STRATEGIC PREVENTION PLAN WORKBOOK FOR COUNTIES

California Department of Health Care Services,
Community Services Division, Operations Branch,
Prevention and Family Services Section
&
Community Prevention Initiative,
Center for Applied Research Solutions

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CHAPTER 1

USING THE STRATEGIC PREVENTION PLAN WORKBOOK

PURPOSE

The purpose of the Strategic Prevention Plan (SPP) Workbook is to provide county guidance for writing an SPP utilizing the Strategic Prevention Framework (SPF). The SPP Workbook is a procedural guide containing requirements, definitions, and resources. According to the county Substance Abuse Prevention and Treatment Block Grant (SABG) application, every county receiving primary prevention (Pv) funds must have a current SPP utilizing the SPF. Final SPP approval depends on the county's inclusion of the required components detailed in this SPP Workbook.

STRATEGIC PREVENTION FRAMEWORK

The SPF is the Substance Abuse and Mental Health Services Administration's (SAMHSA)[1] five-step planning process to guide states, jurisdictions, tribes, and communities in the assessment, capacity building, planning, implementation, and evaluation of effective, culturally appropriate, and sustainable Pv services and efforts.

WORKBOOK STRUCTURE

This SPP Workbook has eight chapters. The county SPP will contain six chapters as follows:

- Chapter 1: County Introduction
- Chapter 2: Assessment (SPF Step One)
- Chapter 3: Capacity Building (SPF Step Two)
- Chapter 4: Planning (SPF Step Three)
- Chapter 5: Implementation (SPF Step Four)
- Chapter 6: Evaluation (SPF Step Five)

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[1] Substance Abuse and Mental Health Services Administration. (2019, June). *A Guide to SAMHSA's Strategic Prevention Framework*. 26. Retrieved August 25, 2020, from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf#:~:text=A%20GUIDE%20TO%20SAMHSA%E2%80%99S%20STRATEGIC%20PREVENTION%20FRAMEWORK%206,help%20planners%20to%20identify%20and%20prioritize%20the%20substance

Most of the SPP Workbook material derived from SAMHSA's Substance Abuse Prevention Skills Training Manual (June 2013). Contact DHCS Prevention and Family Services for a copy of training materials.

Each SPF chapter (SPP Workbook chapters four through eight) begins with a “Required Component” section informing the county exactly what to include in the narrative of the SPP. Following the “Required Components” are corresponding chapter steps if counties need more guidance. Each “Required Component” refers to the corresponding chapter steps for easy reference. Each chapter contains definitions, resource links, and examples.

Tips for Using the SPP Workbook

- Complete a preliminary read of the chapter to understand the required components and chapter guidance for each SPF step.
- The Department of Health Care Services (DHCS) does not recommend reading further than the chapter being worked on since chapter steps are sequential.
- The SPP Workbook uses the terms “intervention,” “service,” “effort,” and “program” interchangeably.
- When developing an SPP, the number of pages does not equate to a quality SPP. A quality SPP can be fifteen pages long, include the necessary components, and be clear, concise, and comprehensive.
- If you have questions regarding SABG allowable expenditures, email sabg@DHCS.ca.gov.

II CHAPTER

GUIDING PRINCIPLES[2]

To develop an effective SPP, the SPF requires integrating the guiding principles of cultural competence and sustainability throughout strategic Pv planning. This section provides considerations and best practices counties can address when writing about cultural competence and sustainability for each SPF step chapter.

When addressing cultural competence and sustainability, the SPF strives to:

1. Engage partners who represent and work with sub-populations experiencing behavioral health disparities in the county's sustainability planning efforts.
2. Sustain processes that have successfully engaged members from the identified focus populations.
3. Sustain programs that produce positive outcomes for the identified focus populations.
4. Ensure Pv practices produce positive outcomes for members of diverse population groups. Communities must engage in an inclusive and culturally appropriate approach to identifying and addressing their substance use disorder (SUD) problems.

Culturally competent prevention is the only type of prevention worth doing—and sustaining.

[2] Substance Abuse and Mental Health Services Administration. (2019, June). *A Guide to SAMHSA's Strategic Prevention Framework*. 26. Retrieved August 25, 2020, from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf#:~:text=A%20GUIDE%20TO%20SAMHSA%E2%80%99S%20STRATEGIC%20PREVENTION%20FRAMEWORK%206,help%20planners%20to%20identify%20and%20prioritize%20the%20substance

GUIDING PRINCIPLE: CULTURAL COMPETENCE[3]

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

Cultural competence requires organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policymaking, administration, practice, service delivery, and involve consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Individuals and organizations are at various knowledge and skill levels along the cultural competence continuum. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Principles of cultural competence include:

1. Define culture broadly.
2. Value clients' cultural beliefs.
3. Recognize complexity in language interpretation.
4. Facilitate learning between providers and communities.
5. Involve the community in defining and addressing service needs.
6. Collaborate with other agencies.
7. Professionalize staff hiring and training.
8. Institutionalize cultural competence.

Improved quality of care is the outcome measure that indicates whether implementing training programs, policies, and culturally or linguistically appropriate standards makes a difference. Integrating cultural competency in a focused or strategic way can be a helpful

[3] Centers for Disease Control and Prevention, National Prevention Information Network. (2020, August 17). *Cultural Competence in Health and Human Services*. Retrieved August 25, 2020 from https://npin.cdc.gov/pages/cultural-competence#what

adjunct to the quality improvement process. For example, if a program wants to analyze access to services, it might examine variables such as age, gender, or race/ethnicity. If the analysis reveals adolescents have the highest rate of non-participation, the program can target specific strategies to this group. Does the program need to have weekend hours when teens can more easily slip away from home? Would providing free transportation or reminder calls/texts help teens participate with Pv services? Does the service provider reflect a youth-sensitive approach?

What is the difference between cultural competence, awareness, and sensitivity?

Cultural competence emphasizes the idea of effectively operating in different cultural contexts and altering practices to reach different cultural groups. Cultural knowledge, sensitivity, and awareness do not include this concept. Although they imply understanding of cultural similarities and differences, they do not include action or structural change.

STEPS FOR INTEGRATING CULURAL COMPETENCE

Step 1 - Understand Cultural Competence

To further understand cultural competence, research the following resources:

- Community Prevention Initiative (CPI). (2017, May 17). *Introduction to Cultural Competence* [Webinar]. Access the recorded webinar at https://adobe.ly/3hfb5cP. This recorded session will take 44 to 90 minutes.

Step 2 - Understand Culturally and Linguistically Appropriate Services (CLAS)

To further understand CLAS, research the following resources:

- United States Department of Health and Human Services Office of Minority Health. (2018, October 2). The National CLAS Standards. Retrieved August 25, 2020, from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.
- CPI. (n.d.) *CLAS Webinar Series. (1) Introduction to Cultural Competence. (2) Introduction to CLAS and the First Four Standards: Governance, Leadership, and Workforce: CLAS Standards 2-4. (3) Theme 3: Communication and Language Assistance: CLAS Standards 5-8. (4) Theme 4: Engagement, Continuous Improvement, & Accountability: CLAS Standards 9-15 [Webinars]*. Access the recorded webinars at http://www.ca-cpi.org/cultural-competence-resources/.

Step 3 - Integrate Cultural Competence throughout the SPF[4]

ASSESSMENT

- Work with the community throughout the assessment.
- Take steps to identify focus populations who experience behavioral health disparities.
  - Collect and use cultural competence-related information and/or data. Culturally competent data helps identify focus populations that endure health disparities i.e. culturally and linguistically appropriate surveys/questionnaires, key informant interviews, socioeconomic data, and population-based data (race, ethnicity, sex, sexual identity, disability, geographic location data).
- Identify culturally relevant risk factors and other underlying conditions specific to the focus populations.
- Hire culturally competent staff and evaluators to support the community needs assessment.
- Identify data gaps specific to serving focus populations and take efforts to remedy them.
- Develop plans to share and solicit input about assessment findings with members of the focus populations and describe these findings using terms and phrases that are devoid of jargon.

[4] Substance Abuse and Mental Health Services Administration. (2019, June). *A Guide to SAMHSA's Strategic Prevention Framework*. 27-28. Retrieved August 25, 2020, from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf#:~:text=A%20GUIDE%20TO%20SAMHSA%E2%80%99S%20STRATEGIC%20PREVENTION%20FRAMEWORK%206,help%20planners%20to%20identify%20and%20prioritize%20the%20substance

CAPACITY BUILDING	• Build the knowledge, resources, and readiness of Pv practitioners and community members to address disparities and implement CLAS standards. • Ensure practitioners understand the role of cultural competence in their overall work and the unique needs of the focus populations experiencing disparities. • Develop new partnerships that will help engage members of the focus population(s) in Pv planning efforts. • Ensure tools and technology follow CLAS standards i.e. Pv reading materials are available in the languages spoken by the community. • Support building cultural competence skills and knowledge of participants and collaborative partner organizations.
PLANNING	• Prioritize community representation in the planning process i.e. planning workgroups should mirror community demographics and focus populations. • Involve members of the focus population as active participants and decision-makers. • Identify and prioritize protective factors associated with focus populations and disparities. • Consider community history when identifying Center for Substance Abuse Pv (CSAP)[5] strategies. • Develop objectives that include a reduction in health disparities as a long-term outcome. • Integrate culturally responsive communication skills to promote inclusion and implement conflict resolution if misunderstandings arise. • Build cultural competence skills among the people that will participate in the planning process.
IMPLEMENTATION	• Incorporate effective Pv programs and practices developed for and evaluated with an audience representing the focus population. • Involve members of the focus populations in the design and delivery of programs. • Consider community history when identifying Pv programs. • Understand people may choose to participate in different ways and learn differently. • Adapt and/or tailor evidence-based practices to be culturally relevant. For example, create a virtual format version of a training originally designed for in-person implementation in the event direct contact is not practical. • Create a culturally competent method for focus populations to provide feedback during program participation.
EVALUATION	• Conduct process and outcome evaluations to demonstrate whether selected programs and practices are having the intended impact on identified disparities and/or focus populations. • Track program adaptations and/or modifications. • Allocate the evaluation resources necessary to detect whether the selected interventions are having the intended impact on the behavioral health disparities the county expects to reduce. • Conduct follow-up interviews with program participants to understand program evaluation findings; be sure to include feedback from individuals representing the focus populations. • Engage partners who represent and work with sub-populations.

[5] https://www.samhsa.gov/about-us/who-we-are/offices-centers/csap

GUIDING PRINCIPLE: SUSTAINABILITY[6]

In Pv, sustainability is the capacity of a community to produce and maintain positive Pv outcomes over time. To maintain positive outcomes, counties and communities will want to sustain an effective strategic planning process, programs, and practices that produce positive Pv results. Accomplishing these dual tasks requires the participation, resolve, and dedication of diverse community members and careful planning. It is important to sustain an effective strategic planning process for the following reasons:

1. ***Prevention takes time.*** While communities are likely to achieve some short-term outcomes initially, it can take many years to produce long-term results. When practitioners help the SPF process develop over time, communities are much more likely to make a significant and lasting impact on SUD problems.
2. ***SUD problems and priorities change.*** Pv needs and capacity are always evolving with new SUD issues arising that no one can anticipate right now. With a well-established strategic planning process like the SPF already in place, communities will be able to recognize and respond effectively to these important changes over time.
3. ***Successful implementation of the SPF depends on collaboration.*** The SPF is widely recognized by many public health funders and practitioners. Adherence to a common planning process can help planners establish a shared language across health issues and build the interdisciplinary partnerships needed to make a real difference.

A primary goal of an effective strategic planning process is to identify the right combination of programs and practices to address local Pv priorities. Many factors contribute to the effectiveness of implementing Pv programs/services. In general, programs and practices must operate in a variety of community settings and influence local risk and protective factors at both the individual and population-based levels. Thus, a comprehensive Pv plan might include:

- A school-based youth skills promotion program
- Parent education to support children's healthy development
- Organizational/community rules and regulations that support healthy behavior
- Enforcement of rules and regulations that support healthy behavior

Some programs and practices may work better than others e.g. they produce positive outcomes and/or receive community support. To maintain positive outcomes over time, it is important to identify and sustain those Pv programs and practices that work well for a community.

[6] Substance Abuse and Mental Health Services Administration. (2019, June). *A Guide to SAMHSA's Strategic Prevention Framework*. 29. Retrieved August 25, 2020, from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf#:~:text=A%20GUIDE%20TO%20SAMHSA%E2%80%99S%20STRATEGIC%20PREVENTION%20FRAMEWORK%206,help%20planners%20to%20identify%20and%20prioritize%20the%20substance

STEPS FOR INTEGRATING SUSTAINABILITY

Step 1 - Understand Sustainability

To further understand sustainability, research the following resources:

- Community Anti-Drug Coalitions of America. (2018). *Fostering Long-Term Change to Create Free Communities*. National Coalition Institute. https://www.cadca.org/sites/default/files/resource/files/sustainability.pdf.
- CPI. (2015, April 30). Enhancing Sustainability through Capacity [Webinar]. Access the recorded webinar at adobe.ly/3rEEWjP. This recorded session will take 44 to 90 minutes.
- Nolfo, P. (2014). *Sustaining Prevention: Eight Capacity Building Factors for Success*. CPI. http://www.cars-rp.org/publications/Prevention%20Tactics/PT09.13.14.pdf.

Step 2 - Integrate Sustainability Throughout the SPF[7]

ASSESSMENT	• During assessment, practitioners begin making decisions based on a clear understanding of local Pv needs. They also begin building relationships with data keepers and stakeholders who can play important roles in supporting and sustaining local Pv efforts over time. • Utilize data collection as an opportunity to identify champions and leaders. • Conduct interviews with community leaders from the focus populations throughout the writing and implementation of the SPP. • Recruit community members with skills in needs assessment.
CAPACITY BUILDING	• Intentional capacity building at all levels helps to ensure successful programs are sustained within a larger community context and therefore less vulnerable to local budgetary and political fluctuations. • Effective capacity building increases the ability to respond to changing issues with innovative solutions. • Building capacity also involves promoting public awareness and support for evidence-based Pv and engaging partners and cultivating champions who will be vital to the success—and sustainability—of local Pv efforts. • Convene and provide training to engage stakeholders in the Pv effort. • Develop a list of accessible and available resources for the Pv effort. • Create recruitment strategies for new and non-traditional Pv collaborative partners. • Develop agreements with current and new stakeholders and collaborative partners to solidify their roles and levels of involvement. Involvement level types and examples can be found in *Table 5.1 Levels of Involvement* in Chapter V, Steps for Capacity Building, Step 2.

[7] Substance Abuse and Mental Health Services Administration. (2019, June). *A Guide to SAMHSA's Strategic Prevention Framework*. 30. Retrieved August 25, 2020, from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf#:~:text=A%20GUIDE%20TO%20SAMHSA%E2%80%99S%20STRATEGIC%20PREVENTION%20FRAMEWORK%206,help%20planners%20to%20identify%20and%20prioritize%20the%20substance

PLANNING	• When developing a comprehensive approach to SUD Pv, communities should consider the degree to which Pv interventions fit with local needs, capacity, and culture: the better the fit, the more likely interventions are to be both successful and sustainable. • Engage stakeholders in strategic planning meetings. • Encourage involvement in the selection of policies, programs, and strategies. • Consider adaptability of the identified Pv efforts; ensure they reflect the needs of the community.
IMPLEMENTATION	• By working closely with community partners to deliver evidence-based programs and practices as intended, closely monitoring and improving their delivery, and celebrating "small wins" along the way, planners help to ensure their effectiveness and begin to weave Pv into the fabric of the community. • Develop recruitment and retention plans to involve stakeholders, community representatives, members from focus populations, and collaborative partners into program implementation planning. • Build data collection methods within program implementation to assess effectiveness.
EVALUATION	• Through process and outcome evaluation, communities can make important midcourse corrections to Pv efforts, identify which programs/services are worth expanding and/or sustaining, and examine ongoing plans to progress toward sustaining programs/services that work. • By sharing evaluation findings, planners can also help build the support needed to expand and sustain effective programs/services. • Analyze collected data. • Review processes, outcomes, and effectiveness of Pv efforts. • Develop recommendations to improve the quality of the Pv effort. • Create an evaluation report. • Share results and discuss recommendations with partners, focus populations, and stakeholders. This will also enhance community ownership of Pv efforts in the county.

III CHAPTER

COUNTY INTRODUCTION

The county introduction is the first chapter of the SPP. This is the only chapter that does not require a cultural competence and sustainability section.

Use the format below and include the following:

SUD PREVENTION COMMITMENTS

Insert the county's organizational vision, mission statement, and values relative to SUD Pv, if applicable.

COUNTY PROFILE

A county profile provides an overview of the county's demographics and geographic characteristics. Only include information that affects current and future SUD Pv services. Describe how socio-economic, geographic, political, economic, and cultural issues influence substance use trends and how these issues may challenge SUD Pv service delivery. Do not copy and paste the county's geographical attributes from a website. Examples may include a county experiencing SUD challenges related to the social or geographic location such as a "college town," a "tourist" location, or a "border" county. In the instance of a "border" county, the profile should include information about border relations and drug trafficking challenges specific to be a "border" county.

PRIOR SPP OVERVIEW

Provide information about the prior SPP and discuss what worked, what did not work, and what the county learned to improve future Pv efforts.

Achievements

Discuss overall program implementation and/or capacity building achievements the county accomplished during the prior SPP. Refer to the prior SPP and respond to the following questions:

- What outcomes and/or objectives did the county achieve? List them and describe what contributed to accomplishing them.
- How did the county increase protective factors to address objectives?
- Which programs, if any, were the most effective with supporting the county achieve outcomes?
- Which programs/services had the greatest impact? For example, passing a social host ordinance to decrease youth accessing substances from adults, extending services to another community or more schools, or implementing a new program.

Lessons Learned

Discuss overall program implementation and/or capacity building challenges the county experienced during the prior SPP. Refer to the prior SPP and respond to the following questions:

- What outcomes and/or objectives were unsuccessful? List them and describe what prevented them from being successful.
- What were the program implementation and/or capacity building challenges the county experienced?
- What course of action did the county take to resolve those challenges?
- What infrastructural or program changes will the county implement to avoid these challenges in the future?

IV CHAPTER ASSESSMENT

Assessment is the second chapter of the SPP.

Assessment involves the systematic gathering and examination of data related to SUD problems, as well as related conditions and consequences in the community. Assessing the problems means pinpointing where the problems are in the community, as well as the populations that are affected. It also means examining the conditions that put a community at risk and identifying conditions that can protect against those problems.

REQUIRED COMPONENTS FOR THE ASSESSMENT CHAPTER

Assessment consists of two parts, Data Assessment and Capacity Assessment. "Steps for Assessment" immediately follow this section if counties need more resources, definitions, and/or clarity for the "Required Components" below.

DATA ASSESSMENT

Assessment Process
Provide a brief narrative about the assessment process.

Include the following:

- ***Assessment Support.*** Identify each contributor, their relationship with the county, their role in the process, and their contribution. Contributors can include but are not limited to other government departments, collaborative partners, community members, community-based organizations, LEAs, stakeholders, etc.
- ***Data Methods.*** Describe the qualitative and quantitative data methods used and why they were selected. The county may include surveys and interview/focus group questions as attachments to the SPP.
  - Did the county develop data tools such as surveys or key informant interviews?
    - If yes, who developed the tools?
  - How did the county implement these tools?
  - How did the county determine participants?
- ***Data Limitations.*** Describe factors influencing accessibility or availability that may have limited findings or may limit findings in the future.

Data Sources and Key Findings, Refer to Steps 1 through 4
List each qualitative and quantitative data source and include the following information for each:

- Title of the data source
- Participant demographics
- Publication date (month/year)
- Key findings listed in bullet list format

Data Analysis Summary, Refer to Steps 5 and 6
The *Data Analysis Summary* includes the identification of priority areas, consequence/consumption issues, major data trends, focus populations, and contributing factors that emerge across data sources. This summary will describe the most important issues from consumption, consequence, and contributing factors data.

Prioritization of Risk Factors, Refer to Steps 7 and 8
Considering importance and changeability, prioritize risk factors for the most important consumption and/or consequence issues from the Data Analysis Summary.

- Insert *Table 4.1 Prioritizing Risk Factors for Consumption and Consequence Issues* to illustrate prioritized risk factors.
- Explain why the county ranked risk and protective factors in the stated order.

Problem Statement(s), Refer to Step 9
Develop problem statements for each priority area that include the prioritized risk factors and focus populations for each identified consumption and/or consequence issue.

CAPACITY ASSESSMENT

Prevention Capacity
Describe the county's current SUD Pv capacity.

Include the following:

- ***County Staff.*** Identify each staff position assigned to SUD Pv services. Include SABG funded and non-SABG funded staff. List position titles and provide a brief description of their primary duties. Indicate whether the position is a full-time employee (FTE), half time (.5 FTE), part time (.25 FTE, etc.), or volunteer. Indicate the funding sources for each position. Ex. 1.0 FTE, 50% SABG Pv Set-Aside/50% Mental Health Block Grant.
- ***County Services and Programs.*** List the Pv services and/or programs the county currently implements and provide a brief description of the program and the focus population(s) the program serves.
- ***County Sub-contractors and Services.*** List the SABG Pv-funded organizations and a brief description of services and/or programs the organization is responsible for implementing. Skip this section if the county does not have sub-contractors.
- ***Coalitions/Workgroups.*** List community coalitions/workgroups in which the county participates.

- Indicate the capacity in which the county participates (lead or participant).
- Describe the coalition/workgroup's purpose. Be sure to include how the coalition/workgroup relates to SUD Pv.

- ***SUD Pv Workforce Development.*** Describe the training and technical assistance (TTA) the county provides to SUD Pv staff, stakeholders, and sub-contractors.

Resource and Community Readiness, Refer to Steps 10 through 12
Assess resource and community readiness for each priority substance. The county will need to determine if sufficient resources are available (resource readiness) and identify the readiness level for each focus population and/or community (community readiness) prior to service implementation.

Include the following:

- Complete and insert *Table 4.2 Resource Readiness Assessment*. This table illustrates capacity deficiencies for community, fiscal, human, and organizational resources for each priority area.
- Complete and insert *Table 4.4: Capacity Challenges/Gaps.* Referencing *Table 4.2 Resource Readiness Assessment* and *Table 4.3* Resource Readiness Assessment, this table summarizes the readiness stage and capacity challenges for each priority area. The county will address these capacity deficiencies in the Capacity Building Chapter.
- Provide summary about how the county assessed the resource and community readiness for each priority area.

Cultural Competence, Refer to Chapter II: Guiding Principles
Describe how the county incorporated cultural competence in the Assessment Chapter.

Include the following:

- Which focus populations did the county identify?
  - What data informed the county's selection of focus populations?
  - If the SPP will focus on health disparities:
    - Identify which focus populations experience health disparities.
    - Discuss the health disparities specific to each focus population.
    - Identify which data informed the health disparity issues.
- How did the county incorporate the identified focus population throughout the assessment process, if applicable?
  - What roles did representatives from the focus population assume?
  - How did the county consider the focus population's perspectives?
  - Did individuals from the focus populations assume leadership and/or decision-making roles?
    - If yes, describe the specific roles and/or decisions in which the focus population contributed.

- Which risk factors did the county prioritize specifically for each focus population?
- Did the county hire staff and/or evaluators/consultants to support culturally responsive assessment methods and protocols?
    - If yes, briefly explain their role and contribution to the Assessment.
- Describe data gaps specific to identified focus populations and health disparities, if applicable.
- How did the county share assessment findings with members from the focus population, if applicable?

Sustainability, Refer to Chapter II: Guiding Principles
Describe how the county incorporated sustainability in the Assessment Chapter.

Include the following:

- Did the county utilize stakeholders (includes community champions and leaders) to conduct Assessment efforts?
    - If yes, identify who and describe how each stakeholder participated i.e. participated with planning meetings to impact decision-making, conducted interviews, provided staff to facilitate focus groups? Use group descriptions e.g. business partners, community leader, Hispanic Chamber of Commerce. Do not indicate the names of people.
- Did the county identify new community champions and leaders during the Assessment process? Do not indicate the names of people.
- How did the county recruit staff and/or stakeholders to participate with assessment efforts?
- Describe training the county provided to staff and stakeholders to conduct assessment efforts, if applicable.

STEPS FOR ASSESSMENT

Step 1 - Understand Assessment

To further understand Assessment, research the following resources:

- CPI. (n.d.) Conducting a Needs Assessment [Tip Sheet]. http://www.ca-cpi.org/docs/Publications/Other/SPFTipSheet_01_NeedsAssessment.pdf
- CPI. (n.d.). Module 1: Assessment [Webinar]. Access the recorded competency at http://www.ca-cpi.org/training/TA_Training.php. This webinar will take 56 minutes.
- SAMHSA. (n.d.). Risk and Protective Factors. https:www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf
- SAMHSA's Center for the Application of Prevention Technologies. (2017). Preventing Marijuana Use: Factors Associated with Use. https://mnprc.org/wp-content/uploads/2019/01/preventing-youth-marijuana-use-factors-2017.pdf
- Seltzer, C. (n.d.) Focus Groups - Helpful Tools for Strategic Prevention Planning. CPI. http://www.ca-cpi.org/wp-content/uploads/2018/03/CPI-Focus-Groups.pdf.

Step 2 - Research and Identify Data Sources

The first task is to research which local data sources are available. Local data may include data gathered from county Pv programs, formal program evaluations, and/or data from other county departments that include demographic characteristics and/or trends for program participants over the last three years.

The 4 C's refer to the four data types the Pv field uses to assess and identify SUD needs. The 4 C's are as follows:

1. ***Consumption Data*** references substance use patterns e.g. age of onset, 30-day use, binge drinking rates, etc.
2. ***Contributing Factors Data*** references risk and protective factors that predict the level of risk for substance use e.g. parents use substances; peers view use as normal; poor or lacking adult/youth relationships; poor or lacking connections to adults, school, and community; etc.
3. ***Consequence Data*** references negative impacts of consumption e.g. emergency visits; DUIs; health issues; etc.
4. ***Capacity Data*** illustrates available county resources and identifies resource challenges/gaps within the county's current capacity to address SUD problems.

Quantitative Data

Quantitative data indicates how often a behavior or event occurs or to what degree it exists. This list is not exclusive; other quantitative data sources may be available. Even though the following list includes many data sources, they may not be available for every county.

CPI provides each county with CPI County Indicator Toolkits. The three Toolkits provide county-level quantitative data related to consumption, consequences, and contributing factors for substance use. Data sources for the Toolkits are identified below with an asterisk.

- California Healthy Kids Survey (CHKS), http://chks.wested.org/*
- Court Records
- Emergency Department Data (visits related to substance abuse)*
- Emergency Medical Service Data
- Epidemiology Groups (If the county does not have an epidemiological entity, contact the Public Health Department and/or other health service agencies to investigate if there is an epidemiology department or designated staff that focus on epidemiological work and find out the types of data they offer)
- Hospital Discharge Data
- Medical Examiner or Coroner Data*
- Police Reports/Arrest Data*
- School Incident Records and Discipline Reports
- DataQuest, http://data1.cde.ca.gov/dataquest/*
- Alcohol/Drug Admission to SUD Treatment Services Data

Qualitative Data

Qualitative data explains why people behave or feel the way they do. Counties may lack accessible quantitative data. In these situations, qualitative data will be useful. Qualitative data sources include:

- Surveys – Standardized questionnaires that ask pre-determined questions
- Interviews – Structured or unstructured, one-on-one directed conversations with key individuals or leaders in a community
- Focus Groups – Structured interviews with small groups of like individuals using standardized questions, follow-up questions, and the exploration of other topics that arise to better understand the issues emphasized by focus group participants
- Observation – In structured or systematic observation, the researcher conducts data collection using specific variables and according to a pre-defined schedule. In unstructured observation, the researcher conducts data collection in an open and free manner without pre-determined variables or objectives. [8]

Quantitative Data

- Answers "How many" and "How often"
- Typically uses "numbers" as descriptors
- Methods include random sample surveys and archival sources
- Draws general conclusions about a population

Epidemiology is the study of the distribution and determinants of the health and wellness of populations. In the SUD Pv field, epidemiologists study the patterns of use and abuse and the factors associated with an increased or decreased risk of developing substance abuse problems.

Qualitative Data

- Can help provide answers to "Why," "Why not," "Why here," or "What does it mean"
- Uses "words" as descriptors
- Examines an issue or population in more depth to understand underlying issues, i.e. contributing factors or community norms
- Methods include surveys with open-ended questions and focus groups
- Can be particularly useful when communities do not have much quantitative data available

[8] Business Research Methodology. Retrieved September 30, 2020 from https://research-methodology.net/research-methods/qualitative-research/observation/

Step 3 (Optional) - Create Data Methodologies

Due to lack of local data sources, a county may need to develop and administer their own data collection tools. Counties may conduct interviews, surveys, and/or focus groups as part of their qualitative data. Data collection tools may be in-person, online, or by telephone. Be mindful of the time it takes to develop, plan, administer, and analyze these types of assessment tools. A county may need many months to complete some of these data methods.

Step 4 - Examine Data Sources and Summarize Key Findings

Examine the data using the following criteria:

1. Magnitude - Which problem seems to have the largest impact? Is there a problem or problems that consistently "pop up" in different data sets?
2. Time Trend - Is the problem getting worse over time or is it getting better?
3. Severity - What is the gravity of the problem? Does the problem result in mortality? Is it costly?
4. Changeability - Is the problem amendable to change?

Tips when assessing data

- Compare county data to that of neighboring counties, to the state, and to the nation.
- Examine different kinds of data. Substance use and behavioral health problems are complex. Utilizing both qualitative and quantitative data can provide a more accurate and complete picture of the problems.
- Look for patterns over time and relationships between data.
- Search for data gaps. Use qualitative data to fill quantitative data gaps.
- Be cautious when analyzing data with small population sizes. Smaller numbers can amplify the extent of change over time. For example, a 100% increase in a consumption rate sounds extraordinary. However, it could mean an increase from just 1 to 2 participants.
- Small numbers can yield exaggerated percentage change. This is also true when considering disparities based on group membership. For example, an age or racial group may have a much higher rate of ER visits than other groups; however, it may also be that there are very few individuals in the county that are a part of that group (for example, ten or fewer). These few individuals may be outliers within their own group i.e. not representative of the experience of that group.
- While it is important to analyze disparities, it requires looking at data over time to assess trends and reviewing other sources to determine if there is a reliable disparity. Over-attributing a relationship between group membership and the extent of an issue is the reason why most large datasets do not produce rates when there are fewer than five to twenty individuals within a group.
- Be aware that not all data is equal. Some data is more reliable or valid than other data. Most datasets will include limitations or caveats to interpretation of the data.

- Qualitative data is less objective. It is highly recommended to discuss qualitative data with other stakeholders, colleagues, and coalitions to acquire further information and feedback. For counties that lack substantial quantitative data, the county can compile multiple qualitative data sources to identify county needs.
- Be sure to enlist the help of county departments that also deal with issues related to substance abuse, such as the Department of Public Health and Environmental Health.

SPP Narrative Example: Data Sources and Findings

California Healthy Kids Survey, San Joaquin County Secondary, Focus Population: 11th grade youth; (2008-2009)

- 23% of 11th graders reported age of onset for alcohol between ages 15 and 16.
- 16% of 11th graders reported age of onset for cannabis between ages 15 and 16.
- 18% of 11th graders and 14% of 9th graders drank alcohol in the past two days.
- 19% of 11th graders reported being "high" from using drugs.
- 12% of 11th graders reported binge drinking in the past two days.

Focus Group developed locally by Behavioral Health Department, Focus Population: 15 female teens ages 14 through 16, (July 2016)

- 25% of participants reported that they drink because their friends do.
- 10% of participants reported that they only drank alcohol one time.
- 50% of participants reported that they drink during family functions/events.
- 65% of participants reported that they would like an adult to talk to about problems.

Step 5 - Identify Priority Areas
Based on the assessment data, identify the substances the data reveals are the most problematic in the county. These substances are the priority areas the county will focus on.

Step 6 - Identify Critical Consequence and/or Consumption Issues
After presenting the data, analyze the consumption and consequence data issues most critical for the county. Based on the data analysis, the county may elect to address either consumption, consequences, or both. To help identify which issues to address, consider the following:

- What issues are prominent in the data? Consumption, consequences, or both?
- What SUD problems are most pressing? Consumption, consequences, or both?
- Has the county or community asked to focus on specific problems?

Step 7 - Identify Risk Factors for Consequence and/or Consumption Issues

Once the county identifies the specific issues (consumption and/or consequences), identify the most prevalent risk factors impacting the consumption and/or consequence issues for each priority area. Risk factors should be specific to different focus populations. For example, risk factors for opioid use among youth should differ from risk factors for opioid use among older adults.

Step 8 - Prioritize Risk Factors for Consumption/Consequence Issues

Since it is impossible to address every risk factor, use *Table 4.1: Prioritizing Risk Factors for Consumption and Consequence Issues* to prioritize the risk factors for each consequence/consumption issue using the criteria of importance and changeability. When prioritizing risk factors, the county may need to consider which consequences are the most severe and require urgency. Sometimes, consumption data can be a risk factor for a consequence issue.

Note: The consumption, consequence, and risk factor data the county prioritizes will transition into objectives in the Planning Chapter's logic model. Be certain these priorities are measurable.

A ***Risk Factor*** is a characteristic at the biological, psychological, individual, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

IMPORTANCE: How much does a particular risk factor impact the SUD problem in the community?

Importance refers to how much a risk factor affects the SUD problem in a community. Will the risk factor influence other behavioral health issues? Does the risk factor address the specific developmental stage of the identified focus population?

CHANGEABILITY: Does the community have the capacity (readiness and resources) to change a particular risk factor?

A risk factor has high changeability if the following are true:

- a community has sufficient resources and readiness to improve a particular risk factor,
- a suitable evidence-based intervention exists, and
- if change can occur within a reasonable timeframe, and

The risk factor has low changeability if a community does not have adequate resources, is not ready to address the risk factor, or changing the risk factor will take too long.

Table 4.1: Prioritizing Risk Factors for Consumption and Consequence Issues

Underage Drinking	Importance		Changeability		Priority Rank
	Low	High	Low	High	
Consumption Data: Youth have high rates of past 30-day use					
Teens have a favorable attitude towards drinking		X		X	3
Parents do not believe that drinking is harmful		X		X	2
Substances are accessible to teens by adults and retailers		X		X	1
Early/persistent problem behaviors: drinking at a young age		X	X		No Rank
Consequence Data: High rates of youth-involved traffic accidents involving alcohol					
Problem behavior: youth driving without license		X	X		No Rank
Substances are accessible to teens by adults and retailers		X		X	1
Youth intoxication (binge drinking)		X		X	2

Table 4.1 Instructions for Prioritizing Risk Factors

Table 4.1: Prioritizing Risk Factors for Consumption and Consequence Issues includes examples of how to assess the "importance" and "changeability" for each risk factor.

- Copy, paste, and add rows, if necessary, to complete *Table 4.1* for each critical consumption and/or consequence issue the county chooses to address.
- Score each risk factor "low" or "high" for importance and changeability.
- Rank ONLY the risk factors graded "high" for both "importance" and "changeability"; 1 being the highest priority.
- If the county identifies a risk factor high in importance and low for changeability, or vice versa, the county may elect to build capacity for the low-rated risk factor(s) and include capacity building efforts for the risk factor(s) in the Capacity Building Chapter.

Step 9 - Develop Corresponding Problem Statements

Each priority area will have one problem statement using the highest ranked risk factors for each consumption/consequence issue (see example below). Create a problem statement using the selected consumption and/or consequence issues and the corresponding prioritized risk factors. A problem statement does not repeat data statistics or state how the county will resolve the issue.

Note: The county will copy the problem statement(s) into the logic model(s) in the Planning Chapter.

SPP Narrative Example: Problem Statements
(two possibilities)

Example 1: Underage drinking (past 30-day use) is a priority in X County because alcohol is accessible by teens from adults and retailers, parents do not believe drinking is harmful, and teens have a favorable attitude toward drinking. Binge drinking and youth accessibility for alcohol lead to high rates of youth involved traffic accidents involving alcohol.

In this example, there are three prioritized risk factors for past 30-day use: 1. youth accessibility of alcohol from adults and retailers, 2. low perception of harm of underage drinking by parents, and 3. Teens have a favorable attitude among youth about drinking. There are two risk factors for youth involved car accidents involving alcohol consumption: 1. Binge drinking and 2. Youth accessibility of alcohol from adults and retailers

The logic model in the Planning Chapter will include seven objectives: 1. Past 30-day youth use, 2. Parent's low perception of harm, 3. Teens have a favorable attitude about alcohol consumption, 4. Youth access alcohol from parents, 5. Youth access alcohol from retailers, 6. Youth binge drinking, and 7. Youth involved traffic accidents involving alcohol.

Example 2: At this time, a county may focus completely on "youth accessibility of alcohol from adults and retailers" and re-write the problem statement since it is a risk factor for both critical issues. For example - Underage drinking (past 30-day use) is the highest priority for X County because youth access alcohol from adults and retailers.

The logic model in the Planning Chapter will include three objectives: 1. Past 30-day youth use, 2. Youth access alcohol from parents, and 3. Youth access alcohol from retailers.

Step 10 - Assess Resource Readiness

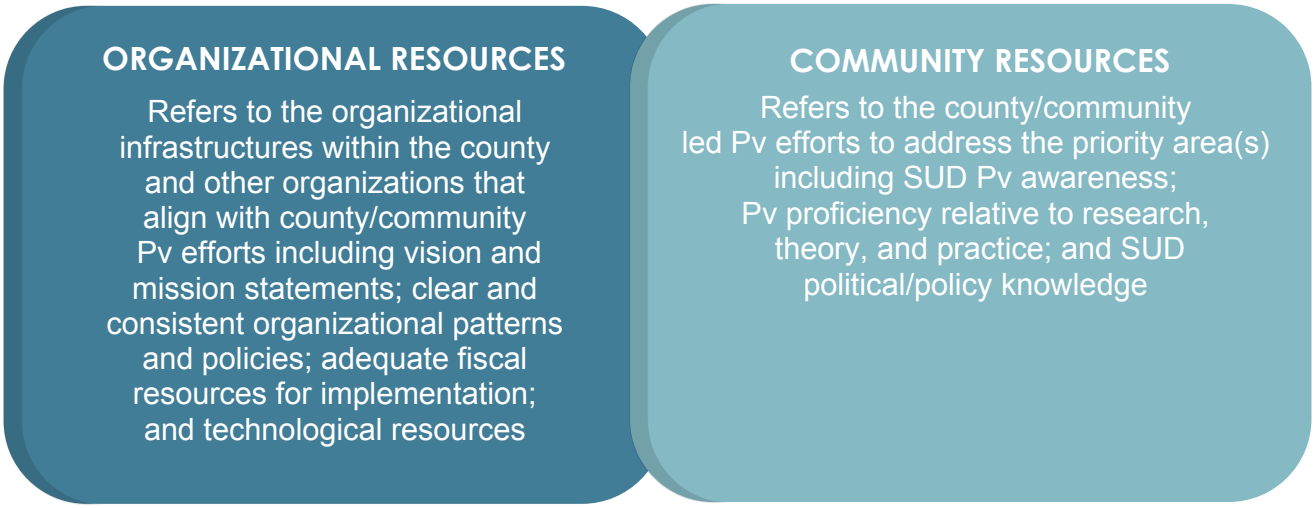
Assess existing resources for each priority area to identify county needs. Assessing the fiscal, human, organizational, and community resources available throughout the county will determine if the county is "resource ready" to address each priority area. The four components indicating resource readiness are:

FISCAL RESOURCES

Refers to indirect and direct funds that support Pv efforts including grants/donations, computer hardware/ software, meeting space, food, equipment, promotion, and advertising

HUMAN RESOURCES

Refers to the people who assist with Pv efforts including staff, trainers, consultants, volunteers, stakeholders, partners, and community leaders/champions



Complete a Resource Readiness Assessment. Use *Table 4.2: Resource Readiness Assessment* to identify if the county has sufficient resources to implement Pv services for each priority area. Enter a plus sign (+) to indicate sufficient resources. Enter a negative (-) to indicate have insufficient resources. Enter a plus sign and negative sign (+/-) for resources that lie in the middle. Enter "n/a" for unnecessary resources.

Note: The county will address resources with a (-) or (+/-) in the Capacity Building Chapter.

If a priority area has more negatives (-)/(+/-), the county may conclude:

1. The county does not have sufficient resources to proceed with the priority area and efforts may need to focus on another priority area.

   OR

2. The county deems Pv efforts toward the priority area as critical and will need to identify resources to increase capacity. The county will need to identify the negatives, or "gaps," in Step 12 of this chapter and create a capacity-building plan to respond to those gaps in Chapter 4: Capacity Building.

Table 4.2: Resource Readiness Assessment
CAN: Cannabis UD: Underage Drinking Rx: Prescription Drugs

Enter (+), (n/a), (-) or (+/-) to measure resources for each priority area.		Priority Areas		
		CAN	UD	Rx
Community Resources	Community awareness	+	-	+
	Specialized knowledge about Pv research, theory, and practice	+	+	+
	Practical experience	+	+	+
	Political/policy knowledge	-	-	-

Fiscal Resources	Funding	n/a	n/a	n/a
	Equipment: computers, Xerox, etc.	+	+	+
	Promotion and advertising	-	-	+
Human Resources	Competent staff	+	+	+
	Training	+	+	+
	Consultants	+	+	+
	Volunteers	+	+	+
	Stakeholders	+	+	+
	Other agency partners	+	+	+
	Community leaders	+	+	+
Organizational Resources	Vision and mission statement	-	+	+
	Clear and consistent organizational patterns and policies	+	+	+
	Adequate fiscal resources for implementation	-	-	-
	Technological resources	+	+	+
	Specialized knowledge about Pv research, theory, and practice	+	+	+

Step 11 - Assess Community Readiness

Assessing community readiness will determine how prepared the community is to work and commit its resources to addressing the identified priority area(s). The Tri-ethnic Center Community Readiness model[9] illustrates the nine stages of community readiness. Determine the readiness stage of the community for each priority area. *Table 4.3: Community Readiness Stages and Descriptions* provides descriptions for the nine stages of the community readiness continuum. DHCS recommends counties determine the readiness stage for the county or a specific community with a group of people that have knowledge of the focus population(s). Include community members, if possible, to encourage collaborative decision-making. This promotes cultural competence and sustainability.

> ***Community Readiness*** identifies the community acceptance stage. Each community stage describes a unique community perception level about whether the SUD problem needs to change and if community is ready to take action to change.

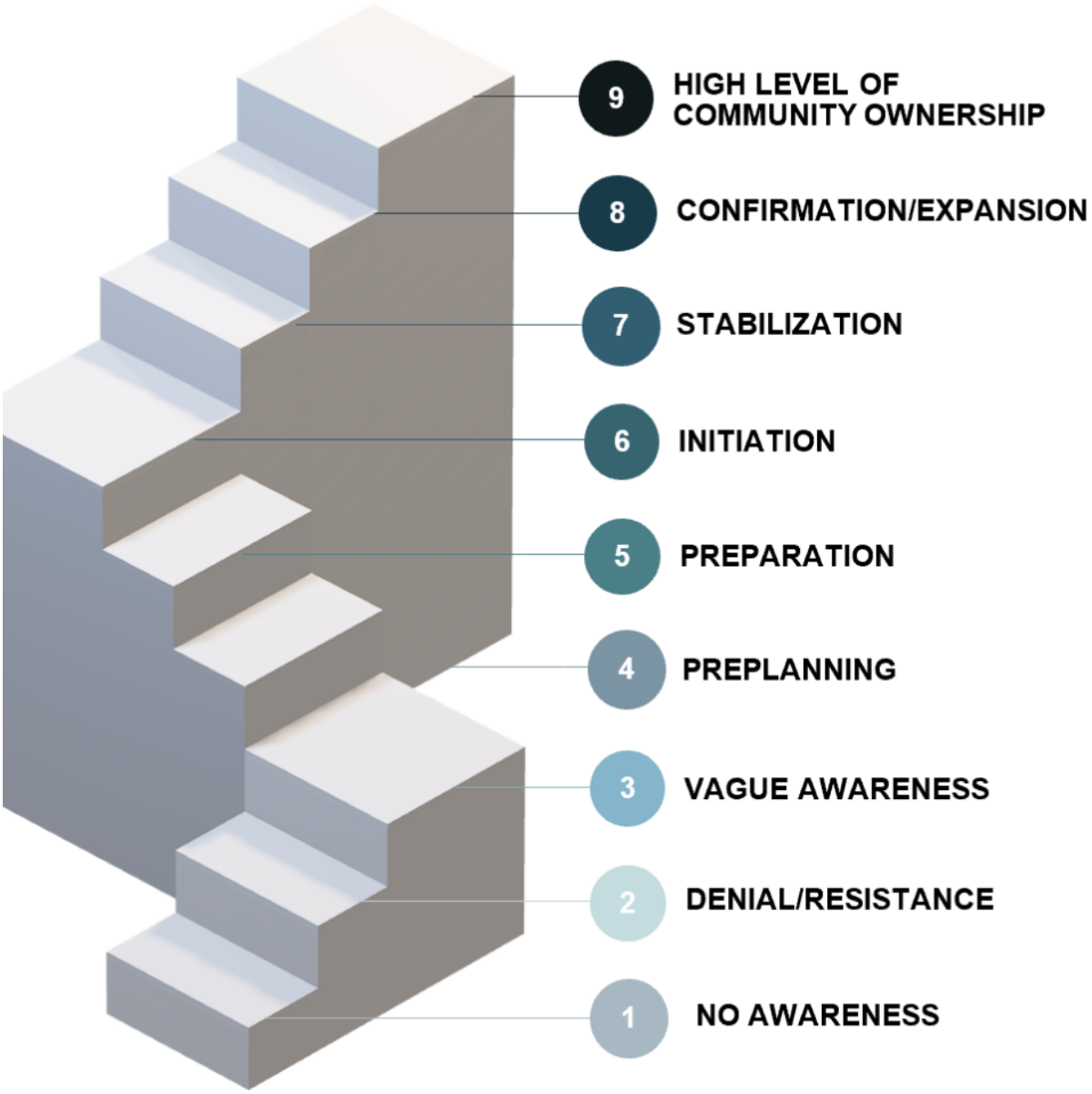
Establishing a community readiness stage will assist the county to determine gaps before proceeding with implementation. For example, if a community assesses

[9] Tri-Ethnic Center. (2014). Community Readiness for Community Change. Retrieved from https://tec.colostate.edu/communityreadiness/

their community readiness at stage 3 for underage drinking, then the county may determine the community is not ready for implementation. Pv efforts may need to focus on community capacity building by increasing public awareness about underage drinking. Community readiness levels may also differ among various communities within a county. Counties will need to determine which communities are ready for implementation and which communities need to build capacity.

For each priority area, combine the resource readiness analysis from Step 10 and community readiness analysis from Step 11 to determine if the county is ready for implementation or if the county needs to focus on building capacity first.

Table 4.3: Community Readiness Stages and Descriptions



STAGE 1: NO AWARENESS
•Community has no knowledge about local efforts addressing the issue. •Leadership believes that the issue is not much of a concern. •The community believes that the issue is not a concern. •Community members have no knowledge about the issue. •There are no resources available for dealing with the issue. “Kids drink and get drunk.”

STAGE 2: DENIAL/RESISTANCE
•Leadership and community members believe that this issue is not a concern in their community, or they think it can’t or shouldn’t be addressed. •Community members have misconceptions or incorrect knowledge about current efforts. •Only a few community members have knowledge about the issue, and there may be many misconceptions among community members about the issue. •Community members and/or leaders do not support using available resources to address this issue. “We can’t (or shouldn’t) do anything about it!”

STAGE 3: VAGUE AWARENESS
•A few community members have at least heard about local efforts but know little about them. •Leadership and community members believe that the issue may be a concern in the community but show no immediate motivation to act. •Community members have only vague knowledge about the issue (e.g. they have some awareness that the issue can be problem and why it may occur). •There are limited resources for further efforts to address the issue. “Something should probably be done, but what? Maybe someone else will work on this.”

STAGE 4: PREPLANNING
•Some community members have at least heard about local efforts but know little about them. •Leadership and community members acknowledge that the issue is a concern in the community and that something has to be done to address it. •Community members have limited knowledge about the issue. • There are limited resources for further efforts to address the issue. “This is important. What can we do?”

STAGE 5: PREPARATION
•Most community members have at least heard about local efforts. •Leadership is actively supportive of continuing/improving current efforts or in developing new efforts. •The community is concerned about the issue and wants to do something about it. •Community members have basic knowledge about causes, consequences, signs, and symptoms. •There are some resources for further efforts to address the issue; community members or leaders are actively working to secure these resources. “I will meet with our funder tomorrow.”

STAGE 6: INITIATION
•Most community members have at least basic knowledge of local efforts. •Leadership plays a key role in planning, developing, and/or implementing new, modified, or increased efforts. •The community assumes responsibility and some community members are actively addressing the issue. •Community members have basic knowledge about the issue and are aware the issue occurs locally. •Leadership/community obtained and/or allocated resources to support further efforts to address the issue. “This is our responsibility; we are now beginning to do something to address this issue.”

STAGE 7: STABILIZATION
•Most community members have more than basic knowledge of local efforts, including names and purposes of specific efforts, target audiences, and other specific information. •Leadership is actively involved in ensuring or improving the long-term viability of the efforts to address this issue. •Community has taken responsibility; ongoing community involvement exists to address the issue. •Community members have more than basic knowledge about the issue. •A considerable part of allocated resources is from sources that are expected to provide continuous support to address the issue. “We have taken responsibility.”

STAGE 8: CONFIRMATION/EXPANSION
•Most community members have considerable knowledge of local efforts, including the level of program effectiveness. •Leadership plays a key role in expanding and improving efforts. •Most of the community strongly supports efforts or the need for efforts. Participation level is high. •Community members have more than basic knowledge about the issue and have significant knowledge about local prevalence and local consequences. •A considerable part of allocated resources is expected to provide continuous support. Community members are looking into additional resources to implement new efforts. “How well are our current programs working and how can we make them better?”

STAGE 9: HIGH LEVEL OF COMMUNITY OWNERSHIP
•Most community members have considerable and detailed knowledge of local efforts. •Leadership continuously reviews evaluation results of the efforts and is modifying financial support accordingly. •Most major segments of the community are highly supportive and actively involved. •Community members have detailed knowledge about the issue and have significant knowledge about local prevalence and consequences. •Diversified resources and funds are secured and efforts are expected to be ongoing. “These efforts are an important part of the fabric of our community.”

SPP Narrative Example: Resource and Community Readiness

Underage Drinking
The county is in Stage 2: Denial/Resistance. Data shows an alarming rate of youth receiving alcohol from adults and retailers. The community does not believe underage drinking is an issue indicated by the high number of alcohol-involved traffic accidents. Community members have misconceptions about how underage drinking relates to alcohol-involved traffic accidents.

Cannabis
The county is in Stage 5: Preparation. According to the capacity assessment, it was determined that the county is resource and community ready to implement efforts to decrease cannabis use among youth. However, the county determined to focus cannabis Pv efforts in community X because of the high density of dispensaries in that community.

Prescription Drugs
The county is in Stage 3: Vague Awareness. The county needs to focus on community capacity building by raising awareness of Rx drug use and consequences. Outreach efforts will focus on seniors (ages 55+) since the data shows seniors have the highest prescription drug use rates and the highest rates of emergency visits due to Rx drug misuse. Community members have very little knowledge about how Rx drug misuse impacts health and wellness for older adults. Because of this, there are limited resources available to address this issue.

Step 12 - Identify Resource Challenges/Gaps

Utilizing *Table 4.2: Resource Readiness Assessment*, the county will complete *Table 4.4: Community and Resource Challenges/Gaps. Table 4.4* will identify community readiness levels and resource challenges or "gaps" (from *Table 4.2*) for each priority area. Copy, paste, and complete Table 4.4 with information specific to the county. Enter the county's priority areas in the first row. Refer to *Table 4.3: Community Readiness Stages and Descriptions* to identify the community readiness stage and enter it in the second row. Refer to *Table 4.2* and use the negative (-) resource components to complete Table 4.4. Underage drinking examples are included for reference.

Table 4.4: Community and Resource Challenges/Gaps

Priority Areas	Cannabis	Underage Drinking (UD)	Rx/Opioid Use
Community Readiness		Stage 2: Denial/Resistance - Community does not recognize a UD problem.	
Community Resources		Adults and retailers provide alcohol to minors, adults are not aware of the consequences of UD, adults and retailers need to know about the legal ramifications about providing alcohol to minors, youth/adults do not perceive UD as harmful, alcohol related traffic accidents involve teens.	
Fiscal Resources		There is not enough funding for advertising the harmful effects of underage drinking and the legal ramifications.	
Human Resources		n/a (no negatives in *Table 4.3 Resource Readiness Assessment*)	
Organizational Resources		There is not enough funding allocated toward underage drinking.	

V CHAPTER

CAPACITY BUILDING

Capacity Building is the third chapter of the SPP.

The capacity building plan does two things. First, it addresses the capacity building gaps/challenges identified in the Assessment Chapter. Second, it describes how to build additional capacity to advance Pv efforts. Concentrating on capacity before planning is imperative for the following reasons:

1) Aligns the identified priority area(s) with the resources necessary to address capacity challenges/gaps;
2) Addresses challenges/gaps in advance; and
3) Provides an understanding of how capacity may influence the planning, selection, and adaptation of Pv efforts specific to the county.

READINESS + RESOURCES = CAPACITY

REQUIRED COMPONENTS FOR THE CAPACITY BUILDING CHAPTER

In this chapter, the county will develop a capacity building plan to address challenges/gaps. "Steps for Capacity Building" immediately follow this section if counties need more resources, definitions, and/or clarity for the "Required Components" below.

Include the following:

Capacity Building Plan, Refer to Steps 1 through 4
Complete a Capacity Building Plan for each priority area. Step four includes a sample capacity-building plan. Each capacity building plan is a timeline of efforts to address the capacity challenges and gaps identified in *Table 4.4: Community and Resource Challenges/Gaps* from the Assessment Chapter along with steps to build additional capacity. The capacity-building plan shall include staff/community development and training needs.

Capacity Building Summary
Provide a summary below each capacity building plan and include the following:

- Describe how the county will increase efforts to address challenges/gaps relative to the key elements of building capacity.
- Provide possible action steps to establish countywide Pv systems and infrastructures to foster capacity-building opportunities.

Cultural Competence, Refer to Chapter II: Guiding Principles
Describe how the county will build culturally competent knowledge, resources, and readiness of sub-contractors and stakeholders to understand CLAS and health disparities.

- How will the county ensure Pv staff understand the role of cultural competence in their work to serve identified focus populations; specifically focus populations experiencing health disparities?
- Are there any new partnerships the county will seek to support identified focus populations better?
- How will the county ensure resources and services follow CLAS standards?

Sustainability, Refer to Chapter II: Guiding Principles

- Did the county provide training to staff and stakeholders about the strategic Pv planning process and/or SPP development?
  - If yes, briefly describe the trainings.
- Does the county have an inventory of accessible and available community resources for Pv services?
  - If not, how can the county engage this effort with other agencies?
- Does the county have a recruitment plan to sustain existing partnerships and build new partnerships?
  - If yes, briefly describe the recruitment plan.
- Does the county document stakeholder agreements i.e. memorandums of understanding, contracts detailing roles and expectations for the county and stakeholder?

STEPS FOR CAPACITY BUILDING

Step 1 - Understand Capacity Building
To further understand Assessment, research the following resources:

- CPI. (n.d.). *Module 2: Community Organizing and Capacity Building* [Webinar]. Access the recorded competency at http://www.ca-cpi.org/training/TA_Training.php. This module is 67 minutes.

Step 2 - Understand the Key Elements of Building Capacity
The four key elements to build capacity are:

1) Engage stakeholders and form partnerships;
2) Strengthen collaborative groups;
3) Increase community awareness; and
4) Mobilize communities.

It is extremely beneficial to identify the benefits each stakeholder will acquire by collaborating Pv efforts with the county. Stakeholders should understand how the collaboration will value and contribute to their work and interests.

> ***Stakeholders*** are the people and organizations in the community who have 1) a "stake" in Pv because they care about promoting health and well-being and/or 2) something to gain or lose by the county's Pv efforts. Stakeholders can be SUD professionals and professionals from other fields e.g. education, mental health, law enforcement, community members, researchers, volunteers, or local businesses, etc.

Engage Stakeholders

Stakeholders may want to participate with Pv efforts to different degrees. *Table 5.1* provides more information on how to differentiate between stakeholder levels of involvement.

Table 5.1 Levels of Involvement

Level	Expression	Examples
No Involvement	"You do your thing; we will do ours."	Stakeholders engage in separate activities, strategies, and policies.
Networking	"Let's talk and share information."	Stakeholders share what they are doing during an interagency networking meeting. They talk about community issues in which they all have a stake or communicate with each other about existing resources, programs, activities, or services.

Cooperation	"I will support your program, and you will support mine, or we can even co-sponsor one."	Partners promote each other's programs i.e. organization newsletters, write letters in support of each other's grant applications, co-sponsor professional development activities, and/or share resources such as printing or meeting space.
Coordination	"Let's partner on an event."	Stakeholders work together by participating with planning committees, workgroups, coalitions, and/or community boards Some partnerships may even implement programs or services together.
Collaboration	"Let's work together on a comprehensive plan to address the issue; after all, our missions overlap."	Participating organizations create formal agreements i.e. memoranda of understanding or formal contracts, develop common data-collection systems across organizations and community sectors, partner on joint fundraising efforts, leverage resources, and/or create professional development efforts together.

Counties also engage stakeholders by providing training about Pv issues, e.g. the assessment process and findings, resources, and future opportunities to participate with the SPF process. Opportunities to collaborate not only depend on recruiting stakeholders to attend county meetings, but also to co-partner meetings. County staff should participate in partner meetings to illustrate a collaborative approach and discover common goals. If the county neglects these opportunities, the county may risk exclusion from important conversations, decisions, and funding opportunities. Ask to be a part of other coalitions and describe the value the county can bring to the group. Use data to identify overlapping interests, goals, and agendas.

> ***Community*** refers to a group of people defined by a common geography, affiliation, or interest that have the potential to act together and support each other.
>
> A ***Community Coalition*** is a group of residents and/or representatives of local, public, and private sectors that will develop a formal collaborative agreement to achieve a common goal and identify strategies that will address local SUD problems.

Strengthen Collaborative Groups

Many informal partnerships exist in a community. Most communities have a collaborative group, such as a task force, coalition, or interagency group. The county can strengthen a collaborative group in the following ways:

- Recruit new members to create cross-system representation.
- Identify recruitment opportunities. Develop a communication method for effective communication with stakeholders. Identify effective techniques for engaging with these agencies, organizations, or population groups.
- Increase the knowledge of members through training and technical assistance.
- Improve the structure and function of the collaborative groups through clear and formalized roles and procedures, adequately addressing task and maintenance functions, and developing and maintaining quality management strategies i.e. effective communication, conflict resolution, shared decision-making, and effective leadership.

Increase Community Awareness

Building awareness and training stakeholders and community members is important for the following reasons:

- Increases awareness of the issues and the need for Pv and health promotion;
- Engages potential partners;
- Increases readiness of partners and the community to address the issues;
- Ensures the importance of considering diversity throughout the SPF process; and
- Sustains Pv efforts over time.

Mobilize Communities

The county should develop a coalition and/or collaborative group if none exist. The county may decide to emphasize SUD trends and risk factors that impact other systems of care and communities to attract group participants. Cultural competence is critical to mobilize communities successfully. Consider the demographics of the county and specific communities the county serves. A community coalition does not implement direct programs or services, but may serve as a consulting or decision-making body. An effective community coalition will guarantee diverse representation and build resources that ensure sustainability.

Step 3 - Understand Capacity Building Specific to Implementation

Below are recommendations for building capacity relative to implementation.

Increase community awareness about available and future programs/services. This will help improve individual and community access to Pv programs/services that will increase community readiness. Prior to implementation, increase awareness about SUD Pv issues among stakeholders, sub-contractors, community leaders/members, policy makers, and focus populations.

Introduce Pv efforts to stakeholders to obtain their buy-in and expand partnerships. Expand capacity to include new partners, individuals, or organizations. Intentionally recruit agencies and/or individuals with specific skill sets and expertise to contribute to SUD Pv goals. Select sub-contractors that can address the needs and strategies identified in the county SPP. Replace existing sub-contractors unable to meet the identified SPP needs or strategies.

Create and administer professional development plans and curriculum. Train staff to implement programs/services professionally and equitably. Create training curriculum specific

for new staff learning about SUD Pv for the first time. Always include a specific plan and curriculum for veteran staff who wish to acquire advanced Pv training. Training builds professional confidence and clarifies work expectations.

Step 4 - Create a Capacity Building Plan
Identify how the county will increase efforts to build capacity for future Pv efforts. Include the resource areas with a (-) or (+/-) from *Table 4.4: Community and Resource Challenges/Gaps*. Refer to the example below.

SPP Narrative Example: Capacity Building Plan

Priority Area: Underage Drinking (UD)

Community Readiness Stage: 2. Denial

Course of Action (e.g. training, coalition building, mobilization efforts)	Proposed Timeline
Community Resources	
1. Develop an inventory of community resources within various social service, healthcare, community based, and educational settings to identify potential partners	Year 1
2. Develop a plan to inform alcohol retailers about the law against selling alcohol to minors	Year 2
3. Increase collaboration with law enforcement to conduct more alcohol surveillance activities	Year 2
4. Identify existing services that address risk and protective factors for underage drinking; network with the agencies providing those services	Years 1-2
5. Coordinate a town hall meeting and invite community agencies from the inventory list and community members	Year 2
6. Transition to Community Readiness, Stage 4: Pre-Planning	Year 3
7. Implement retailer education/campaign and surveillance activities with law enforcement	Years 3-5
8. Increase education to adults and high school students about the legal ramifications of providing alcohol to minors and consequences of UD	Years 1-3
Organizational Resources Funding for marketing will wait until the next SPP. This SPP will focus on community resources with the hopes of leveraging funds for the next SPP.	
Human Resources n/a (no negatives in *Table 4.2 Resource Readiness Assessment*)	
Fiscal Resources Funding for UD programs will wait until the next SPP. This SPP will focus on community and resource readiness with the hopes of leveraging funds for the next SPP.	

VI CHAPTER PLANNING

Planning is the fourth chapter of the SPP.

Planning is pivotal to Pv success. Planning will increase the effectiveness of Pv efforts by ensuring staff and stakeholders work toward the same goals. Thorough planning relies on effective collaboration. Decisions must reflect the ideas and input of individuals from the county, community stakeholders, and the focus population (s). SPP planning will not yield positive outcomes if planning represents the thoughts of one entity or person. Quality SPPs include the following planning activities:

- Selection of evidence based Pv interventions that are most likely to influence the identified risk factors (conceptual fit) and are feasible and relevant to the population the intervention will serve (practical fit).
- Development of a comprehensive logic model that includes priority areas, problem statements, contributing factors, goals, objectives, strategies, outcomes, and indicators.
- Collaboration within a formal coalition or among an informal group of partners to represent the thoughts and ideas of individuals from various sectors within the community and the focus population(s).

REQUIRED COMPONENTS FOR THE PLANNING CHAPTER

So far, the county completed a needs and capacity assessment, selected priority areas, prioritized risk factors, and developed a capacity-building plan. Now, the county will identify protective factors, corresponding CSAP strategies, and develop logic models. “Steps for Planning” immediately follow this section if counties need more resources, definitions, and/or clarity for the “Required Components” below. Include the following:

Planning Process
Briefly summarize the planning process. Indicate partners involved with creating the logic models, their contributions to the process, and how the planning process will support collaborative partner efforts.

Protective Factors and CSAP Strategies, Refer to Steps 2 and 3
Insert and complete *Table 6.1: Protective Factors and CSAP Strategies for Prioritized Risk Factors.* This table includes the prioritized risk factors from *Table 4.1: Prioritizing Risk Factors for Consumption and Consequence Issues* and the corresponding protective factors and CSAP strategies.

Protective Factors and CSAP Strategies Summary
Below *Table 6.1: Protective Factors and CSAP Strategies for Prioritized Risk Factors*, briefly describe how the identified protective factors and CSAP strategies address the prioritized risk factors for each priority area.

Logic Model(s), Refer to Step 4
Insert a logic model for each priority area. An example is available at the end of this chapter.

Cultural Competence, Refer to Chapter II: Guiding Principles

- Did the individuals who contributed to the planning chapter represent community demographics?
  - If not, how will the county create inclusivity for further planning throughout the duration of the SPP?
  - If yes, how did the county train community representatives about the planning process and cultural competence?
- Did the county include members from the identified focus population(s) in the planning process?
  - If yes, what techniques did the county implement to ensure inclusion i.e. community training?
- How did the county consider cultural relevance when selecting strategies?
  - How do the identified protective factors address issues specific to the identified focus populations and health disparities, if applicable?
  - Were objectives or long-term outcomes focused on health disparities?
  - If yes, how do the objectives and/or long-term outcomes aim to decrease health disparities specific to each identified focus population(s)?

Sustainability, Refer to Chapter II: Guiding Principles

- How did the county engage stakeholders with planning meetings?
- Did the county use stakeholder input when selecting CSAP strategies and identifying protective factors to address prioritized risk factors?
  - If yes, mention the agency the stakeholders represent and describe their role. Do not identify stakeholders by name.
- How did the planning processes/methods ensure CSAP strategies and protective factors address community needs?

STEPS FOR PLANNING

Step 1 – Understand Planning

To further understand Planning, research the following resources:

- CPI. (n.d.). *Module 3: Planning* [Webinar]. Access the recorded competency at http://www.ca-cpi.org/training/TA_Training.php. This module is 36 minutes.
- Seltzer, C. (2019, March 28). *Introduction to Logic Models* [Webinar]. Access the recorded webinar at https://tinyurl.com/yymsru85.

Step 2 - Learn the CSAP-6

SAMHSA's Center for Substance Abuse Prevention promotes the six CSAP strategies, also known as the "CSAP 6," to categorize Pv efforts. Below are the CSAP strategy definitions from the Code of Federal Regulations[10].

Information Dissemination (ID)	This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, and drug use, abuse, and addiction, and their effects on individuals, families, and communities. It also provides knowledge and awareness of available Pv programs and services. Information Dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
Education (ED)	This strategy involves two-way communication and is distinguished from the Information Dissemination Strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systemic judgement abilities.
Alternatives (ALT)	This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs and would, therefore, minimize or obviate resort to the latter.
Problem Identification and Referral (PIDR)	This strategy aims at identification of those individuals who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs and to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of SUD treatment.
Community Based Process (CBP)	This strategy aims to enhance the ability of the community to more effectively provide Pv services for alcohol, tobacco, and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing the efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.
Environmental (ENV)	This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco, and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives.

Step 3 - Identify Protective Factors and CSAP Strategies

Copy and complete *Table 6.1: Protective Factors and CSAP Strategies for Prioritized Risk Factors.* Under the *Risk Factor* column, enter and number the prioritized risk factors for each priority area from *Table 4.1: Prioritizing Risk Factors for Consumption and Consequence*

[10] Cornell Law School. (n.d.). *45 CFR 96.125 Primary Prevention*. Retrieved August 25, 2020, from https://www.law.cornell.edu/cfr/text/45/96.125.

Issues completed in the Assessment Chapter. Identify protective factors that will address the prioritized risk factors under the *Protective Factors* column. Identify the risk factors each protective factor will address by entering the corresponding protective factor number in parenthesis. Then, select the CSAP strategies that will increase the protective factors and decrease the prioritized risk factors. The county will identify specific programs corresponding with CSAP strategies in the next chapter. DHCS recommends adding ID and CBP to each priority area because these CSAP strategies contain planning, capacity building, and outreach efforts. *Table 6.1* includes examples for priority areas underage drinking, underage cannabis use, and Rx drugs.

> A ***Protective Factor*** is a characteristic at the biological, psychological, individual, family, community, or cultural level that is associated with a lower likelihood of problem outcomes.

Table 6.1: Protective Factors and CSAP Strategies for Prioritized Risk Factors

Priority Area	Risk Factors	Protective Factors	CSAP Strategies
Underage Drinking	1. Substances are accessible to teens by adults and retailers. 2. Parents do not believe underage drinking is harmful. 3. There are high rates of alcohol-involved traffic accidents involving teens. 4. Teens do not believe underage drinking is harmful.	Educate teens, parents, and retailers about the dangers of underage drinking, drinking and driving, and laws about selling and supplying alcohol to minors (1,2,3,4) Coordinate activities to reinforce current laws about selling and supplying alcohol to minors and increase surveillance activities with law enforcement (1,3)	Information Dissemination Community Based Process Education Environmental
Underage Cannabis Use	1. Cannabis production is integrated into the economy. Acceptance of use is at an economic policy level. 2. Youth have no/low perception of harm.	Norms are clear and encourage non-use (1) Laws, policies, and/or ordinances are consistently enforced (1) Youth have med/high perception of harm (2)	Environmental Information Dissemination Community Based Process Education
Rx Drugs	1. Youth Rx drug use is increasing. 2. Community is not aware of the dangers of Rx drug use. 3. Rx drugs are easy to get.	Educate youth about Rx drug use (1) Increase community awareness about the consequences of Rx drug use (2) Work with pharmacies to build policy about excessive prescribing (3)	Education Information Dissemination Community Based Process Environmental

Step 4 - Develop the Logic Model

The county will compile information to create a logic model. **Counties must develop a logic model for each priority area.** The SPP Workbook includes a sample logic at the end of this chapter.

The logic model sample utilizes a simple format that contains the following:

- ***Problem statement(s)***. The county created problem statements in the Assessment Chapter. Copy the problem statements from the Assessment Chapter and enter them into your logic model(s).

Problem statement example: The availability of alcohol to youth from adults and retailers, the low perception of harm of underage drinking by parents, and the favorable attitude among youth about drinking contribute to higher consumption rates and alcohol-related traffic accidents.

- ***Goal*** for each priority area. Create one goal for each priority area. A goal is a measurable statement of the desired long-term outcome.
- ***Objective(s)*** for each priority area. There can be more than one objective under each goal. Objectives will align with the prioritized consumption and/or consequence issues and risk factors.

Note: *These objectives include data from three of the 4 C's described in the Assessment chapter: Consumption, Consequence, and Contributing (Risk Factors). The Capacity Building Chapter already addressed the fourth C - capacity.*

A well-planned objective must be **SMART:**

Specific
Measurable
Achievable
Results-focused
Timely

Objective(s) directly support the goal. Each critical consumption and/or consequence issue and prioritized risk factor(s) MUST have an aligning objective. Each objective MUST also specify a focus population.

Objectives must follow the following format:

How much, of what change, will happen to what population/or in what place, by when, as measured by what?

- **CSAP strategies** to accomplish each objective. Refer to the example below.
- **A SMART long-term outcome** for each objective. Objectives state the intention for the future. Long Term Outcomes state the objective as if the county already accomplished the objective. Refer to the example below.

SPP Narrative Example: Objectives, CSAP Strategies, and Long-Term Outcomes			
Objectives	By 2023, the number of alcohol impaired traffic accidents involving teenagers will decrease by 3% as measured by police records. Baseline (2020): 85 accidents (consequence)	By 2023, adults and parents will increase their perception that underage drinking is harmful by 3% as measured by pre-posttests. (contributing-risk factor)	By 2023, the number of 10th graders who report past 30-day use of cannabis will decrease by 5% as measured by CHKS. Baseline (2020): 45% (consumption)
CSAP Strategies	ED, ENV, ID, CBP	ED, ID, CBP	ED, ALT, ID, CBP
Long Term Outcomes	In 2023, the number of alcohol impaired accidents involving teenagers will have decreased by 3% as measured by police records.	By 2023, adults and parents will have increased their perception that underage drinking is harmful by 3% as measured by pre-posttests.	In 2023, the number of 10th graders who report past 30-day use of cannabis will have decreased by 5% as measured by CHKS.

- **Short-term and intermediate outcomes for each objective.** Short-term outcomes measure process change. Intermediate outcomes measure changes in risk and protective factors or change in knowledge or skills.
- **Indicators for each objective.** Indicators are the data instruments and/or tools the county will use to measure progress toward meeting objectives.

Table 6.2: Logic Model Format – One Logic Model for EACH priority area (substance).

The Problem Statement includes the (1) critical consumption issue, "higher consumption rates" measured by "past 30-day use," (2) one critical consequence issue, measured by "alcohol-related traffic accidents," (3) and four risk factors: 1. availability of alcohol to youth by adults; 2. availability of alcohol to youth by retailers; 3. parents' low perception of underage drinking's harm; and 4. favorable attitudes among youth toward underage drinking. Each align with a SMART objective.

Priority Area: Underage Drinking (copy from the Assessment Chapter)

Problem Statement: The availability of alcohol to youth from adults and retailers, the low perception of harm of underage drinking by parents, and the favorable attitude among youth about drinking contribute to higher consumption rates and alcohol-related traffic accidents. (copy from the Assessment Chapter)

Goal (Behavioral Change): Decrease underage drinking. (Decrease [priority area] use among [focus populations]).

Objective What do we want to accomplish?	**Strategies** What CSAP strategies will the county implement to accomplish the objective?	**What is going to happen as a result of implemented strategies?**			**Indicators** How will the county measure what happened?
		Short Term Outcomes Immediate implementation: measures process change.	**Intermediate Outcomes** Measures change in contributing factors and/or change in knowledge or skills.	**Long Term Outcomes** Match the objective as if it was accomplished.	
By 2023, the number of adults who provide alcohol to youth will decline by 5% as measured by pre/posttests. Baseline to be figured during pre-test.	Education Information Dissemination Community Based Process	By 2020, recruit 80 parents to participate in community and school-based educational programs.	By 2021, 75% of parents in community and school-based educational programs will demonstrate their understanding that providing alcohol to youth is harmful as measured by pre/posttests.	In 2023, the number of adults who provide alcohol to you will have declined by 5% as measured by pre/posttests.	Pre/posttests

By 2023, reduce retail availability of alcohol to minors by 5% as measured by Alcoholic Beverage Control (ABC) infractions. Baseline (2019): 15 infractions	Education Environmental Information Dissemination Community Based Process	By 2020, conduct ten Retailer Beverage Service trainings with identified retail establishments who received underage alcohol infractions. By 2021, develop and implement retailer education programs about the legal ramifications and social/health consequences of underage drinking.	By 2022, retailers will increase their knowledge about the legalities of supplying alcohol to minors by 25% over base line as measured by pre-post surveys.	In 2023, the number of retailers distributing alcohol to minors will have decreased by 5% as measured by ABC infractions.	PPSDS Pre/posttests ABC data
By 2023, parents will increase their perception that underage drinking is harmful by 3% as measured by CHKS. Baseline (2020): 15% of parents reported underage drinking was not harmful	Education Information Dissemination Community Based Process	By 2021, recruit 80 parents to participate in community and school-based educational programs.	75% of parents enrolled in parent education programs will communicate to their children they do not approve of underage drinking as measured by pre/posttests.	In 2023, parents will have increased their perception that underage drinking is harmful by 3% as measured by CHKS.	Pre-post tests Sign-in logs CHKS

By 2023, the number of youth who report a favorable attitude toward underage drinking will decrease by 5% as measured by pre/posttests. Baseline to be figured during pre-test.	Education Information Dissemination Community Based Process	By 2020, recruit 45 high school freshmen to participate in *Too Good for Drugs* after school curriculum.	By 2022, the number of youth who report a favorable attitude toward underage drinking will decrease by 3% as measured by pre/posttests.	In 2023, the number of youth who report a favorable attitude toward underage drinking will have decreased by 5% as measured by pre/posttests.	Pre/posttests Sign-in logs
By 2023, the number of 10th graders who report past 30-day use of alcohol will decrease by 5% as measured by CHKS. Baseline (2020): 18% of 10th graders reported past 30-day use	Education Information Dissemination Community Based Process	By 2020, recruit five 10th grade classrooms to participate in student educational groups.	By 2021, the number of 10th graders who report past 30-day use of alcohol will decrease by 3% as measured by CHKS.	In 2023, the number of 10th graders who report past 30-day use of alcohol will have decreased by 5% as measured by CHKS.	PPSDS CHKS
By 2023, the number of alcohol impaired traffic accidents involving teenagers will decrease by 3% as measured by police records.	Education Environmental Information Dissemination Community Based Process	By 2019, provide 20 annual presentations to the community and high school students about the dangers of driving under the influence	By 2022, teens will increase decision-making skills to avoid drinking and driving or getting in cars with adults who have been drinking as measured by pre-posttests.	In 2023, the number of alcohol impaired accidents involving teenagers will have decreased by 3% as measured by police records.	PPSDS Police Records Pre-post tests

Baseline (2020): 65 accidents		and underage drinking. By 2020, coordinate with law enforcement to increase surveillance activities.			

VII CHAPTER

IMPLEMENTATION

Implementation is the fifth chapter of the SPP.

Implementation is putting the logic model from the Planning Chapter into action. When implementing Pv programs, practices, or strategies, consider the following:

Implementation plan development. An action plan is a written document that details how the county will implement specific programs, efforts, or services. The action plan describes what you expect to accomplish, the specific steps you will take to get there, and who will be responsible for doing what.

Fidelity and adaptation. Fidelity is the degree to which a county implements an evidence-based program as the original developer intended. Adaptation refers to how much, and in what ways, a program, effort, or service needs to change to fit local circumstances.

Factors that may influence implementation. These include staff selection, training, on-going consultation and coaching, staff and program evaluation, program/sub-contractor monitoring, administrative support, and program implementation history.

REQUIRED COMPONENTS FOR THE IMPLEMENTATION CHAPTER

Now that logic models detailing goals, objectives, outcomes, and CSAP strategies are complete, the county will identify specific programs/services and develop implementation timelines for each. "Steps for Implementation" immediately follow this section if counties need more resources, definitions, and/or clarity for the "Required Components" below.

Include the following:

Implementation Plan, Refer to Steps 3-4
Insert implementation plans for each primary Pv program/service.

Implementation Plan Summary
Describe how the Pv programs will meet the identified needs and long-term outcomes identified in the logic model.

Sub-Contractor Selection
Describe how the county selects sub-contractors, also referred to as providers.

- If the county administers a competitive bidding process to select sub-contractors, describe the Request for Proposal (RFP) process.
  - Describe how the county utilizes the SPP in the RFP process.

Note: *While writing the SPP, counties may not know who their sub-contractors will be or what services they will provide. In this case, describe the process the county will administer for sub-contractor selection. Do not stop writing the SPP to recruit and contract providers. DHCS does not approve SPP deadline extensions for this reason as the county can add sub-contractors later. When the county secures sub-contracts, the county can amend the SPP with an email to the DHCS analyst indicating the name of each sub-contractor and the programs each sub-contractor will implement.*

- If the county does not administer an RFP process, indicate the selection criteria the county administers for sub-contractor selection.

Sub-contractor Contributions to the SPP
If applicable, discuss if and how sub-contractors contributed to the development of the SPP.

Cultural Competence, Refer to Chapter II: Guiding Principles
- Explain how the chosen Pv programs are culturally relevant to the identified focus population(s).
- Did the county include representation from the identified focus populations to support the identification of Pv programs and services intended for them?
  - If yes, explain why the focus population(s) identified specific programs?
- Did the county conduct research and/or collaborate with community stakeholders to understand community history when selecting Pv programs?
  - If no, why not?
- Describe how the county will include continuous program feedback from the identified focus populations.

Sustainability, Refer to Chapter II: Guiding Principles
- How did the county involve stakeholders to support program selection?
- What program monitoring tools and/or procedures will the county implement to guarantee quality program implementation? Include how often the county will implement program monitoring.

STEPS FOR IMPLEMENTATION

Step 1 - Understand Implementation
To further understand Implementation, research the following resources:

- CPI. (n.d.). *Module 4: Implementation* [Webinar]. Access the recorded competency at http://www.ca-cpi.org/training/TA_Training.php. This module will take 40 minutes.
- SAMHSA Evidence-Based Practices Resource Center. (n.d.) https://www.samhsa.gov/ebp-resource-center
- SAMHSA Online Course on the Primary Prevention Component of the SABG. (2015). *Primary Prevention and the Six Strategies*. https://www.samhsa.gov/grants/block-grants/sabg/primary-prevention-course

- SAMHSA Online Course on the Primary Prevention Component of the SABG. (2015). *The Six Primary Prevention Strategies and the Institute of Medicine Model*. https://www.samhsa.gov/grants/block-grants/sabg/primary-prevention-course

Step 2 - Understand Program Selection and Monitoring

At the end of this chapter, the county will create an implementation plan to illustrate how the county will implement programs/services. To complete a quality implementation plan, it is important to know what implementation entails.

> ***"Evidence-based"*** signifies that the approach has undergone scientific evaluation. This contrasts with approaches based on tradition, convention, belief, or anecdotal evidence. The shift to evidence-based programs seeks to enhance the potential for positive results. Today, many foundations, government agencies, and state decision-makers encourage or require the use of evidence-based programs and/or practices in service delivery plans.

1) Implement evidence-based programs, policies, and practices, paying specific attention to adaptation and fidelity issues.
   - Balance fidelity with adaptation. Fidelity refers to the degree to which the county implements a program as its developer intended. It is sometimes necessary to adapt an intervention to fit certain population groups or local circumstances. When adapting a program, select programs with the best practical fit to address local needs and conditions. Change capacity before changing the program. Consult with the program developer, if necessary. Retain core components and add to the program rather than subtract from it. Interventions implemented with fidelity are more likely to be effective. Consider the following questions:
     - In what ways can and should the program(s) be tailored to fit local circumstances?
     - Will adaptations compromise fidelity?
     - Has the county developed an implementation plan outlining who is responsible for doing what and when?
     - Has the county considered potential implementation challenges?
   - Develop an implementation plan detailing what will occur, the responsible parties, and a timeline. Like an itinerary for a trip, this implementation plan will help ensure everyone involved is on the same page and program implementation is successful.

2) Monitor implementation, collect evaluation data, and make mid-course corrections based on what the results show.
   - Monitor implementation to determine if the county/sub-contractor delivered the program as designed. For example, did the sub-contractor present the same material, in the same number of sessions, over the same timeframe, using the same methods? To find out, you will need to collect data about implementation details. Any adaptations, even those that are seemingly minor, could influence evaluation results. Consider the following questions:
     - How will the county know if the sub-contractor implemented the intervention successfully?

- What will the county do if results do not meet projected outcomes?

- Make mid-course corrections to the program if the monitoring data are not what you anticipated. An example might be that the implementation plan called for six classes per year, but the sub-contractor will only complete four by the end of the year. Identify and correct the issue. It may be necessary to modify the plan, county/sub-contractor expectations, and/or program logistics.

Step 3 - Identify Specific Interventions/Programs
In the Planning Chapter, the county identified CSAP strategies. Now, the county will identify specific programs/services that will align with the CSAP strategies to address the goal and objectives for each priority area. Refer to the examples below.

Examples
Specific Intervention/Programs for Identified CSAP Strategies

Strategies (from logic model)	Specific Program/Intervention
Education	Strengthening Families
Education	Friday Night Live
Education	Mentoring Program
Environmental	Parents who Host Lose the Most

- Sometimes, counties develop their own local-innovative programs, which may prove to be successful over time. Initially, these programs may not have names. In these cases, counties should invent descriptive program names.

- Selecting programs because “we have always done it” defeats the purpose of utilizing the SPF and may not be applicable once a thorough assessment is complete.

Step 4 - Identify Levels of Risk for Selected Interventions
Pv implements programs/services prior to the onset of an SUD with intentions to reduce the risk of diagnosis. Pv is about striving to optimize health and well-being. To be efficient, programs must adapt to different levels of risk as defined by the Institute of Medicine (IOM). It is critical to define risk levels for individuals, groups, or communities to ensure the county selects appropriate programs to successfully address needs of the focus population(s).

IOM Categories: Levels of Risk Definition and Examples		
Universal	**Selective**	**Indicated**
Pv interventions that focus on the "general public or a population subgroup that have not been identified on the basis of risk." **Universal Direct** programs/efforts are individual-based and serve identifiable participants where the individual risk of participants is unknown and are individual-based. (ED, ALT, CBP-training only) **Universal Indirect** programs/efforts are population-based and serve unidentifiable participants. (ID, CBP, ENV) **Examples** Increasing community awareness about underage drinking, enacting or enforcing substance use policies on college campuses, providing education for physicians on Rx drug misuse, facilitating SUD Pv education for youth in schools	Pv interventions that focus on individuals or subgroups of the population whose risk of developing SUDs is higher than average. (ED, ALT, PIDR) **Examples** Pv education for immigrant families, children or siblings of substance abusers, youth identified by school administration and/or teachers needing Pv services, senior citizens using Rx medication incorrectly	Pv interventions that focus on individuals whose risk of developing an SUD is significantly higher than average. (ED, ALT, PIDR) **Examples** Referral of a college student who violated campus drug policies on alcohol and drugs, a middle school student who reports experimental use whose behaviors may be reversed

Step 5 - Develop the Implementation Plan

The implementation plan will illustrate the major tasks required for program/service implementation. Utilizing the information from the logic model, complete an implementation plan for each program/service. Copy the goals, objectives, service populations, and CSAP strategies from the Logic Model. Counties will use the implementation plan format illustrated in the following examples. The three examples below illustrate implementation plans for Strengthening Families, Friday Night Live, and Social Host Efforts, respectively.

SPP Narrative Examples (3):
Objectives, CSAP Strategies, and Long-Term Outcomes

Program/Intervention: Strengthening Families (SF)

Goal(s): Decrease Underage Drinking (Copied from Logic Model)

Objective(s): By 2023, adults and parents will increase their perception that underage drinking is harmful by 3% as measured by pre-posttests. (Copied from Logic Model)

IOM Category(ies): Universal

Population(s): Parents/Families

Major Tasks	Timeline	Responsible Party	Strategy
1. Outreach to recruit program implementation locations	Jul-Sep Annually	Sub-Contractor A	CBP/ID
2. Recruit parents to participate	Jul-Apr Annually	Sub-Contractor A	CBP/ID
3. Implement five sessions *Session 1 @ Community Ed Center* *Sessions 2-3 @ Edison H.S.* *Sessions 4-5 @ Edison H.S.*	8/1 - 9/30 10/1 - 1/15 2/1 - 3/15	Sub-Contractor A	ED
4. Evaluation Report: pre-posttest analysis	May Annually	Sub-Contractor A	CBP

Program/Intervention: Friday Night Live (FNL)

Goal(s): 1) Decrease Underage Drinking 2) Decrease cannabis youth use (Copied from Logic Model)

Objective(s): 1) By 2023, juvenile hall participants will increase their perception that underage drinking is harmful by 3% as measured by the FNL Youth Survey. 2) By 2023, 9th grade students reporting past 30-day cannabis use will decrease by 5% as measured by FNL Youth Survey. (Copied from Logic Model)

IOM Category(ies): Universal, Indicated (juvenile hall participants)

Population(s): HS Students, Youth (risk category: juvenile justice system involvement)

Major Tasks	Timeline	Responsible Party	Strategy
1. Attend CFNLP annual training	Jul Annually	County & Sub-contractors	CBP
2. FNL implementation for six school site chapters/one juvenile hall chapter	Aug-Jun	Sub-Contractor A	ALT
3. FNL Youth Evaluation	Jul Annually	County	CBP

Program/Intervention: Parents who Host Lost the Most

Goal(s): Decrease Underage Drinking (Copied from Logic Model)

Objective(s): By 2023, social host infractions will decrease by 2% as measured by police records. By 2023, adults and parents will increase their perception that underage drinking is harmful by 3% as measured by pre-posttests. (Copied from Logic Model)

IOM Category(ies): Universal

Population(s): Adults, Parents/Families

Major Tasks	Timeline	Responsible Party	Strategy
1. Continue working with other systems to collaborate efforts	Ongoing	County & Sub-contractors	CBP or ENV
2. Presentations to community groups and agencies to mobilize communities	4 per month Annually	County & Sub-contractors	ID or ENV
3. Collaborate with local law enforcement to enact and enforce SHO	Ongoing	County & Sub-contractors	ENV
4. Annual report: analysis of social host violations and SHO efforts	Jul Annually	County	CBP or ENV
5. Enact social host ordinance	Jun 2022	County	ENV
6. Presentation to stakeholders	Aug 2020 & 2022	County	CBP or ENV

VIII CHAPTER EVALUATION

Evaluation is the sixth chapter of the SPP.

Evaluation is the systematic collection and analysis of information about program activities, characteristics, and outcomes to reduce uncertainty, improve effectiveness, and make decisions. Good evaluation can help counties and communities detect organizational and programmatic areas for improvement. The county should use evaluation results to determine what Pv efforts are necessary to guide sustainability efforts. Ultimately, good evaluation will help improve internal and external efforts.

Evaluation is useful for the following reasons:

- Helps to assess program/service progress;
- Identifies what does and does not work in a particular setting with specific focus populations;
- Builds community capacity and influences decision-makers;
- Strengthens collaborations and accountability; and
- Validates sustainability efforts.

REQUIRED COMPONENTS FOR THE EVALUATION CHAPTER

This chapter will describe the evaluation process the county will implement to determine if Pv efforts are effective in meeting objectives and outcomes. *"Steps for Evaluation"* immediately follow this section if counties need more resources, definitions, and/or clarity for the "Required Components" below.

Include the following:

Evaluation Plan, Step 4
Create an evaluation plan using the format from *Table 8.1: Evaluation Plan*. *Table 8.1* includes responses to the following questions:

- **Outcomes.** What data will the county collect? Refer to the logic model to access baseline data.
- **Performance Measures.** What are the data collection procedures?
- **Research Methods for Data Collection.** What data methods will the county institute?
- **Indicators/Data Sources.** What qualitative and quantitative sources will the county use to evaluate processes and outcomes?

- **Roles and Responsibilities.**
  - Who is responsible for collecting data?
  - Who will be responsible and/or involved with the evaluation process?
  - Will the county be working with an evaluator?
    - If yes, what are the roles and responsibilities of the evaluator?
- **Timeframe.** What is the timeframe for data collection and reporting?

Evaluation Plan Summary
In narrative form, provide a summary of the Evaluation Plan. Explain how the county will use the data to modify programs/services to improve overall Pv performance?

Dissemination Plan, Step 5
Create a dissemination plan to report your evaluation results using the format from *Table 8.2: Reporting Evaluation Results* which includes responses to the following questions:

- How will the county brief stakeholders regularly throughout the process?
- Identify the various audiences that need to see the results. Include who will receive the information, the information you will provide, and how you will distribute the information.
- Research appropriate reporting formats and discuss the reporting format(s) the county will administer.

Cultural Competence, Refer to Chapter II: Guiding Principles
- Were representatives of the focus population(s) included in the Evaluation process?
  - If yes, what were their contributions?
  - If no, how was the county culturally responsive to address the needs of the identified focus population(s)?
  - How will the county implement participation for the future?
- What process and outcome evaluation methods will the county implement to demonstrate whether selected programs/services have the intended impact on the identified focus population(s)?

Sustainability, Refer to Chapter II: Guiding Principles
- Who was responsible for evaluating data and how did the county ensure they were proficient in evaluation?
- How were stakeholders involved in the evaluation process?
- What is the county's process for developing and sharing evaluation recommendations within the county department, to stakeholders, and to the general community?
- How will the county track program adaptations/modifications over time?

STEPS FOR EVALUATION

Step 1 - Understand Evaluation
To further understand Evaluation, research the following resource:

- CPI. (n.d.). *Module 5: Evaluation* [Webinar]. Access the recorded competency at http://www.ca-cpi.org/training/TA_Training.php. This module will take 44 minutes.

Step 2 - Understand Process and Outcome Evaluation
An evaluation can be used to collect both process and outcome data. Process evaluation occurs during and after program implementation. Outcome evaluation occurs after program implementation. Collecting these types of data will help monitor implementation, improve performance, and determine which interventions and outcomes the county will sustain.

Evaluation is useful if you do it!

1. ***Monitor Implementation.*** Counties will need to develop a process to monitor implementation.
2. ***Improve Implementation.*** Counties will need to determine a plan for using data to improve implementation and performance.
3. ***Make Future Decisions.*** The county should use data to determine which interventions and outcomes to sustain.

Step 3 - Understand the Steps to Develop an Evaluation Plan
Evaluation involves a series of steps to create a customized evaluation plan. Evaluation can be simple or complex depending on available resources.

Process Evaluation documents aspects of program/service implementation and describes how the county/provider implemented it.

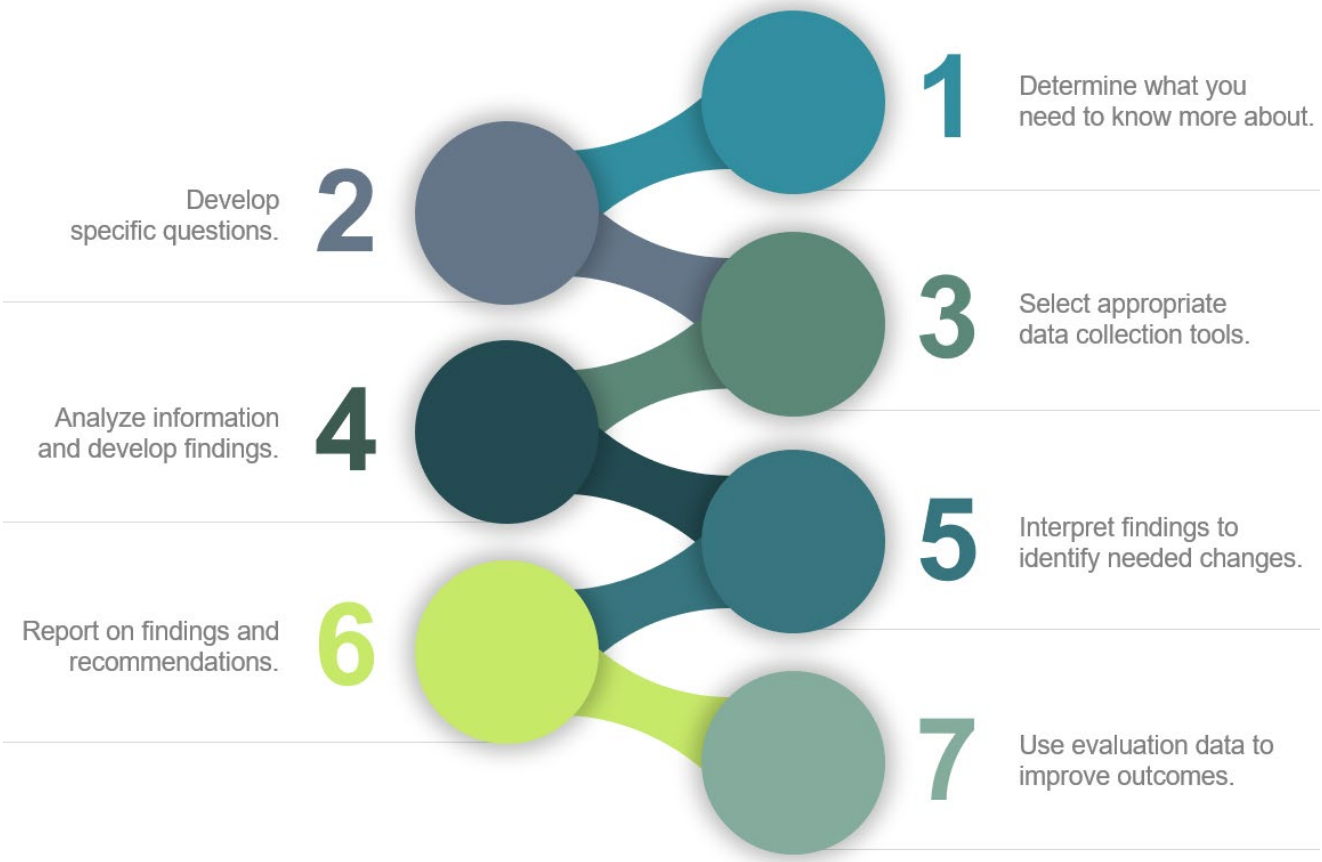
Process evaluation answers the questions:

- Did we do what we said we would do?
- Who participated and for how long?
- Did the county and/or providers make adaptations to program curriculum or implementation?
- Were the resources sufficient?
- What obstacles did the county encounter?

Outcome Evaluation documents whether the program/service made a difference, and if so, what changed? It documents the effects achieved after implementation, such as short-term and long-term changes in knowledge, attitudes, skills, or behavior.

Outcome evaluation answers the questions:

- Did the intervention make a difference?
- Did the intervention affect the risk and protective factors and problems the county expected to address?
- What population level change occurred, if any?
- How did these changes compare to the expected outcomes?



Considerations for Developing an Evaluation Plan

Selection of an evaluation design is dependent on five considerations:

1. **Information needs**. What kind of information does the county/stakeholders need?
2. **Evaluation resources.** What resources are available?
3. **Evaluator(s)**. How skilled does the evaluation team need to be and how sophisticated should the evaluation research be?
4. **Internal validity**. Will those involved in the evaluation process do the research effectively?
5. **External validity**. Do the same results occur in other settings?

Step 4 - Identify Data Collection Methods

Once the county responds to the evaluation considerations, the next step is to identify appropriate data collection methods. The county can use a combination of several methods to collect relevant data. Standard data collection methods include written surveys, questionnaires, interviews, focus groups, assessments, observations, reviews, and archival data sets.

Step 5 - Create an Evaluation Plan

Once the county identifies data collection methods, the county will create an evaluation plan. The evaluation plan should align the evaluation outcome, performance measure, and data collection method with logistics related to how and when the county will collect data and who will collect it. *Table 8.1 Evaluation Plan* is the format the county will use.

Considerations for Preparing an Evaluation Plan

- What questions do your stakeholders or funders have?
- What resources are available?
- What standards does the county require?
- Is participant confidentiality an issue?
- How and when will the county collect, analyze, and report information?

Table 8.1: Evaluation Plan

Outcomes	Performance Measures	Method of Data Collection	Indicators/ Data Source	Roles and Responsibilities	Timeframe
(Degree of Change: Short-Term, Intermediate, and Long-Term) from the logic model(s)	How will you track change?	(Interviews, surveys, observations, record comparisons)	(CHKS, program documentation, etc.)	(Who collects data? Position title, peer leader, outside expert)	(E.g. Before, during, and after program)

Step 6 - Create a Dissemination Plan

Administrators use evaluation results to improve programs, sustain positive outcomes, and improve a community's overall plan for addressing SUD issues and promoting wellness. The county should share evaluation results with the people who can use them. *Table 8.2 Dissemination Plan* is the format the county will use.

Consider the following when sharing the evaluation results:

- **Identify the audience.** Identify the various audiences that need to see the results i.e. stakeholders, coalitions, focus population(s), and how the county will deliver the information. Be sure to highlight the information that is most useful to the audience.
- **Select appropriate reporting formats.** Not all formats are appropriate for all audiences. Think carefully about the best venue or vehicle for delivering results. Should the distribution format be a public presentation, a section of the county website, or a formal report?
- **Help stakeholders understand the data.** Take time to review the findings with stakeholders and discuss the ramifications of the findings. Do not shy away from negative or unexpected results. Instead, use the results as an opportunity to inform future Pv efforts. Utilize stakeholder expertise to determine what outcomes are important to achieve and help identify measures of success. If possible, provide stakeholders with a draft of the evaluation plan to review before the evaluation plan is public.

Tailor Dissemination.

Stakeholders will be most concerned about the findings that relate to or affect their individual interests. One size does not fit all. Answer the following questions (in the order stated) to ensure the dissemination format is most relevant to the various stakeholders and community members:

- WHAT data did the county collect?
- WHY does the county want to share the data?
- WITH WHOM will the county share data?
- HOW will the county present data?
- WHO will present the data?
- WHERE will the county present data?
- WHEN will the county present data?

Table 8.2: Dissemination Plan

Enter the expected date of completion in the correct box. Counties will use *Table 8.2* to illustrate dissemination formats and audiences. Dissemination formats may not be pertinent to all audiences listed. **The county will need to edit the dissemination formats and audience relative to their unique dissemination plans and processes.**

Audience	Abstracts & Briefings	Annual/ Evaluation Reports	Fact Sheets & Infographics	Social Media	Exhibits	Press Conference	Press Release	Town Meetings
Current/ Potential Funder								
New Potential Funder								
Administrator								
Board Members								
Community Groups								
Organizations								
Media								

SPF RESOURCES

	Resource Title	Link	Source
SPF	A Guide to the Strategic Prevention Framework (SPF)	https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf	SAMHSA
	Strategic Cultural Framework (working with Native American/ American Indian communities)	https://www.samhsa.gov/tribal-ttac/about-us/strategic-cultural-framework	SAMSHA
Assessment	SPF: Tip Sheet - Conducting a Needs Assessment	http://www.ca-cpi.org/publication/spf-tip-sheet-1-conducting-a-needs-assessment/	CARS
	Survey Data Sources for AOD Prevention-A Review and Summary	http://www.ca-cpi.org/publication/survey-data-sources-for-aod-prevention-a-review-and-summary/	CARS
Capacity Building	SPF: Tip Sheet -Determining Prevention Priorities and Problem Statements	http://www.ca-cpi.org/publication/spf-tip-sheet-2-determining-prevention-priorities-and-problem-statements/	CARS
	Prevention Drug Use Among Children and Adolescents	https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf	NIDA
	Cross-Sector Collaboration	http://www.ca-cpi.org/publication/cross-sector-collaboration/	CARS
	Social Determinants of Health: A Common Language for Collaborating Across Sectors	http://www.ca-cpi.org/publication/social-determinants-of-health-a-common-language-for-collaborating-across-sectors/	CARS
	People Power: Mobilizing Communities for Policy Change	https://www.cadca.org/sites/default/files/resource/files/communitymobilization.pdf	CADCA

Planning	Using Data to Establish Needs: Using the SPF Planning Process	http://www.ca-cpi.org/publication/using-data-to-establish-needs-using-the-spf-planning-process/	CARS
	SPF Tip Sheet: Developing Measurable Goals and Objectives	http://www.ca-cpi.org/publication/spf-tip-sheet-3-developing-measurable-goals-and-objectives/	CARS
	Selecting and Implementing Evidence Based Prevention through the SPF Process	http://www.ca-cpi.org/publication/selecting-and-implementing-evidence-based-prevention-through-the-strategic-prevention-framework/	CARS
Implementation	Selecting and Implementing Evidence-Based Prevention through the Strategic Prevention Framework	http://www.ca-cpi.org/publication/selecting-and-implementing-evidence-based-prevention-through-the-strategic-prevention-framework/	CARS
	Environmental Prevention	http://www.ca-cpi.org/publication/environmental-prevention/	CARS
	Culturally Responsive Environmental Prevention	http://www.ca-cpi.org/publication/culturally-responsive-environmental-preventionPv/	CARS
	Policy Strategies to Reduce Underage and Binge Drinking	http://www.ca-cpi.org/publication/policy-strategies-to-reduce-underage-and-binge-drinking/	CARS
	The Coalition Impact: Environmental Prevention Strategies	https://www.cadca.org/sites/default/files/resource/files/environmentalstrategies.pdf	CADCA
Evaluation	Tip Sheet: Digital Storytelling and Participatory Evaluation	http://www.ca-cpi.org/publication/tip-sheet-digital-storytelling-and-participatory-evaluation/	CARS
	Evaluating Environmental Strategies	https://tinyurl.com/yys2poer	CARS

	Focus Groups: Helpful Tools for Strategic Prevention Planning	http://www.ca-cpi.org/new-cpi-resource-on-planning-and-conducting-focus-groups/	CARS
Cultural Competence	CLAS	https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.	DHHS
	Improving Cultural Competence	https://store.samhsa.gov/product/Improving-Cultural-Competence/sma16-4931	SAMHSA
	Webinar: Cross-Cultural Considerations in Community Based Prevention	https://tinyurl.com/CCCinCBP	CARS
	Webinar: CLAS Webinar Series	http://www.ca-cpi.org/ta-training-services/cpi-webinars/archived	CARS
Sustainability	Sustaining Prevention: Eight Capacity Building Factors for Success	http://www.ca-cpi.org/publication/sustaining-prevention-eight-capacity-building-factors-for-success/	CARS

DHCS SUD PRIMARY PREVENTION CONTACTS

Refer to your assigned DHCS analyst and CPI consultant for SPP support. Below are additional resources counties may need for other SUD Primary Pv inquiries.

CFNLP Contract Monitor..……..……..……..……..……DHCSFNL@dhcs.ca.gov

Cost Report Guidance…….....……Jarrett.davis@dhcs.ca.gov

CPI Project Director……..……...……..……egreen@cars-rp.org

DHCS MPF (County/Provider Changes)……..…..……..……...DHCSMPF@dhcs.ca.gov

SABG Application/Allowable Expenses……..……SABG@dhcs.ca.gov

SABG Regulations…….....…..SABGPolicyManualComments@dhcs.ca.gov