ASSEMBLY BILL 75 (AB 75)
ANNUAL REPORT TO THE LEGISLATURE

Transfer of Administrative and Programmatic Functions of the Department of Alcohol and Drug Programs to the Department of Health Care Services

August 2018
(For Calendar Year 2017)

Submitted by the Department of Health Care Services
In Fulfillment of Requirements of
Health and Safety Code, Section 11750.1

Transfer of Administrative and Programmatic Functions of the Department of Alcohol and Drug Programs to the Department of Health Care Services

Table of Contents

I. OVERVIEW 3

BACKGROUND 3

DEPARTMENT OVERVIEW 3

PURPOSE OF THE REPORT 4

II. CONTINUITY OF CARE 5

III. SAVINGS (OR COSTS) TO STATE AND LOCAL GOVERNMENT 5

IV. IMPROVED EFFICIENCY AND MAXIMIZATION OF RESOURCES 6

V. IMPROVED COORDINATION AND INTEGRATION OF PHYSICAL HEALTH CARE SERVICES 8

VI. ACCESS AND EFFECTIVENESS OF SUBSTANCE USE DISORDER PREVENTION AND TREATMENT SERVICES 8

VII. CONTRIBUTION TO DISCUSSIONS OF DELIVERY OF HEALTH CARE SERVICES 23

VIII. STAKEHOLDER INVOLVEMENT 24

IX. APPENDIX 1 – STATEWIDE TREATMENT ADMISSIONS DATA 26

X. APPENDIX 2 – SPECIAL OR VULNERABLE POPULATIONS ADMISSIONS 27

XI. APPENDIX 3 – STATEWIDE TREATMENT SERVICES 28

I. Overview

Background

Enactment of 2011 Public Safety Realignment marked a significant shift in the State's role in administering programs and functions related to substance use disorder (SUD) services. Realignment also redirected funding for the Drug Medi-Cal (DMC) Treatment Program and discretionary SUD programs to the counties. Reflecting this shift, the administration announced its intent in the Fiscal Year (FY) 2011-12 May Revision, and then proposed in the FY 2012-13 Governor's Budget to reorganize the Department of Alcohol and Drug Programs (ADP). As part of the FY 2013-14 budget process, Governor Brown signed Assembly Bill (AB) 75 (Committee on Budget, Chapter 22, Statutes of 2013), which enacted law to eliminate ADP. All remaining administrative and programmatic functions were transferred from ADP to the Department of Health Care Services (DHCS), with exception to the Office of Problem Gambling, which transferred to the California Department of Public Health (CDPH). Previously, in FY 2011-12, Governor Brown signed AB 106 (Committee on Budget, Chapter 32, Statutes of 2011), which enacted law to transfer the administration of the DMC Treatment Program from ADP to DHCS, effective July 1, 2012. Consolidating responsibility for SUD services and community mental health services under DHCS aligned California with its federal, state, and county partners. Nearly all community mental health programs from the former Department of Mental Health (DMH) transferred to DHCS with the enactment of the FY 2012-13 Budget, effective July 1, 2012.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has been moving towards administrative integration in the application for its block grant by encouraging states to submit one combined application. As of December 2017, 46 other states had SUD and mental health services combined into one department. Only three of California's counties operate as autonomous substance use services agencies (Los Angeles, Solano, and Santa Clara).

In early 2011, DHCS and ADP began collaborating on transitions by planning for the transfer of the DMC Treatment Program. For the transfer of the remaining administrative and programmatic functions of ADP, both departments built upon that infrastructure. The two departments also had a joint Executive Steering Committee, which included senior staff from both DHCS and ADP. They also formed a joint transition team, which consisted of unit-level managers from the departments. Each department identified a project manager and created a work plan for the transition. A project manager from both DHCS and ADP each participated in the transition team, focusing on implementing the transition work plans of each department. Since 2011, all identified transitioning functions have been completed.

Department Overview

DHCS' mission is to preserve and improve the health status of all Californians by providing residents with access to affordable, high-quality health care, including

medical, dental, mental health, SUD, and long-term services and supports. DHCS' vision is to preserve and improve the physical and mental health of all Californians. DHCS works closely with federal officials, health care professionals and organizations, county governments, and health plans in the administration of health care programs and services. DHCS plays a critical role in supporting a health care safety net for California's low-income and disabled persons.

As of October 2017, there were over 13.3 million Medi-Cal eligible individuals in California. One in three Californians is eligible to receive health care services financed or organized by DHCS, making DHCS the largest health care provider in the State. DHCS invests over $103 billion in public funds to provide health care services. DHCS provides access to comprehensive health services and emphasizes prevention-oriented health care that promotes human health, well-being, and individual choice. DHCS oversees appropriate and effective expenditure of public resources to serve those with the greatest health care needs. The health care programs and services administered by and financed through DHCS help maintain the health care delivery safety net by providing California's low-income individuals, families, children, pregnant women, seniors, and individuals with disabilities with access to critical health care services.

DHCS programs are designed to:

- Deliver health care services to low-income individuals and families who meet defined eligibility requirements;
- Emphasize prevention-oriented health care measures that promote health and well-being;
- Provide access to comprehensive health services through the use of public and private resources; and
- Oversee the appropriate and effective expenditure of public resources to serve those with the greatest health care needs.

The transfer of administrative and programmatic functions from ADP provided the opportunity for DHCS to improve efficiencies, maximize resources, and strengthen the coordination and integration of physical health care services. These opportunities align with the commitment strategies and actions outlined in the DHCS Strategic Plan. (Note that underlined texts in this report are links to information on the DHCS website.)

Purpose of the Report

AB 75 directs DHCS to report annually to the Joint Legislative Budget Committee, the appropriate budget subcommittees, and the policy committees of the Legislature on SUD programs. The report addresses the impact of the transition of ADP programs to DHCS and establishes a baseline for evaluating, on an ongoing basis, how and why alcohol and other drug prevention and treatment service deliveries have improved, or otherwise changed, as a result of this transition. Pursuant to Health and Safety Code Section 11750.1(c) the requirement to submit an annual report to the Legislature

becomes inoperative on July 1, 2018, therefore this is the last AB 75 Annual Report to the Legislature.

II. Continuity of Care

There have been no reported disruptions in prevention, treatment, and recovery services reported to DHCS since the transfer of administrative and programmatic functions from ADP. In fact, since the two SUD Divisions transitioned to DHCS, opportunities for program expansion have been developed, such as the Drug Medi-Cal Organized Delivery System. In addition, increased partnerships with primary care have created many opportunities to work in a cross-system, coordinated manner. Cross-system coordination will be explained in more depth throughout this report.

III. Savings (or Costs) to State and Local Government

Upon transition, all costs for transferring the administrative and programmatic functions were absorbed within existing resources of ADP and DHCS. No additional budget authority was authorized. The primary costs to transfer the functions were associated with information technology (IT) systems and staff relocation. Additional costs were incurred due to the investment of significant staff time in planning, tracking, and operationalizing the transfer.

As part of the transfer, DHCS received six complex IT systems and more than 200 staff from ADP with computing needs. The IT goals were to ensure the transition of these systems and meet staff computing needs while avoiding infrastructure and security risks to the DHCS network. Over the years, DHCS' Enterprise Innovation Technology Services Division (EITSD) has continued to work collaboratively with the SUD divisions to identify business needs, prioritize IT efforts (projects, enhancements, upgrades), consolidate functionality of the IT systems (where applicable), and provide improvements through the process of re-engineering. Progress on various IT solutions will be presented in the subsequent sections of this report.

In early 2014, a significant number of administrative staff from human resources, legal services, accounting, IT, etc., were relocated to the East End Complex. Program staff were relocated to the East End Complex in December 2014. The costs for relocation of staff were absorbed and new administrative support processes initiated.

Upon transition, DHCS partners and stakeholders indicated that the transfer resulted in increased costs related to contract and payment delays, staff time related to the recertification process for the DMC Treatment Program, and processing contract amendments with counties, vendors, and service providers. In 2013, transitioning federal authority for SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG), Strategic Prevention Framework State Incentive Grant (SPF SIG) and California Access to Recovery (CARE) grants delayed payments to the State that resulted in late payments to counties and providers. Since that time, the SPF SIG and CARE grants ended and DHCS received two new grants, known as the Strategic

Prevention Framework Partnerships for Success Grant (SPF PFS) and the State Targeted Response Opioid Grant (Opioid STR).

IV. Improved Efficiency and Maximization of Resources

The transfer of the remaining SUD administrative and programmatic functions from ADP to DHCS reunited the State administration of the DMC Treatment Program with the remaining SUD programs. This consolidated the SUD programs within DHCS to foster coordination of SUD programs with community mental health and primary care, improve efficiencies in the administration of the programs, and maximize resources. The reorganization offered numerous benefits to the SUD system, including:

- Aligned with federal and county partners;
- Promoted opportunities for improvement of health care delivery;
- Coordinated SUD, mental health, and primary care programmatic expertise within DHCS;
- Enhanced oversight of SUD programs; and
- Reflected realignment.

In anticipation of the transfer of programs from the former DMH and the DMC Treatment Program from ADP, DHCS began an effort in early 2011 to identify key business processes transferring from the departments to conduct risk assessments and to identify opportunities for process improvement. The Business Process Reengineering (BPR) effort provided collaboration between DHCS, DMH, and ADP subject matter experts and stakeholders. The BPR identified key business processes to be examined and assessed for ease of transfer to DHCS, identification of efficiencies that could be operationalized at transfer, and/or any potential risks. The BPR Team identified seven ADP business processes to document. This effort was led by DHCS' Internal Audits Branch of the Audits and Investigations Division, who worked with ADP subject matter experts, by flow-charting the processes. Claims processing and payments, cost report and settlement, and financial audits and appeals were among the initial ADP business processes to document.

DHCS' Internal Audits (IA) Branch conducted a risk assessment on the remaining four processes and gathered the related statutory language. As a result, EITSD worked with the Short Doyle system to ensure system improvement. DHCS' IA Branch continues to provide information to DHCS on historical perspectives of the processes in place prior to the transition of ADP. Once ADP transitioned into DHCS, business processes were taken over by SUD divisions, and process improvements are now being made, as needed.

<u>Contract and Grant Administration</u>

DHCS' Contracts Management Unit (CMU) worked with ADP contract staff prior to the transfer to determine the most efficient means to transfer the county contracts. The team developed an efficient and expeditious method to amend and extend existing

county and direct-provider contracts by transitioning authority to DHCS. This method was effective in eliminating potential service disruptions. Therefore, some of the SUD Program, Policy, and Fiscal Division (PPFD) sections have migrated away from utilizing the Clinical Assurance and Administrative Support Branch (CAASD) for contract support, and work directly with CMU.

The DHCS Director's Office, CMU, CAASD, Budgets, and Accounting Sections all continue to play active roles in the submission of federal financial reports, grant applications, funding authority requests, and other key administrative functions of the SABG, SPF PFS, and Opioid STR grants.

IT and Data Management

In 2014, The Behavioral Health Data Modernization Project was initiated as a long-term project with two separate phases: Phase I – Planning Advanced Planning Document (PAPD) to gather all the system requirements, business rules and planning for the system; and Phase II – Advanced Planning Document in which implementation of the plan starts. The project is intended to modernize the systems utilized by both mental health and SUD. DHCS will then assess the systems to determine areas of duplications and/or gaps in data collection and work to address those gaps moving forward. The PAPD has been approved by the Center for Medicare & Medicaid Services and is moving forward to securing contractors to implement Phase I.

DHCS' IT infrastructure provides an opportunity to improve some longstanding issues with California Outcomes Measurement System-Treatment (CalOMS Tx). For example, one vision in the early stages of CalOMS Tx development under ADP was to create an online reporting system into which counties and providers could directly enter CalOMS Tx data. However, ADP did not have the IT infrastructure to support such an online platform. As a result, counties and providers built local systems and submitted data in monthly batches. The greater capacity of DHCS' IT infrastructure provides an opportunity to move toward an alternative reporting platform that improves local reporting of CalOMS Tx data.

Recently, IT and program staff convened to review the current functionality of CalOMS Tx in order to write updated business requirements and begin the migration process of the CalOMS Tx system to a cloud-based server. Two stakeholder meetings were convened in 2017 to gather input regarding the system migration and potential future enhancements.

In addition, the SUD PPFD Prevention and Family Services Section (PFSS) procured a new web-based data collection service in 2017. The new vendor, FEI Systems, Inc., has developed and implemented the new data collection service known as the Primary Prevention SUD Data Collection Service (PPSDS). DHCS staff are currently working with counties to implement the new system. The system is used to collect primary prevention process data required for SABG annual reporting.

The Substance Use Disorder Cost Reporting System was implemented ahead of schedule in April 2017. SUD staff utilized the new platform to settle cost reports for FY 2014-15. System revisions will be made to accommodate cost reporting needs as the Drug Medi-Cal Organized Delivery System waiver is implemented.

Public Reporting of Treatment Statistics

The transfer to DHCS has provided opportunity to improve the public reporting of statistics. The SUD Office of Applied Research and Analysis, DHCS' specialized SUD research branch, has access to additional data and analysis tools and resources. Whereas research/evaluation was historically focused primarily on SUD treatment data, there may be opportunities in the future to look at SUD treatment service recipients across other physical and mental health services. Such research and evaluation could provide a greater understanding of all services accessed and utilized, service outcomes, program performance, and long-term health outcomes of SUD treatment service recipients.

V. Improved Coordination and Integration of Physical Health Care Services

The transfer of programs from ADP to DHCS has resulted in improved coordination and integration of physical health care services with SUD prevention and treatment services, both at the State and local level.

SUD programs are easily and efficiently able to collaborate with multiple DHCS divisions involved in physical health care (e.g., Managed Care Quality and Monitoring, Benefits, Provider Enrollment, Audits and Investigations, Pharmacy Benefits, Office of the Medical Director). This expanded and collaborative approach has increased integration of SUD programs with mental health and other health programs to improve health outcomes for beneficiaries receiving services via multiple delivery systems (e.g., managed care, fee-for-service, and county delivery systems). DHCS staff from various divisions meet internally and externally with stakeholders on a regular basis to ensure that crosscutting issues are addressed appropriately. As a result, the transfer of SUD programs into DHCS directly connects those programs to the physical health care issues, policies, and delivery systems in a new and more effective method.

Staff in the SUD divisions work with counterparts from the Mental Health Services Division to ensure improved coordination and integration of physical health care through attendance at DHCS meetings with medical directors from managed care and mental health plans.

VI. Access and Effectiveness of Substance Use Disorder Prevention and Treatment Services

Prevention Services

Prevention of Substance Use Disorders

Substance use begins as an experimental behavior and can lead to various negative consequences, including later onset of a SUD, which is a chronic, clinical condition. According to SAMHSA, SUD prevention is defined as activities directed at individuals who do not require treatment for an SUD. Such activities may include education, counseling, or changes to the social/community environment that reduce risk factors and increase protective factors, thereby reducing the risk of individuals developing a SUD.

The major federal funding source for SUD prevention services in California is the SABG 20 percent Primary Prevention Set-Aside. The Primary Prevention Set-Aside is administered by DHCS SUD PPFD PFSS and distributed to all counties through a population-based allocation formula. The annual allocation for the Federal FY 2017 was $47,162,776.

Prevention Services Data Sources

Each of California's 58 counties are required by contract to develop a Strategic Prevention Plan, with measurable goals and objectives, using SAMHSA's Strategic Prevention Framework (SPF). The SPF consists of five phases: needs assessment, capacity building, planning, implementation, and evaluation. The needs assessment includes collecting and analyzing local data to determine the major contributing factors associated with SUD use locally, and an assessment of the local capacity and resources to reduce and/or prevent SUD use.

DHCS works to make data readily available for county needs assessments by providing funding from the SABG and SPF PFS grant for the California Healthy Kids Survey, California Department Public Health's (CDPH) Epi Center, and the California Friday Night Live (FNL) Youth Development Survey. In 2016, the SUD PPFD worked with CDPH to add questions on adult marijuana use to the Center for Disease Control's Behavioral Risk Factor Surveillance System. The ongoing support for data collection will help the state and counties understand which communities are most impacted by the harms and consequences associated with use of various drugs so they may plan for prevention and/or treatment services.

Through the SPF process, counties prioritize areas of focus, develop goals and objectives, and select strategies from SAMHSA's approved Center for Substance Abuse Prevention (CSAP). The CSAP strategies for allowable use of SABG funding are:

- **Information Dissemination** to provide awareness and knowledge of the nature and extent of substance use, abuse, and addiction, and their effects on individuals, families, and communities. This dissemination is usually a one-way communication from a source to an audience, with limited contact between the two (e.g., printed materials, websites).
- **Education** is two-way communication between an educator/facilitator and the

participants (e.g., classroom curriculum). Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systematic judgment abilities.

- **Alternatives** provide opportunities to participate in activities that exclude substance use. Activities must contain a SUD component and provide for youth leadership opportunities (e.g., youth involvement in a local coalition focusing on preventing excessive alcohol consumption at annual community events).
- **Problem Identification and Referral** involves identifying those 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 in order to assess if their behavior can be reversed through education. This strategy does not include any activity designed to diagnose if a person is in need of treatment. **Community-Based Process** enhances the ability of the community to more effectively provide prevention services for SUD. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implemented, interagency collaboration, coalition building, and networking.
- **Environmental** efforts establish or change community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives (e.g., social host ordinances, establishing policies) and those that relate to the service and action-oriented initiatives (e.g., law enforcement and retailer education, media campaigns).

Access to Prevention Services

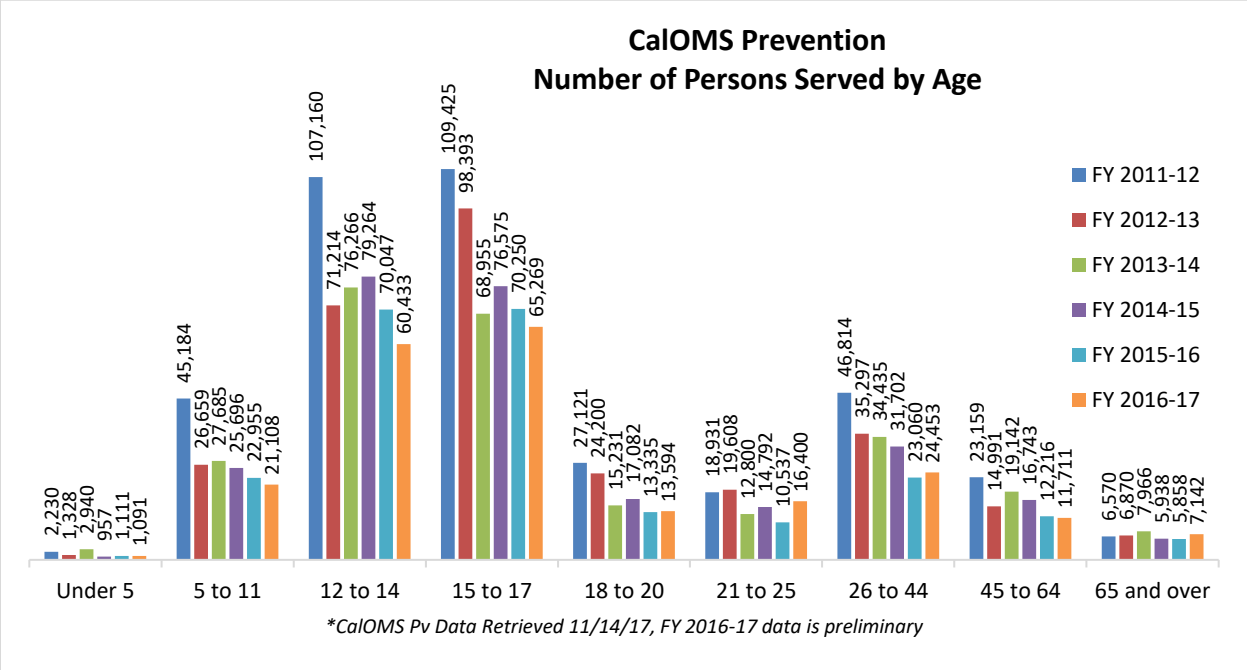
SUD Prevention Services are provided at the individual and population levels. Individual-level prevention services are characterized as one-on-one or group sessions that are interactive and engage participants in structured SUD prevention services. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviors that ultimately prevent SUD use. Individual-level services allow demographic information to be collected.

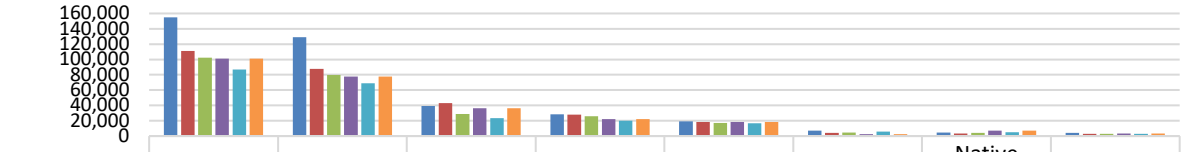
Population-level prevention focuses on settings such as neighborhoods. Prevention services at this level are typically designed to impact the climate, community processes, and policies in a given system. Social norm and marketing campaigns are often used to foster neighborhood climates that promote healthy relationships. Because population-level prevention is delivered to the community at large, demographic data is not collected. This comprehensive prevention service delivery structure allows counties to provide the maximum benefit for the largest number of people, thereby mitigating service access issues.

The charts on pages 11 and 12 depict data on age, race, and gender collected in the California Outcomes Measurement Service for Prevention (CalOMS Pv). Note that counties are only required to report services in CalOMS Pv that are funded with SABG dollars; services provided with other funds are not reflected in data. In addition, the FY

2016-17 CalOMS Pv data are preliminary until year-end cost reports are received and reconciled. Also, note that the CalOMS Pv service was replaced by the PPSDS as of July 1, 2017.

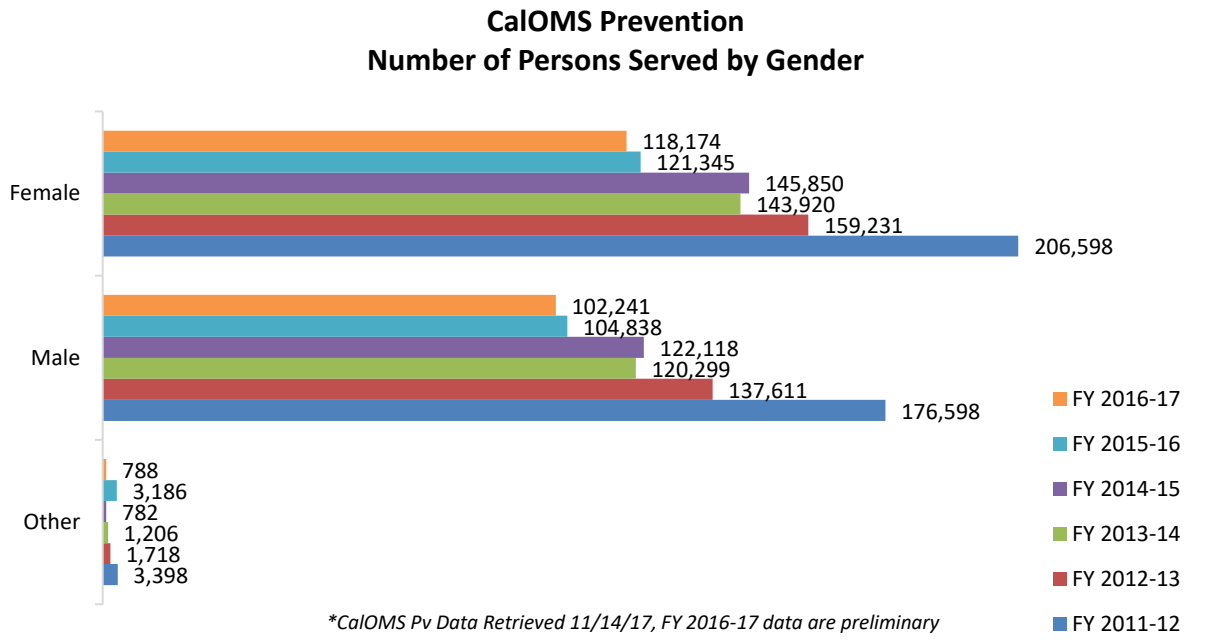
According to the National Center on Addiction and Substance Abuse at Columbia University, 90 percent of Americans with SUDs began using substances before age 18. Therefore, targeted prevention activities for this age range is crucial. The chart on this page conveys that the majority of SABG-funded primary prevention services are targeted to young people ages 12 to 17, hence reaching the age group of highest need. As well, the data reported on race and gender is representative of the demographic makeup of California's overall population.





	Hispanic or Latino	White not Hispanic	African American	Asian American	Multi-racial	Other	Native Hawaiian or Pacific Islander	Native Am or Alaska Native
FY 2011-12	154,937	128,960	39,359	28,495	19,245	6,976	4,637	3,985
FY 2012-13	111,112	87,695	43,032	28,120	18,357	4,081	3,265	2,898
FY 2013-14	102,341	79,685	28,933	25,810	17,266	4,514	4,112	2,764
FY 2014-15	101,005	77,837	36,399	22,175	18,264	2,598	6,992	3,480
FY 2015-16	86,870	68,829	23,220	19,967	16,505	5,675	5,123	2,931
FY 2016-17	101,005	77,837	36,399	22,175	18,264	2,598	6,992	3,480

**CalOMS Pv Data Retrieved 11/14/17, FY 2016-17 data are preliminary*



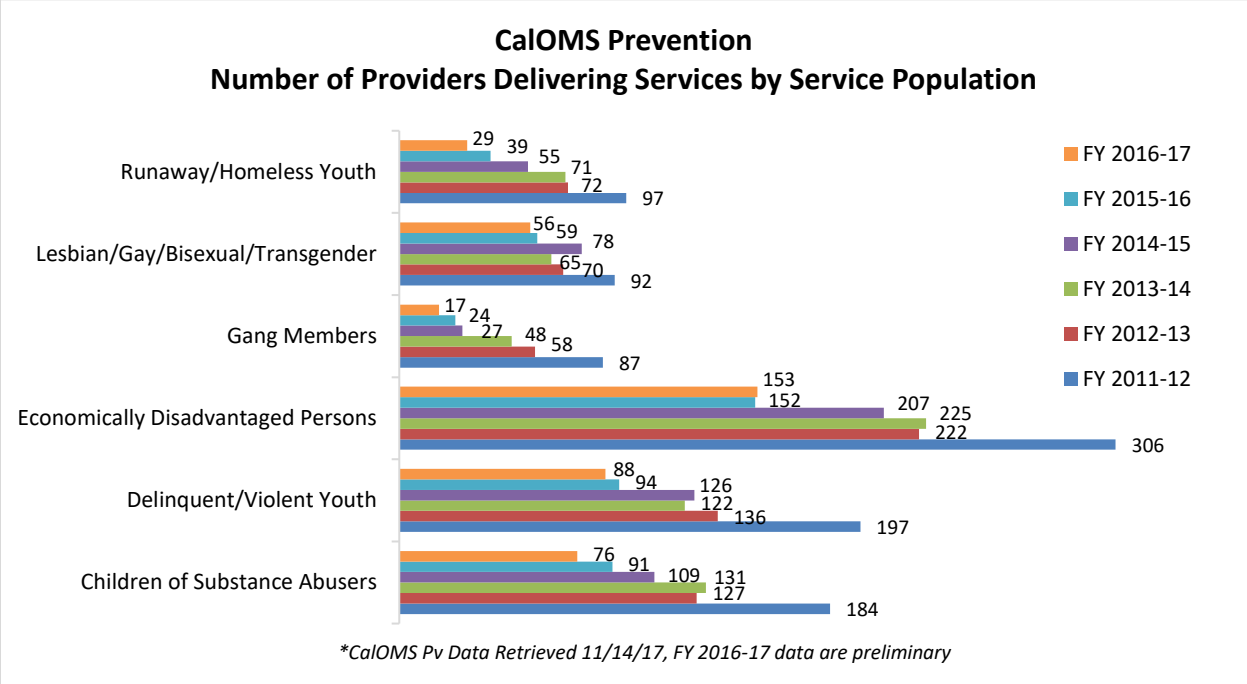
Prevention Services for Vulnerable and Underserved Populations

To help counties, DHCS, through the Community Prevention Initiative (CPI), held two regional trainings aimed at examining cultural competency in SUD Prevention. The training topics included: 1) using cultural competence to guide prevention efforts; 2) instituting Culturally and Linguistically Appropriate Services (CLAS) Standards organizationally and programmatically; and 3) supporting specific populations through culturally competent SUD prevention strategies. As well, a series of four introductory

webinars on the CLAS Standards were developed as prerequisite courses to the regional trainings.

At the local level, while many counties serve vulnerable and underserved populations, these populations are seldom reported as specific targeted populations for SUD prevention services. As mentioned previously, counties are required to engage in a strategic planning process that identifies specific local needs. Through this process, counties may identify needs for specific underserved and vulnerable populations, and contract with providers to address those specific populations. The CalOMS Pv data collection system allows service providers to identify the underserved and vulnerable populations they serve, but it is not a requirement for the submission of data. Note that CalOMS Pv does not have the capacity to capture specific individual level demographics for underserved/vulnerable populations, but rather the total number of providers that deliver services to these populations. This will also be the case for the new PPSDS reporting system as well. The chart on this page represents the most frequently identified service populations considered underserved and/or vulnerable.

Per the SABG application, economically disadvantaged persons are defined as persons with net income less than 130 percent of the poverty level. This aligns with other similar federal requirements for free school lunches, women, infants and children, etc. The terminology “economically disadvantaged persons” aligns with the terminology used by CSAP.



Prevention Services System Capacity and Infrastructure

The SUD PPFD PFSS develops and maintains a comprehensive, statewide prevention system that aims to avert and reduce substance use to improve the health, safety, and economic conditions of California residents. The SUD PPFD PFSS provides technical assistance and guidance to the counties and their providers, as well as oversight that the requirements for the SABG funds are being met. As previously stated, the SABG 20 percent Primary Prevention Set-Aside is the primary funding source for SUD efforts in California. The majority of this funding is allocated to the counties, making SUD prevention in California county-driven, guided by the counties' stra plan. Counties determine the focus of their prevention efforts and identify target populations and any gaps in services. This process allows for expanded county-level service capacity.

Performance Management and Accountability

Strategic Planning

As previously stated, each of California's 58 counties are required by contract to have a Strategic Prevention Plan, with measurable goals and objectives, developed using SAMHSA's SPF. Every three to five years, counties submit a new strategic plan to DHCS for review and approval; enter the identified priorities, goals, and objectives into CalOMS Pv; and assign each objective to one or more contracted providers.

Service Delivery

When the providers report SUD prevention services to DHCS, each service must align with the county-assigned objective. This allows both the county and DHCS to ensure that the services, strategies, goals, and objectives meet county needs based on data. Over time, progress toward meeting the goals are tracked and modifications are made, as necessary.

Technical Assistance

DHCS and the current contractor of the DHCS-funded CPI, Center for Applied Research Solutions (CARS), provide free technical assistance and training to counties that need assistance with strategic plan development, as well as selecting and implementing appropriate strategies, including evidence-based programs and program evaluation.

The Strategic Training and Education for Prevention Planning (STEPP) Project was developed by DHCS staff and CARS to coordinate and provide cohesive, strategic technical assistance services to counties that have strategic prevention plans due to expire. The STEPP is designed to transform a complex process into a segmented, easy-to-follow format. Ongoing SPF strategic prevention plan training by competent prevention experts has increased the quality of strategic prevention plans submitted by the counties.

When counties incorporate SPF into their everyday business practices and utilize available technical assistance and training, it allows for expanded local system capacity. One phase of the SPF is to build local capacity. This includes working with a county so it has the resources and readiness to support its chosen prevention programs and practices. Programs and practices that are well supported are more likely to succeed and to be sustained over time.

Another source for county technical assistance is through the California Friday Night Live Partnership (CFNLP). The CFNLP provides leadership and field support needed for continued growth and enhancement of the California-developed, evidence-based, youth development program, known as FNL. This program is implemented in 50 counties and funded primarily with SABG dollars.

Performance Tracking and Indicators

Since the transfer from ADP, the SUD PPFD PFSS continues its priority development and strategic planning with the DHCS Office of the State Medical Director. The following SUD PPFD PFSS goals have been included in the DHCS Strategy for Quality Improvement in HealthCare that outlines DHCS' seven quality strategy priorities:

- Quality Strategy Priority 5: Advance Prevention: The SUD PPFD PFSS' goals are related to increasing participation of the Interagency Prevention Advisory Council (IPAC) and identifying gaps in youth treatment services.
- Quality Strategy Priority 6: Foster Healthy Communities: The SUD PPFD PFSS' goals relate to SPF PFS, which addresses underage and excessive drinking by utilizing evidence-based programs, and increasing FNL program fidelity.

The ways in which the SUD PPFD PFSS has strategized to meet these goals include:
1) continuing to develop professional competencies for the prevention field;
2) increasing the importance of strategic planning at the county level;
3) changing the format of IPAC to be more inclusive of county and local-level agencies; and,
4) convening a Youth Advisory Group (YAG) of stakeholders to collectively work on youth service gaps.

Fiscal Reconciliation Process

To provide accountability and full expenditure of the SABG prevention dollars, DHCS engages in a reconciliation process in which budget and cost data are compared to the services reported in CalOMS Pv. The chart below indicates the number of prevention providers in the state engaging in each CSAP strategy. Note: The figures captured below illustrate higher counts as providers are able to select more than one CSAP strategy per service. Over time, the overall number of providers reporting to each of the CSAP Strategies has declined. This may be due to the increased emphasis on strategic planning and using data to inform strategy selection in targeted, high need

communities.

CalOMS Prevention Number of SUD Prevention Providers Reporting per CSAP Strategy						
CSAP Strategy	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Information Dissemination	241	209	222	206	193	173
Education	227	178	181	164	152	154
Alternatives	165	140	149	128	120	111
Problem Identification and Referral	71	55	48	46	36	37
Community-Based Process	246	220	240	224	202	210
Environmental	150	154	170	165	154	154
**CalOMS Pv Data Retrieved 11/14/17*						

Prevention Services System Outcomes

DHCS worked in collaboration with the State Epidemiological Workgroup (SEW), a multi-agency collaborative of researchers convened as a requirement of the SABG and other SAMHSA discretionary grants, to develop and implement three data indicator toolkits that would empower counties and providers to collect and analyze local consumption, consequence, and contributing factor data. The first toolkit was piloted at the 2016 CPI Regional Trainings. In 2017, the last two data indicator toolkits were completed and are currently undergoing review by the SEW. Data collected utilizing the toolkits provides meaningful contribution to SABG-required local needs assessments and strategic planning.

DHCS also used the SPF SIG grant project to pilot a study using evidence-based programs and practices. In September 2010, ADP was awarded SAMHSA's SPF SIG to streamline existing SPF processes at the county and community level, and to demonstrate effective implementation of research-based prevention strategies in communities.

In following the SPF five-phase process, the SPF SIG Workgroup conducted a statewide needs assessment, the results of which identified underage and excessive drinking among 12 to 25 year-olds as the priority of the California SPF SIG project.

Environmental prevention strategies were implemented in 12 communities in California. Results were compared to 12 control communities that have been matched with the SPF SIG communities. The SPF SIG implementation communities were selected based on local alcohol and other drug use and consequence data. The communities were: Livermore (Alameda County); Antioch (Contra Costa County); Walnut Creek (Contra Costa County); Santa Monica (Los Angeles County); San Rafael (Marin County); Merced (Merced County); Huntington Beach (Orange County); Folsom (Sacramento County); Redlands (San Bernardino County); Santa Barbara (Santa Barbara County); Santa Rosa (Sonoma County); and Ventura (Ventura County).

These communities focused on underage and binge drinking and employed evidence-based strategies that fall into three primary strategies: 1) retail access, 2) social access, and 3) drinking and driving. To date, the following strategies have been used: Driving Under the Influence (DUI) roadside checkpoints, DUI saturation patrols, responsible beverage service training, party patrols, downtown foot patrols, compliance checks, Remind and Reward Programs, conditional use permits, deemed approved ordinances, social host liability, keg registration, neighborhood watch, place-of-last-drink surveys, alcohol use permits, entertainment permits, minor decoy operations, and visibility messaging on both compliance and enforcement operations.

Archival data from various sources were used to evaluate intervention effects on community-level outcomes, such as alcohol-related motor vehicle crashes, assaults, injuries, and underage drinking. Baseline and follow-up surveys of 2,400, 18 to 30 year-olds (~100 per city) and 1,500 adolescents (~60 per city) were conducted in 2013 and 2015. Process and outcomes evaluations are complete, and the grant came to a close in 2016.

The process evaluation has helped to understand the paths to success and why initiatives in some communities may have worked better than in other communities. Findings were presented at the February 2018 meeting of the IPAC. Information, tools, and techniques from the project will be incorporated into the workshops and trainings of the CPI technical assistance contract. The final report along with other supporting documentation on the project can be found on the SPF SIG webpage.

Treatment Services

Treatment Services Data Sources

Statistics on SUD treatment services and service recipients come from DHCS' CalOMS Tx data system. DHCS is required to collect CalOMS Tx admission and discharge data from all SUD treatment providers in California that receive public funding, and/or that are licensed and/or certified by DHCS. For future reference, these are called "publicly monitored treatment services." Pursuant to AB 75, FY 2011-12 data are included as baseline data. FY 2012-13, FY 2013-14, FY 2014-15, and FY 2015-16 are included for trend analyses. FY 2015-16 is the most current and complete fiscal year of CalOMS Tx data available.

Treatment data include the following treatment service modalities:

- Outpatient Drug Free – individual and/or group counseling provided in an outpatient setting;
- Narcotic Treatment Program (NTP) Maintenance – provision of narcotic replacement medications such as methadone or buprenorphine in an outpatient setting that also includes individual and/or group counseling;
- Intensive Outpatient Treatment – provision of three hours of counseling and rehabilitation services three days per week;
- Outpatient Detoxification – rendered in less than 24 hours that provides for safe withdrawal in an ambulatory setting. Services are designed to support and assist participants undergoing a period of planned withdrawal from SUD dependence and explore/develop plans for continued service. Administration of prescribed medication may be included in this type of service;
- NTP Detoxification – rendered in less than 24 hours and provides narcotic withdrawal treatment to clients undergoing a period of planned withdrawal from narcotic dependence;
- Residential Detoxification – includes hospital and non-hospital detoxification services. Hospital detoxification services are provided in a licensed hospital where participants are hospitalized for medical support during the planned SUD withdrawal period. Non-hospital detoxification services are provided in a residential facility, which supports the participant during a planned SUD withdrawal period; and
- Residential Treatment – includes short-term (less than 30 days) and long-term (more than 30 days) treatment services provided in a residential setting. Services may include the following elements: personal recovery/treatment planning; educational sessions; social/recreational activities; individual and group sessions; and information about/assistance in obtaining, health, social, vocational, and other community services.

Access to Treatment Services

CalOMS Tx collects data on individuals admitted to publicly-monitored treatment services. These data do not include those seeking, but not receiving, publicly monitored treatment.

The following provides CalOMS Tx based demographic information on persons admitted into SUD treatment (see Appendix 1 on page 25). These statistics are derived from the admission data analyses and cover all admissions for all service types.

In FY 2015-16, the overall number of reported admissions has decreased slightly from 169,875 in FY 2011-12, 175,114 in FY 2012-13, 170,742 in FY 2013-14, and 165,779 in FY 2014-15, to 163,200 in FY 2015-16. Most of the service recipient information remained relatively stable for FY 2012-13 through FY 2015-16, except where noted.

(Note: An individual may be admitted to multiple service types in a given year or be admitted to the same service type multiple times. Therefore, admissions will not equal the number of unique treatment service recipients.)

- Almost one-third of admissions into SUD treatment (32.7 percent) are for service recipients 26 to 35 years old. The 36 to 45 age group represents 19.4 percent of the total, followed by the 18-25 age group (17.4 percent) and the 46 to 55 age group (15.5 percent). Those under 18 years of age represent 7.3 percent, and those 56 and older represent 7.7 percent. Since FY 2011-12, there has been an annual decrease (from 14.90 percent in FY 2011-12 to 7.30 percent in FY 2015-16) in the overall percentage of service recipients who are under 18 years of age.
- 62.3 percent of the admissions were males and 38.0 percent were females.
- Most admissions were for service recipients identifying their race or ethnicity as either White (44.9 percent) or Hispanic (36.5 percent). The percent of African Americans decreased from 14.4 percent in FY 2011-12 to 11.1 percent in FY 2015-16.
- 45.7 percent of admissions referred themselves to treatment or are referred by a relative or friend. 27.3 percent are referred from the criminal justice system and 8.3 percent from other sources in the community. The remaining 18.7 percent are referred from a variety of other sources.
- The most commonly reported primary drug used at admission is methamphetamine (30.3 percent), an increase from 25.8 percent in FY 2011-12. Heroin is second (25.5 percent), followed by alcohol (20.5 percent), marijuana (13.8 percent), and cocaine/crack (3.1 percent). The remaining 6.8 percent is comprised of a variety of other drugs. The percent of service recipients reporting heroin as the primary drug has gradually increased since FY 2011-12, with the greatest increase between FY 2012-13 and FY 2013-14.
- 27.2 percent of admissions report injecting drugs in the past year. Prior intravenous drug use has risen with the increase in heroin users entering treatment. In FY 2015-16, about 71 percent of these heroin users report injection as the main route of administration. It is also worth noting that over 16 percent of those admitted with methamphetamine as their primary drug report injection as their route of administration.

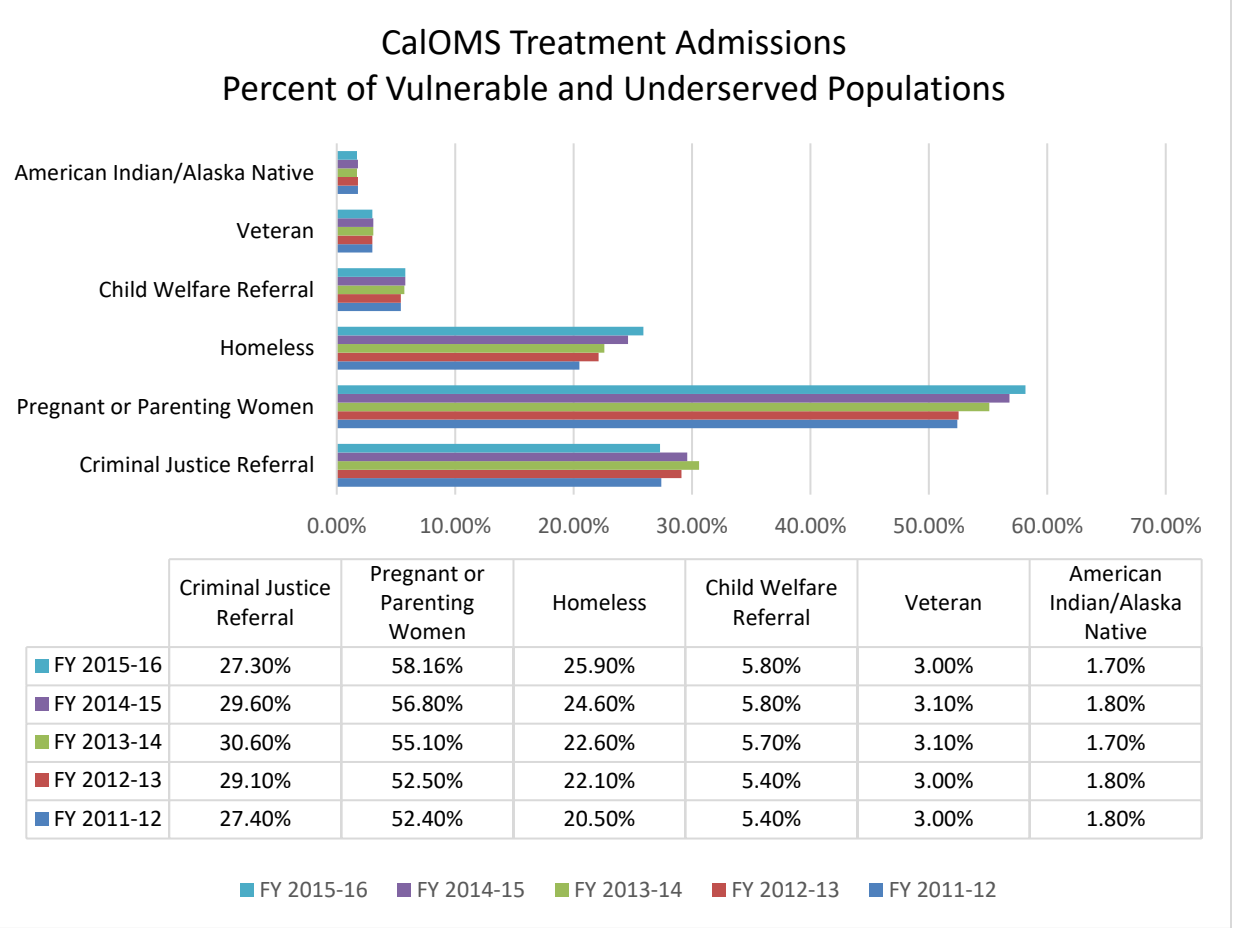
Note: Drug trends for those in treatment are not necessarily reflective of drug use trends in the general population. For instance, while alcohol is the most commonly used and abused drug in the general population, methamphetamine is the most commonly reported primary drug for those in treatment.

Treatment Services for Vulnerable and Underserved Populations

CalOMS Tx collects information on the following vulnerable and underserved populations (see chart on page 20 and Appendix 2 on page 26). Service recipients

may be included in more than one of these populations. The overall number of admissions to CalOMS Tx in FY 2011-12 was 169,875, with an increase to 175,114 in FY 2012-13, and a decrease to 163,200 in FY 2015-16. This chart shows that the vulnerable and underserved populations remained relatively stable, with two exceptions:

- In FY 2011-12, the homeless population was 20.5 percent of total admissions. By FY 2015-16, they had increased to 25.9 percent of total admissions.
- In FY 2011-12, pregnant or parenting women was 52.4 percent of all female admissions. By FY 2015-16, this percentage had increased to 58.2 percent.



	Criminal Justice Referral	Pregnant or Parenting Women	Homeless	Child Welfare Referral	Veteran	American Indian/Alaska Native
FY 2015-16	27.30%	58.16%	25.90%	5.80%	3.00%	1.70%
FY 2014-15	29.60%	56.80%	24.60%	5.80%	3.10%	1.80%
FY 2013-14	30.60%	55.10%	22.60%	5.70%	3.10%	1.70%
FY 2012-13	29.10%	52.50%	22.10%	5.40%	3.00%	1.80%
FY 2011-12	27.40%	52.40%	20.50%	5.40%	3.00%	1.80%

Treatment Services System Capacity and Infrastructure

The following provides CalOMS Tx based information on persons served in SUD treatment. “Served” counts provide information on all “active” service recipients during a given period (e.g., FY 2015-16). These counts include service recipients admitted during the year plus those admitted in prior years but still receiving

treatment services during the year. Each admission is counted for service recipients with multiple admissions.

The treatment "served" counts decreased slightly from approximately 248,000 in FY 2011-12, to approximately 245,000 in FY 2015-16. "Served" counts are obtained from a live dataset. Increases and/or decreases of "served" counts each year may result from data cleanup. The following provides additional information by service type (see Appendix 3 on page 27):

- Outpatient Drug Free – This service type has the largest percent of total served. The percent served in this service type decreased each year from 47.6 percent in FY 2011-12 to 37.8 percent in FY 2015-16.
- NTP Maintenance – The percent served in this service type increased from 19.9 percent in FY 2011-12 to 29.8 percent in FY 2015-16.
- Intensive Outpatient Treatment – The percent served in this service type declined slightly from 4.3 percent in FY 2011-12, and 4.0 percent in FY 2013-14, to 3.3 percent in FY 2015-16.
- NTP Detoxification – The percent served in this treatment type decreased slightly from a high of 3.5 percent in FY 2012-13 to 2.5 percent in FY 2015-16.
- Residential Detoxification – The percent served in this service type remained relatively stable with 8.9 percent in FY 2011-12 to 9.7 percent in FY 2015-16.
- Long Term Residential (>30 Days) – The percent served in this treatment type remained stable in each of the five years with between 15.2 percent in FY 2011-12 to 16.2 percent in FY 2015-16.
- Short Term Residential (<31 Days) and Outpatient Detoxification (non-NTP) each comprised less than one percent of all service recipients served in each of the five years.

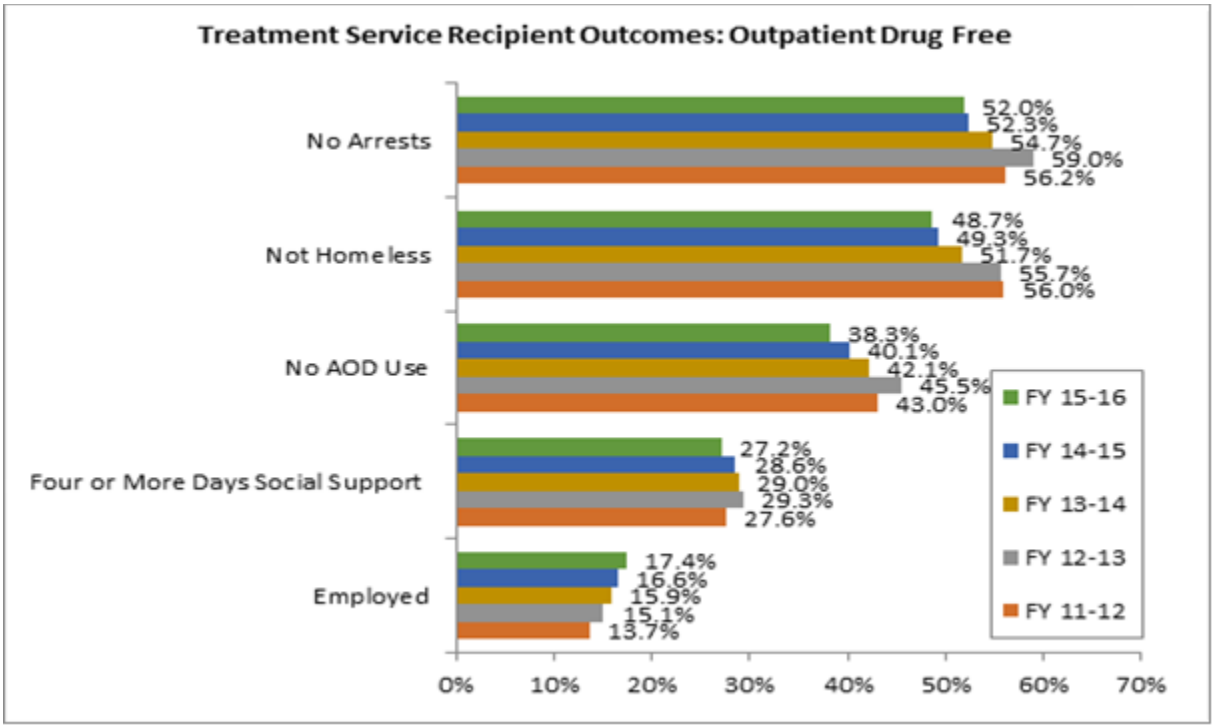
In addition to examining "served" counts, waiting list information also provides insight about treatment system capacity. Out of all treatment admissions during FY 2015-16 (163,200), about 24.3 percent of service recipients reported waiting at least one day to gain admission to treatment services. The percent waiting at least one day has been relatively stable for the last four years with 24.5 percent in FY 2011-12. The percent that reported waiting at least one day varies by service type. Those seeking residential services had the largest percentages waiting for treatment admission. The percent waiting at least one day to receive residential services has decreased slightly from 52.6 percent in FY 2011-12 to 46.7 percent in FY 2015-16.

Treatment Service Recipient Outcomes

The CalOMS Tx system collects data on the treatment recipient functioning (e.g., using drugs or not, arrested or not) at the time of the recipient's admission to and discharge from publicly-funded SUD treatment services and/or licensed narcotic treatment programs. CalOMS Tx collects a variety of treatment service recipient outcome measures in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. Outcome measures collected in these areas indicate the impact of treatment services.

These CalOMS Tx measures, along with the percentage of administrative discharges (i.e., the service recipient left treatment prior to their planned discharge and could not be reached for discharge data collection), are used to measure and compare service recipient outcomes across multiple years. Outcomes are only reported at the statewide level. The historical outcome measurement method of comparing recipients' functioning at admission and discharge to determine differences after treatment (i.e., pre-post design outcome measurement methodology) did not accurately measure all recipients' actual outcomes because counties vary substantially in the number of discharges reported without client level of functioning data. This discharge data is necessary to provide generalizable and comparable outcomes across counties. DHCS is in the initial stages of developing county-level statistical reports documenting how many discharge records are submitted without the client level of functioning data necessary to measure outcomes.

Treatment service recipient data included in this report are for Outpatient Drug Free (ODF) services. This service type represents the largest proportion of treatment admissions to publicly-monitored treatment programs. In addition, ODF is typically the last service type in an episode of treatment (i.e., when a service recipient progresses from more intensive to less intensive treatment services). From FY 2011-12 through FY 2015-16, the CalOMS Tx data indicated that ODF service recipient outcomes showed improvement in only one of the following five outcome measures (i.e., Employed). The five outcomes measures are No Arrests, Not Homeless, No Alcohol and Other Drug Use, Adequate (Four or More Days) Social Support Participation, and Employed.



The five key measures for outcomes in the chart above provide service recipient outcomes by year for ODF services. Percentages for the Adequate Social Support Participation outcome have remained relatively stable across fiscal years. The “No Arrests” measure shows a slight increase from FY 2011-12 to FY 2012-13 of about three percentage points, but then drops by seven percentage points through FY 2015-16. The “Not Homeless” measure dropped over seven percentage points through FY 2015-16. “No AOD Use” showed a slight increase from FY 2011-12 to FY 2012-13, but then drops over seven percentage points in FY 2015-16. The only positive outcome is in “Employment”. Participants have shown a slight, but steady, increase from 13.7 percent in FY 2011-12 to 17.4 percent in FY 2015-16. Again, the main challenge to analyzing the data and measuring these outcome trends is the continued increase in missing CalOMS Tx discharge data. Counties/SUD treatment providers fail to report the data to DHCS. DHCS is in the initial stages of developing county-level statistical reports documenting how many discharge records are submitted without the client level of functioning data necessary to measure outcomes. DHCS is hopeful that the reports will be completed by the end of the calendar year.

VII. Contribution to Discussions of Delivery of Health Care Services

As demonstrated throughout this report, the transfer of ADP administrative and programmatic functions to DHCS provides SUD issues a greater and more prominent platform for public policy discussions related to the delivery of health care services in California. There is now increased recognition of the relationship between high costs and poor outcomes for individuals with co-occurring SUD, mental illness, and chronic health conditions.

State-level integration of the administration of SUD and mental health programs and primary care facilitate coordination of health care to benefit health outcomes for individuals with SUD and co-occurring disorders. The consolidation of mental health and SUD services under one directorate in DHCS demonstrates the commitment to integration of physical and behavioral health. Substantive discussions of behavioral health programs in the delivery of health care services within DHCS, with federal and county partners and stakeholders such as the County Behavioral Health Directors Association (CBHDA), are enriched through this integration.

In 2016, The Centers for Medicare and Medicaid Services issued the Medicaid Mental Health Parity Rule that applies some requirements to the Mental Health Parity and Addiction Equity Act of 2008. SUD staff have played integral roles in department-wide discussions pertaining to the impact of the new requirements, such as quantitative treatment limitations around alcohol misuse screening and counseling, network adequacy standards, and the adoption of a continuity of care policy for SUD services.

VIII. Stakeholder Involvement

To ensure continued engagement with stakeholders on improving SUD programs, DHCS has maintained, and continues working with, the advisory groups that ADP convened prior to the transfer.

DHCS maintains engagement with:

- CBHDA
- IPAC
- Counselor Certification Advisory Committee
- NTP Advisory Committee
- DUI Advisory Group

Beyond maintaining the advisory groups from ADP, opportunities for stakeholder involvement have both changed and been enhanced because of the transition. SUD stakeholders now have direct access to DHCS leadership and the extensive resources of DHCS regarding SUD program and policy issues. An example of expanded resources is the work accomplished through the 21st Century Cures Act to address the national opioid crisis. DHCS received $90 million over a period of two years (May 2017 through May 2019) to implement the California Medication Assisted Treatment (MAT) Expansion Project.

The MAT Expansion Project aims to serve over 20,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. The project focuses on populations with limited MAT access, including rural areas, American Indian and Alaskan Native tribal communities, and statewide access to buprenorphine. This work compliments the ongoing statewide efforts of the Statewide Opioid Safety Workgroup led by CDPH.

Of note, stakeholder involvement of IPAC continues to increase, adding many local entities. Structurally, IPAC has changed immensely. The IPAC was once a forum utilized for networking and information sharing. IPAC has now transformed into an action-oriented council with a strategic plan based on data. Through the planning process, workgroups were established to address priorities. As well, strategic partnering areas were established in order to map onto greater state-level efforts. This allows IPAC partners to reduce redundancies in stakeholder participation. The workgroups and strategic partnering areas are as follows:

- Underage Marijuana Prevention Workgroup;
- Underage Alcohol Use Workgroup;
- Suicide and Depression;
- Prescription Drug Misuse; and
- Impaired Driving.

Finally, in 2016 the YAG was convened by DHCS as a quarterly workgroup to examine the youth treatment and recovery infrastructure in California. The workgroup is comprised of county behavioral health offices, providers, and community non-profits that serve youth. In 2017, the YAG completed a needs assessment, established a mission and vision, and set priority areas.

IX. Appendix 1 – Statewide Treatment Admissions Data

California Outcomes Measurement System – Treatment (CalOMS – Tx) Statewide Admission Data for Fiscal Years (FY) 2011 – 12 Through 2015 – 16						
Total Admissions Client and Service Characteristics		FY 2011 – 12	FY 2012 – 13	FY 2013 – 14	FY 2014 – 15	FY 2015 – 16
		169,875	175,114	170,742	165,779	163,200
Age						
	Under 18 years	14.90%	13.50%	9.70%	8.00%	7.30%
	18-25 years	18.00%	18.20%	17.80%	17.40%	17.40%
	26-35 years	25.70%	27.10%	29.20%	31.40%	32.70%
	36-45 years	18.60%	18.20%	18.90%	19.40%	19.40%
	46-55 years	16.60%	16.40%	17.20%	16.50%	15.50%
	56-65 years	5.50%	5.80%	6.50%	6.50%	6.80%
	66 and older	0.70%	0.80%	0.70%	0.80%	0.90%
Gender						
	Male	61.90%	62.60%	63.00%	62.80%	62.30%
	Female	38.10%	37.40%	37.00%	37.20%	38.00%
Race/Ethnicity						
	African American	14.40%	14.50%	12.80%	11.70%	11.10%
	American Indian/Alaskan Native	1.30%	1.30%	1.20%	1.30%	1.20%
	Asian/Pacific Islander	2.20%	2.30%	2.20%	2.10%	2.00%
	Hispanic	35.20%	35.40%	35.90%	35.80%	36.50%
	Multiracial	2.00%	2.00%	2.20%	2.30%	2.30%
	Other	1.90%	1.80%	1.60%	1.90%	1.90%
	White	43.00%	42.70%	44.10%	44.90%	44.90%
Primary Drug Used						
	Alcohol	22.50%	21.80%	19.20%	20.10%	20.50%
	Cocaine/Crack	5.90%	5.10%	4.30%	3.60%	3.08%
	Heroin	17.90%	19.10%	24.00%	25.10%	25.50%
	Marijuana/Hashish	20.20%	19.40%	16.00%	14.30%	13.80%
	Methamphetamine	25.80%	27.50%	29.40%	30.10%	30.30%
	Other	7.70%	7.10%	7.10%	6.80%	6.90%
Route						
	Oral	29.50%	28.60%	26.10%	26.70%	27.30%
	Smoking	47.30%	47.00%	44.70%	44.20%	43.20%
	Inhalation	4.60%	4.90%	5.20%	5.50%	5.70%
	Injection	18.20%	19.20%	23.50%	23.20%	23.20%
	Other	0.40%	0.30%	0.50%	0.40%	0.50%
Used Needles (in past 12 mos.)						
	Yes	21.70%	22.90%	27.30%	27.20%	27.20%
	No	78.30%	77.10%	72.70%	72.80%	72.80%
Referral Source						
	12 Step Mutual Aid	0.10%	0.10%	0.10%	0.10%	0.10%
	SUD Program	5.80%	5.90%	6.90%	7.00%	7.10%
	Child Protective Services	5.40%	5.40%	5.70%	5.80%	5.80%
	Criminal Justice	27.40%	29.10%	30.60%	29.60%	27.30%
	Employer/EAP	0.20%	0.10%	0.10%	0.10%	0.10%
	Individual	42.10%	40.70%	42.80%	44.20%	45.70%
	Other Community Referral	11.40%	11.50%	8.50%	8.30%	8.30%
	Other Health Provider	2.20%	2.40%	2.40%	2.70%	3.20%
	School/Education	5.40%	4.80%	2.90%	2.20%	2.40%

X. Appendix 2 – Special or Vulnerable Populations Admissions

	FY 2011 – 12		FY 2012 – 13		FY 2013 – 14		FY 2014 – 15		FY 2015-16	
Total Admissions	169,875		175,114		170,742		165,779		163,200	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Special or Vulnerable Populations (Number/ Percent)										
Criminal Justice Referral	46,602	123,273	50,961	124,153	52,259	118,483	49,068	116,711	44,624	118,576
	27.40%	72.60%	29.10%	70.90%	30.60%	69.40%	29.60%	70.40%	27.30%	72.70%
Pregnant or Parenting Women	33,908	30,782	34,411	31,160	34,796	28,387	35,033	26,638	35,729	25,698
	52.40%	47.60%	52.50%	47.50%	55.10%	44.90%	56.80%	43.20%	58.16%	41.84%
Homeless	34,895	134,980	38,610	136,504	38,681	132,061	40,758	125,021	42,185	121,015
	20.50%	79.50%	22.10%	77.90%	22.60%	77.40%	24.60%	75.40%	25.90%	74.10%
Child Welfare Referral	9,142	160,733	9,395	165,719	9,686	161,056	9,701	156,078	9,520	153,680
	5.40%	94.60%	5.40%	94.60%	5.70%	94.30%	5.80%	94.20%	5.80%	94.20%
Veteran	5,108	164,767	5,238	169,876	5,269	165,743	5,167	160,612	4,881	158,319
	3.00%	97.00%	3.00%	97.00%	3.10%	96.90%	3.10%	96.90%	3.00%	97%
American Indian/Alaska Native	3,016	166,859	3,089	172,025	2,857	167,885	3,021	162,758	2,770	160,430
	1.80%	98.20%	1.80%	98.20%	1.70%	98.30%	1.80%	98.20%	1.70%	98.30%

XI. Appendix 3 – Statewide Treatment Services

California Outcomes Measurement System – Treatment (CalOMS – Tx) Statewide Service Recipients Served* Data for Fiscal Years (FY) 2011-12 Through 2015-16					
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Service Type	Frequency/Percent				
Outpatient Drug Free	117,775	112,284	103,656	98,484	92,745
	47.6%	45.2%	42.1%	40.2%	37.8%
Narcotic Treatment Program Maintenance	49,203	51,176	59,890	67,911	73,076
	19.9%	20.6%	24.3%	27.7%	29.8%
Intensive Outpatient Treatment	10,687	11,634	9,897	7,953	7,971
	4.3%	4.7%	4.0%	3.2%	3.3%
Outpatient Detoxification	125	225	225	234	92
	0.1%	0.1%	0.1%	0.1%	0.1%
Narcotic treatment Program Detoxification	8,441	8,705	8,129	6,735	6,227
	3.4%	3.5%	3.3%	2.7%	2.5%
Residential Detoxification	22,093	24,397	23,427	23,482	23,695
	8.9%	9.8%	9.5%	9.5%	9.7%
Short-Term Residential (<31 Days)	1,760	1,304	1,304	1,336	1,665
	0.7%	0.5%	0.5%	0.5%	0.7%
Long-Term Residential (>30 Days)	37,531	38,898	39,677	38,822	39,767
	15.2%	15.7%	16.1%	15.9%	16.2%
Total	247,615	248,624	246,205	244,957	245,238
	100%	100%	100%	100%	100%

* Served counts include service recipients admitted into treatment during the year, plus those admitted in prior years, but are still receiving treatment services during the year. Each admission is counted for service recipients who have multiple admissions during the year.