STATEWIDE NEEDS ASSESSMENT AND PLANNING REPORT

Fiscal Year 2025

For the Substance Use Prevention, Treatment, and Recovery Services Block Grant Federal Reporting Requirement

California Department of Health Care Services

Community Services Division

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CONTENTS

EXECUTIVE SUMMARY

The 2025 Statewide Needs Assessment and Planning (SNAP) Report provides compelling substance use and misuse data delivering a high-level overview of California's substance use disorder (SUD) incidence and prevalence, the capacity to meet the behavioral health needs of individuals, and a preview of the state's Strategic Initiatives designed to minimize, if not close, the gaps exposed during the assessment phase.

The 2025 SNAP Report provides California's SUD incidence and prevalence rates among Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) members, racial and ethnic groups, and youth, and identifies related service utilization, client outcomes, and program performance. California data shows fluctuations in alcohol misuse for junior high- and high school-aged youth, as well as misuse of prescription medications for high school-aged youth, as students returned to in-person learning after the COVID-19 pandemic. Survey respondents who were 18 years or older continued to show a decline in the misuse of prescription medications.

DHCS's assessment of California's SUD consumption and consequence data revealed that while the nation battles the opioid use disorder (OUD) epidemic, the state experienced an alarming increase in overdose deaths related to psychostimulants with abuse potential such as cocaine and methamphetamine since 2015. The number of hospitalizations and deaths due to alcohol and drug misuse continues to be a grim fact as an estimated annual average of 19,335 alcohol attributable deaths occurred in California from 2020 through 2021. Males accounted for a majority of these deaths. In 2023, California hospitals tallied 53,555 emergency department (ED) visits and 19,242 non-fatal drug overdose hospitalizations. During the same year, 11,359 Californians died from a drug-related overdose; 7,847 of those were opioid-related and 7,137 involved fentanyl.[1]

With substantial investment in behavioral health at the federal level from the American Rescue Plan Act of 2021 and Coronavirus Response and Relief Supplemental Appropriations Act of 2021, and at the state level, California continues to implement innovative initiatives focused on improving outcomes for all members receiving prevention, harm reduction, treatment, and recovery services. While the SNAP Report meets the federal reporting requirements for Substance Use Prevention, Treatment, and

[1] California Overdose Surveillance Dashboard. Accessed on February 3, 2025. Prepared by the California Department of Public Health (CDPH) Substance and Addiction Prevention Branch (SAPB), February 2025.

Recovery Services Block Grant (SUBG,) this report also highlights various other behavioral health programs.

DHCS contracts with counties receiving SUBG funding on a biennial basis and continues the minimum percentage of SUBG primary prevention funding at 25 percent of the total SUBG allocation for each county. For SFY 2023-2024, California served approximately 359,007 individuals using four of the six Center for Substance Abuse Prevention (CSAP) Strategies, including Education, Alternative, Problem Identification and Referral, and Environmental. The other two CSAP Strategies, Information Dissemination and Community-Based Process, were widely employed during the SFY but the nature of these activities does not lend towards individual counts. DHCS has carefully considered the data collected for the 2023 SNAP Report and used it to develop three Strategic Initiatives. California plans to prioritize these initiatives over the next two SFYs to improve access to and availability of SUD treatment and prevention services for Californians. DHCS will report progress toward the completion of these initiatives in the 2023 and 2024 SUBG Annual Reports, copies of which will be available to the public via DHCS SUBG website upon final submission to SAMHSA.

Department of Health Care Services

August 2025

INTRODUCTION

The California DHCS publishes the SNAP Report biennially as required by the Code of Federal Regulations (CFR) 45 CFR § 96.133 governing recipients of the SUBG. According to 45 CFR § 96.133(a)(1) through (a)(6), DHCS is required to submit to the Secretary of the U.S. Department of Health and Human Services (HHS) an assessment of the need for SUBG-authorized activities in California. The report is organized in accordance with the applicable statute. The final SNAP Report is accessible on the DHCS website as a resource for behavioral health programs to develop or modify existing strategies, goals, and objectives, or to create future ones.

In this 2025 SNAP Report, California presents a broad range of data collected between 2017 and 2023. Some data sources collect and report data biennially, while others are on the calendar year (CY), SFY, or Federal Fiscal Year (FFY). Data is drawn from the most recent and current available sources, although the date ranges for the data may vary. Some data sources have altered the wording of their survey questionnaires in the past two years. These changes may have elicited different responses from participants; therefore, DHCS cannot draw conclusions about increases or decreases, or make year-over-year comparisons. In such instances, DHCS notes and provides the prior year's data for reference only.

STATE INCIDENCE AND PREVALENCE OF SUBSTANCE USE 45 CFR § 96.133(A)(1)

This section of the SNAP Report focuses on SUD-related consumption and consequence to provide a snapshot of the impact of SUD on individuals using the most current information available. "Incidence" refers to the number of new cases that emerge within a given time period. "Prevalence" refers to the total number of cases at any given moment in time.

Substance Use Disorder-Related Consumption Data

California Healthy Kids Survey[2]

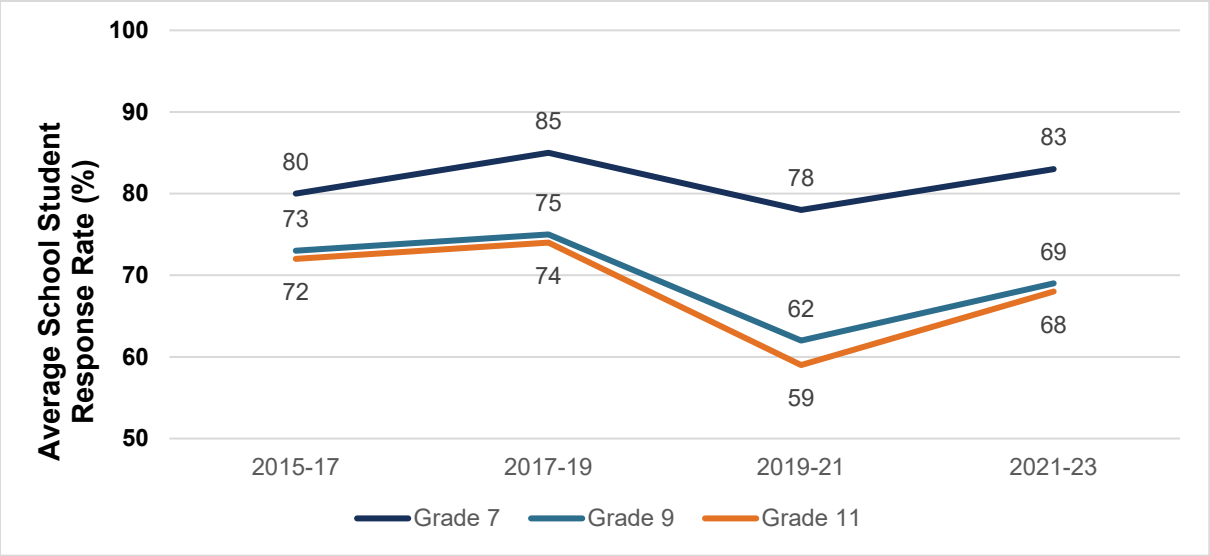
The State California Healthy Kids Survey (CHKS) is an anonymous statewide survey administered biennially to students in grades 7, 9, and 11. CHKS collects data to assess

[2] The California School Climate, Health, and Learning Survey (CalSCHLS) System - Reports & Data.

the well-being of California students and how well California schools are meeting student needs. The data collected covers key indicators of student engagement, positive development, mental health, and risk behavior, particularly substance use. For the purpose of this SNAP Report, DHCS will utilize 2017-2019, 2019-2021, and 2021-2023 CHKS data to report youth substance use perceptions and patterns.

Data collection of the 19th Biennial State CHKS (2021-2023) was conducted as students returned to in-person learning after the COVID-19 pandemic. Survey response rates increased across all grade levels compared to the 18th Biennial State CHKS but had not fully returned to pre-pandemic levels. See Exhibit 1. Additionally, questions about school climate and on-campus experiences, which were excluded from the 18th Biennial State CHKS due to remote learning conditions, were reintroduced in this administration. Data collected during this period reflect the ongoing recovery from the pandemic's effects on student engagement, well-being, and school safety.

Exhibit 1: Student Survey Response Rates by Survey Administration Period



Source: Biennial State California Healthy Kids Survey Data, 2015-2017, 2017–2019, 2019–2021, and 2021-2023

In California, alcohol use among youth has decreased. The 2021-2023 CHKS data in Table 1 groups the frequency of alcohol use in the past 30 days into increments of days. The combined total for students who reported they drank one or more drinks in the past 30 days is 3.5 percent of 7th graders, 6.6 percent of 9th graders, and 10.7 percent of 11th graders. In comparison, the 2019-2021 CHKS shows a combined total of 2.7 percent of 7th graders, 6.5 percent of 9th graders, and 13.6 percent of 11th graders stated that they had used one or more drinks of alcohol in the past month.

Table 1: Frequency of Alcohol Use (One or More Drinks) in the Past 30 Days

Frequency	Grade 7		Grade 9		Grade 11	
	2019-2021	2021-2023	2019-2021	2021-2023	2019-2021	2021-2023
0 days	97.3%	96.5%	93.5%	93.4%	86.4%	89.3%
1 or 2 days	2.3%	2.7%	4.8%	4.9%	9.2%	7.2%
3 to 9 days	0.3%	0.4%	1.0%	1.0%	3.2%	2.3%
10 to 19 days	0.0%	0.3%	0.3%	0.3%	0.6%	0.7%
20 or more	0.1%	0.1%	0.4%	0.4%	0.6%	0.5%

In addition, the level of alcohol use among youth has been steadily declining since 2019-2023. The 2021-2023 CHKS data in Table 2 measures the level of alcohol use for lifetime drinking and driving involvement, binge drinking (5 drinks in a single setting), and very drunk or sick after drinking alcohol. The combined total among high schoolers for lifetime drinking and driving involvement is 43.8 percent, binge drinking (5 drinks in a single setting) is 9.2 percent, and very drunk or sick after drinking alcohol is 20.1 percent. In comparison, the 2019-2021 combined total for high schoolers lifetime drinking and driving involvement is 44.3 percent, binge drinking (5 drinks in a single setting) is 11 percent, and very drunk or sick after drinking alcohol is 24.3 percent.

Table 2: Measures of Level of Alcohol Use

Frequency	Grade 7		Grade 9		Grade 11	
	2019-2021	2021-2023	2019-2021	2021-2023	2019-2021	2021-2023
Lifetime drinking and driving involvement	25.6%	28.5%	7.0%	6%	11.7%	9.3%
Binge Drinking (5 drinks in a row at a single setting)	0.8%	0.9%	2.8%	3.1%	7.4%	5.2%
Very drunk or sick after drinking alcohol	1.8%	2.3%	6.8%	6.2%	15.7%	11.6%

The 2021-2023 CHKS data in Table 3 shows a decrease of three points in 11th grade, a one-point decrease among 9th grade, and a 0.3 increase in 7th grade students using marijuana in the past 30 days by smoking, vaping, eating, or drinking compared to 2019-2021. Reductions also occurred for engaging in each of the methods of marijuana

ingestion (smoking, vaping, and oral ingestion). However, since 2017-2019, the decline in vaping marijuana has been less pronounced than smoking, indicative of the increased popularity of vaping.

Table 3: Current Marijuana Use (Past 30 Days)

Data Year	Grade 7	Grade 9	Grade 11
2019-2021	1.5%	6.1%	12.1%
2021-2023	1.8%	5.1%	8.8%

When examining responses to CHKS's age of onset of marijuana use question, we find the highest percentage of 7th graders first used marijuana at age 11 or 12, 9th graders at age 13 or 14, and 11th graders at age 15 or 16. According to this data, the age of onset appears to be dropping to a younger age than in past years.

Table 4: Age of Onset - Marijuana Use

Age of Onset	Grade 7		Grade 9		Grade 11	
	2019-2021	2021-2023	2019-2021	2021-2023	2019-2021	2021-2023
Never	95.6%	95.4%	87.0%	88.1%	72.8%	77.9%
10 years or under	0.6%	0.8%	0.8%	1.0%	0.9%	0.7%
11-12 years old	3.0%	2.3%	2.7%	2.2%	2.0%	2.4%
13-14 years old	0.4%	0.7%	8.5%	6.9%	9.4%	7.8%
15-16 years old	0.1%	0.0%	0.7%	1.2%	13.9%	9.9%
17 years old	0.4%	0.8%	0.3%	0.6%	0.9%	1.2%

The 2021-2023 CHKS asked students in grades 9 and 11 about their past 30-day use of prescription pain medications to get "high" or for reasons other than prescribed. The question included examples of prescription pain medications such as Vicodin, OxyContin, Percodan, Ritalin, Adderall, and Xanax.

The results in Table 5 show an overall decline in past 30-day misuse of prescription medications for surveyed students in 2021-2023 compared to 2019-2021.

Table 5: Past 30-day Misuse of Prescription Pain Medication

Data Year	Grade 7	Grade 9	Grade 11
2019-2021	Not Asked	1.2%	1.4%
2021-2023	Not Asked	0.9%	0.9%

California Health Interview Survey[3]

The California Health Interview Survey (CHIS) is the largest state health survey in the nation. CHIS is a web and telephone survey that asks questions on a wide range of health topics. The University of California Los Angeles Center for Health Policy Research conducts this web- and telephone-based survey on a continuous basis allowing the survey to generate timely one-year estimates.

As demonstrated in Table 6, the CY 2022 CHIS asked youth aged 12 to 17 if they ever had more than a few sips of an alcoholic drink. The survey results showed that 116,620 out of 595,000 youth, or 19.6 percent, reported having more than a few sips of an alcoholic drink, a 2 percent decrease from the previous year.

Table 6: Ever Had More than a Few Sips of an Alcoholic Drink (12–17 years old)

Data Year	Percentage	95% CI	Population
2020	21.5%	18.6 - 24.4	676,000
2021	21.6%	18.9 - 24.4	673,000
2022	19.6%	17.2 - 22.0	595,000

In CY 2022, survey results in Table 7 showed that out of 15,207,000 youth aged 12 and older, 7,101,669 (46.7 percent) reported having ever tried marijuana or hashish in any form. This percentage remained relatively steady in this population compared to CY 2021. Of those who reported having ever used marijuana or hashish, 34.4 percent of respondents aged 18 years or older reported using it within the past 30 days.

Table 7: Ever Tried Marijuana or Hashish in Any Form (12–17 years old)

Data Year	Percentage	95% CI	Population
2020	45.5%	44.5 - 46.4	14,911,000
2021	46.5%	45.7 - 47.2	15,225,000
2022	46.7%	46.1 - 47.4	15,207,000

[3] California Health Interview Survey (CHIS), University of California Los Angeles.

In CY 2022, Table 8 shows that 1.7 percent of CHIS respondents over the age of 18 reported using a prescription painkiller in the past year in a way that did not follow their doctor's directions. This is a 0.3 percent decrease from CY 2021.

Table 8: Misused a Prescription Pain Killer in the Past 12 Months

Data Year	Percentage	95% CI	Population
2019	2.6%	2.3 - 3.0	791,000
2020	2.0%	1.7 - 2.3	603,000
2021	2.0%	1.7 - 2.2	583,000
2022	1.7%	1.5 - 1.8	502,000

National Survey on Drug Use and Health[4]

In 1971, SAMHSA launched the National Survey on Drug Use and Health (NSDUH) to collect current data on tobacco, alcohol, and drug use, mental health, and other health-related issues in the United States. Various research organizations utilize the information from the NSDUH to support prevention and treatment programs, monitor substance use trends, estimate the need for treatment, and inform public health policy.

According to the NSDUH Frequently Asked Questions about data and trend comparability, a fully mixed-mode survey approach was adopted in 2021. This approach includes responses collected through both web and in-person methods. Repeated analyses indicate that web responses are not directly comparable to in-person responses, and the differences are not consistent enough to be fully accounted for using weights or other statistical measures. As a result, years that included a web response option cannot produce comparable estimates to years without it. Because of this, data from 2021 should not be compared to estimates from 2019 or earlier.[5]

The following are some results from the 2021-2022 NSDUH report:

- 22.83 percent of Californians aged 12 and older used marijuana in the past year.
- The perception of risk from smoking marijuana once a month varies by age and those 18 to 25 years old perceived there to be the least risk at 12.56 percent, with youth aged 12 to 17 at 19.35 percent.

[4] 2021-2022 NSDUH State Reports | samhsa.gov.

[5] NSDUH Frequently Asked Questions | CBHSQ Data.

These data points highlight the ongoing need for harm reduction and early intervention efforts targeting the young adult population, as older youth are showing increased regular use and a "normalized" perception of harm.

In CYs 2021-2022:

- 3.69 percent of Californians aged 12+ years reported illicit drug use other than marijuana.
- 2.29 percent of Californians aged 12+ years reported cocaine use.
- 1.35 percent of Californians aged 12+ years reported methamphetamine use.
- 1.49 percent of Californians aged 12+ years reported pain reliever use disorder.[6]
- 2.98 percent of Californians aged 12+ years reported pain reliever misuse.[7]

Additionally, in CYs 2021-2022, the percentage of Californians aged 12+ years who reported alcohol use disorder or binge drinking was noted as follows:

- 11.24 percent of Californians aged 12+ years reported alcohol use disorder.
- 21.07 percent of Californians aged 12+ years reported binge[8] alcohol misuse.

Substance Use Disorder-Related Consequence Data

Drug Use

California continues to face a serious drug crisis with substantial health and economic impacts. According to the California Overdose Surveillance Dashboard, in 2023, 11,359 Californians (29 per 100,000; age-adjusted) died from a drug-related overdose. There were 7,847 Californians who died from an opioid-related overdose and 91 percent

[6] Pain Reliever Use Disorder is defined as meeting criteria for pain reliever dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past-year users of prescription drugs, regardless of whether they misused prescription drugs. Pain relievers are a type of prescription drug. These estimates include pain reliever use disorder data from all past year users of pain relievers.

[7] Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

[8] NSDUH defines Binge Alcohol Use drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days.

(7,137) of those deaths were fentanyl-related. There were 53,555 ED visits and 19,242 hospital admissions related to a non-fatal drug overdose in 2023. California's overall rate of drug-related overdose deaths was below the national average (31 per 100,000; age-adjusted) in 2023.[9]

Table 9 displays drug-related overdose deaths per 100,000 California residents for multiple types of drugs over time. The trend for opioid-related overdose deaths in California is concerning, with an increase in death rates from 2019 to 2023. The rate of any opioid-related overdose deaths in California increased 12 percent from 2022 to 2023. Increases in opioid-related overdose deaths are largely driven by increases in synthetic opioid-related fatal overdoses (namely, fentanyl). California continues to implement interventions to reduce fentanyl and other drug-related overdose deaths.

Table 9: Drug-Related Overdose Deaths in California by Drug Type, Age-Adjusted Rate (95 percent Confidence Interval) per 100,000 Residents, 2019-2023[10]

Data Year	Any Opioid	Prescription Opioids (without Synthetics)	Synthetic Opioids (excluding methadone)	Heroin	Cocaine	Psychostimulants with Abuse Potential
2019	7.9 (7.6,	2.6 (2.4, 2.7)	4.2 (4.0, 4.4)	2.4 (2.2,	2.0 (1.9, 2.2)	6.9 (6.7, 7.2)
2020	13.5 (13.2,	2.9 (2.7, 3.0)	10.0 (9.7, 10.3)	2.4 (2.3,	2.9 (2.7, 3.0)	10.7 (10.3, 11.0)
2021	18.0 (17.6,	2.9 (2.7, 3.1)	15.5 (15.1, 15.9)	1.9 (1.7,	3.4 (3.2, 3.5)	14.1 (13.7, 14.5)
2022	18.7 (18.2,	2.6 (2.5, 2.8)	16.7 (16.2, 17.1)	1.2 (1.1,	3.4 (3.2, 3.5)	14.4 (14.0, 14.7)
2023	20.8 (20.3,	2.4 (2.3, 2.6)	19.2 (18.7, 19.6)	0.8 (0.7,	4.0 (3.8, 4.2	15.9 (15.5, 16.3)

[9] Center for Disease Control and Prevention, Drug Overdose Data.

[10] California Overdose Surveillance Dashboard. Accessed on February 3, 2025. Prepared by the California Department of Public Health (CDPH) Substance and Addiction Prevention Branch (SAPB), February 2025.

Additionally, overdose deaths related to psychostimulants with abuse potential, such as methamphetamine, increased from 14.1 per 100,000 California residents in 2021 to 15.9 per 100,000 in 2023. Overdose deaths involving both an opioid and a psychostimulant with abuse potential increased from 8.35 per 100,000 California residents in 2021 to 10.70 per 100,000 California residents in 2023 (data not included in table). These data are consistent with the "fourth wave" of the overdose crisis, which includes overdose deaths involving both fentanyl and stimulants. However, care should be taken when interpreting these findings as polysubstance use because individuals may have unintentionally ingested contaminated substances.

According to Table 10, there was a wide variation in the rate of deaths due to opioid-related overdose across California counties in 2023. San Francisco County had the highest stable opioid-related overdose death rate of 54.8 per 100,000 residents, which totaled 509 deaths. Of further concern is the opioid-related overdose death variance by zip code. San Francisco's most impacted zip code had a stable age-adjusted death rate of 401 per 100,000 residents for opioid-related overdoses. However, rates range widely across the county and other zip codes have much lower rates.

Humboldt County followed closely with an opioid-related overdose death rate of 50.3 per 100,000 residents which totaled 67 deaths. Los Angeles County had an opioid-related overdose death rate of 17.1 per 100,000 residents and accounted for the largest death count of 1,603.

Table 10: Any Opioid-Related Overdose Deaths in California, Age-Adjusted Rate per 100,000 Residents, 2023[11]

Death Rate (per 100,000 residents)	County List
Rate ≥ 50	Humboldt and San Francisco
Rate 40-49	Butte, Del Norte, Lake, Mendocino, Santa Cruz, Shasta, Siskiyou, Tehama
Rate 30-39	Glenn, Kern, Lassen, Nevada, San Luis Obispo, Tuolumne
Rate 20-29	Alameda, Calaveras, Riverside, Sacramento, San Joaquin, Sonoma, Stanislaus, Ventura, Yuba
Rate 10-19	Contra Costa, El Dorado, Fresno, Imperial, Kings, Los Angeles, Marin, Merced, Monterey, Napa, Orange, Placer, San Benito, San Bernardino, San Diego, San Mateo, Santa Barbara, Santa Clara, Solano, Sutter, Tulare, Yolo
Rate 0-9	Madera, Modoc, Mono, Trinity
Unstable Rate*	Alpine, Amador, Colusa, Inyo, Mariposa, Plumas, Sierra

**Rate is or may be unstable*

Table 11 shows the rates of all drug-, any opioid-, amphetamine-, cocaine-, and cannabis-related non-fatal overdose ED visits per 100,000 California residents. In 2023, there were 53,555 ED visits in California for a drug related nonfatal overdose. The rate of opioid-related non-fatal overdose ED visits increased by 10% between 2022 (54.9 per 100,000) and 2023 (60.5 per 100,000), while all drug-related non-fatal overdose ED visits have not changed significantly.

[11] California Overdose Surveillance Dashboard. Accessed on (February 3, 2025). Multiple Cause of Death and California Comprehensive Death Files. Prepared by California Department of Public Health (CDPH) Substance Addiction Prevention Branch (SAPB), February 2025. Age-adjusted rates are calculated using the projected year 2000 U.S. standard population using the direct method.

Table 11: Emergency Department Visits for Non-Fatal Drug Overdoses in California by Drug Type; Age-Adjusted Rate (95 percent Confidence Interval) per 100,000 Residents, 2019-2023[12]

Data Year	All Drug	Any Opioid	Amphetamines	Cocaine	Cannabis
2019	124.7 (123.6, 125.8)	28.8 (28.3, 29.3)	6.9 (6.6, 7.1)	1.8 (1.7, 2.0)	7.1 (6.8, 7.4)
2020	130.7 (129.6, 131.9)	40.9 (40.3, 41.6)	7.4 (7.1, 7.7)	1.9 (1.7, 2.0)	7.0 (6.8, 7.3)
2021	148.2 (147.0, 149.4)	53.8 (53.1, 54.6)	7.8 (7.5, 8.1)	1.8 (1.7, 1.9)	7.0 (6.7, 7.2)
2022	143.7 (142.5, 145.0)	54.9 (54.1, 55.6)	54.9 (54.1, 55.6)	1.6 (1.5, 1.7)	6.6 (6.4, 6.9)
2023	143.8 (142.6, 145.0)	60.5 (59.7, 61.3)	5.8 (5.5, 6.0)	1.5 (1.3, 1.6)	6.5 (6.2, 6.7)

Alcohol-Related Disease Impact

Table 12 displays the average number of deaths due to excessive alcohol use in California across 2020 and 2021. An average of 19,335 deaths per year were attributable to chronic and acute alcohol related conditions, with males accounting for the vast majority (70 percent) of the alcohol-attributable deaths (AADs). The top three causes of AADs for males were alcoholic liver disease, other poisonings, and motor vehicle crashes. The top three causes of AADs among females were alcoholic liver disease, hypertension, and other poisonings. Other poisonings indicate deaths involving another substance (e.g., drug overdoses) in addition to a high blood alcohol concentration (0.10 g/dL). Of the 12,013 annual deaths attributable to chronic causes, 6,356 were 100 percent alcohol-attributable, with the primary cause being alcoholic liver disease.

[12] California Overdose Surveillance Dashboard. Accessed on (February 3, 2025). California Department of Health Care Access and Information (HCAI), formerly Office of Statewide Health Planning and Development - ED visit and patient discharge data. Prepared by California Department of Public Health (CDPH) Substance and Addiction Prevention Branch (SAPB), February 2025. Age-adjusted rates are calculated using the projected year 2000 U.S. standard population using the direct method.

Table 12: Average Annual Alcohol-Attributable Deaths in California Due to Excessive Alcohol Use, by Sex – All Ages, 2020-2021[13]

Causes	Males	Females	Overall
Chronic Causes	7,747	4,266	12,013
Acute Causes	5,698	1,624	7,322
Total	13,445	5,890	19,335

Other Substance Use Disorder Related Health and Societal Consequence Data

Human Immunodeficiency Virus[14]

From 2018 through 2022, California experienced an increase in both the annual number and rate of new HIV diagnoses. The number of new diagnoses increased by 0.4 percent from 4,863 in 201 to 4,882 in 2022, while the rate of new diagnoses per 100,000 population remained relatively stable. During this period, the number of individuals living with diagnosed HIV infection in California increased from approximately 136,100 to over 142,700. In 2022, the prevalence rate of diagnosed HIV infection was 355.6 per 100,000 population, compared to 343.1 in 2018 – an increase of 3.7 percent.

The Centers for Disease Control and Prevention categorizes risk factors for HIV transmission, as follows, from most to least likely: male-to-male sexual contact (MMSC), heterosexual contact (non-high-risk), high-risk-heterosexual contact, perinatal, injection drug use (IDU) alone, MMSC and IDU. Among cisgender men newly diagnosed with HIV infection in 2022, 67.4 percent had MMSC alone, 4.3 percent had IDU alone, and 3.8 percent had MMSC and IDU as their transmission categories. Among cisgender women newly diagnosed with HIV infection in 2021, 14.6 percent had IDU alone as their transmission category.

Among cisgender men living with diagnosed HIV infection in 2022, 77.1 percent had MMSC alone, 4.0 percent had IDU alone, and 7.1 percent had MMSC and IDU as their transmission categories. Among cisgender women living with diagnosed HIV infection in 2022, 16.1 percent had IDU alone as their transmission category.

[13] CDC. Alcohol-Related Disease Impact (ARDI) application, 2022.
[14] California Department of Public Health, Office of AIDS, California HIV Surveillance Report — 2022.

Tuberculosis

In 2023, there were 2,113 cases of Tuberculosis (TB) reported in California, up from 1,848 reported in 2022. Addressing TB in individuals with SUD is essential, as drug use is often linked to unique clinical traits and environments that promote disease spread. It can also disrupt TB treatment and contribute to outbreaks. Thorough contact assessments and better case management can help prevent outbreaks and improve treatment outcomes for TB.[15]

Data Strengths and Limitations

45 CFR 96.133(a)(1) requires that States provide a summary in their needs assessment describing the weakness and bias in the data used and any descriptions of how DHCS plans to strengthen data in the future. They are as follows:

- CHKS includes the CORE module and Alcohol and Other Drug (AOD) Module which requires continuous marketing at the state and local levels to gain buy-in to administering these modules. DHCS's State Epidemiological Workgroup (SEW) worked collaboratively with the survey developer, WestEd, to revise the Core and AOD Module in 2020-2021, expanding the scope to a broader behavioral health module and to provide support to students in various instructional settings including in-person and at home.
- Changes in some CHKS question wording among survey years limit the ability to interpret longitudinal trends. Exercise caution in determining whether differences reflect actual behavior changes.
- Student surveys such as CHKS may not capture use among the general adolescent population, although the CHKS can be administered in continuation and charter schools.
- CHIS uses a well-established, reliable, and scientifically valid random-digit-dial telephone methodology to produce a representative sample of California's noninstitutionalized population. While the CHIS utilizes a large and representative adult sample, the adolescent sample is smaller. However, the methodology for collecting the data changed in 2019, CHIS transitioned to a mixed-mode survey (web and telephone), which is a change from being only a telephone survey.

[15] TB Disease Data and Publications.

- The AskCHIS query system is easy to navigate and allows users to customize their data tables to look at age, gender, and race/ethnicity breakdowns.
- The NSDUH provides national and state-level estimates of alcohol, tobacco, illicit drug, and nonmedical prescription drug use among a representative sample of civilian, noninstitutionalized persons aged 12 or older. The sample is relatively smaller than the CHIS and CHKS datasets.
- Although the number of administrative discharges in the California Outcomes Measures System for Treatment (CalOMS Tx) has decreased by 10.2 percentage points since SFY 2021-2022, these discharges continue to contribute to limitations in reporting reliable discharge data. This underscores the need for ongoing local technical assistance and continued enhancements to data reporting methodologies.
- DHCS is committed to strengthening public behavioral health reporting to improve transparency and accountability through the Comprehensive Behavioral Health Data Systems Project. This project intends to identify technology solutions to modernize and streamline data collection and reporting, analysis, and other data-related functions, and develop a consolidated reporting and analysis platform that integrates data from 12 existing behavioral health data systems. More information can be found by visiting DHCS Information Technology Projects.

CURRENT SUBSTANCE USE DISORDER PREVENTION AND TREATMENT ACTIVITIES 45 CFR § 96.133(A)(2)

Intended Use of Funds Relating to Prevention and Treatment

Description of Statewide Substance Use Disorder Primary Prevention Capacity

In SFY 2023-2024, DHCS disbursed approximately $65 million[16] of SUBG funds to each of the 58 counties to conduct locally identified primary prevention activities.[17] Counties were tasked with identifying the most effective combination of service deliveries from

[16] DHCS BH INFORMATION NOTICE No: 20-034, Exhibit A.
[17] DHCS BH INFORMATION NOTICE No: 20-034, Exhibit B.

each of SAMHSA's Prevention Strategies based on the individual county's local needs. As of January 17, 2025, there were 264 providers authorized by DHCS specifically to provide primary prevention services to Californians.

Primary Prevention Activities – Strategies Used

Exhibit 2: Number of Individuals Served by Primary Prevention Service Strategies SFY 2023-2024

Data Source: DHCS, ECCO 11 NOIR | Prepared by: DHCS, 01/17/2025

Information Dissemination Strategy

DHCS' primary prevention data collection system in SFY 2023-2024 did not collect quantitative and demographic data for Information Dissemination services as these types of activities serve the general population. The most commonly reported Information Dissemination Strategy activities for SFY 2023-2024 were:

- Resource and Information Services = 19,474
- Multi-Media = 10,431
- Community and School Outreach Events = 10,437
- Printed Materials = 6,976
- Presentations = 6,133
- Website Development and Maintenance = 1,628

Education Strategy

The number of primary prevention service activities reported under the Education Strategy for SFY 2023-2024 include:

- Community and School Educational Services = 25,087

- Parenting and Family Management Services = 1,687
- Peer Leader and Helper Programs = 1,267
- Mentoring = 747

Alternative Strategy

The most commonly reported Alternative Strategy service activities for SFY 2023-2024 were:

- Youth and Adult Leadership Activities = 22,527
- Social and Recreational Events and Activities = 3,493
- Community Service Activities = 1,247

Problem Identification and Referral Strategy

Problem Identification and Referral Strategy services are instrumental in identifying early substance use behaviors and directing individuals to education, rather than referring individuals directly to treatment. The most commonly reported Problem Identification and Referral Strategy service activities for SFY 2023-2024 were:

- Student Assistance Program (SAP) = 2,830
- Brief Intervention = 2,115
- Prevention Screening and Referral Services = 1,410
- Community/School Educational Services = 538

Community-Based Process Strategy

DHCS' primary prevention data collection system in SFY 2023-2024 did not collect quantitative and demographic data for Community-Based Process services as these types of activities serve the general population. The Community-Based Process Strategy supports each county's effort to plan, coordinate, and build its capacity to provide effective prevention services. County providers predominately take advantage of available Training and Technical Assistance (TTA) as well as make those services available to community stakeholders to build capacity. The most commonly reported Community-Based Process Strategy service activities for SFY 2023-2024 were:

- Multiagency Coordination and Collaboration = 35,714
- TTA = 10,280
- Coalition and Workgroup Activities = 10,109
- Systematic Planning = 8,887

- Evaluation Services = 5,085
- Accessing Services and Funding = 2,754

Environmental Strategy

The Environmental Strategy focuses on creating systems and policy change in social, community, and retail environments. For the SFY 2023-2024, the most commonly reported Environmental Strategy service activities were:

- Retailer Compliance and Recognition = 797
- Social Drivers of Health = 393
- Retailer Laws and Regulations = 195
- Substance Disposal = 118
- Land Utilization and Zoning = 103

Primary Prevention Activities – Demographics

Gender

More individuals self-identifying as females than males were served in SFY 2023-2024 (see Table 13). The general population of California contains fewer females than males while individuals self-identifying as something other than male or female are not reported in the larger population by the US Census Bureau.[18] Accordingly, these gender differences will require future targeted planning efforts.

[18] Demographic Profile - California and Counties.

Table 13*: Number of Individuals Served by Primary Prevention Service Strategies, by Gender, SFY 2023-2024[19]

Gender	Persons Served	California Population[20]	Percentage of Populations Served	Percent of Total Population by Gender
Male	234,378	19,708,947	1.19%	50.1%
Female	238,449	19,647,157	1.21%	49.9%
Non-Binary	275	N/A	N/A	N/A
Transgender	87	N/A	N/A	N/A
Something Else	239	N/A	N/A	N/A
Prefer not to Respond	185,579	N/A	N/A	N/A
Total	659,007	39,356,104	1.67%	100%

Age

Prevention services data in SFY 2023-2024 below (see Table 14) showed youth aged 12-14 were the largest group of recipients of prevention services. This group makes up nearly 1.96 percent of California's youth population. Though California has been serving a majority of youth between the ages of 12 and 17 as early as 2012, there is still more work to be done in this age group.

*Table 13 presents data derived from the U.S. Census Bureau; however, the age categories reported in the census do not align with the age groupings used by SAMHSA. As a result, adjustments were made to ensure compatibility with SAMHSA's reporting standards.

[19] DHCS primary prevention data collection system.
[20] US Census Bureau.

Table 14: Number of Individuals Served by Primary Prevention Service Strategies, by Age Group, SFY 2023-2024[21]

Age Group	Persons Served	California Population[22]	Percentage of Population Served	Percentage of Total Population by Age
0-4	13,862	2,258,308	0.61%	5.74%
5-11	33,170	2,368,158	1.4%	6.02%
12-14	51,148	2,613,036	1.96%	6.64%
15-17	37,284	2,599,130	1.43%	6.60%
18-20	13,573	N/A	N/A	N/A
21-24	17,438	2,674,774	0.65%	6.80%
25-44	102,152	11,235,259	0.41%	28.55%
45-64	78,741	4,977,216	1.58%	12.65%
65 & Over	46,233	10,630,223	0.43%	27.01%
Age Unknown	265,406	N/A	N/A	N/A
Total	659,007	39,356,104	1.67%	100%

Race

The Race demographic in DHCS' primary prevention data collection system is categorized by White, Black or African American, Native Hawaiian/Other Pacific Islander, Asian, American Indian/Alaska Native, More Than One Race, and Race Not Known. For a comparison of individuals receiving prevention services, the 2024 California population data from the US Census Bureau is used.

Table 15 provides a summary of all prevention services delivered in SFY 2023-2024, by race. The reported highest number of persons served through SUBG-funded primary prevention strategies is the Race Not Known group, followed by the White racial group. The remaining groups, in order of highest number of persons served, were Other, Asian,

[21] DHCS primary prevention data collection system.
[22] US Census Bureau.

Black/African American, More Than One Race, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander.

Race data from the U.S. Census was restructured to align with SAMHSA's reporting categories. This ensures consistency in prevention reporting while maintaining accuracy and compatibility with SAMHSA's reporting standards.

Table 15: Number of Individuals Served by Primary Prevention Service Strategies, by Race, SFY 2023-2024[23]

Race	Persons Served	California Population[24]	Percentage of Population Served	Percentage of Total Population by Race
White	107,927	18,943,660	0.57%	48.13%
Black or African	34,665	2,202,587	1.57%	5.60%
Native Hawaiian/Other	1,939	150,531	1.29%	0.38%
Asian	53,399	5,949,136	0.90%	15.12%
American Indian/Alaska	4,694	394,188	1.19%	1%
More Than One	25,822	5,327,003	0.48%	13.54%
Race Not	362,753	N/A	N/A	N/A
Other	67,808	6,388,999	1.06%	16.23%
Totals	659,007	39,356,104	1.67%	100.00%

Ethnicity

Table 16 provides a summary of all primary prevention services delivered in SFY 2023-2024 by ethnicity. The highest number of persons served by Primary Prevention Services Strategies is Hispanic or Latino, followed by Ethnicity Unknown and the Not Hispanic or Latino group.

[23] DHCS primary prevention data collection system.
[24] Demographic Profile - California and Counties.

Table 16: Number of Individuals Served by Primary Prevention Service Strategies, by Ethnicity, SFY 2023-2024[25]

Ethnicity	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Ethnicity
Hispanic or Latino	264,182	15,617,930	1.69%	39.68%
Not Hispanic or Latino	185,950	23,738,174	0.78%	60.32%
Ethnicity Unknown	208,875	N/A	N/A	N/A
Total	659,007	39,356,104	1.67%	100.00%

Big 5 by 2025 Initiative

DHCS launched an initiative that supports and builds a state-level infrastructure for prevention services to reach communities with the highest need for behavioral health prevention across California. Through a multi-program approach, DHCS is implementing five key projects coined "The Big 5 by 2025 Initiative" or the Big 5. The goals of the Big 5 are to strengthen the state-level primary prevention planning and evaluation process, encourage widespread use of evidence-based practices and community-defined practices for behavioral health prevention, streamline data collection and reporting, and reimagine the statewide technical assistance and training platform.

The Big 5 consists of the following statewide behavioral health prevention projects:

- Substance Use Prevention Plan (SUPP) – California's first SUPP specifically designed for counties and providers utilizing the SUBG primary prevention set-aside funding. Through consultation and review by the SEW, the SUPP demonstrates DHCS' commitment addressing SAMHSA's strategic plan, introduces an equity-focused primary prevention paradigm that focuses on decreasing health disparities by addressing social drivers of health, and utilizes SAMHSA's Strategic Prevention Framework to provide federal and state guidance for SUBG primary prevention funded providers.
- Substance Use Prevention Evidence-based Resource (SUPER) – A centralized online resource to assist California providers serving youth in identifying evidence-based practices and community-defined evidence practices that are

[25] DOF Population Estimates.

culturally relevant and linguistically appropriate and demonstrate effective prevention strategies and outcomes.

- Substance Use Prevention, Treatment, and Recovery Services Block Grant Program Prevention Set-Aside Application
- Advance Behavioral Health Prevention California (ABHPC) – A TTA program for behavioral health services in California. ABHPC provides TTA, at no cost to the requestor, using evidence-based strategies and best practices in primary prevention. It also employs an approach that centers on the social drivers of health and applies a health equity lens.
- Primary Prevention Data Collection System/ECCO 11 – A data reporting system that collects SUBG Primary Prevention Set-Aside data required by all SUBG primary prevention set-aside-funded counties to report population- and individual-based primary prevention services and efforts.

State Epidemiological Workgroup

The SEW enhances statewide analytical capacity by functioning as an expert data advisory group that recognizes the importance of consistent statewide evaluations to monitor and track outcomes.

The SEW has coordinated efforts with DHCS and the California Department of Education to provide feedback on the CHKS Core and AOD modules, provided feedback on the SUPP development, and supported the California Department of Public Health through collaboration on the California Opioid Overdose Surveillance Dashboard through the Strategic Prevention Framework-Partnerships for Success Epidemiological contract.

Behavioral Health Response and Rescue Project

The Behavioral Health Response and Rescue Project (BHRRP) is funded by SAMHSA through supplements to the SUBG and the Community Mental Health Services Block Grant. BHRRP increases access to behavioral health care for all Californians by assisting communities in need by expanding the behavioral health workforce, supporting mobile crisis services, and funding other projects such as behavioral health justice intervention services, telehealth expansion, and recovery services.

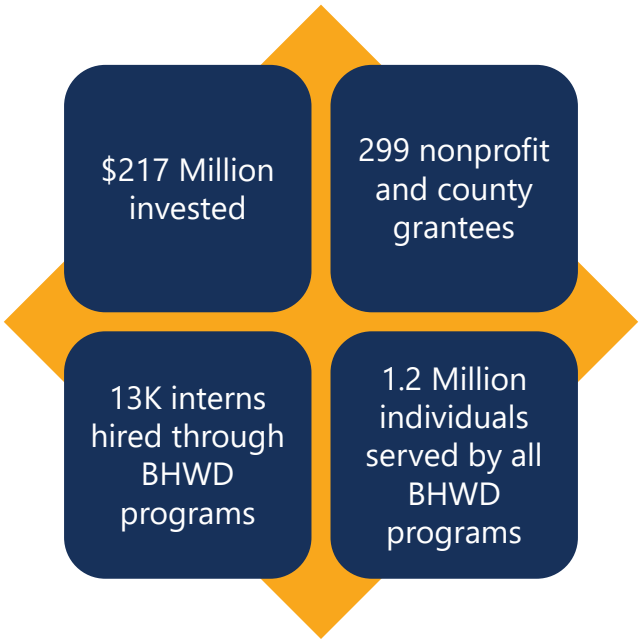
Behavioral Health Workforce Development Initiative

DHCS established the Behavioral Health Workforce Development (BHWD) Initiative through the BHRRP in 2021 to support the Medi-Cal Peer Support Specialist Certification program, peer-run organization start-up activities, and implementation of continued efforts by non-profit behavioral health providers, tribal organizations, and county-operated providers to increase the behavioral health workforce through training,

internships, and retention strategies. Since 2021, approximately $217 million has been invested through the BHWD initiative to recruit, mentor, and retain behavioral health professionals, including significant investment in the peer workforce, who can facilitate access to care, support retention in services, and advocate for those with substance use and opioid addiction in their recovery process. As of July 2023, 299 grantees across 40 California counties have been awarded funds that support the expansion of their behavioral health operations through the initiative.

The BHWD grant programs primarily concluded in December 2024. However, DHCS is continuing to support our certifying bodies by providing organizational enhancements and support aimed at improving and modernizing the Substance Use and Driving Under the Influence counselor certification process in California and reducing the 90% registrant-to-counselor drop-off rate. This effort began in late 2023, and so there are no outcomes to report at this time. For more information on each of the funded projects, visit https://www.workforce.buildingcalhhs.com.

Exhibit 3: BHWD Investment and Reach



California Friday Night Live

The California Friday Night Live (FNL) Program is designed for high school-aged youth and is motivated by youth-adult partnerships that create essential opportunities to enhance and improve local communities and create positive and healthy youth development. FNL engages youth as active leaders and resources in their community and encourages youth-driven and youth-led programming. DHCS contracts with the

Tulare County Office of Education, California Friday Night Partnership (CFNLP), which includes the allocation of stipends to counties to support the widespread implementation of the FNL program and provide no-cost program TTA to providers ensuring program components are followed with fidelity. The CFNLP and partners have developed a myriad of resources over the years to support the FNL Program and reported activities within the Alternative Strategy for Youth/Adult Leadership Activities that include those conducted for and by participants in FNL.

Description of Statewide Substance Use Disorder Treatment Capacity

DMC is a treatment funding source for eligible Medi-Cal members. For DMC to pay for covered services, eligible Medi-Cal members must receive SUD services at a DMC-certified program. SUD services funded by DMC are listed in Title 22, CCR, Section 51341.1 (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment. Each of California's 58 counties contracts with DHCS to provide a continuum of primary prevention services and requires counties to provide SUBG allowable treatment services. These services are to supplement, not supplant, SUD services not otherwise covered by California's Medicaid State Plan (Title XIX), DMC. California also sponsors various other SUD initiatives, programs, partnerships, and activities. For more information about DMC services visit Drug_Medi-Cal_Overview.

Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a SUD treatment program that delivers treatment services to eligible Medi-Cal members with SUDs. The DMC-ODS provides a continuum of care modeled after the American Society of Addition Medicine (ASAM) Criteria for SUD treatment services.

Prior to DMC-ODS, members with Medi-Cal coverage frequently did not have access to medications. DMC-ODS added all Food and Drug Administration-approved drugs to its formulary, ensuring that doctors and other providers could prescribe whichever medications would be best for their patients' needs. Besides medications, treatment includes counseling and other medical and supportive therapies. The DMC Standard Program included services for outpatient drug-free treatment, intensive outpatient treatment, residential SUD services for perinatal women only (limited to facilities with 16 beds or fewer), naltrexone treatment, narcotic treatment program (NTP) (methadone only), and in-patient hospital detoxification. The DMC-ODS expanded these services to include multiple levels of residential SUD treatment (not limited to perinatal women or to facilities with 16 beds or fewer), case management, NTP expansion to include buprenorphine, disulfiram, and naloxone, withdrawal management (at least one ASAM

level), recovery services, physician consultation, partial hospitalizations, and additional MAT.

The DMC-ODS is a voluntary opt-in program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal members with a SUD. Counties that choose to participate in the DMC-ODS are required to provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine Criteria. This approach is expected to provide eligible Medi-Cal members with access to the care and services they need for a sustainable and successful recovery.

In December 2021, DHCS received approval from the Centers for Medicare and Medicaid Services to reauthorize DMC-ODS, shifting the managed care authority to the consolidated California Advancing and Innovating Med-Cal (CalAIM) 1915(b) waiver and using the Medicaid State Plan to authorize the majority of DMC-ODS benefits. Authority to provide reimbursable Medi-Cal services for DMC-ODS members residing in institutions for mental disease remains in the 1115 demonstration through December 31, 2026.

As of January 2025, there are 40 counties that have opted into the DMC-ODS Program, representing 96.92% of California's Medi-Cal population. To learn more about DMC-ODS program and updates pursuant to CalAIM, please see BHIN 24-001.

California Advancing and Innovating Medi-Cal

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform changes across the Medi-Cal program. CalAIM identifies and manages member's risks and needs through whole-person care approaches and addresses social determinants of health, moves Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and improves quality outcomes, reduces health disparities, and drives delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

CalAIM strengthens the state's behavioral health continuum of care and promotes better integration with physical health care, streamlines policies to improve access to behavioral health services, simplifies how treatment and prevention services are funded, and supports administrative integration of mental health and SUD treatment.

Substance Use Prevention, Treatment, and Recovery Services Block Grant

DHCS continues to use a population-based formula to distribute SUBG funds; however, DHCS has implemented a policy that only counties with a population of 140,000 or less may opt out of expending their youth treatment allocation and perinatal set-aside. This

option is now open to all counties with the knowledge that the county relinquishes the amount of those set-aside funds to DHCS, who will ensure that funds are expended appropriately. These funds may be redistributed to counties that have greater need and ability to appropriately expend additional funds, or DHCS may retain the funds to expend on state-level projects that align with the intended set-aside.

DHCS continues to utilize a County Performance Contract (CPC) which sets forth conditions and requirements counties must meet in order to receive SUBG funding. DHCS requires counties to prepare and submit a biennial County SUBG Application consisting of enclosures detailing various rules, regulations, and county requirements, in addition to program narratives and budgets. Counties are required to adhere to the terms and conditions of the County SUBG Application, as its enclosures are incorporated by reference in the CPC.

Lastly, beginning in SFY 2021-2022, SUBG funds could be used for Cost Sharing Assistance purposes for the maintenance of private health insurance coverage to individuals for behavioral health services. Block grant funds may be used to cover health insurance deductibles, coinsurance, copayments, or similar charges to assist individuals in meeting their cost-sharing responsibilities. Cost-sharing assistance does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

California DHCS Opioid Response

DHCS created the California Medication Assisted Treatment (MAT) Expansion Project to increase access to MAT, reduce unmet treatment needs, and reduce opioid overdose-related deaths by investing in prevention, harm reduction, treatment, and recovery. DHCS has renamed the California MAT Expansion Project the California DHCS Opioid Response to reflect its comprehensive response to the opioid crisis. The California DHCS Opioid Response has expanded the initial California MAT Expansion Project through the extension or creation of various initiatives, programs, and partnerships with the aim of preventing opioid misuse and overdose deaths. The projects focus on populations with limited MAT access including youth, individuals in rural areas, and American Indian and Alaska Native tribal communities. Additionally, these projects prioritize underserved communities in promoting health and racial equity. Some California DHCS Opioid Response projects are also made available through cooperation with California State General Funds and Opioid Settlement Funds, such as MAT Access Points and Naloxone Distribution Project, to name a few. For more information about current projects, visit the California DHCS Opioid Response website. Here are a few notable examples.

Behavioral Health Transformation

Behavioral Health Transformation is the initiative that implements the ballot measure known as Proposition 1. In 2024, Californians voted to pass Proposition 1 to modernize the behavioral health delivery system, enhance accountability and transparency, and expand the capacity of behavioral health care facilities across the state. This proposition includes up to $6.4 billion in bonds to finance the construction of new supportive housing and community-based treatment facilities.

CA Bridge State Opioid Response

DHCS contracted with the CA Bridge Program in 2018 utilizing funds appropriated from SAMHSA through their State Opioid Response (SOR) I grant and again in 2020 through the SOR II grant. Through the success of the 2020 SOR II Behavioral Health Pilot Project, SAMHSA awarded DHCS a SOR III grant in 2022 and a SOR IV grant in 2024 to facilitate the expansion of patient access to MAT for OUD in California hospitals. Since 2018, SOR programs have been awarded $58,928,339 in funds to expand access to MAT at urgent care, EDs, inpatient hospital wards, and hospital-based specialty clinic settings for onsite OUD patients with behavioral health navigators, through the development of community outreach, training, and technical assistance to providers, clinicians, and administrative personnel, and multiple innovative programs, such as the CalBridge Behavioral Health Navigator Program.

California Youth Opioid Response Project

DHCS has identified youth access to services as a strategic priority within the statewide opioid response, as demonstrated through the California Youth Opioid Response (YOR California) initiative. This initiative is designed to enhance the capacity of, and access to, prevention, treatment, and recovery services—including MAT—for individuals aged 12 to 24 and their families. YOR California provides supplemental funding to newly awarded grantees for the implementation of initiatives that either deliver direct treatment services to youth or focus on capacity-building efforts aimed at expanding access to high-quality care. Additionally, the initiative incorporates peer-to-peer learning opportunities through learning collaboratives and offers ongoing technical assistance to support grantee implementation and program development. YOR California is funded through the federal State Opioid Response (SOR) grant, administered by DHCS.

California Hub and Spoke System

The California Hub and Spoke System, aims to increase access to MAT services throughout the state, particularly in counties with the highest overdose rates. The Hub & Spoke System has increased the availability of MAT for patients with OUD by

increasing the total number of physicians, physician assistants, and nurse practitioners prescribing buprenorphine. The Hub & Spoke System consists of narcotic treatment programs which are referred to as "Hubs" and serve as experts in treating OUD, as well as office-based treatment settings which are referred to as "Spokes" and provide ongoing care and maintenance treatment.

Hub & Spoke System participants also participate in Learning Collaboratives to engage CA Hub & Spoke System providers and physician participants in the process of shared learning to facilitate the implementation of services and provide opportunities for interactive problem-solving.

Low-Barrier Opioid Treatment at Syringe Service Programs

The Low-Barrier Opioid Treatment at Syringe Service Programs supports the integration of low-barrier opioid treatment services by providing grants for syringe service programs to integrate opioid treatment services and other harm reduction services into existing sites. This increases the availability and access to treatment services and allows related supportive services, such as case management and peer support, to be offered.

Naloxone Distribution Project

The Naloxone Distribution Project (NDP) is funded by State General Funds, Opioid Settlement Funds, and federal grants administered by DHCS. The NDP aims to reduce opioid overdose deaths through the provision of free naloxone in its nasal spray and intramuscular formulations. Eligible entities include law enforcement agencies such as police departments, county jails and probation; fire, emergency medical services and first responders; schools and universities; county public health and behavioral health departments; harm reduction organizations; and community organizations. As of February 18, 2025, the NDP has approved 14,397 applications for naloxone and distributed 5,832,176 kits of naloxone, which have been used to reverse more than 337,000 opioid overdoses, since the project began in October 2018.

The DHCS California Opioid Response Outcomes webpage contains all the programs discussed above and their respective outcome data.

Other California DHCS Opioid Response Projects

- Buprenorphine Utilization Performance Evaluation (BUPE) Registry Pilot, develops a buprenorphine performance registry and referral system to monitor buprenorphine programs in California's prehospital and hospital settings. This system streamlines addiction service referrals from emergency medical services to social services, automating the tracking of care for patients with OUD and improving efficiency across operations.

- California Overdose Prevention Network, creates a statewide learning network for coalitions, organizations, and individuals working with OUD patients.
- California Overdose Prevention and Harm Reduction Initiative builds a movement to strengthen connections within communities and provide access to knowledge, training, and resources to implement solutions that save lives.
- DUI MAT Integration/Outreach, provides the framework to optimize select driving under the influence programs to become new and effective access points for MAT and other treatment modalities.
- Emergency Medical Services Buprenorphine Use Pilot Project, supports the implementation of opioid overdose intervention and treatment in the prehospital setting by engaging emergency medical services agencies and 911 transport providers in partnership with public health departments to provide opioid use prevention and treatment.
- MAT Access Points, increases access to comprehensive prevention, education, and treatment for opioid and stimulant use disorders to improve health outcomes for communities of color disproportionately impacted by and penalized for SUDs.
- Media Campaign - Choose Change CA, in partnership with Media Solutions, creates a multi-media and multilingual advertising campaign covering various cities within the state of California, specifically targeting highly effected communities.
- Provider Training – General, provides various training programs regarding current OUD treatment, prevention, and barriers, such as regarding the X-waiver elimination to prescribe buprenorphine.
- Statewide Anti-Stigma Campaign – UNSHAME, commits to changing attitudes about substance use and SUD.
- Tribal MAT Project, promotes opioid safety, improves the availability and provision of MAT, and facilitates wider access to naloxone with special consideration for Tribal and Urban Indian values, culture, and treatments.
- Youth Opioid Education and Awareness and Fentanyl Education and Awareness Campaign is a $40.8 million statewide program to prevent opioid overdoses and educate the public about fentanyl contamination among youth and young adults aged 16 to 21. It also addresses overdose risks for those aged 20 to 35 through a

harm-reduction approach while empowering families and communities to respond effectively to the overdose crisis

- Young People in Recovery provides support services for organizations focused on creating recovery-ready communities throughout the nation for young people in or seeking recovery.
- Youth Peer Mentor Program trains justice-involved youth to provide recovery support to peers and assist them with their substance use and rehabilitative challenges.

Pregnant and Parenting Women

DHCS continues to prioritize service delivery to the Pregnant and Parenting Women (PPW) population and provide leadership and TTA to SUD PPW programs funded by SUBG Perinatal Set-Aside. DHCS publishes resources, such as the SUD Perinatal Practice Guidelines (PPG) to ensure California providers deliver quality SUD treatment services and adhere to state and federal regulations. Additionally, DHCS publishes the Perinatal Directory to ensure that California counties and those in need of SUD treatment have access to a comprehensive list of SUD treatment programs for PPW. DHCS uses the county monitoring tool during on-site monitoring visits to ensure counties are meeting the requirements for SUBG-funded treatment programs for the PPW population set forth in 45 CFR § 96. In FY 2025-2026, DHCS will address the following priority areas for PPW in the monitoring instrument: Outreach and Engagement, Care Planning, and Capacity Management.

Identities of Service Providers and Their Programs

Each California County is responsible for providing SUD treatment and primary prevention services through their behavioral health, public health, or AOD Office, or through contracts with local service providers. Counties are responsible for providing DMC State Plan services or DMC-ODS services, and SUBG primary prevention and treatment services to their own clients. DHCS requires that SUD residential and NTP facilities be DHCS licensed. DHCS's Provider Enrollment Division must certify programs before they provide DMC State Plan or DMC-ODS SUD treatment services. DHCS does not license or certify SUD primary prevention providers; however, DHCS provides oversight and TTA to counties to ensure that providers properly adhere to the same provisions and conditions as in their DMC State Plan or DMC-ODS Contract.

As of February 2023, California counties contracted with 964 SUD treatment facilities to provide a wide range of treatment services. There were 242 provider sites engaged in

primary prevention services, and 37 provider sites engaged in secondary prevention services including early intervention, outreach, and referral screening and intake.

Treatment Utilization

DHCS tracks annual "served" counts using its CalOMS Tx database. These data allow DHCS to use the state management information system to track treatment capacity and service utilization.

Unique Clients Served

Unique clients served means all clients admitted during the year and clients admitted prior to the current year who continue to receive treatment services during the year. Using CalOMS Tx data submitted to DHCS, the number of clients served decreased in SFY 2022-2023, in contrast to the increase observed in SFY 2021-2022. During SFY 2022-2023, approximately 152,500 unique clients were served,[26] representing a decline of about 12,300 clients compared to SFY 2021-2022.

Total Served

The term "total served" means all admissions to all service types (e.g., Detoxification, Residential, and Outpatient) during the year plus all admissions prior to the current year that continued to receive treatment services during the year. DHCS uses these "served" counts to estimate the number of admissions in which the client is still participating in treatment to estimate current "active" treatment participation.

During SFY 2022-2023, the total served count was approximately 196,300 about a 5.4 percent decrease from the 207,500 reported in SFY 2021-2022.

Of the total served count in SFY 2022-2023, Table 17 shows the percentages served in each major service type.

Table 17: Total Served by Service Type, SFY 2021-2022 and 2022-2023

Major Service Type	SFY 2021-2022	SFY 2022-2023
Outpatient Drug-Free (ODF)	30.8	30.1

[26] Unique clients served means all clients admitted during the year and clients admitted prior to the current year that continue to receive treatment services during the year.

Narcotic Treatment Program (NTP)	36.5	35.8
Residential (Short/Long Term)	18.6	19.2
Residential Detoxification	6.5	7.4
Intensive Outpatient Treatment (IOT)	7.2	7.2
NTP Detoxification	0.4	0.2
Non-NTP Detoxification	0.0	0.0

Examination of the various service types shows the following trends from SFY 2021-2022 through SFY 2022-2023:

- There were decreases in ODF, NTP, and NTP Detoxification.
- There were increases in Residential (Short/Long Term) and Residential Detoxification.

One-Day Counts

On April 3, 2022, 72,187 clients were in treatment. The distribution of the one-day counts among the service types was:

Table 18: One-Day Counts by Service Type, SFY 2021-2022 and 2022-2023

Major Service Type	SFY 2021-2022	SFY 2022-2023
Narcotic Treatment Program (NTP)	66.7	65.2
Outpatient Drug-Free (ODF)	21.7	22.9
Residential (Short/Long term)	7.0	7.6
Intensive Outpatient Treatment (IOT)	3.8	3.7
Residential Detoxification	0.7	0.6
NTP Detoxification	0.2	0.1
Non-NTP Detoxification	0.0	0.0

Treatment Client Admission and Discharge Information

DHCS analyzes CalOMS Tx data on clients receiving SUD treatment services in publicly-funded treatment programs and private, for-profit NTP programs, regardless of funding source. During SFY 2022-2023, there were approximately 128,036 admissions to treatment. This includes admissions to publicly monitored SUD detoxification, residential, and outpatient services, and about 96,378 unique clients admitted to treatment during the same period. Clients having multiple admissions to treatment

during a year account for the difference between the number of admissions and the number of clients.

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

Table 19: Admissions per Service Type, SFY 2021-2022 and SFY 2022-2023

Major Service Type	SFY 2021-2022	SFY 2022-2023
Outpatient Drug-Free (ODF)	33.8	35.6
Residential (Short/Long Term)	25.2	26.1
Narcotic Treatment Program (NTP)	20.7	17.7
Residential Detoxification	10.5	11.2
Intensive Outpatient Treatment (IOT)	9.6	9.1
NTP Detoxification	0.2	0.2
Non-NTP Detoxification	0.0	0.0

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

Detoxification admission data were not included in the summary below. The figures in this section reflect admission data for 113,459 non-detoxification admissions.

Client Characteristics

Compared with SFY 2021-2022, SFY 2022-2023 admissions among the following clients saw similar declines, aged 18-25 category declined from 10.7 percent to 9.5 percent, those in the 26-35 category declined from 38.1 percent to 37.4 percent, and those 55 and older declined from 10.4 percent to 10.2 percent. Admissions among the following clients saw similar increases, those aged 17 and younger increased from 3.8 percent to 4.6 percent, those in the 36-45 category increased from 25.4 percent to 26.7 percent, and those in the 46-54 category increased from 11.6 percent to 11.7 percent.

Table 20: Client Age, SFY 2022-2023

Age	SFY 2022-2023
Under 17 years	4.6%
18-25 years	9.5%

26-35 years	37.4%
36-45 years	26.7%
46-54 years	11.7%
55 and older	10.2%

Compared with SFY 2021-2022, admissions in SFY 2022-2023 by race/ethnicity remained largely consistent, apart from Hispanics, whose admissions increased from 43.0 percent to 45.0 percent, and White clients, whose admissions decreased from 38.2 percent to 36.7 percent. Admissions by race/ethnicity were as follows:

Table 21: Client Race/Ethnicity, SFY 2022-2023

Race/Ethnicity	SFY 2022-2023
Hispanic	45.0%
Non-Hispanic White	36.7%
African American	10.5%
Multiracial	2.6%
Other	2.2%
Asian/Pacific Islander	1.8%
American Indian/Alaska Native	1.1%

Gender proportions for SFY 2022-2023 were about the same as for SFY 2021-2022. Admissions by Gender were as follows:

Table 22: Client Gender, SFY 2022-2023

Gender	SFY 2022-2023
Male	61.7%
Female	38.1%
Other	0.2%

**Due to rounding, some client characteristics percentage columns may not total 100%.*

Primary Drug Reported at Admission

The primary drug reported at treatment admission is defined as the drug causing the greatest challenge to the client at the time of admission. Between SFY 2021-2022 and SFY 2022-2023, the proportions of clients reporting heroin as their primary drug at admission declined significantly by 7.1 percentage points. In contrast, methamphetamine increased by 1.2 percentage points, alcohol saw an increase of 1.0 percentage points, and other opiates or synthetics rose by 4.6 percentage points. The proportions for the remaining substance categories remained relatively consistent with those reported in 2021-2022.

Table 23: Primary Drug at Admission, SFY 2021-2022 and SFY 2022-2023

Primary Drug	SFY 2021-2022	SFY 2022-2023
Methamphetamine	30.3	31.5
Alcohol	22.5	23.5
Other Opiates or Synthetics	11.8	16.4
Heroin	19.0	11.9
Marijuana/Hashish	9.2	9.6
Cocaine/Crack	2.5	2.6
Other	1.9	2.0
Oxycodone/OxyContin	1.5	1.1

Discharge Statistics

During 2022-2023, there were approximately 124,182 discharges from treatment services (i.e., detoxification residential, outpatient) for about 96,243 unique clients. There were approximately 110,363 non detoxification discharges. Similar to admissions, clients may have multiple discharges in a given year since facilities submit a discharge at the end of each treatment service to which the clients were admitted. This accounts for any difference between discharge counts and client counts. Detoxification services are brief and frequently repeated multiple times a year, therefore, they have been excluded from the analyses in this section so as not to bias the discharge statistics.

Of the two types of discharges, standard and administrative, 55.1 percent of discharges were standard discharges and 44.9 percent of discharges were administrative during 2022-2023. In 2021-2022, 49.5 percent of discharges were standard, and 50.5 percent

were administrative. A standard discharge is used whenever the client is available to respond to DHCS's outcomes measurement questions. When the client is not available to respond, DHCS categorizes the discharge as administrative. To respond to public comment, DHCS implemented new discharge protocols aimed at reducing the number of administrative discharges. The 5.6 percent decrease in the number of administrative discharges from 2021-2022 indicates that county technical training and assistance have enhanced treatment providers' capacity to collect data to measure the following criteria adopted in 2010 for any discharges coded as "completed treatment":

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

To further reduce the percentage of administrative discharges, DHCS has conducted county listening sessions, provided technical assistance, and implemented quarterly monitoring of progress to decrease administrative discharges. Additionally, updated discharge protocols have been introduced to promote more accurate discharge data collection. Outreach efforts are specifically focused on counties with administrative discharge rates exceeding 50 percent.

Length of Stay

The length of stay is the number of days a client stays in treatment from admission to discharge. Research verifies that longer stays in treatment are associated with positive outcomes. Conversely, shorter lengths of stay are related to a lack of engagement in treatment and poor treatment outcomes.

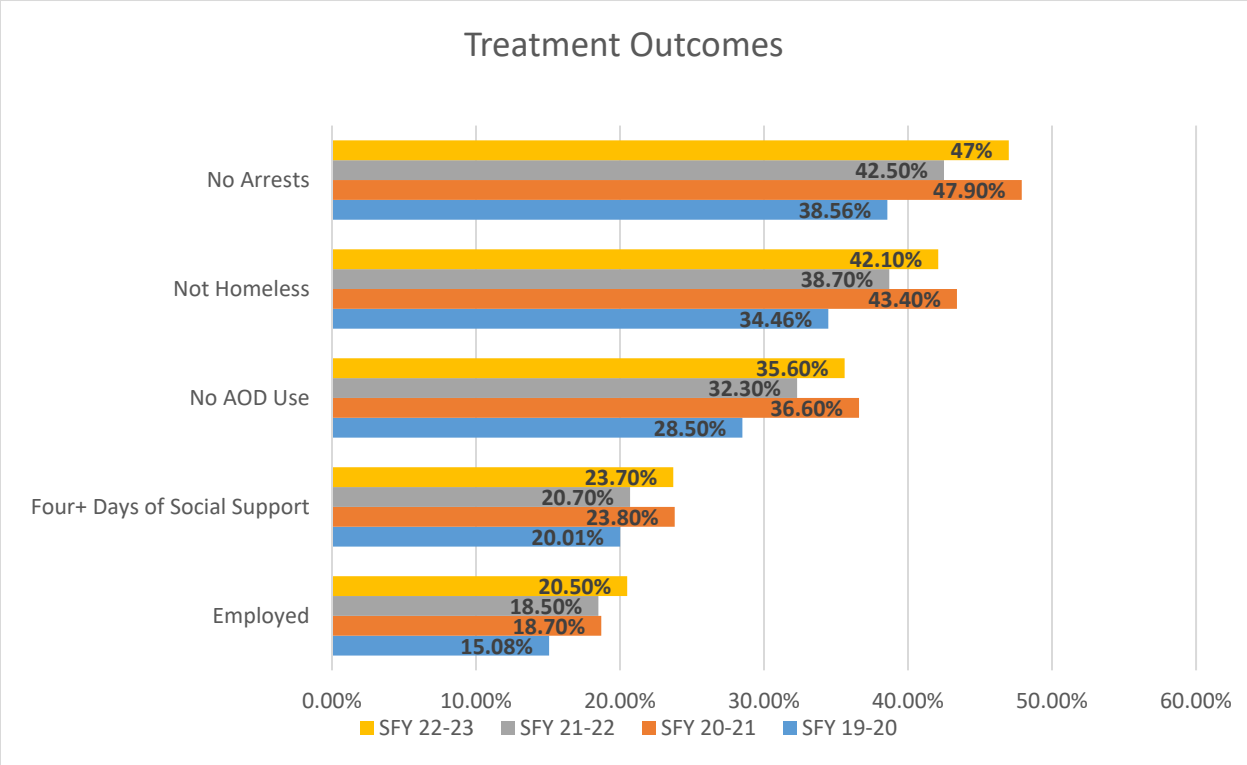
- The longest stays occur in NTP services, with 29.4 percent of the clients receiving services for one year or more.
- There were 29.6 percent of the clients receiving outpatient treatment services and 7.1 percent in intensive day-care programs that stayed 31 or more days.
- There were 9.6 percent of outpatient treatment stays were 30 or fewer days.

The decrease in the length of outpatient treatment stays highlights an ongoing opportunity to enhance treatment engagement strategies, particularly for treatment providers with higher rates of short stays.

Client Outcome Measures

Exhibit 2 shows five treatment outcome measures from SFY 2019-2020 through SFY 2022-2023 for outpatient treatment services. The cross-year comparisons of treatment outcomes measures include Administrative Discharges, which may be partially responsible for the decreases in percentages for selected outcome criteria during previous reporting years. Employment, adequate social support, no alcohol or other drug use, those not homeless, and no arrests all saw an increase among outpatient treatment clients during the study period.

Exhibit 4: Treatment Service Recipient Outcomes: Outpatient Drug-Free



Data Source: CalOMS Tx SFY 2019/2020 through 2020/2023

TECHNICAL ASSISTANCE NEEDS TO CARRY OUT SUBG ACTIVITIES, INCLUDING COLLECTION OF INCIDENCE AND PREVALENCE DATA 45 CFR § 96.133(A)(3)

DHCS is committed to providing TTA across the continuum of care and views TTA as a crucial element in achieving its statewide goals and objectives.

Perinatal Services Substance Use Disorder

DHCS meets with SUD perinatal county coordinators and their providers funded by the SUBG Perinatal Set-Aside twice a year to provide support and tailored TTA specific to each county's needs. The TTA is tailored to assist with program development and address county compliance. Since SFY 2021-2022, DHCS plans, coordinates, and provides oversight for the Perinatal Annual Collaborative Event (PACE). DHCS holds the PACE to facilitate peer resource sharing and to strengthen the partnership and collaboration between DHCS and SUD perinatal services coordinators. During PACE, DHCS reviews policy changes and facilitates open discussion. In addition, DHCS invites SUD perinatal county coordinators to present their successes, challenges, strategies, and best practices during PACE.

Advance Behavioral Health Prevention California

Beginning July 1, 2023, DHCS launched ABHPC, an innovative TTA program for behavioral health primary prevention services. ABHPC supports the Statewide Primary Prevention Behavioral Health Framework and the Statewide Workforce Framework for the behavioral health prevention workforce, enhancing key partnership efforts among behavioral health primary prevention professionals. Additionally, the ABHPC makes available a repository of resources for prevention-related materials, including activities from several SUD primary prevention workgroups. This also encompasses specific initiatives for opioid prevention, such as TTA for opioid coalitions. Participants in ABHPC TTA spaces can network, discuss, and directly engage with the ABHPC consultant team when taking part in the different trainings: events, prevention application and prevention pathways community of practice spaces, prevention pathways program, and individualized consultation and customized trainings. All services, including continuing education units, are free of charge to primary prevention providers and professionals.

For more information, visit the ABHPC website at ABHPC.org.

Annual training goals for the ABHPC are:

- 2,100 participants trained
- 6,500 service hours
- 36 training events

Exhibit 5: Achievements as of February 26, 2025

5,072	13,838	81
participants trained	direct service hours	traininng sessions

GOALS AND OBJECTIVES 45 CFR § 96.133(A)(4)

Based on the data collected and the analyses performed during the production of this SNAP Report, the state has established the Strategic Initiatives described below to improve SUD treatment and prevention activities and will report on progress for goals and objectives created to affect the achievement of these initiatives during the annual SUBG Application process.

Strategic Initiative #1: Expand programs that address the opioid and stimulant epidemic through the health, justice-impacted, Tribal, youth, and other delivery systems through California's MAT Expansion Project, ED-based MAT programs, and other opioid prevention and treatment initiatives.

Strategic Initiative #2: Strengthen California's prevention infrastructure through implementation of the Big 5 Initiative including a state-level Substance Use Prevention Plan, expanded SEW activities, and scaled up evidence-based and community-defined evidence programs through the SUPER.

Strategic Initiative #3: Improve access and reduce disparities among youth in school and community-based settings through widespread implementation of youth focused efforts especially in communities disproportionally affected by the war on drugs.

EXTENT TO WHICH THE AVAILABILITY OF PREVENTION AND TREATMENT ACTIVITIES IS INSUFFICIENT TO MEET THE NEED FOR SERVICES, AND AVAILABILITY OF INTERIM SERVICES 45 CFR § 96.133(A)(5)

Meeting the Need for Services

The State's priority on reducing health care disparities between populations for SUD and other mental health disorder services provides opportunities to increase service capacity and to attain parity in providing SUD services. NSDUH's data estimates are an invaluable resource in assisting DHCS with monitoring California's treatment capacity. According to NSDUH's estimates, 5,163,000 (81.87 percent) of Californians age 12+ needed but did not receive SUD treatment. The 2022 estimates focus on a smaller group of Californians with an alcohol or drug use disorder, unlike previous estimates that included all Californians.

Interim Services

California passes the strict network adequacy requirements for SUBG recipients, outlined in the Public Health Services Act (42 USC § 300x 21 through 300x 66), through to California Counties via a DMC-ODS State-County Contract. Counties are required to meet or exceed network capacity requirements and adjust the number of providers in their network to support changes to the number of members enrolled. For time or distance standards, if a County is unable to provide services within the established standards, the county must authorize out-of-network services that meet time or distance standards. If an out-of-network is not available within time or distance standards, the County must arrange for telehealth or transportation to an in-person visit. DHCS created the capacity management and waiting list program, Drug Alcohol Treatment Access Report (DATAR), for Counties to report when they reach 90 percent of their capacity to admit individuals into treatment.

STATE INFORMATION MANAGEMENT SYSTEM 45 CFR § 96.133(A)(6)

California Outcomes Measurement System Treatment

DHCS maintains the CalOMS Tx data system as the statewide database that provides data regarding all clients receiving SUD treatment services from publicly monitored treatment programs. CalOMS Tx collects service data for DMC, DMC-ODS, SUBG, and county contracted NTP programs regardless of funding source and the outcomes achieved at the time of discharge from treatment. CalOMS Tx is used to report many facets of treatment, including treatment utilization, client's admission and discharge information, length of stay, client outcome measures, and program performance measures.

Drug Alcohol Treatment Access Report

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

ECCO

As previously mentioned under the BIG 5 Initiative, ECCO 11 is used by California counties to collect and report primary prevention SUD program and activity data. All counties and subcontracted providers funded with SUBG primary prevention dollars are required to report data that meet defined standards of quality in the Primary-Prevention Data Quality Standards.

CONCLUSION

Information presented in this SNAP Report is intended to provide guidance to state and local planners working in the behavioral health field. Through ongoing administration of California's federal and state-funded programs, DHCS utilizes data highlighted in this

SNAP Report and continuously involves stakeholders and program participants in planning processes that inform capacity-building needs and determine program priority areas and populations.

Proper monitoring by DHCS of grant-funded programs involves allocating resources effectively for activities that generate the highest public benefit, while diligently improving programs and processes to effectively address gaps and emerging trends in behavioral health. California has been serving youth between the ages of 12 to 17 as early as 2012 and continues to recognize that primary prevention services must focus on these age groups. Nevertheless, there is more to do. DHCS has developed two Strategic Initiatives that will impact youth prevention. Specifically, Strategic Initiative #2 aims to strengthen California's prevention infrastructure through statewide strategic planning efforts, and expand the number of California programs, practices and strategies deemed to have some level of evidence of positive outcomes. Similarly, Strategic Initiative #3 seeks to improve access and reduce disparities among youth in communities of color, tribal communities and other communities disproportionately affected by the war on drugs through widespread implementation of the Children and Youth Behavioral Health Initiative, Elevate Youth CA, California YOR Project, and other statewide, culturally responsive youth empowerment efforts.

The implementation of California's DHCS Opioid Response has saved many lives and continues to save more by funding and coordinating 30 projects that provide more access points for MAT, reduce the stigma of opioid addiction, and distribute and train individuals on the use of the overdose reversal drug, naloxone. However, statistics still show that overdose ED visits and deaths continue to increase, and there is a threefold increase in the use of psychostimulants in California (including methamphetamine). To address the growing epidemic of stimulant use, DHCS will specifically focus on expanding treatment in diverse settings: health care, justice, Tribal, and other delivery systems and to leverage opportunities through CalAIM and BHRRP.

In order to continue to meet the behavioral health needs of individuals, DHCS will emphasize all of the Strategic Initiatives outlined above to improve access to and availability of primary and secondary prevention, treatment, and support services to all Californians. Through its continued strategic planning process, DHCS will examine each strategic priority and develop goals, objectives, and strategies to address SUD in California. CalAIM and the Children and Youth Behavioral Health Initiative represent a major shift in the way California provides behavioral health services statewide. DHCS will continue to work collaboratively with its stakeholders, providers, and community partners to address system gaps, evaluate system efficiency and effectiveness, and make

course corrections where needed. Finally, the FFY 2024-2025 SUBG application priorities, goals, and performance measures take into account and plan around overarching and rapidly changing health care policy topics, all in an effort to improve the physical, behavioral, and emotional health of all Californians.