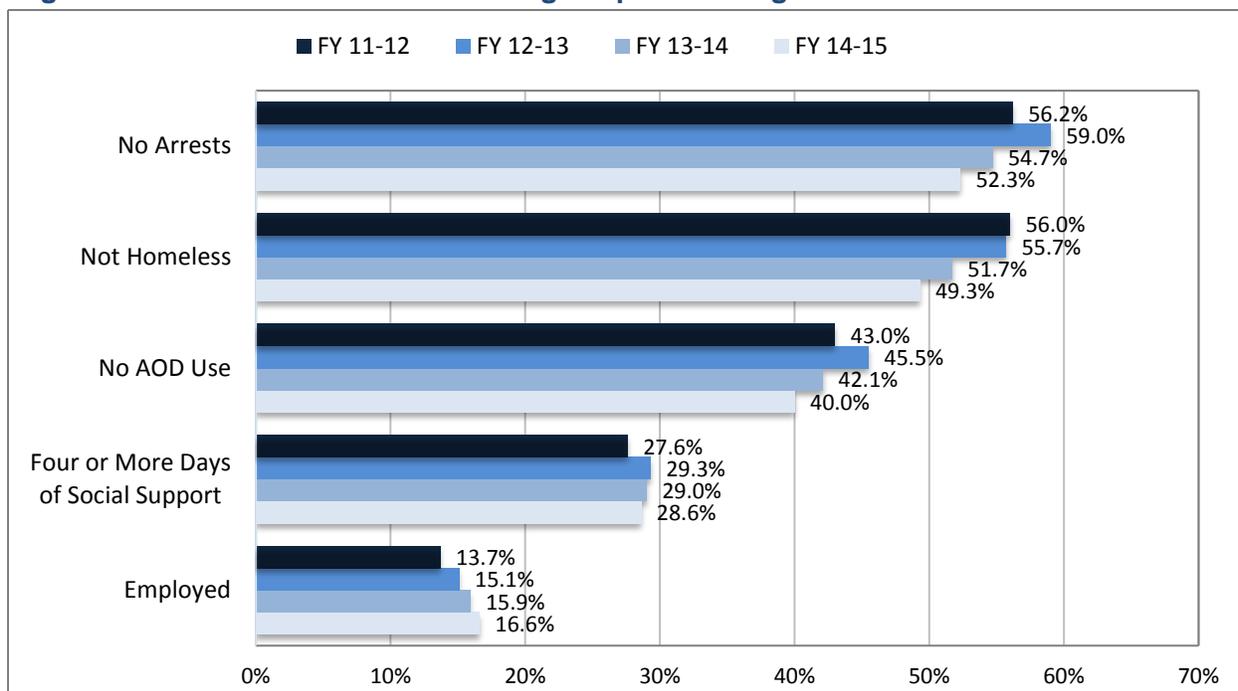
beneficiaries entering treatment are using drugs, whereas all beneficiaries would have either reduced or achieved abstinence at treatment discharge. However, many beneficiaries admitted to a treatment service are coming from controlled environments (e.g., jail, prison) or other SUD treatment services. Many beneficiaries report not using drugs in the month prior to admission. Also, participation in social support recovery activities is more important prior to discharge from treatment when the beneficiary is moving in the continuum of care from the treatment phase to the longer-term recovery phase (e.g., disease management) that follows.

Moreover, there are variations across counties and years in the percentage of discharges that are administrative. DHCS uses this type of discharge when the beneficiary leaves the treatment service abruptly, and the provider is unable to contact the beneficiary (in person or by phone). For administrative discharges, very limited discharge data is collected. Because counties cannot often contact the beneficiary to collect data on the beneficiary’s functioning at discharge, this data is sometimes not collected, and therefore all outcomes cannot be measured.

The largest percentage of admissions to treatment each year is to ODF services (as compared to Residential, Narcotic Treatment Programs, or Detoxification services). ODF is also usually the last service type in an episode of treatment services. A treatment episode refers to when a beneficiary progresses through several treatment types with fewer than 30 days between them (e.g., the beneficiary may first go into detoxification, then residential, and finally ODF services in a “step-down model” from more-intensive and shorter-term stays to less-intensive outpatient). DHCS used this methodology (examining the percentage of beneficiaries meeting the desired level of beneficiary functioning at discharge and factoring in the number of administrative discharges) to report on ODF beneficiary outcomes in five key areas.

Figure 12 shows slightly less positive beneficiary treatment outcomes from SFY 2011-12 to SFY 2014-15 for ODF services on three key measures: No Arrests, Not Homeless, and No AOD Use. Adequate Social Support percentages are stable but need improvement. Employment is up

**Figure 12: Treatment Outcomes among Outpatient Drug-Free Beneficiaries**



slightly. Again, a slight increase in missing data related to administrative discharge reporting contributes to DHCS not being able to document outcomes for many beneficiaries.

## Data Considerations for Beneficiary Outcome Measures

DHCS needs further data management and information technology resources to improve data collection to fully assess and address data quality issues. In general, it is reasonable to assume that the outcomes for beneficiaries that left treatment unexpectedly would be worse than for beneficiaries with planned discharges. Generalizing outcomes of all treatment beneficiaries from the outcome data collected in the standard discharges (i.e., from the beneficiaries with better outcomes) creates a positive bias. Paradoxically, counties (or fiscal years) with larger percentages of discharges missing outcome data (i.e. administrative discharges) may appear to produce more positive outcomes since the outcomes would be generalized from only the limited number of beneficiaries completing the standard discharge, who may have been more engaged in treatment. Outcome measurement bias and variability is reduced when the administrative/missing data is factored into comparisons across years and between counties or providers.

### Discharge Records - Example

During SFY 2014-15, county A has 1,331 total discharge records. Only 12.6% (167) of these records are missing data. The 1,164 (1,331 - 167) discharge records with data show 261 beneficiaries are employed and 903 are not ( $261/1,164 = \text{about } 22\%$  employed). County B has 83 total discharge records. But 81.9% (68) of these discharge records are missing data. The 15 (83 - 68) discharge records with data show that five are employed and 10 are not ( $5/15 = \text{about } 33\%$  employed). These comparative statistics would erroneously indicate 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% ( $261/1,331$ ) employed at discharge. County B had 83 total discharges with five documenting employment. Therefore, county B shows 6.0% ( $5/83$ ) employed at discharge.

The example above underscores the importance of ongoing data quality monitoring and management. CalOMS Tx contains numerous automated data quality controls to prevent erroneous data from entering the system. However, due to high turnover among county and provider staff, ongoing training and technical assistance by the state is needed to assist local agencies in understanding data errors and standards, correcting and resubmitting data rejected for error, and accurately reporting data.

DHCS needs to increase work with counties, treatment providers, and other stakeholders to reduce the number of CalOMS Tx administrative discharges and to increase the collection of treatment outcome data. It is important to factor in administrative/missing data when providing objective outcome comparisons. Counties and providers that increase their outcome data reporting and decrease administrative discharge record reporting should not be ranked lower in the comparison of outcomes. It is also important to factor in administrative/missing data when making comparisons across time periods (e.g., fiscal years) to provide more objective “apples to

apples” outcome comparisons and trends.

Moreover, one of the key considerations in the development of the CalOMS Tx data system was beneficiary outcome measurement. Beneficiary outcomes can include areas of beneficiary functioning that are often beyond the direct responsibility of the treatment provider. For instance, while the percent employed at discharge from treatment is an outcome measure, and longer-term gains in employment are linked to longer-term recovery, the treatment provider has limited influence over the immediate employability of the beneficiary and changing economic conditions in their area. Nevertheless, in this example, the effort to gather data may encourage providers to support beneficiary employment, thus leading to other improved outcomes.

## **Program Performance Measures**

Program performance measures can be used to help evaluate the effectiveness of treatment programs in providing care to their beneficiaries. Previously, DHCS worked with various subcommittees and others on possible program performance measures and models using CalOMS Tx data. The following information is based on those efforts.

CalOMS Tx collects a limited number of measures for evaluating program performance. More information needs to be collected to more thoroughly assess program performance. CalOMS Tx does not collect information on certain areas such as the percentage of beneficiaries who are engaged in treatment after being screened and assessed for needing treatment, level of service matching assessed levels of SUD severity, and specific types and amounts of services each beneficiary received in treatment (e.g., number of counseling sessions). Though much work on developing and using data systems for program performance lies ahead, important steps in program performance measurement can be initiated with the basic measures currently collected in CalOMS Tx.

Research indicates that beneficiaries who remain in treatment for at least 90 days are more likely to have positive outcomes at discharge and maintain recovery. For ODF services, staying 90 days or longer, being abstinent from drug use, and participating in four or more days of social support recovery activities in the 30 days prior to discharge are indicators of successful ODF treatment completion. These three CalOMS Tx measures, along with information about the percentage of discharges that are administrative, can be used to develop composite program performance measures and composite measure categories to compare ODF programs across years and counties.

Program performance measures and models serve best as “indicators” (not the only or absolute measures) to evaluate the effectiveness of treatment and to identify counties and individual programs with more effective services and those needing improvement. Not every beneficiary admitted to a treatment program for the first time, or at any time, completes all treatment goals and is “cured” for life. There are many different paths and steps in the road to long-term recovery from the chronic illness of SUD. Nevertheless, research shows that people engaged in recovery efforts eventually do well. Even beneficiaries that only stay in treatment for shorter periods and do not complete all program goals often benefit from improved functioning and opportunities on the path to recovery. Long-term recovery often includes relapses and the need for further treatment and recovery services.

The ODF Data Indicator Report (see figure on following page) illustrates eight categorical

groupings of these data measures, and provides program performance comparisons for SFY 2011-12 through SFY 2014-15. The eight columns range from the percentage of all ODF discharges that meet all three of the treatment completion criteria (and provide standard discharges with the beneficiary outcome data) on the left side, to the percentage of discharges that meet none of the criteria, including not providing the beneficiary outcome data (an administrative discharge) on the right side. Ninety days is again used as the benchmark for maximum length of stay (Note: Length of stay is also obtained from administrative discharge record data.).

The percentage meeting all three criteria and completing the standard discharge, has remained stable at about 19% each year. The percentage missing only adequate social support recovery has declined from 13.4% to 10.2%.

The two furthest right hand columns provide information on the percentages of administrative discharge records for ODF services and have no outcome data reported. The administrative discharges comprised 45.9% (12.9% + 33.0%) of all ODF discharges in SFY 2014-15. The percent of discharges reported as administrative, not reporting the discharge data necessary to measure beneficiary outcomes, and with stays less than the 90-day benchmark increased from 25.9% to 33.0%. These declining program performance statistics show that many SUD treatment providers need to increase efforts to retain beneficiaries in ODF services, and to report more discharge data to CalOMS Tx. Likewise, these measures also show DHCS needs to increase efforts to collect this important CalOMS Tx discharge data.

The other middle columns provide some detail about program performance issues that need further attention for ODF programs to meet all the program performance criteria. DHCS needs to continue to work with the providers to reduce administrative discharge reporting. DHCS and the providers need to promote abstinence, adequate lengths of stay (retention), and beneficiary participation in social support recovery activities and other recovery support services. DHCS continues to strive to use continuous quality improvement models and systems, as well as data-driven processes and systems, to improve health care quality.

**Table 10: Outpatient Drug-Free Data Indicator Report**

Discharge Type	Standard	Standard	Standard	Standard	Standard	Standard	Administrative*	Administrative*
<b>Performance Criteria</b>	90+ Days with 3 Criteria Met: Meets All 3 Criteria	90+ Days with 2 Criteria Met: Inadequate Social Support	90+ Days with 2 Criteria Met: Drug Use Present	90+ Days With 1 Criteria Met: Adequate Length of Stay Only	<90 Days: Drug Abstinence	<90 Days: Drug Use	1 Criteria Met: Adequate Length of Stay Only	Met No Criteria
<b>Drug Use Goal: 0 days</b>	0 Days	0 Days	>0 Days	>0 Days	0 Days	>0 Days	Data Not Collected*	Data Not Collected*
<b>Length of Stay Goal: 90+ days</b>	90+ Days	90+ Days	90+ Days	90+ Days	<90 Days	<90 Days	90+ Days	<90 Days
<b>Social Support Goal: 4+ days</b>	4+ Days	<4 Days	4+ Days	<4 Days	**	**	Data Not Collected*	Data Not Collected*

**Percent of Total Discharges**

<b>SFY 2011-12</b>	19.0%	13.4%	2.2%	5.2%	11.9%	7.7%	14.7%	25.9%
<b>SFY 2012-13</b>	19.1%	13.6%	2.4%	4.9%	12.7%	7.9%	13.3%	26.0%
<b>SFY 2013-14</b>	18.5%	11.5%	2.6%	3.6%	12.5%	8.1%	13.3%	30.3%
<b>SFY 2014-15</b>	18.5%	10.2%	2.2%	3.7%	11.3%	8.1%	12.9%	33.0%

\* When providers conduct an administrative discharge they do not complete a standard discharge, and data are not collected for Social Support and Drug Use.

\*\* Some beneficiaries also meet the 4+ days social support recovery benchmark, but all beneficiaries stay less than 90 days.

**Notes:** Percentages are calculated for each criteria group (columns) based on total beneficiary discharges for the corresponding fiscal year using CalOMS Tx Discharge Data. This table excludes Administrative discharges for deceased and incarcerated beneficiaries.

**Source:** DHCS California Outcomes Measurement System for Treatment

## Conclusion

DHCS produces this SNAP report to give guidance to state and local planners working in the SUD prevention and treatment field. This report includes an Executive Summary, a needs assessment, and California's strategic priorities, which are:

- Prevention of SUD
- Recovery Support
- Workforce Development

Through the SNAP process, DHCS strives to use SABG funds for improvements to SUD prevention, treatment, and recovery services. The gathering of stakeholder feedback on identified priorities helps implement best practices strategies and promote interventions designed to bring about improved outcomes. Broad stakeholder feedback is the key to the SABG monitoring process and is required to help DHCS create goals and performance measurements.

DHCS is mindful that gathering input involves establishing, implementing, and documenting processes for consultation with both county stakeholders and federally-recognized tribal governments, or governing tribal lands within our borders, during the SABG planning process. DHCS' stewardship of over \$250 million in SABG funds annually involves more than ensuring that resources are allocated and expended responsibly. DHCS must manage the SABG funds to ensure that taxpayer dollars are safeguarded and spent conscientiously.

DHCS will emphasize the three strategic priorities outlined above in DHCS' FFY 2017-18 SABG application, due to SAMHSA October 2, 2017. The strategic planning process must also identify key factors or potential barriers that are external to DHCS, are beyond its control, and could significantly affect the achievement of the strategic goals. These factors include economic, demographic, social, and environmental risks. DHCS must develop strategies to overcome these challenges.

Finally, the FFY 2017-18 SABG application priorities, goals, and performance measures must take into account and plan around the health care policy topics articulated in SAMHSA's *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018* and its strategic initiatives. These initiatives reflect SAMHSA's programmatic priorities and policy drivers including the new Health and Human Services strategic plan and the transition to full implementation of the Affordable Care Act.

One method for stakeholders to submit feedback is through e-mail communications directed to [SNAPReport@dhcs.ca.gov](mailto:SNAPReport@dhcs.ca.gov). DHCS looks forward to receiving stakeholder input upon the release and broad circulation of this report. DHCS will place a strong emphasis on incorporating stakeholder feedback into the SABG monitoring process.

## List of Acronyms

AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
BRFSS	Behavioral Risk Factor Survey Surveillance
CalOMS Pv	California Outcome Measurement Service for Prevention
CalOMS Tx	California Outcomes Measurement System for Treatment
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CFR	Code of Federal Regulations
CHKS	California Healthy Kids Survey
CHSI	Center for Health Statistics and Informatics
CMS	Centers for Medicare and Medicaid Services
CMU	County Monitoring Unit
COD	Co-Occurring Disorders
CY	Calendar Year
DATAR	Drug and Alcohol Treatment Access Report
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSM-V	Diagnostic and Statistical Manual of Mental Disorders 5 <sup>th</sup> Edition
EBP	Evidence-Based Practice
ED	Emergency Department
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FY	Fiscal Year
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICD-10	International Classification of Diseases, 10th Edition
IDU	Injection Drug Use
IOT	Intensive Outpatient Treatment
IPAC	Interagency Prevention Advisory Council
IPR	Independent Peer Review
ISAP	Integrated Substance Abuse Program
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Questioning
LPHA	Licensed Practitioner of the Healing Arts
MACR	Monthly Arrest and Citation Register
MIHA	Maternal Infant Health Assessment
MITA	Medicaid Information Technology Architecture
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
ODF	Outpatient Drug Free
OSHPD	Office of Statewide Health Planning and Development
OWPYS	Office of Women's, Perinatal, and Youth Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SABG	Substance Abuse Prevention and Treatment Block Grant

SBIRT	Screening, Brief Intervention, and Referral to Treatment
SFY	State Fiscal Year
SNAP	Statewide Needs Assessment and Planning
SPF	Strategic Prevention Framework
SPF-SIG	Strategic Prevention Framework-State Incentive Grant
SUD	Substance Use Disorder
SUDCD	Substance Use Disorder Compliance Division
SUDPPFD	Substance Use Disorder Program, Policy and Fiscal Division
SWITRS	Statewide Integrated Traffic Records System
UCLA	University of California, Los Angeles
UCLA-ISAP	University of California, Los Angeles, Integrated Substance Abuse Program