Sacramento County

ALCOHOL AND DRUG SERVICES STRATEGIC PLAN

2012-2014

Prepared for: Sacramento County Department of Health and Human Services
Behavioral Health Services Division
Alcohol and Drug Services Program

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Sacramento County Alcohol and Drug Services 2012-2014 Strategic Plan

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INTRODUCTION

Forecasting major changes in the alcohol and drug services system as a result of policy changes at the Federal, State, and local levels, Sacramento County Alcohol and Drug Services (ADS) – with support from the Sacramento County Alcohol and Drug Advisory Board – launched a strategic planning process in Fall of 2010. Knowing that the environment will continue to grow more complex emphasized the need to establish formal priorities and goals that will help ensure that ADS operations most effectively respond to the needs of the community.

Although strategic planning was prompted by the anticipation of future changes, ADS's recent history also contributes to the need for a plan. ADS has been in a state of organizational transition over the past three years, morphing from a division within the County's Department of Health and Human Services, to a division within the County's Department of Behavioral Health Services, to a program of the County's Behavioral Health Services Division, under the County's Department of Health and Human Services. As the ADS program settles into its spot within the organizational structure, it is expected that the strategic plan will help retain focus for the ADS program.

The need for a strategic plan is further highlighted by the fact that shrinking resources are leading to limited capacities within ADS. The strategic plan seeks to focus energy on a limited number of key goals that will have strong, system-wide impact on the capacity and effectiveness of alcohol and drug services.

SCOPE

This strategic plan focuses on operational issues for County Alcohol and Drug Services. The plan does not dictate particular modes of service delivery or define target populations, but rather prescribes processes that can be used to help achieve these and other ends. In other words, the plan is not designed to outline the exact services that will be offered through ADS in the years to come. The goals, objectives, and strategies in this strategic plan establish direction for ensuring the ongoing responsiveness, effectiveness, and integrity of services provided and funded by County ADS.

It is also important to establish that the strategic plan is designed and written for Sacramento County Alcohol and Drug Services as an entity. Although there is much that external entities can contribute to help improve the overall system, responsibilities for strategies are targeted internally. This was not done to exclude external entities from participating. In fact, to be successful, many of the strategies will require cooperation and participation from providers, administrators, and other stakeholders. External entities are welcome to incorporate relevant strategies into their own operations, as they desire. But the responsibility will rest with ADS and the ADS Advisory Board to effectively involve all needed parties.

The plan addresses the entire continuum of care, including prevention, early intervention, treatment, and recovery. Although some goals may be specific to a particular component of the continuum of services (and are clearly worded as such), the majority of goals are intended to apply to all aspects of the continuum. Having a continuum in which all elements work cohesively and abide by the same values and vision will help ensure the best overall community outcomes.

Similarly, the strategic plan is applicable to service planning and delivery inclusive of all demographic segments of the population, including youth, adults, and seniors, as well as all genders, races and ethnicities. Unless specifically noted otherwise, mechanisms and processes described in the goals, objectives, and strategies are intended to be universally applied.

The strategic plan should be considered a living document, meaning that although specific goals and objectives are outlined, emerging issues or unanticipated developments may require adaptations over the life of the plan. In light of its "living document" status, progress on the strategic plan must be assessed at routine intervals. This will serve to assure that strategies are being implemented as intended. It will also allow for evaluation of efforts underway to ensure that they are meeting intended objectives, and if they are not, to make needed adjustments.

METHODOLOGY

The strategic planning process was led by a steering committee consisting of Alcohol and Drug Services staff, Alcohol and Drug Advisory Board members, and service providers. The Steering Committee provided guidance throughout the process and developed the substantive content for the plan. Although the Steering Committee

itself was limited in size, it placed a strong emphasis on the involvement of a variety of stakeholders throughout the process. Considerable time was committed in early meetings to identifying potential stakeholders to engage in the process (in total, stakeholders representing more than 25 distinct interest areas were identified and placed on the information distribution list). By providing opportunities for diverse stakeholders to participate, the Steering Committee sought to achieve three objectives: (1) assure transparency; (2) secure a comprehensive view of stakeholders' interests and perceptions, and (3) begin building the support and relationships needed to successfully implement the adopted strategic plan.

In order to most efficiently engage stakeholders, the steering committee took two approaches. First, the steering committee engaged groups already populated with a variety of critical stakeholders, such as the ADS Advisory Board committees and ADS staff meetings, to gather input on perceived strengths and challenges within the current system. The effort to reach out to existing groups successfully obtained very diverse viewpoints, but also clearly highlighted the most commonly held views. Within those discussions, participants were also able to indicate the broader environmental issues that influence alcohol and drug services, and how those issues needed to be considered as strategic goals are identified.

The second approach employed by the steering committee was to develop draft elements of the strategic plan, such as the mission, principles, goals, and objectives that were then shared with stakeholders for their review and comment. The drafted materials were paired with a specific set of questions for consideration by stakeholders: (1) what resonates; (2) what is off the mark; (3) what is missing; (4) what is most important. This was done because it was known that stakeholders would have varying levels of awareness and knowledge of the alcohol and drug services system; therefore, having information to respond to would ease the path for engagement. The questions were structured to foster simple, but critical assessment of the information drafted by the Steering Committee. In addition to facilitating response to the information drafted by the Steering Committee, the questions fostered additional insight from stakeholders to ensure that all of their thoughts and opinions could be obtained.

The approach also lent itself to using a variety of methods to obtain input. Drafted information was distributed via email to a wide array of stakeholders and coordinated with follow up phone calls to assure receipt and to solicit comment. Feedback was invited through email response, interviews (via telephone or in person), and in group settings (with pre-existing groups, such as executive directors' meetings and counselors' meetings). This approach fostered substantial response because stakeholders could choose to spend the amount of time they felt appropriate, whether it was commenting on just one goal or carefully examining and commenting on all the draft materials. In total, feedback was collected from nearly 100 individuals in 22 different settings.

Stakeholder input was collected over a two month period. The feedback was compiled and synthesized by the project facilitator and presented back to the Steering Committee for analysis. With the ideas and feedback in hand, the steering committee refined and revised the draft elements to reflect the common priorities and critical elements. Once the second draft was completed, a complete version of the strategic plan (including mission, principles, goals, objectives, and strategies, as well as background narrative) was distributed to all stakeholders for a final review and comment. All additional feedback was then considered by the steering committee, final revisions made, and the final strategic plan developed and adopted.

THE ENVIRONMENT

Successful planning requires knowledge of the current environment, as well as an educated understanding of what the future likely holds. To help shape this understanding, the strategic planning process relied on the intelligence that exists within the system. The input of stakeholders, both within and outside of County Alcohol and Drug Services, set the tone for the plan. The information collected to guide planning can be placed into two buckets: (1) what is known and (2) what is anticipated.

WHAT WE KNOW

The Numbers

The following summary data are presented to provide context as to the scale of alcohol and other drug (AOD) use in our community. According to the Substance Abuse and Mental Health Administration's (SAMHSA's) 2010 National Survey on Drug Use and Health (NSDUH), illegal drug use has increased significantly compared with earlier 2002-2008 rates, driven primarily by increases in marijuana use. Rates of alcohol use and excessive drinking have remained relatively stable, but are at even higher levels than illegal drugs. The NSDUH study found that 8.9% of U.S. residents (age 12 and over) used illegal drugs within the past month, 51.8% drank alcohol within the past month, 23.1% participated in binge drinking, and 6.7% reported heavy drinking in the prior month (defined as consuming five or more drinks on five or more separate occasions in the month). Applied to the Sacramento County population, an estimated 105,000 illegal drug users, 610,000 drinkers, 280,000 binge drinkers, and 80,000 heavy drinkers reside in Sacramento County.

In addition, 8.7% of the population (age 12 or older) met the criteria for alcohol and/or other drug dependence or abuse in the past year. Six percent were dependent or abusing alcohol only, 2% were dependent or abusing other drugs only, and 1% were involved with both alcohol and other drugs. This amounts to an estimated 105,000 residents in Sacramento County in need of treatment services.

State and local consumption and consequence data confirm the pervasive scope and serious nature of the problem. Alcohol and other drug (AOD) use begins early with many of our youth and increases significantly throughout the high school years, peaking among the 18-25 year old population. The 2009-10 California Healthy Kids Survey for Sacramento County shows 58% of 11th graders have drank alcohol one or more times in their short lifetimes, 38% have used marijuana, and 17% have used prescription pain medicines to get high. Only 37% of 11th graders report having not used any alcohol or other drugs. Rates of use in the past 30 days are also alarming. Thirty percent of 11th graders report alcohol use and 20% report marijuana use in the past month. Overall 36% report AOD use in the past month.

Quantifying the specific local impact of alcohol and drug use on society can be difficult, but it is known that alcohol and drug use is associated with increased risks for child abuse and neglect, domestic violence, youth and gang violence, other criminal activity, motor vehicle crashes and other accidents, emergency room use and hospitalization, death, and overall poorer health status. Additionally, alcohol and drug use has significant consequences on individual productivity, whether at work, in school, or at home. All of these factors present financial and emotional costs. These AOD consequences impact individuals, families and communities. Because societal responses to alcohol and drug related issues require the dedication of resources and capacity that could be targeted elsewhere, they harm not just the individual, but the community as a whole.

Specific examples of the local impact of alcohol and drugs come from a variety of sources. As examples, the Sacramento County Criminal Justice Cabinet reports that 70% of adults booked in the Sacramento County Jail were under the influence of alcohol or drugs at the time of arrest; the California Attorney General reports that more than 5,500 arrests for drug violations were made in Sacramento County in 2009; the DMV reports more than 8,000 DUI arrests in Sacramento County in 2008; the California Highway Patrol responded to nearly 1,300 alcohol involved motor vehicle crashes in 2008; Sacramento County Child Protective Services received reports on more than 200 substance-exposed infants in 2009; Sacramento County's 2008 Community Health Status Report found that more than 2,200 alcohol and drug-related deaths occurred between 2000 and 2006 and that the age-adjusted mortality rate due to alcohol and drug-related causes increased by 57% over that same time period.

These figures do not depict a comprehensive understanding of the consequences that alcohol and drug use has on Sacramento County, but they do provide a sense of the far-reaching influence. The

information highlights the integral role that alcohol and drug services play in contributing to quality of life in the Sacramento community.

In light of the challenges faced locally, Sacramento County Alcohol and Drug Services fielded 3,747 referrals for treatment services in FY 2009-10. Even when adding in the number of individuals who received prevention messages and interventions, it is apparent that the service capacity is not currently able to meet the community need. ADS and the broader alcohol and drug community must continue to be creative in how they go about maximizing existing resources and leveraging new resources.

Our Strengths

In meeting with stakeholders who work with or in the alcohol and drug community, it is clear that County ADS has established a number of strengths from which to address alcohol and drug use in the community. Identifying strengths is important, as they represent leverage points from which to make further progress. Among the most commonly noted strengths:

- **Service Variety**. The variety of services that are currently available and the ability of those services to meet the needs of very diverse populations was frequently cited as a strength of the current system. Several stakeholders highlighted the ability of the current system to deliver services across age, cultural, and gender spectrums as a strong point that needed to be retained. The ability to serve a variety of populations was viewed as imperative in Sacramento County due to its diverse population. Stakeholders also appreciated the fact that service providers deliver services throughout the geography of Sacramento County.

- **Holistic Approach**. Alcohol and Drug Services' commitment to a holistic approach was clearly appreciated by stakeholders. This issue was brought up as it relates to administering services across the entire continuum and also the tendency of the system to recognize and try to address the concomitant needs of individuals and families. A number of stakeholders spoke to the concept of trying to address alcohol and drug issues in isolation of other factors, and how such an approach hinders success. Even when a single agency isn't able to address all of an individual's needs, the availability of ancillary services in the community was seen as a positive. Continued recognition, and even fostering of the ability to take multi-faceted approaches, both in treatment and prevention, is desired.

- **Evidence-Based Approach**. Another key strength noted by stakeholders was the existing emphasis on the use of evidence-based and promising practices. Stakeholders expressed an ongoing support for relying on models that have shown positive outcomes, especially given the limited resources available. More significantly, stakeholders noted the advantages that are provided by allowing for flexibility in how recognized models are implemented so that they can be adapted to best address local nuances. Stakeholder feedback indicates an ongoing desire for the alcohol and drug system programs to be based on successful models, tailored to local conditions.

- **Broad Commitment**. The level of commitment and active participation from stakeholders at the local level was frequently noted in stakeholder input. Stakeholders commented on the extreme commitment that is frequently exhibited by a variety of entities at the local level, including ADS staff, the ADS Advisory Board, provider agencies, and locally-based training and advocacy organizations. All of these groups were recognized for the contributions that they have made and the resources and expertise they bring to the system.

The strengths discussed above do not represent a comprehensive list, but they do highlight the most frequently noted assets and areas of success. The strengths discussed also represent ongoing opportunities for alcohol and drug services. The strategic plan's goals and objectives seek to build on the key strengths highlighted by stakeholders in order to best advance the system and achieve positive impacts on the community.

Our Challenges

Stakeholders identified a variety of challenges in the current system that may be impeding progress and community outcomes. Fortunately, in addition to identifying challenges, many stakeholders were also quick to offer potential solutions that could result in positive change. Even when specific solutions were not identified, respondents' input provided the Steering Committee with information that served to focus problem solving discussion. Among the more frequently cited challenges:

- **Communication**. A number of stakeholders expressed a need to improve communication, both internally and externally. The perceived communication shortfalls exist at all levels: between ADS and providers; among providers; between the

alcohol and drug services community and other services; and between the alcohol and drug services community and the public at large.

As it relates to communication within the alcohol and drug services system, concern was expressed that information from ADS is not universally received, resulting in misunderstanding, or differences in understanding that result in problems with expectations and service delivery. In some instances there has been an inconsistency of communication which has not fully taken into account consideration of stakeholder input.

Stakeholders also noted that communication is lacking between providers about emerging issues, availability of resources, and other issues that could help improve service implementation. The lack of communication between providers leaves potentially valuable resources and information on the table. To improve communication within the alcohol and drug services system, stakeholders expressed a need for establishing standardized, consistent forms of communication.

Stated concerns about external communication centered on missed opportunities to leverage support and resources. Because there is no coordinated or deliberate approach to share positive alcohol and drug messages, the community is generally unaware, and therefore, unsupportive of alcohol and drug causes. This creates an unnecessarily difficult operating environment. Additionally, although many collaborative relationships exist, alcohol and drug use has such a widespread impact that many more could be forged. Active communication with an expanded audience could leverage substantial support.

- **Accountability**. Alcohol and Drug Services must be accountable to a variety of audiences, most notably the public, consumers, and providers. A number of stakeholders expressed frustration with how accountability is maintained in the current system. Specifically, frustration was reported that ADS requires (often in response to State and Federal mandates) providers to perform a number of administrative tasks, such as data collection and routine reporting, but there is not clear understanding of how the information is used. Respondents made it clear that they are fully in favor of assuring accountability, but want to make sure that accountability procedures are pursued and conducted in an efficient and practical manner.

  A specific accountability related issue mentioned frequently by stakeholders was the need for focused performance assessment and measures. The current method of collecting and reporting evaluation indicators is commonly viewed as too cumbersome, and the subsequent use of findings from those measures is thought to be limited. Stakeholders reported that to be effective, the selection of common measures is needed, and the results need to be used to drive improvement.

- **Collaboration**. Because of its far-reaching influences and consequences, alcohol and drug use and services interact with a variety of other fields, including social services, health services, criminal justice, education, and employment. The need for mutually beneficial collaboration with all of these areas, as well as the community in general, was reported by stakeholders as something that will continue to expand with time.

  Stakeholders recognized that successful relationships exist, however, many perceived that alcohol and drug services are at times not as equal a partner in collaborative relationships. This is often the result of restrictions or mandates set by the funding sources, as well as higher level decisions which define the scope of services and roles for projects. As a result, alcohol and drug services are not always used in the most effective manner. It is, however, recognized that ADS already successfully collaborates with, and is a major partner in partnerships with CPS, DHA, Drug Courts, and Prop 36. Respondents expressed a need for alcohol and drug services (both ADS and the provider community) to take a more active approach to collaboration by carefully defining the strategies and roles that will have the most positive impact.

- **Access**. The current process for accessing and navigating treatment was frequently mentioned as an area of concern for stakeholders. Although there are multiple points of entry into the ADS treatment system, there are difficulties in transitioning consumers from one element of the continuum to another, parameters dictated by funding sources, and – depending on funding source – limited ability to enter indigent consumers into the system at the time and place they first present. Stakeholders expressed support for a system that maintains a consistent, equitable, and fair process for screening and referral to care. Creating a system that is more user-friendly and better able to address potential consumers where and when they present is desirable.

- **Funding**. Funding was addressed as a major challenge for a variety of reasons. First, stakeholders frequently commented about the lack of local public investment in alcohol and drug services. The lack of County General Fund support

indicates that alcohol and drug services are not a priority for Sacramento County. The lack of local support can make it difficult to leverage other funding opportunities that require evidence of existing support for the services.

Additionally, County ADS needs to grow the capacity to regularly seek out and pursue funding opportunities, such as through grants or other revenue generating activities. As funding tightens, all avenues for securing needed resources need to be pursued.

Third, stakeholders reported significant challenges in the ability to meet client needs given the varying requirements of the funding sources used by the County. It was commented that other jurisdictions have been able to effectively blend funding sources to improve efficiency and flexibility, and that ADS will benefit from continued efforts to blend funding sources.

Finally, extensive concern was expressed about the changing landscape in terms of the public structure. The adopted Affordable Care Act at the Federal level and realignment at the State level present potentially systems-changing requirements that may result in much greater demand for services, as well as changes in funding requirements, expectations, and referrals. Given all the changes, participants expressed a strong need to begin making use of all funding sources, and remain flexible to enable timely response to other changes (and opportunities) that may be on their way.

The above listing of challenges highlights the issues that were most frequently stated by stakeholders and that were viewed by stakeholders and the Steering Committee to be the most pressing to address. These issues were at the forefront in informing the development of the strategic plan's goals and objectives.

WHAT WE ANTICIPATE

Although the future will bring with it many changes, two specific issues most stood out as they relate to future planning for Sacramento County Alcohol and Drug Services: passage of the Affordable Care Act at the Federal level and agreement to State Realignment at the State level. Both these changes will have significant impacts on the implementation on alcohol and drug services.

- **Affordable Care Act**. The Affordable Care Act, scheduled to begin phased in implementation beginning in 2014, will bring a number of changes to the alcohol and drug services field. Among the potential changes are likely increases in the number of individuals eligible to receive alcohol and drug services, better coverage for preventive services, better ability to bill for alcohol and drug treatment services, more rigorous standards for services, and stricter qualification requirements for providers. All of these changes can be viewed as both positive and challenging. As the working details of the Affordable Care Act are interpreted at the Federal and State levels, the understanding of local impact continue to evolve. Monitoring, anticipating, and preparing for the implications of the Affordable Care Act will likely be a challenge up until its official roll out, but keeping apprised is essential to ensure that the local community is as prepared as possible.

- **Realignment of State/County Roles in Alcohol and Drug Services (Realignment)**. Realignment was initiated by the State as part of the FY 2011-12 budget process. Under realignment, functions (and the corresponding dollars) that were once performed at the State level are passed down to counties for administration. Theoretically, realignment could provide local ADS with greater discretion in how it administers programs, such as Drug Medi-Cal, non-Drug Medi-Cal treatment, and drug court. With greater discretion comes the potential for efficiency and the ability to better meet local service needs. Details on realignment are still emerging, so projecting the actual impacts is difficult, but it is another issue that County ADS must closely monitor to ensure readiness.

- **Parity Coverage of Alcohol and Drug Services**. The federal Mental Health Parity and Addiction Equity Act passed in 2008 and went into effect in July of 2010. The purpose of the Act is to provide equal access to alcohol and drug treatment services by requiring health plans that provide alcohol and drug treatment benefits to make them available at the same level as their medical coverage. Implementation could result in an increased number of individuals seeking alcohol and drug services. Although the Act went into effect in 2010, there has been minimal impact on service demand within the ADS system. But as the understanding and use of coverage parity expands, ADS and providers should be prepared to take advantage of the emerging reimbursement source.

- **Organizational Restructuring of State Department of Alcohol and Drug Programs and County Behavioral Health Services**. Responsibilities of the State Department of Alcohol

and Drug Programs are proposed to be transitioned to other lead entities, with some functions being transitioned to counties (realignment) and others going to the State Department of Health Care Services (and potentially other departments). Any transition of responsibilities could be accompanied by episodes of confusion or uncertainty as new roles are established. Additionally, the dissolution of the State Department of Alcohol and Drug Programs could result in a diminished profile of alcohol and drug issues at the State level, resulting in long term consequences on policies and priorities.

For the same reason, the transition of Alcohol and Drug Services within the County from its own division to a program within the Behavioral Health Services Divisions emphasizes the need to retain a prominent voice. As integration continues, the unique needs and traits of alcohol and drug services must be kept at the forefront to ensure that the features and strategies that foster its success are not overwhelmed by other models.

OUR DIRECTION

The findings of the strategic planning process, including what is known and what is anticipated, were used to shape priorities for the goals, objectives, and strategies communicated on the following pages. Because the plan was developed based on the best information available *at a particular point in time*, it is a living document, and it is expected that revisions will need to be made over time to reflect emerging conditions. Although occasional adjustments might be necessary, the guidance provided by the mission statement, principles, goals, objectives and strategies serve as a road map that will be used by Sacramento County Alcohol and Drug Services to best serve the community.

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SACRAMENTO COUNTY ALCOHOL & DRUG SERVICES 2012-2014 STRATEGIC PLAN

Mission Statement

The mission of Sacramento County Alcohol and Drug Services is to promote a healthy community free of the harmful effects associated with alcohol and drug use by providing access to a comprehensive continuum of services, while remaining responsive to and reflective of the diversity among individuals, families, and communities.

Guiding Principles

The following principles guide the work and decisions of Sacramento County Alcohol and Drug Services (the principles are not listed in an order of priority):

- We will provide a wide range of services to meet the range of age, gender, cultural, severity and other needs presented, with a preference to community based providers, whenever appropriate.
- Strategies and services will be based on the best science and knowledge available and must achieve measurable, meaningful and cost effective results and outcomes.
- Services shall achieve high quality standards and continually evolve through quality improvements and quality assurance protocols.
- We will promote a coordinated and integrated continuum of care with multiple, standardized points of entry and screening and comparable standards and protocols across funding sources and the continuum.
- We will embrace opportunities for administrative streamlining in order to reduce barriers and maximize the potential of success for both providers and consumers.
- We will practice and foster collaborative planning, decision making, and implementation.
- We will strive for transparency in decision making.
- Services will be client-centered to match the participant's needs, readiness, resilience, and/or recovery goals.
- We recognize a holistic approach to treating the individual.
- Broad and active participation from diverse public, private, and community based services is critical to overall health promotion.
- A community environment that reduces access to and appeal of alcohol and other drugs, as well as reduces stigma associated with treatment and recovery from alcohol and drug dependency, is critical to prevention, early intervention, treatment, and recovery.
- We will emphasize sobriety/recovery as an essential part of overall health in which prevention and early intervention works, treatment is effective, and people recover.
- We will maintain flexibility in the alcohol and drug services system to best take advantage of the Affordable Care Act to maximize our services.

Goal 1: Deliver effective alcohol and drug services across the entire continuum of services.

Objective A: Fund services based on evidence-based or promising practices across the entire continuum of services.

Strategies	Timeline	Lead
• Strategy 1: To the extent possible, create multi-year spending plans that project funding levels that will be allocated to each area of the continuum of services.	Plan in place by June 30, 2013.	ADS
• Strategy 2: Fund services that are clearly grounded in the best knowledge and science available.	By release of next RFP.	RFP production team

Objective B: Assure that funded services are leading to successful client/community outcomes.

Strategies	Timeline	Lead
• Strategy 1: Define, collect, and report specific evaluation measures on a routine basis.	Measures in place by June 30, 2012.	Quality management task force.
• Strategy 2: Establish a process by which ADS and funded providers regularly review outcome measures and make corresponding revisions to program design.	Process implemented by December 31, 2012.	Quality management task force.
• Strategy 3: Improve aggregated client-level data sharing between providers.	Mechanisms to facilitate data sharing in place by December 31, 2013.	ADS
• Strategy 4: Share evaluation data with stakeholders and the public on a regular basis.	Data sharing with stakeholders underway by December 31, 2013	ADS

Objective C: Assure that services are accessible and appropriately reaching the targeted populations.

Strategies	Timeline	Lead
• Strategy 1: Define the desired scope, scale, and intensity of County funded and provided services.	Preferred scope, scale, and intensity defined by December 31, 2012.	ADS
• Strategy 2: Assess the availability, effectiveness, and feasibility of universal clinical screening	Universal screening tool adopted by December 31,	ADS

and assessment tools to determine the most appropriate for universal, local use.	2013.	
• Strategy 3: Dedicate at least one meeting annually for all funded providers throughout the continuum to discuss improving linkages and smoothing transitions between the prevention, treatment, and recovery spectrums of the continuum.	First "linkages" session held by December 31, 2012.	ADS Administrator
• Strategy 4.A.: Continue to evaluate processes for entry into and transitions within the treatment system in order to recommend the most effective, user-friendly, and efficient models.	Complete feasibility analysis by December 31, 2012.	ADS Advisory Board + Staff
• Strategy 4.B.: Alcohol and Drug Services reviews and responds to the assessment recommendations for entry into and transitions within the treatment system.	Within three months of receiving recommendations.	ADS
• Strategy 5: Monitor implementation and impact of the Prevention Strategic Plan and report progress to stakeholders on a semi-annual basis.	Progress of plan being monitored by January 1, 2012.	ADS
• Strategy 6.A: Develop and implement an annual system-wide client satisfaction assessment process (including surveys and other methods of gathering feedback) to identify barriers, challenges, and opportunities for system and provider improvement.	Process in place by June 30, 2012.	Quality management task force.
• Strategy 6.B: Document provider and system-level changes made in response to the client satisfaction assessment on an annual basis.	First report released by June 30, 2013.	ADS and providers

Objective D: Minimize barriers that hinder the delivery of services.

Strategies	Timeline	Lead
• Strategy 1: Dedicate time at each Executive Directors meeting to identifying and problem solving around barriers to service delivery.	Item established as a standing agenda item by December 31, 2011.	ADS Administrator
• Strategy 2.A: Develop and implement an annual provider-level satisfaction survey to identify barriers, challenges, and opportunities for system improvement.	Survey developed by June 30, 2012.	Quality management task force.
• Strategy 2.B: Document system level changes made in response to the provider satisfaction assessment on an annual basis.	First report released by June 30, 2013.	ADS

Goal 2: Expand resources available for Alcohol and Drug Services.

Objective A: Identify, pursue, and utilize diverse financial resources.

Strategies	Timeline	Lead
• Strategy 1: Advocate for Alcohol and Drug Services realignment funding received from the State to remain under the authority of Alcohol and Drug Services.	County policy regarding use of State Realignment funding is in place by June 30, 2012.	Sacramento County DHHS Director with ADS Advisory Board
• Strategy 2: Research and implement strategies to eliminate barriers to the utilization of multiple funding sources to support needed services.	Potential models identified by June 30, 2013.	ADS
• Strategy 3: Re-establish a grants task force to develop a process for systematically identifying and pursuing State, Federal, Foundation, and other funding opportunities within the Alcohol and Drug Services community.	Process created by June 30, 2013.	ADS
• Strategy 4: Formalize policies to encourage and assist County funded providers to diversify their funding sources, including seeking Medi-Cal certification and insurance panel approval.	Policy established by June 30, 2012.	ADS

Objective B: Continue and strengthen collaboration with non-ADS entities.

Strategies	Timeline	Lead
• Strategy 1: Establish a task force to promote the value and impact of the specialized skills and knowledge of alcohol and drug specific services.	Task force established by June 30, 2012	ADS
• Strategy 2.A: Continue meeting regularly with representatives from County Mental Health, as well as private mental health providers to identify common challenges and establish common goals.	Recurring meeting schedules in place by January 1, 2012.	ADS Administrator
• Strategy 2.B: Continue meeting regularly with representatives from County Primary Care, as well as community clinics and private primary health providers to identify common challenges and establish common goals.	Recurring meeting schedules in place by January 1, 2012.	ADS Administrator
• Strategy 2.C: Continue meeting regularly with representatives from criminal and juvenile justice, including sheriff, police, probation, and courts, to identify common challenges and establish common goals.	Recurring meeting schedules in place by January 1, 2012.	ADS Administrator
• Strategy 2.D: Continue meeting regularly with representatives from other Public agencies, such	Recurring meeting schedules in place by	ADS Administrator

as County Child Protective Services and Education, to identify common challenges and establish common goals.	January 1, 2012.	
• Strategy 3: Identify and meet with non-governmental stakeholders who interact with the alcohol and drug community to discuss common challenges and establish common goals.	Meetings underway by December 31, 2012.	Outreach task force

Objective C: Improve communication between and among Alcohol and Drug Services and ADS funded providers.

Strategies	Timeline	Lead
• Strategy 1: Maintain a set structure for the ADS Executive Directors meetings that builds education, emerging news, troubleshooting, and announcements into all meetings.	Consistent meeting structure in place by January 1, 2012.	ADS Administrator
• Strategy 2: Bi-annually survey (written or verbal) providers on effectiveness of Executive Directors meetings and suggestions for continued improvement.	First survey administered by January 1, 2012.	ADS Administrator
• Strategy 3: Create an interactive, web-based platform to serve as an informational clearinghouse for resources and alcohol and drug services related news.	Communication portal launched by June 30, 2013.	Division of Behavioral Health Services

Objective D: Improve community-wide support for alcohol and drug prevention and treatment efforts.

Strategies	Timeline	Lead
• Strategy 1: Define and promote the financial and societal benefits of alcohol and drug services.	Outreach/promotional messages defined by December 31, 2012	ADS Advisory Board
• Strategy 2: Build and strengthen the network of advocates speaking on behalf of alcohol and drug services.	Roster of community-based supporters developed by December 31, 2012	ADS Advisory Board
• Strategy 3: Identify, support, and help mobilize community-based efforts that address alcohol and drug related issues.	Systematic process for identifying efforts support needs developed by June 30, 2013	ADS Advisory Board
• Strategy 4: Actively utilize media and other communication outlets to promote positive client stories and outcomes resulting from services administered through ADS.	At least two promotional pieces appear in media or DHHS newsletter by December 31, 2012, and annually thereafter.	ADS

Goal 3: Prepare County administered/funded alcohol and drug services for implementation of the Affordable Care Act.

Objective A: Educate and prepare stakeholders to meet requirements of the Affordable Care Act (ACA)

Strategies	Timeline	Lead
• Strategy 1: Host a series of trainings for ADS staff and ADS funded providers on key elements of the ACA.	Training topics and schedule established by June 30, 2012.	ADS
• Strategy 2: Begin phasing in mandates (such as qualifications, certifications, billing requirements, screening and referral processes, etc.) that will be part of ACA into provider contracts.	Mandates incorporated into FY 2013/14 contracts.	Contract Managers
• Strategy 3: Announce/Forward updates on news and status of ACA as new information is released and available.	Announcements being distributed by June 30, 2012	ADS

Objective B: Build relationships with partners that will be essential to allowing for a continued continuum of care under the Affordable Care Act (ACA).

Strategies	Timeline	Lead
• Strategy 1: Recommend the initiation of routine, joint meetings between County Alcohol and Drug Services, Mental Health, Primary Care, Public Health, and DHHS Director to discuss implications of the ACA and initiate changes.	Affordable Care Act focused meetings underway by January 1, 2012	ADS Advisory Board
• Strategy 2: Reach out to private sector, public sector, and community-based partners – including health plans and providers – to define steps that need to be taken to establish effective relationships under ACA requirements.	Outreach to non-public sector partners underway by June 30, 2012.	ADS

SACRAMENTO COUNTY ALCOHOL & DRUG SERVICES
2012-2014 STRATEGIC PLAN
MONITORING PLAN

The Strategic Plan's goals, objectives, and strategies are designed and written for the Sacramento County Alcohol and Drug Services Program (ADS). Therefore, the Alcohol and Drug Services Program has chief responsibility for maintaining and carrying out the Strategic Plan. The following monitoring plan is established to ensure that strategies are implemented within the defined timeframes, and equally as important, to ensure that once strategies are initiated, they continue and are incorporated into routine business practices, as appropriate. The monitoring plan also provides the opportunity to examine the effectiveness of strategies to ensure they are achieving their desired impact. It must be kept in mind that the strategic plan is a living document, and revisions will be needed to accommodate changing conditions.

ADS will report on the progress of the strategic plan on a bi-annual basis (January and July of each year). Reports will be presented by the Alcohol and Drug Services Administrator (or designee) to several audiences to foster awareness and promote transparency. Specifically, status reports will be presented to ADS staff at staff meetings, to service providers at Executive Directors meetings, and to the Alcohol and Drug Services Advisory Board at Advisory Board meetings. Bi-annual status reports should include brief, written statements describing:

1) Steps taken toward strategies that are "due."
2) Accomplishments/Impacts of strategies that have been initiated.
3) Challenges encountered (if any).
4) Steps that still need to be taken (if any).
5) Updates on progress and status of strategies that have previously been initiated.
6) Needed revisions to the strategic plan (if any).

The table of the following page identifies strategy "due" dates. The timeline column within the strategic plan's goals, objectives, and strategies tables describe what is to be accomplished by the due date. In most cases, it is expected that the strategies will be initiated within the timeframe, but implementation will occur on a continuous basis, thereafter.

Strategic Plan Monitoring Schedule

Strategy	January 1, 2012	June 30, 2012	December 31, 2012	June 30, 2013	December 31, 2013
1.A.1				X	
1.A.2.		X			
1.B.1		X			
1.B.2.			X		
1.B.3.					X
1.B.4.					X
1.C.1.			X		
1.C.2.					X
1.C.3.			X		
1.C.4.A.			X		
1.C.4.B.			X		
1.C.5.	X				
1.C.6.A.		X			
1.C.6.B.				X	
1.D.1.	X				
1.D.2.A.		X			
1.D.2.B.				X	
2.A.1.		X			
2.A.2.				X	
2.A.3.				X	
2.A.4.		X			
2.B.1.		X			
2.B.2.A.	X				
2.B.2.B.	X				
2.B.2.C.	X				
2.B.2.C.	X				
2.B.2.D.	X				
2.B.3.			X		
2.C.1.	X				
2.C.2.	X				
2.C.3.				X	
2.D.1.			X		
2.D.2.			X		
2.D.3.				X	
2.D.4.			X		
3.A.1.		X			
3.A.2.				X	
3.A.3.		X			
3.B.1.	X				
3.B.2.		X			