



System of Care Redesign (SOCR)

Report to the Legislature

JANUARY 1, 2003

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
BACKGROUND	3
SYSTEM OF CARE REDESIGN	3
INTENT	3
COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATORS' ASSOCIATION OF CALIFORNIA	4
CONSTITUENCY GROUP PARTICIPATION	4
PILOT FEASIBILITY STUDY	4
“THE CALIFORNIA TREATMENT OUTCOME PROJECT”	4
GOAL	4
FEDERAL FUNDING	4
RESEARCH PARTNERS	5
STUDY DESIGN	5
TIMEFRAME	7
DISCUSSION OF STUDY	8
<u>Standardized Assessment of Client Service Needs</u>	8
<u>Definition of Services</u>	9
<u>Implementation of Automated System</u>	10
Hardware.....	10
Software.....	10
Provider Incentives.....	11
Provider Level Reporting.....	11
<u>Provider Support</u>	12
Communication.....	12
Training.....	12
Regular Meetings.....	12
<u>Linkage with Other State Databases</u>	12
<u>California Client Treatment Outcomes</u>	13
Client Characteristics.....	13
High Problem Severity/Diverse Service Needs.....	13
Legal Status at Admission.....	14
Client Satisfaction.....	14
Significant Improvements Reported in Key Life Areas.....	14
Linkage with Other State Databases Produced Complementary Findings.....	15
<u>National Client Treatment Outcomes</u>	15
CALTOP LESSONS LEARNED	16
ADDITIONAL QUALITY ASSURANCE STANDARDS	17
PROGRAM STANDARDS	18
COUNSELOR CREDENTIALING	18
CAPACITY MANAGEMENT SYSTEM	19
SOCR PLANS FOR THE FUTURE	19
FURTHER ANALYSIS OF CALTOP DATA	19
CALTOP COST OFFSET ANALYSIS	20
STATEWIDE OUTCOMES MEASUREMENT	21
SUMMARY	22
APPENDIX A	24

EXECUTIVE SUMMARY

The California Department of Alcohol and Drug Program's (ADP) System of Care Redesign (SOCR) initiative is a long-term effort to provide and continually improve alcohol and other drug (AOD) prevention, early intervention and recovery/treatment services to individuals, families and communities. Working with key stakeholders and constituency groups, the goal is to provide appropriate treatment based on the needs of the client while monitoring outcomes to ensure quality service delivery and fiscal accountability.

Primary to achieving this goal has been developing, implementing and pilot testing an automated outcome monitoring system (OMS) known as the California Treatment Outcome Project (CalTOP). CalTOP was designed to track client movement through AOD treatment programs, assess client service needs, record service utilization, assess treatment outcomes and client satisfaction, and determine whether AOD treatment produces cost-offsets in criminal justice and other health and social service systems.

Forty-four treatment providers in 13 counties volunteered to participate in the project. By August 2002, 15,618 consecutive client admissions were entered into the CalTOP database. Only clients who were admitted to treatment are included in the study. Findings were derived from a pre and post-treatment evaluation of client functioning in seven life domains: Alcohol, Family/Social, Employment, Drugs, Legal Status, Psychiatric and Medical. Researchers conducted interviews with a subset of clients at 3 months and 9 months after admission to treatment whether or not they had dropped out, completed treatment or were still receiving services. Additionally, ADP established data sharing arrangements with other state departments to document the reduced use of criminal justice, health and social services. The research and analysis were conducted by the University of California Los Angeles (UCLA) Integrated Substance Abuse Programs (ISAP).

CalTOP has demonstrated that for the groups studied:

- Treatment provides measurable benefits to the clients and the communities studied.
- Rates and frequency of drug and alcohol use decline after treatment.
- Employment rates improve after treatment.
- Problems related to family and social relationships, medical status, psychiatric status and legal status all show significant improvement.
- Complementary findings were derived from databases owned by other state departments.
- Results are greater for clients who stay in treatment longer and/or complete treatment.
- Standardized tools effectively provide more consistent assessment of the client's needs and document client condition for future outcome measurement.

CalTOP has successfully demonstrated that development of a statewide OMS to enhance ADP's current management information systems is feasible and appropriate. This system will provide ADP and policy makers on local, state and federal levels with the information necessary to improve the treatment delivery system and document the economic and societal benefits of AOD treatment.

System of Care Redesign (SOCR) – Report to the Legislature

Additionally, ADP continues to make progress in other SOCR goals related to quality assurance standards and capacity management.

BACKGROUND

This report is respectfully submitted by the Department of Alcohol and Drug Programs (ADP) to inform the Legislature on the System of Care Redesign (SOCR) effort and to describe options ADP is pursuing to improve the AOD treatment service delivery system in California.

SB 2015 (Chapter 389, Statutes of 1998) authorized ADP to pilot test elements of the SOCR effort. An interim report on the effort was provided to the Legislature in July 2001. AB 429 (Chapter 111, Statutes of 2001) extended SB 2015 through July 1, 2003 and specified submission of this written report by January 1, 2003.

SYSTEM OF CARE REDESIGN

INTENT

The goal of SOCR is to provide quality AOD prevention, early intervention and recovery/treatment services. Individuals, families, and communities need access to appropriate services delivered within an integrated, coordinated and seamless system. It is ADP's intent to use the SOCR concepts as a long-term, on-going strategy to improve client services and demonstrate efficient use of limited resources.

A fundamental step in this effort has been pilot testing a client-centered treatment delivery system which:

- Uses standardized assessment to identify the client's treatment needs;
- Documents services delivered;
- Tracks client movement through the treatment delivery system;
- Monitors client outcomes by measuring improvements in the client's quality of life resulting from treatment; and
- Addresses the costs of substance abuse to individuals, families and communities while determining offsets of treatment costs by documenting the reduced use of health, criminal justice and other social services.

Additional components of the SOCR effort include quality assurance standards and capacity management.

COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATORS' ASSOCIATION OF CALIFORNIA

The SOCR effort has been undertaken in partnership with the County Alcohol and Drug Program Administrators' Association of California (CADPAAC). See Appendix A.

CONSTITUENCY GROUP PARTICIPATION

Treatment providers, members of the treatment field and other interested parties have actively advised and supported the SOCR effort. The Department acknowledges the generous contributions of numerous individuals and workgroups formed to provide subject matter expertise, build consensus and ensure cultural sensitivity.

PILOT FEASIBILITY STUDY

"THE CALIFORNIA TREATMENT OUTCOME PROJECT"

GOAL

The primary goal of the California Treatment Outcome Project (CalTOP) was to develop and test the feasibility of an outcome monitoring system for clients receiving AOD treatment services. The project provided the opportunity to build and test new software and computer technology to help treatment providers collect and transmit client data. The study offered an opportunity to test standardized assessment and placement tools for both clinical application and outcome monitoring. Finally, the design encouraged the initiation of work to establish a network of data linkages with other state agencies to measure client outcomes and provide for cost offset analysis in terms of AOD abuse and other social service needs.

Lessons learned and data generated from CalTOP are intended to provide local, state and federal decision-makers with key information regarding the effectiveness of AOD services and guide ADP in its long-term strategy to make improvements in California's treatment service delivery system.

FEDERAL FUNDING

As authorized by the Legislature, ADP pursued and obtained federal funding to help underwrite costs of this project. In October 1998 ADP was awarded a \$1.5 million (over 3 years) Treatment Outcomes Performance Pilot Studies Enhancement (TOPPSII) grant (# 1 UR1 TI11478-01) by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). These individual grants have supported 19 participating states in the development and testing of automated systems to track client movement through AOD treatment.

System of Care Redesign (SOCR) – Report to the Legislature

During the planning phase of the TOPPSII studies, a series of TOPPSII questions were developed through a consensus process allowing interstate data comparisons. These Interstate Core Outcome Questions (ICOQ) comprised a subset of the data collected in CalTOP. Responses were submitted to the CSAT Technical Assistance Center (TAC) for inclusion in national findings.

RESEARCH PARTNERS

ADP established an interagency agreement with the University of California Los Angeles (UCLA), Integrated Substance Abuse Programs (ISAP), to provide research support to the project. UCLA-ISAP assisted with aspects of implementation, conducted follow-up and focus group interviews, helped establish data sharing arrangements with other state departments, analyzed the resulting data and are in the process of completing a project final evaluation report. The California Treatment Outcome Project (CalTOP) Final Report by UCLA-ISAP is anticipated to be completed in the first quarter of 2003.

STUDY DESIGN

CalTOP automated data collection involved treatment providers in 13 counties who volunteered to participate in the project.

Thirteen Participating Counties		
Alameda	Orange	San Francisco
El Dorado	Riverside	San Joaquin
Kern	Sacramento	San Luis Obispo
Lassen	San Benito	San Mateo
	San Diego	

Forty-four publicly funded treatment providers within these counties were selected based on client flow and collective ability to produce a purposive sample demographically representative of the State's adult treatment population. Both rural and urban providers representing the array of available treatment services participated (excluding detoxification and alcohol only). Providers with varying technological skills and varying familiarity with assessment tools were sought to test implementation issues. These providers also volunteered to participate.

Types of Treatment Providers (Modalities)	
Outpatient Drug Free	26
Residential	11
Narcotic Treatment Program	4
Mixed Modality	3
Total	44

The CalTOP study was designed to capture client information from multiple sources at specified points in time. This longitudinal outcome evaluation design allows the client's functioning at time of admission to be compared with his or her functioning at time of discharge, 3 months after admission, 9 months after admission and 12 months post admission.

System of Care Redesign (SOCR) – Report to the Legislature

CalTOP Data Collection Summary	
Point in Time	Data Collected
Admission	Data currently collected in the California Alcohol and Drug Data System (CADDs)
	Assessment (pre-treatment) and placement data
	Consent to participate in the follow-up portion of the study
3-month Post Admission	Telephone Interview – Client Satisfaction Survey, Treatment Services Report, and core outcome questions
During Treatment	Service Element Data (services delivered)
Discharge and/or change in level of service	CADDs data
	Core outcome questions
9-month Post Admission	Telephone Interview – Assessment (post-treatment) data – to determine client progress
	Client Satisfaction Survey
12-month Pre and Post Admission	Administrative data link with other departments (“Cross data linkages”)

At the time of admission the provider collects client identifier and demographic information. The treatment provider also conducts a full client assessment using a variation of the Addiction Severity Index (ASI) to determine the client’s level of functioning in seven life domains: Alcohol, Family/Social, Employment, Drugs, Legal Status, Psychiatric and Medical. Additionally, the provider uses the California adaptation of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPCII) to guide the selection of the most appropriate form of treatment in various levels of care.

Providers record detailed information on the services delivered to the client during treatment. The treatment provider also collects core outcome questions, as well as completion status (satisfactory or unsatisfactory), at the time of discharge from treatment.

CalTOP Client Admissions as Recorded by Treatment Providers¹	
Unique Client Admission Records (April 2000 - August 2002)	14,420

At the time of admission, treatment providers also invite clients to voluntarily participate in the follow-up portion of the study. Clients who agree to participate sign an Informed Consent Form and provide locator information for future reference. Confidentiality of client data is assured. Researchers from UCLA-ISAP used the locator information to contact a subset of clients for interviews at 3 months and/or 9 months post admission.

Number of Clients Participating in Follow-up Interviews	
3-month Post-Admission Follow-up Interview (as of August 2002)	2,850
9-month Post-Admission Follow-up Interview (as of August 2002)	2,730

¹ Because not all data elements were complete for all clients at each of the assessment points, sample sizes in this report vary depending on the combination of data elements and specific time points at which the analyses had to be conducted.

System of Care Redesign (SOCR) – Report to the Legislature

At the time of admission sufficient client information is collected to create a Unique Client Identifier (UCI). This UCI is needed to identify client records in other state databases and is used to track client movement through county AOD treatment systems. The UCI consists of elements taken from the client's full birth name, gender, date of birth, place of birth, and mother's first name. The client's social security number and California Department of Corrections (CDC) number, if applicable, are used for verification when necessary.

CalTOP has further established data sharing arrangements with other State departments. Once linkage is established, analysis of the data focuses on the client's use of health, criminal justice and other social services during the period 12 months before and 12 months after treatment admission. The analysis of this data will help identify the societal benefits of treatment, including cost offsets, by documenting reductions in hospitalizations, arrests, incarcerations, etc.

DATA SHARING WAS ESTABLISHED WITH:
Department of Justice (DOJ) Department of Motor Vehicles (DMV) Department of Mental Health (DMH) Office of Statewide Health Planning and Development (OSHPD)
EFFORTS CONTINUE TO ESTABLISH DATA SHARING WITH:
Department of Health Services (DHS) Employment Development Department (EDD)

In November 2000 California voters passed Proposition 36, the Substance Abuse and Crime Prevention Act (SACPA), which diverts first time non-violent drug offenders to treatment. Due to the timeframe for SACPA implementation, a minimal number of individuals entering treatment through CalTOP are reflected in the findings contained in this report and the CalTOP design was not altered to specifically focus on this client base.

TIMEFRAME

Originally planned as a three-year project, delays in the development of a consensus on data elements to be collected by all participating TOPPSII states and challenges encountered during implementation extended the project timeframe. These delays occurred in each of the 19 states participating in the TOPPSII studies. California data collection began in April 2000.

The federal portion of the study, TOPPSII, originally was scheduled to conclude in September 2001. In July 2001 the federal grantors approved a 12-month extension, necessary to achieve data collection goals, to all participating states. The extended federal grant period concluded September 30, 2002. ADP is in the process of finalizing a report, due to CSAT during the first quarter 2003, documenting project details and conclusions.

System of Care Redesign (SOCR) – Report to the Legislature

Limited CalTOP data collection continues to date. The additional outcome data being collected will be analyzed by UCLA-ISAP. Additionally, continued data collection provides an environment for testing system changes and enhancements as a statewide outcome monitoring system is planned and developed.

DISCUSSION OF STUDY

Standardized Assessment of Client Service Needs

Addiction Severity Index

Treatment providers employed a well-respected standardized assessment tool known as the Addiction Severity Index (ASI).² Administered during admission to treatment, the tool, consisting of 150 questions, is designed to measure the client's level of functioning in seven life domains: Alcohol, Family/Social, Employment, Drugs, Legal Status, Psychiatric and Medical. Summary scores are calculated in each of these life areas, which can be used as a baseline measure of client functioning at the time of admission.

To measure client outcomes, the ASI was re-administered by researchers at UCLA-ISAP during phone interviews with over 2,700 clients at 9-months post admission. The data collected during these follow-up interviews has allowed the researchers to measure changes in the client's level of functioning between the time they entered treatment and 9 months later.

In addition to its ability to produce data valued by researchers for outcome evaluation, CalTOP also tested the use of the ASI as a standardized assessment instrument to be used by all providers/clinicians for treatment planning. Currently no standard assessment tool is used uniformly by the treatment field.

The ASI provides a standard format in which a substantial amount of data is collected relevant to the client's condition. Proper use of the tool allows the clinician to become familiar with the client's alcohol and drug use history and other factors that may be negatively affecting the client's life. Further it allows the counselor to address conflicts that may exist in the information the client has provided. Although met with some initial resistance, treatment providers generally learned to incorporate the use of the ASI as part of their standard business practice and learned to appreciate its value in establishing a dialogue with the client and developing a treatment plan.

The use of the ASI as the assessment tool of choice in California continues to gain acceptance. Although every data element may not be used or needed by ADP to demonstrate outcomes associated with treatment, consistent use of this well-accepted

² The ASI used was the Addiction Severity Index – Lite, Clinical Factors, TOPPSII version (ASI-Lite CF TOPPSII) which includes the Interstate Core Outcome Questions (ICOQ) developed through an interstate consensus process by the states participating in the federal Treatment Outcomes Performance Pilot Studies Enhancement (TOPPSII).

System of Care Redesign (SOCR) – Report to the Legislature

tool will make strides in standardizing the assessment of client treatment needs at the time of admission and provide the California treatment field with a professional assessment instrument.

American Society of Addiction Medicine Patient Placement Criteria

Treatment providers also employed the California adaptation of the two page clinical tool known as the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC II). The tool aids clinicians in deriving the answers to three questions: What level of care is needed by the client? What is the level of care to which the client was admitted? What is the reason for any difference?

The ASAM PPC II data was recorded by providers at the time of intake and/or when a change in level of service occurred. Although it may be of value to the clinician, the ASAM PPC requires subjective interpretation, limiting its usefulness as a reliable data collection instrument for outcome monitoring.

CalTOP has documented the value standardized assessment tools can bring to the treatment arena if sufficient training in the proper use of the tool is provided. It is an excellent example of bringing research to practice. As a result of the success of this pilot study, the growing support of the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) and the emerging support of the treatment field, ADP has opted to facilitate the use of an accepted set of assessment tools by all publicly funded treatment providers in California.

Definition of Services

In order to accurately record the services a client receives during treatment, a common definition of services (service elements) was developed. In conjunction with the consulting firm of William M. Mercer, Inc., ADP formed a series of workgroups to develop this common reference. Incorporating valuable input from the CalTOP providers, the final Service Element Manual was issued in March of 2001.

Using the elements defined in the Service Element Manual, providers were asked to record and submit each discrete service element received by every client during treatment. Data recording volume was large, especially for particular types of treatment providers. For some providers the staff time required for data entry exceeded available staff resources. Additionally, no method currently exists to audit the accuracy or completeness of the data.

When recorded consistently, these data hold the potential to help determine why one particular course of treatment is more or less effective than another for clients with specific characteristics or problems. In the future, these data could help refine elements of the treatment delivery system. Other substantial factors (location, client background, clinician, etc.), however, may also contribute to differences in client outcomes and must also be considered.

System of Care Redesign (SOCR) – Report to the Legislature

The recording of every unique service transaction for every client poses a heavy workload for counselors. ADP may opt to investigate other methods for obtaining this information or a subset of these service elements. It may consider sample studies of particularly low performing and high performing treatment providers to determine the differences in the courses of treatment they offer. Alternatively, if the data are to be collected on a census basis, methods for compensating and/or motivating treatment providers to accurately and consistently record service element information will be necessary.

Implementation of Automated System

CalTOP shows that ADP can identify and track clients over time and over several treatment occurrences; that confidential data can be shared with the State using Web technology; and that confidential data can be effectively shared between providers, counties and the State. Brief overviews of significant issues encountered during implementation are described below.

Hardware

As part of participation in CalTOP, each participating provider was given a computer with Internet access and data security registration. Issues related to the unavailability of high-speed data submission lines, especially in rural locations, proved frustrating for some providers. Relatively slow response time prolonged the data submission process. As technology improved and digital subscriber lines (DSL) were employed, however, this obstacle was overcome.

Software

The software used in CalTOP consisted of several distinct modules:

Web-based Admissions

Accessing the CalTOP web site, providers record client admission data via secured data submission methods. By entering the information directly into the CalTOP database, instantaneous edits were available to help eliminate duplicate records and ensure data accuracy. Client service element data, client level of care (level of service) and client discharge data were also submitted via the Web.

Addiction Severity Index – Lite, Clinical Factors, TOPPSII (ASI-Lite CF TOPPSII)

Rather than develop its own web-based ASI software for the project, ADP opted to take advantage of stand-alone desktop ASI software developed and provided to participating TOPPSII states by the federal grantors. A few individual providers purchased alternative third party software.

The stand-alone software met data collection objectives, but the process by which the data were uploaded from the provider site to the State database was cumbersome. As a result, provider frustration was greater than it might have been and an aggressive training plan was required.

System of Care Redesign (SOCR) – Report to the Legislature

Follow-up Data Submission by UCLA-ISAP

Similar to the ASI data collected by providers, the data documenting voluntary client participation in the follow-up portion of the interviews and the data actually collected during the interviews was collected on stand-alone desktop software by the researchers at UCLA-ISAP. Relevant portions of this data were uploaded to the CalTOP database by UCLA-ISAP in a regularly scheduled batch process.

Independent Assessment of the CalTOP System

ADP employed the services of a well-qualified contractor to perform a detailed production readiness assessment. The assessment focused on the technology of the CalTOP system to determine the feasibility of implementing the application statewide. With the incorporation of a limited number of constructive recommendations, the report determined that the application was well positioned for statewide rollout.

Provider Incentives

Minimal financial incentives were given to providers for project participation. Based on conservative workload estimates, data collection was estimated at a minimum of 1.75 hours per client. Based on this estimate, ADP provided \$26 per anticipated client record to participating counties via their standard county contracts with ADP to help offset a portion of provider staff costs.

The workload associated with complete data collection was underestimated. In some cases the data collection and submission workload threatened the provider's ability to focus staff resources on their clients. Additionally, the original payment method was not effective as it was not tied to provider data submission performance.

As providers started to consider terminating their participation in the project before data collection objectives had been achieved, ADP established a supplemental performance-based financial incentive to help offset the costs associated with data collection and submission. Discretionary federal Substance Abuse Prevention and Treatment (SAPT) block grant funds were used during Fiscal Year 2001-2002. Incentive amounts averaged \$2,025 per participating treatment provider site and appeared to have a positive effect on continued participation in the project and timely data submission.

Additionally, a series of "Provider Recognition Awards" were presented at monthly CalTOP meetings. An average of four awards were given each month, noting significant achievements in ongoing or improved data collection results.

Provider Level Reporting

ADP developed automated CalTOP data query functions that allowed participating providers to generate reports for use as management tools. Developed with provider input, over 30 reports are available to the providers including "Client Data Status Report" to identify which data components have been entered for any given client and a series of

System of Care Redesign (SOCR) – Report to the Legislature

demographic and outcome reports. Feedback of this data to the provider has been extremely well received and many providers report using the information in their daily business operations to improve client services.

Provider Support

Communication

In order to effectively communicate with 44 providers, 13 counties and multiple stakeholder groups with differing concerns and communication needs, ADP staff established a multi-tiered communication plan that included a CalTOP Website, Help Desk, e-mail distribution, monthly meetings, direct provider contact and a mentor program. These communication methods were effective.

Training

The skill level of provider staff members, in both use of standardized assessment tools and the automation technology required for CalTOP data submission varied greatly. Training sessions for automation and the use of the Addiction Severity Index (ASI) and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC II) were required for all providers.

Multiple data collection and submission procedures, and the varying skill sets of the staff associated with these tasks, required multiple training sessions, hands-on provider assistance, and multiple site visits by ADP staff. Also, as a fairly high level of staff turnover at provider sites was encountered, training new staff members was an on-going process.

Regular Meetings

Monthly meetings provided ADP staff and participating provider staff the opportunity to exchange information, address challenges, resolve areas of confusion and identify ways to improve operations. One individual from each participating treatment provider and one staff member from each participating county were encouraged to attend. The skill level, duties and title of the attendees varied greatly. Meetings were generally well attended and successfully achieved their intended goal. Minutes were maintained and distributed to document and track project progress.

Additionally, ADP staff members, contractors and the research partners from UCLA-ISAP met on a regularly scheduled basis via teleconference to address system design and implementation issues as they arose.

Linkage with Other State Databases

Establishing data sharing arrangements has been a time consuming and labor intensive process. Barriers included the confidential nature of client data; the data processing costs associated with data sharing; the inability to escalate issues to decision makers in a

System of Care Redesign (SOCR) – Report to the Legislature

timely manner; inherent delays in the availability of specific data from other departments; and competing priorities for the resources of other departments when no clear mandate to cooperate exists.

In spite of these obstacles UCLA-ISAP and ADP were successful in establishing data linkages with four other state departments. Efforts continue to establish linkages with additional agencies and make data sharing arrangements a permanent and on-going business practice. Workgroups were assigned the task of determining how barriers to the establishment of these agreements can be reduced or eliminated.

California Client Treatment Outcomes

The information contained in this section is based on data analysis conducted to date by ADP's research partners at UCLA-ISAP. Client characteristics are based on the analysis of 11,789³ unique client admissions collected through May 31, 2002.

Client Characteristics

GENDER	Male	56.1 %
	Female	43.9%
RACE/ETHNICITY	White	54.5 %
	Hispanic	22.5 %
	African American	16.1 %
	Asian	2.9 %
	Native American	2.4 %
	Other	1.3 %
EDUCATIONAL STATUS	Less than high school	33.9 %
	High school/GED	44.1 %
	Some college	21.4 %
	None	0.4 %
CURRENT MARITAL STATUS	Single/never married	45.3 %
	Divorced/separated/widowed	35.6 %
	Married	18.9 %
AGE⁴	18-25	20.3 %
	26-35	31.2 %
	36-45	33.8%
	46+	14.6 %

High Problem Severity/Diverse Service Needs

All clients entering treatment reported problems with alcohol and/or drug abuse. As the primary drug problem 33% reported methamphetamines and amphetamine, 27% reported alcohol, 15% heroin and 11% cocaine and crack cocaine. Other diverse service needs included the finding that 54% had psychiatric problems; 24% had significant physical medical problems; 44% had a history of being physically abused; 28% had a history of being sexually abused; and 6% of women were pregnant.

³ Because not all data elements were complete for all clients at each of the assessment points, sample sizes in this report vary depending on the combination of data elements and specific time points at which the analyses had to be conducted.

⁴ CalTOP collected data only on clients 18 years of age or older.

Legal Status at Admission

At time of admission 54.5% reported some form of involvement in the legal system; approximately 40% were on probation, approximately 7% were on parole with the California Department of Corrections (CDC), 2% were on parole other than with CDC, and approximately 5.5% were participating in a diversion program. No legal involvement was reported by 45.5% of the clients.

Client Satisfaction

Based on three-month post-admission interviews with 2,677 clients for which a full admission record existed, 91.2% of clients reported being generally satisfied with services received and 91.3% reported that they would recommend the services they received to someone with AOD abuse issues.

Significant Improvements Reported in Key Life Areas

The 2,730 clients who participated in the nine-month post-admission follow-up interviews reported substantial improvements in overall client circumstances and behaviors. Findings are based on ASI scores and questions comparing the client's level of functioning during the 30 days prior to admission with the level of functioning during the 30 days prior to follow-up.

- *Drug Use* Drug use severity declined by 82%. Primary drug use was reduced by an average of five days per month. Eighty-three percent reported no alcohol and no drug use at follow-up and 88% reported no drug use at follow-up.
- *Alcohol Use* Alcohol use severity declined by 78% and a two-day per month reduction in heavy alcohol use was reported.
- *Employment* Employment problem severity was reduced by 18%. Twenty-six percent more clients reported employment at follow-up.
- *Psychiatric Status* Psychiatric problem severity was reduced by 41% and there was an average of three days per month reduction in psychological problems.
- *Family and Social Relationships* Reported family/social problem severity was reduced by 60%.
- *Legal Status* There was an 81% reduction in legal problem severity.

System of Care Redesign (SOCR) – Report to the Legislature

- Medical Status⁵ Reported medical problem severity was reduced by 17%, with 5% fewer reporting emergency room visits and 2% fewer reporting hospital stays.

Linkage with Other State Databases Produced Complementary Findings⁶

As previously mentioned, CalTOP has established data sharing arrangements with other State departments. Below are examples of data that has been generated by these linkages. This data focuses on the client's use of health, criminal justice and other social services during the period of 12 months before and 12 months after treatment admission.

Department of Motor Vehicles

- Rates of arrests for driving under the influence (DUI) decreased from 5% during the year before treatment to 3% during the year after treatment.
- Rates of motor vehicle accidents decreased from 6% to 4%.
- Clients who stayed longer than 90 days in treatment had a lower DUI arrest rate (2%) during the year after treatment admission, compared to clients with shorter treatment retention (3%).

Department of Justice

- Rates of arrests decreased from 44% during the year before treatment admission to 30% during the year after.
- Rates of incarceration remained at 5% to 6%.
- Clients who stayed longer than 90 days in treatment had a lower arrest rate (24%) during the year after treatment admission, compared to clients with shorter treatment retention (34%).
- Clients who stayed longer in treatment had a lower incarceration rate (4%) during the year after treatment admission, compared to clients with shorter treatment retention (8%).

Department of Mental Health

- Rates of inpatient mental health services remained at 3% to 4%.
- Rates of outpatient mental health services remained at 20% to 21%.

National Client Treatment Outcomes

The final meeting for TOPPSII was held in Bethesda, Maryland on September 23-25, 2002. This meeting provided an opportunity for the 19 participating states to compare results and identify common implementation issues and themes in the data that was collected.

CalTOP was by far the most comprehensive undertaking among the 19 states. CalTOP tested more aspects of automated outcome monitoring and produced more significant

⁵ As clients become less addicted, they generally are more willing to address medical issues unrelated to their addiction.

⁶ 6,545 clients were tracked through administrative databases from other state departments.

System of Care Redesign (SOCR) – Report to the Legislature

findings than any other participating state. For example, California submitted 13,381⁷ complete admission records (including ASI data and meeting federal edit requirements) while Illinois, with the second largest submission, provided records for 1,569 clients. California was also the only state to undertake an extensive methodology which included both primary data collection (data collected by providers and by researchers from treatment clients) and secondary collection (information obtained via linkage with the administrative databases of other state departments).

Preliminary results from the collective TOPPSII data largely parallel CalTOP data findings. National findings include:

- Client functioning improves after treatment.
- Improvements are greater when length of stay in treatment is longer.
- Regardless of modality, clients who complete treatment are more likely to be abstinent at the time of discharge.
- A longer length of stay in treatment directly relates to a greater likelihood of employment at discharge.

National findings will be published in a Center for Substance Abuse Treatment (CSAT) report anticipated in Spring 2003.

CalTOP LESSONS LEARNED

CalTOP successfully demonstrated the feasibility of developing and implementing an automated outcome monitoring system. As a more broad-based data collection system is pursued for California, the significant lessons learned during CalTOP will be carefully considered. Primary issues include:

- The testing of standardized assessment tools was a success. Use of such tools provides more consistent and in-depth assessment of the client's needs when entering treatment while documenting client condition for future outcome measurement.
- ADP must facilitate a consensus process by which standard definitions are created. Such definitions should include what sequence of events compose a completed treatment episode and a definition of "treatment success." For example, UCLA-ISAP has defined treatment success as "no illicit drug use, no crime and living in the community in the past 30 days".
- Each successive "deeper" level of data collection comes at a higher cost. The data needs and requirements of multiple stakeholders must be distinguished from data that is merely desired or marginally beneficial. Outcome measures must be ranked in order of priority so that scarce resources can be used to address the issues of highest concern.
- Data collection and submission generates an additional workload for treatment providers. Data collection should be limited to the minimum number of elements

⁷ Because not all data elements were complete for all clients at each of the assessment points, sample sizes in this report vary depending on the combination of data elements and specific time points at which the analyses had to be conducted.

System of Care Redesign (SOCR) – Report to the Legislature

needed to achieve mutually agreed upon goals. Supplemental resources will need to be identified if large-scale data collection is embraced; otherwise, the level of service provided to clients will suffer.

- The current workload and associated cost of collecting detailed service element data for all clients appear to outweigh the incremental benefit derived from the data. It would also present a significant barrier to statewide implementation. In such situations, where costs associated with data collection on a census basis are high, sampling may prove a more cost-effective solution.
- Duplication of effort and duplicate data entry must be avoided. ADP will have to work with counties and providers to enhance their existing data collection systems whenever data extract proves a more efficient method of obtaining the data the State requires.
- For data not extracted from existing systems, development of a user friendly, centralized data submission process is essential. The additional planning and development costs required are far less than the resources required to implement, train for and support a lesser system.
- Site specific implementation plans should be designed to address site-specific implementation barriers. These specific implementation plans must be incorporated into a larger system-wide implementation plan which links change management, system rollout and provider/county training.
- Clinician level buy-in is essential. For any data collection system to succeed, value must be perceived at all participating organizational levels. Looping the data back to the provider has proved a very successful method of generating clinician level buy-in.
- A client-centered ethos prevails at treatment provider sites. Any tool, procedure or workload that is perceived as interfering with or jeopardizing the relationship between clinician and client will be met with strong opposition.
- Support of the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) is vital when developing large-scale data collection studies or systems and resulting policy proposals.
- Emphasis must be placed on pursuing permanent, ongoing data sharing relationships with other state departments.
- Correspondence between problem severity at time of admission and the services received during the first three months of treatment need to be better matched. Further analysis as to why this gap exists is needed.
- As has been previously documented, length of stay has a direct impact on treatment success. Methods to improve client retention and length of stay are needed to maximize the positive results treatment delivers.

ADDITIONAL QUALITY ASSURANCE STANDARDS

To determine quality of services delivered, CalTOP measured client satisfaction as well as documented the difference between assessed treatment need and the actual treatment services received. In addition, ADP has embraced two other quality assurance initiatives: Program Standards and Counselor Credentialing.

PROGRAM STANDARDS

Legislative changes required for ADP to obtain statutory authority to set standards and provide oversight for facilities must be identified and pursued. It may be more effective to utilize technical assistance programs to provide business skills training for providers and program administrators. Current standards do not adequately specify program curriculum for treatment services, except for driving under the influence (DUI) programs. Current standards also do not adequately protect or support youth in treatment programs, and ADP lacks statutory authority to license facilities for the treatment of youth. The ADP Licensing and Certification Regulations Workgroup is revising existing regulations and has proposed language to address the protection of children accompanying parents in treatment.

Currently, ADP and its Youth Standards Workgroup are developing appropriate standards for youth treatment. Once the standards have been completed, they will be incorporated into ADP's licensing standards and regulations.

COUNSELOR CREDENTIALING

Insufficient or non-existing standards have on occasion led to the perception that AOD counselors lack the necessary skills and awareness of ethical behaviors to provide professional service. The field looks to ADP for leadership in adoption of professional standards, as well as education and experience requirements. Resources for improving the effectiveness of counselors through education and training are not being utilized. There also may be a lack of qualified people willing to work in what has historically been a low-wage field.

California does not mandate or regulate the credentialing or certification of AOD counselors, nor does it accredit organizations that provide certification services. However, in 2001, Governor Davis vetoed SB 537 (Vasconcellos) and directed ADP to promulgate regulations to require that counselors in drug and alcohol treatment facilities be certified for quality assurance purposes.

In response, ADP referred the issue to the Licensing and Certification Division Regulations Workgroup. The workgroup has recommended that ADP, by regulation, require all persons delivering AOD "counselor services" be certified by an organization ADP accepts as meeting the State requirements for being a certifying agency. ADP will designate a nonprofit organization comprised of entities that certify individuals who complete their prescribed AOD counselor training and education courses and maintain a register of all certified AOD counselors. The basic standard for membership in the nonprofit organization will be certification based upon the *Addiction Counseling Competencies; The Knowledge, Skills, and Attitudes of Professional Practice*, commonly referred to as TAP 21, a publication of the U.S. Department of Health and Human Services, CSAT.

TAP 21 advocates that all addiction-focused disciplines be built on common foundations serving as prerequisites to the development of competency. These foundations include

System of Care Redesign (SOCR) – Report to the Legislature

understanding addiction, treatment knowledge, application to practice and professional readiness. TAP 21 includes eight practice dimensions of addiction counseling necessary for effective performance of the counseling role: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and, professional and ethical responsibilities.

Staff currently employed in AOD programs providing counselor services would be allowed five years to obtain certification.

CAPACITY MANAGEMENT SYSTEM

ADP currently collects summary facility-based information on treatment capacity and waiting lists from publicly funded AOD treatment providers and licensed narcotic treatment programs via its Drug Abuse Treatment Access Report (DATAR) system. DATAR supplies provider based information by service modality on total treatment capacity, publicly-funded treatment capacity, number of clients on a waiting list at month-end and average duration of the waiting list period for those clients who have been admitted. This information is supplied monthly by providers throughout the state to ADP, where it is input into a batch processing system and maintained for data analysis, evaluation and reporting.

ADP plans to upgrade or replace this legacy batch processing system with a fully automated web-enabled version in order to increase data accuracy, timeliness of data submission and compliance reporting rates. An analysis has been conducted to define the scope of the project, which may require the preparation of a Feasibility Study Report, if this project is implemented. This effort will also assess ADP's capacity data collection model and determine the data needed to more accurately manage access to publicly funded treatment.

ADP's strategic plan includes evaluation of barriers to treatment access. One barrier that has been identified is the complex linkage needed between available physical treatment capacity and available treatment funding, from a multitude of sources. Results of this evaluation will enable ADP to plan a capacity management system that will not only report on issues related to treatment service capacity, but may better link treatment needs to treatment resources throughout the State.

SOCR PLANS FOR THE FUTURE

FURTHER ANALYSIS OF CalTOP DATA

The depth of the data collected under CalTOP has yet to be fully analyzed. ADP also continues to pursue data sharing arrangements with other State departments. The interagency agreement currently in place with the UCLA-ISAP has been extended through August 31, 2003 to allow analysis and evaluation of data collected through June 30, 2003.

CalTOP COST OFFSET ANALYSIS

Cost offset analysis focuses on the question “What is the return on each dollar spent on substance abuse treatment?” In the past, ADP conducted studies using statewide, scientifically-based samples and self-reported information to identify the socioeconomic benefits of AOD treatment. The most recent of these studies is the 1994 California Drug and Alcohol Treatment Assessment (CALDATA) study that measured tangible and intangible savings associated with substance abuse treatment. Intangible savings considered in that study included the value of lost productivity, victim losses, and losses due to theft associated with AOD abuse. The CALDATA study demonstrated significant societal and taxpayer benefits resulting from investments made in providing treatment services to abusing populations.

One objective of the present CalTOP pilot study is to test the feasibility of linking cost of treatment data with administrative databases of other State departments to identify and measure treatment cost-offsets (e.g. the reduced use of criminal justice and other social services). The study also uses self-report data for comparison with data obtained from administrative data linkages for the cost-offset analysis. Unlike the CALDATA study, which measured overall societal benefits, CalTOP focused primarily on service reductions funded by taxpayers.

The CalTOP cost offset analysis has limitations. First, the original goal for the CalTOP study differed from that of the CALDATA study. CalTOP primarily was a study designed to test the feasibility of developing an outcome monitoring system whereas the CALDATA study focused on the benefits of substance abuse treatment. Second, because the CalTOP study was a pilot to determine feasibility of such a system, the CalTOP study used a purposeful design (specifically, it relied on voluntary participation by counties, providers, and program participants). Using a purposeful sampling design allowed the study to examine, in-depth, descriptions of the levels of treatment by CalTOP providers. Third, the current cost offset analysis relies on preliminary data. The final report will provide an analysis based on complete data. That report is due to ADP in the first quarter of 2003. The cost offsets calculated varied widely across treatment service types. This variation results from differences in treatment type and data sources used. Finally, because the study did not use a random design its findings cannot generalize to non-CalTOP providers.

Although the goals and methodology of CALDATA and CalTOP differ (e.g. CalTOP used a purposeful sample), a cautious analysis of the data collected to date suggest that the CalTOP results complement the CALDATA results. Based on preliminary data, results from the CalTOP pilot study suggest that for every dollar spent on substance abuse treatment, the public receives about \$7 in benefits, primarily due to increases in employment earnings and reductions in crime, incarceration, and emergency room use. Outpatient treatment showed the highest ratio of benefits to costs and methadone maintenance showed the lowest ratio. This variation likely is due to the long-term nature of client treatment with methadone maintenance. This does not suggest a lack of support for methadone treatment. Such treatment options remain important and critical to successful treatment regimes. Excluding measures based on self-reported data, a

System of Care Redesign (SOCR) – Report to the Legislature

conservative, preliminary analysis reveals \$4 in savings for each dollar spent on treatment. This estimate only considers savings associated with reduced mental health services use and crime victimization costs. These are the only sources of cost-offset information available from administrative data.

CalTOP demonstrated the feasibility of establishing data linkages with other state departments to measure cost offsets. With continued access to this information, ADP can develop and implement a sustainable system of accountability as a component of a future statewide outcome monitoring system.

STATEWIDE OUTCOMES MEASUREMENT

As CalTOP has shown, it is feasible to implement an outcomes measurement system to track client movement through the treatment delivery system. It has demonstrated benefits of using standardized assessment tools. It has documented improvements in quality of life for those who participate in treatment. It has demonstrated the benefits society receives by providing treatment services.

The data collected by the Department's California Alcohol and Drug Data System (CADDs), implemented in 1991, is insufficient to meet evolving federal reporting requirements and does not generate outcome data on which policy decisions and continuous treatment system improvements must be based.

As discussed earlier in this report, CalTOP was intended to serve as a pilot study to test standardized assessment tools and the feasibility of an automated outcome monitoring system (OMS). Although the CalTOP data collection model is too extensive for a statewide system at this time, it did successfully demonstrate that an OMS is feasible and provided valuable information to prioritize key elements.

With the full support of the County Alcohol and Drug Program Administrators' Association of California (CADPAAC), ADP has incorporated development of a statewide OMS into its strategic plan. A feasibility study report for the California Outcomes Measurement System (CalOMS) has been approved by the Department of Finance at the time of this writing. CalOMS will build on the CADDs foundation and use the valuable lessons learned from the CalTOP experience.

ADP intends to define and establish consensus on the specific data elements to be collected employing the skills of Project Management, Requirements Management and Systems Development contractors.

Outcomes can be measured on varying levels of depth and intensity at varying costs. ADP must determine the level of outcome monitoring that will derive the greatest amount of client and societal benefit in light of fiscal realities and limitations.

System of Care Redesign (SOCR) – Report to the Legislature

The proper level of outcome data will:

- Meet critical and evolving federal and State reporting requirements.
- Document efficient and effective use of limited resources.
- Improve accountability by better matching client treatment needs to treatment services received.
- Allow for continuous improvement in the management and delivery of treatment services.

Based on experience gained during CalTOP (See CalTOP LESSONS LEARNED, pages 16-17), ADP is:

Implementing new initiatives

- Recommend the use of the ASI tool for adult client assessment in all publicly funded treatment facilities in California.
- Develop a uniform definition of a treatment episode for reporting purposes.
- Pursue cooperation from other departments to establish long-term data sharing arrangements.
- Identify an effective method to consistently assess level of client treatment need.

Building into CalOMS

- Limit elements to those needed for federal reporting requirements and essential client outcome measures.
- Eliminate or minimize duplicate data entry.
- Maximize user-friendliness of automated systems.
- Partner with counties to develop specific system implementation plans.
- Provide management reports for counties and providers.
- Minimize impact data collection has on the client/clinician relationship.
- Include CADPAAC representation in steering and advisory capacities.

Considering for future system enhancement

- Define cost-effective methods of collecting detailed service element data.

SUMMARY

The Department of Alcohol and Drug Programs (ADP) continues to make progress and focus efforts to improve the delivery of alcohol and other drug (AOD) treatment and ancillary service referrals provided through almost 1,100 publicly funded treatment facilities. California counties serve as the brokers of treatment services to local communities, so any system changes must be made with their full cooperation and support of the County Alcohol and Drug Program Administrators' Association of California (CADPAAC).

A large portion of the System of Care Redesign (SOCR) vision included the development, implementation and testing of an automated data system to help standardize client assessment and record critical data necessary to measure the benefits treatment provides to the individual, family, and society. The California Treatment Outcome Project (CalTOP) provided this testing environment.

System of Care Redesign (SOCR) – Report to the Legislature

CalTOP successfully demonstrated that the development and implementation of a statewide outcome monitoring system with well-defined data collection goals is feasible and desirable. Such a system will help standardize service delivery to clients and will provide a stream of data that can be used to incrementally, yet continuously, improve treatment delivery at the provider, county, and State levels. It will also provide the data necessary to meet and exceed federal data submission requirements.

CalTOP data has once again documented the positive impact of treatment, has demonstrated that treatment is a cost-effective solution to a complex societal problem and gives ADP specific information which can be used to target areas needing performance improvement.

Based on the valuable lessons learned during this pilot study, with support of CADPAAC and the AOD treatment field, ADP is moving forward with the development of the California Outcomes Measurement System (CalOMS). CalOMS is anticipated to be fully operational in August 2005.

APPENDIX A

Letter of support from Toni Moore, President, County Alcohol and Drug Program Administrators' Association of California (CADPAAC), to Kathryn P. Jett, Director, California Department of Alcohol and Drug Programs, dated October 31, 2002.
(See next page)

CADPAAC

County Alcohol and Drug Program Administrators Association of California

Dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs.

President

Toni Moore

Sacramento County

Past President

William J. Demers

Sierra County

Vice Presidents

Yvonne Frazier

San Mateo County

Connie Moreno-Peraza

Stanislaus County

Treasurer

David Reiten

Shasta County

Secretary

Robert Garner

Santa Clara County

Large Counties

Robert Garner

Santa Clara County

Medium Counties

Gino Giannavola

Sonoma County

Small Counties

Randy Snowden

Napa County

MBA

Mike Beard

Lassen County

Los Angeles County

Patrick Ogawa

Cultural Competency

Connie Moreno-Peraza

Stanislaus County

Jeronimo Breen

San Bernardino County

Criminal Justice

Patrick Ogawa

Los Angeles County

Co-Occurring Disorders

Chuck Deutschman

Contra Costa County

Fiscal

Gino Giannavola

Sonoma County

Prevention

George Feicht

San Joaquin County

Al Medina

San Diego County

Social Services

Rosalind McNeely

Monterey County

Sandra Fair

Orange County

Youth

Robert Garner

Santa Clara County

Strategic Plan

Yvonne Frazier

San Mateo County

October 31, 2002

Kathryn P. Jett, Director
California Department of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95814

Re: Participation by the County Alcohol and Drug Program Administrators' Association of California in the System of Care Redesign effort

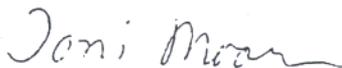
Dear Ms. Jett:

This letter is to affirm our continued support and express our appreciation for the working partnership between the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) and the Department of Alcohol and Drug Programs (ADP) in the development and testing of a comprehensive, client-centered system of care.

CADPAAC is pleased to have been actively included in the System of Care Redesign (SOCR) effort and the pilot testing of the California Treatment Outcome Project (CalTOP). CADPAAC members have actively participated in advisory committees and specialized workgroups that have provided ADP with recommendations and input from the alcohol and other drug (AOD) treatment community. The full CADPAAC membership has been regularly advised of progress in the SOCR effort and CalTOP.

After reviewing the SOCR Report to the Legislature – January 1, 2003, we feel it accurately reflects our significant progress in improving the treatment delivery system in California and in developing and testing an outcome monitoring system. CADPAAC looks forward to continuing this working partnership with ADP as, together, we strive to improve the delivery and accountability of AOD treatment services in California.

Sincerely,



Toni Moore
President, CADPAAC