

California State Targeted Response to the Opioid Crisis Needs Assessment Report

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California Health and Human Services Agency
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UCLA Integrated Substance Abuse Programs



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Introduction

This needs assessment has been produced to support California's Medication Assisted Treatment (MAT) Expansion, funded through a SAMHSA State Targeted Response to the Opioid Crisis grant. California will strategically focus on populations with limited or no MAT access including rural areas, American Indian and Native Alaskan (AI/NA) tribal communities and statewide access to buprenorphine. This needs assessment is meant to provide a snapshot of current needs in order to inform future strategic planning and implementation of the project.

Section I: Summary of the most recent annual data obtained from the State's Prescription Drug Monitoring Program (PDMP)

California in Context: Opioid Painkiller Prescriptions in United States

In 2012 health care providers wrote 259 million prescriptions for painkillers nationwide. Although California had a relatively lower rate of age-adjusted prescriptions rate compared to some other states, it still accounted for 9% of nationwide opioid prescriptions at 23.4 million in 2012.¹

California ranks first in the nation in population size with nearly 40 million residents.² The 58 counties in the State vary in widely in terms of area, population size, and degree of urbanization.

Number of opioid painkiller prescriptions by county

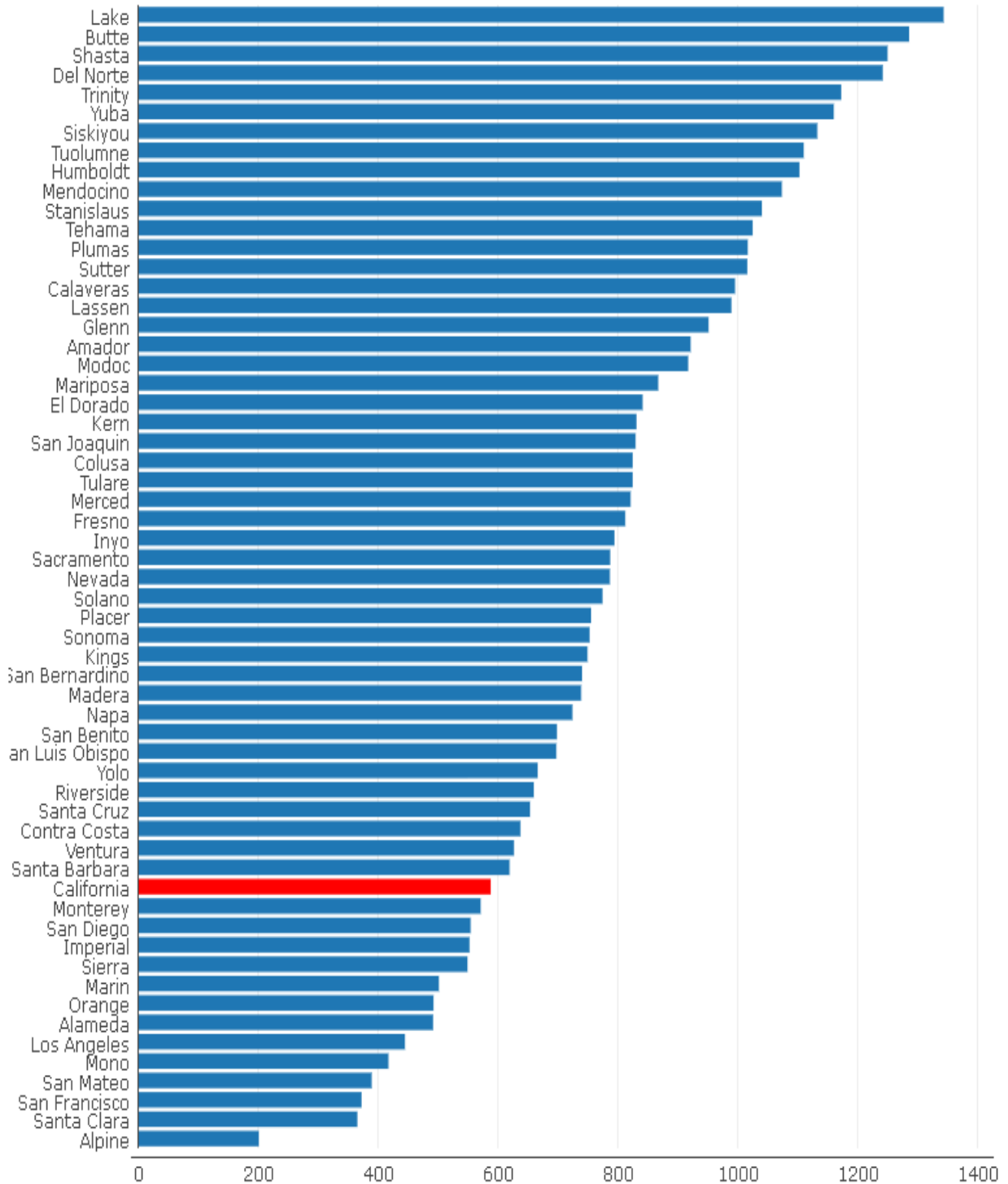
Fourteen counties in Northern California have an opioid prescription rate per 1,000 residents that exceeds 1,000 (more than one per person). These counties include Lake, Butte, Shasta, Del Norte, Trinity, Yuba, Siskiyou, Tuolumne, Humboldt, Mendocino, Stanislaus, Tehama, Plumas and Sutter. The prescription rate per 1,000 in these counties ranges from 1,343 in Lake County to 1,015 in Sutter County. The lowest rate is in Alpine county with a rate of 200. Including Alpine county, there are eight counties in the State that have a prescription rate lower than 500 per 1,000 persons. These counties are Orange, Alameda, Los Angeles, Mono, San Mateo, San Francisco, Santa Clara and Alpine. These rates are shown in Figure 1.1. Map 1.1 shows rates per 1,000 residents.

¹ National Prescription Audit, 2012. Center for Disease Control and Prevention.

² Source: U.S. Census Bureau, Population Division Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016 (NST-EST2016-01)

<https://www.census.gov/data/tables/2016/demo/popest/state-total.html>

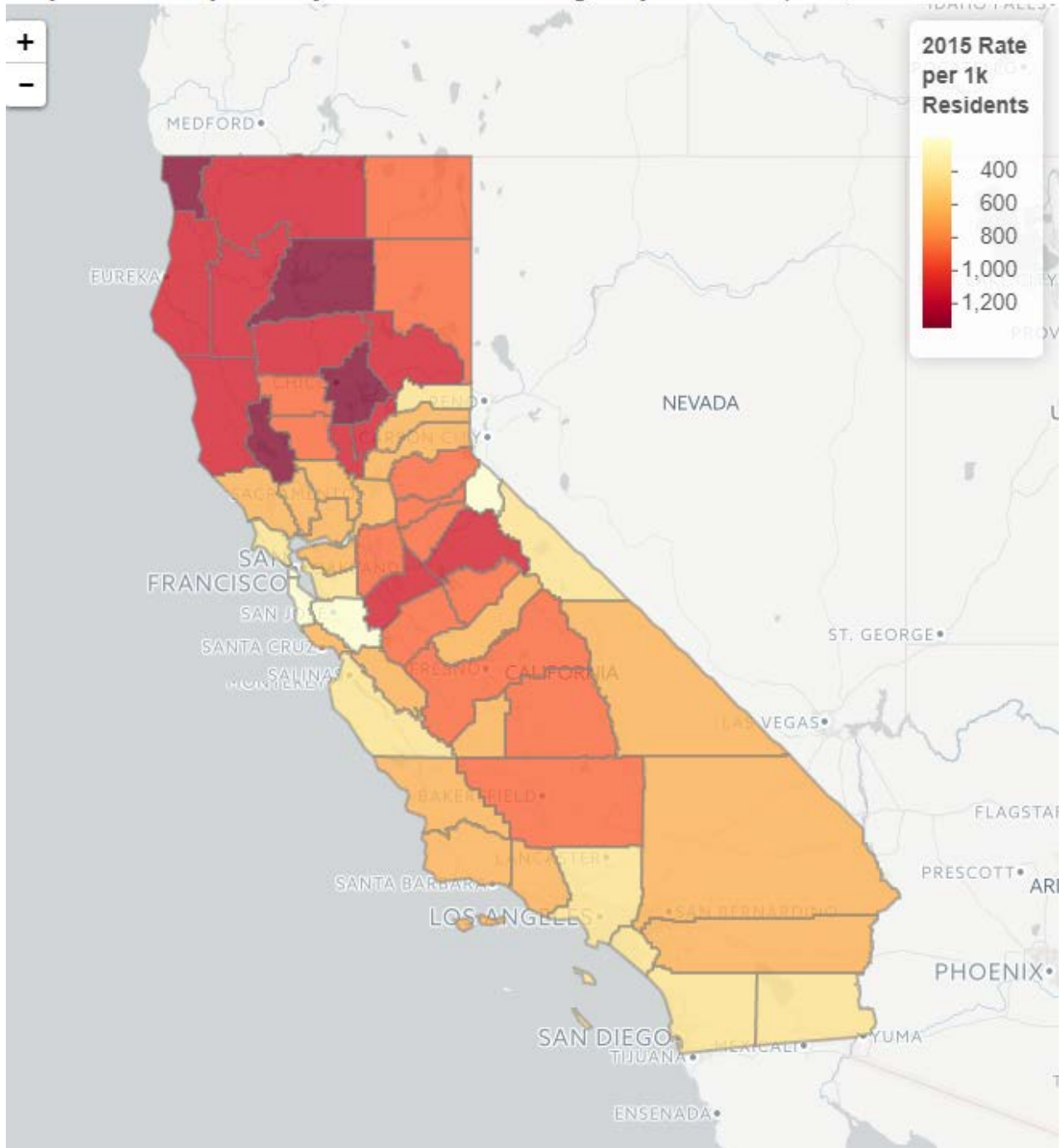
Figure 1.1. Opioid Prescriptions per 1,000 persons by county (2015)



Data Source: CURES 2.0, via the California Opioid Overdose Surveillance Dashboard.

Map 1.1

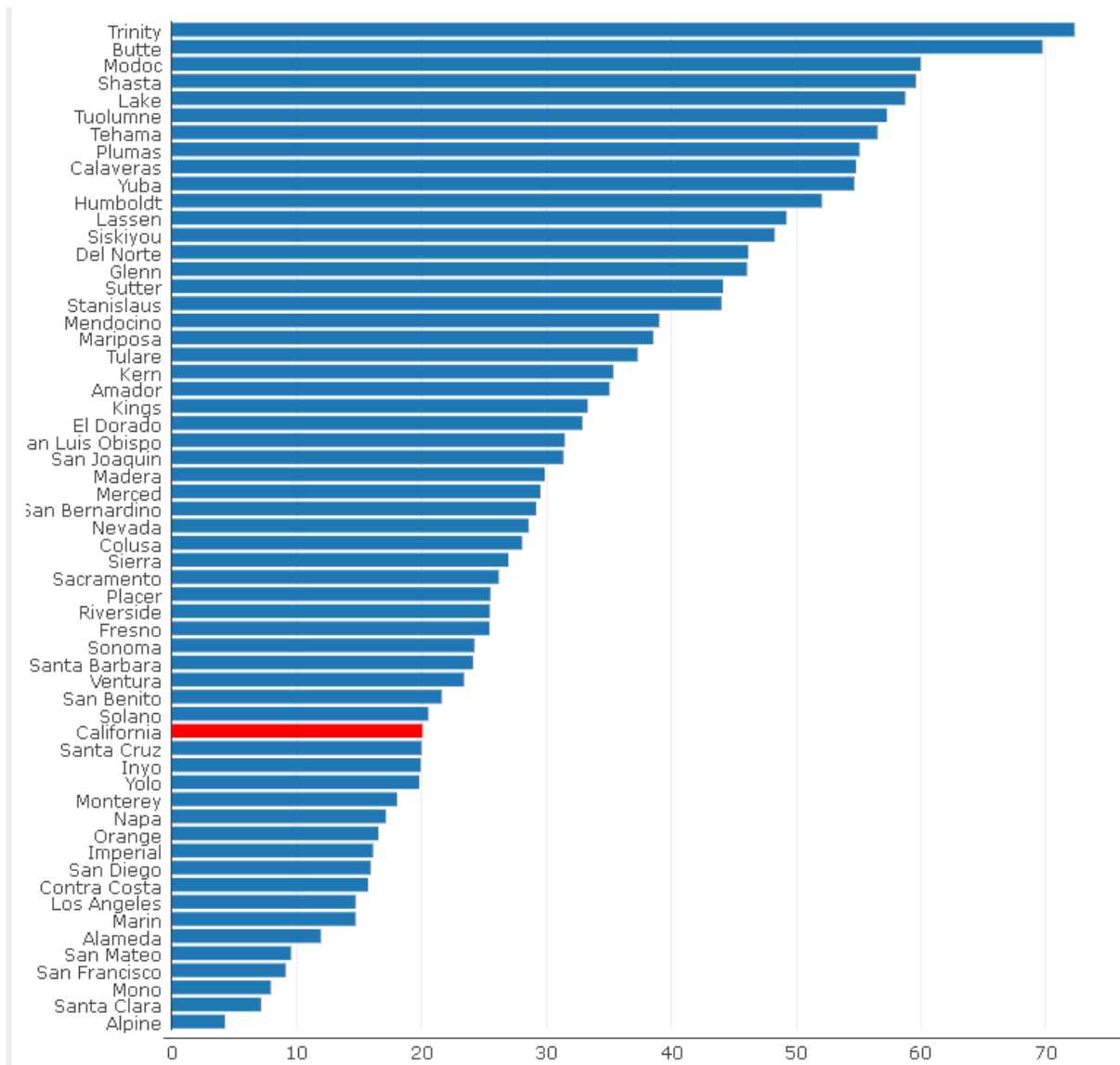
Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents



Data Source: CURES 2.0, mapped by the California Opioid Overdose Surveillance Dashboard.

Analysis of data, implications including identification of counties and municipalities at a higher risk of opioid-involved painkiller and benzodiazepine overprescribing

Figure 1.2 California Residents with Overlapping Opioid/Benzodiazepine prescriptions: Age-Adjusted Rate per 1,000 Residents by county, 2015



Overlapping opioid and benzodiazepine prescriptions

Concomitant use of opioids and benzodiazepines is associated with the occurrence of fatal and non-fatal opioid overdoses. Figure 1.2 shows rates of overlapping opioid and benzodiazepine prescriptions in California. Trinity and Butte counties had particularly high rates of overlapping prescriptions. Not surprisingly, counties with high opiate prescribing rates also generally had high rates of overlapping opioid/benzodiazepine prescribing

(Trinity and Butte ranked 5th and 2nd in opioid prescribing, respectively). An exception, however, was Modoc, which was 19th in opioid prescriptions but 3rd in overlapping prescriptions, suggesting the overlapping rates may be due to unusual benzodiazepine prescribing.

Rural and Metropolitan Classification

Opioid prescription rate data was also analyzed by rural versus metropolitan counties. Nearly 80% of California's wide geographic region is defined as rural, but includes only about 6% of population as compared with small, medium and large size metropolitan areas (urban and semi-urban) where the remaining 94% of the population resides.³ According to the US Census Bureau, rural is defined as all territory, population and housing units that are located outside of the urban areas and urban clusters. Urban areas and clusters are determined by population density and size.

According to the Centers for Disease Control and Prevention (CDC) the 58 counties in California can be categorized into three categories, i.e., rural, small to medium metropolitan areas and large metropolitan areas (2013, NCHS Urban-Rural Classification Scheme for Counties, Vital and Health Statistics, Series 2, Number 166, April 2014. US Department of Health and Human Services, CDC, National Center for Health Statistics). Based on this classification, there are **21 rural counties** (*Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Sierra, Siskiyou, Tehama, Trinity and Tuolumne*), **21 small to medium metropolitan counties** (*Butte, Fresno, Imperial, Kern, Kings, Madera, Merced, Monterey, Napa, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura and Yuba*) and **16 large metropolitan counties** (*Alameda, Contra Costa, El Dorado, Los Angeles, Marin, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Yolo*),

In 2015, the average number of prescriptions in California per 1,000 persons was 795.2 with significantly higher rates in rural counties as compared with metropolitan counties (See Table 1.1). The average rate in rural counties was significantly higher at 924.8 prescriptions per 1,000 persons. In contrast, large metropolitan counties average rate per 1,000 persons was 586.5.

³ Quick facts About Rural California, California Communities Program, Citizenship Governance Prosperity, University of California http://ucanr.edu/sites/UC_CCP/files/125967.pdf

Table 1.1 - Opioid Prescriptions per 1,000 persons by Rural/Metropolitan Classification in California - 2015

Region	Mean	SD	95% Confidence Interval	Median
Rural (N = 21)	924.8	271.1	801.4 – 1048.2	989
Small to medium metropolitan (N = 21)	824.6	210.4	728.8 – 920.4	773
Large metropolitan (N = 16)	586.6	18.3	503.6 – 670.0	595
California	795.2	257.7	727.5 - 863.0	786

Data Source: California Opioid Overdose Surveillance Dashboard, California Department of Public Health

Given the differences in Opioid Prescription Rates by region, correlation analysis was conducted between Opioid Overdose Deaths and Opioid Prescriptions. The results show a positive significant correlation for rural and large metropolitan counties but not in the small to medium metropolitan counties suggesting additional factors may need to be explored between opioid overdose deaths and opioid prescriptions in the small to medium metropolitan counties.

Table 1.2 - Correlation between Opioid Prescription and Opioid Overdose Deaths in California by Rural/Metropolitan classification – 2015

	Opioid Prescriptions	Statistical Significance
Rural (N = 21)	.70	p<.01
Small to medium metropolitan (N = 21)	-.15	.NS*
Large metropolitan (N = 17)	.46	p=.06
California	.46	p<.01

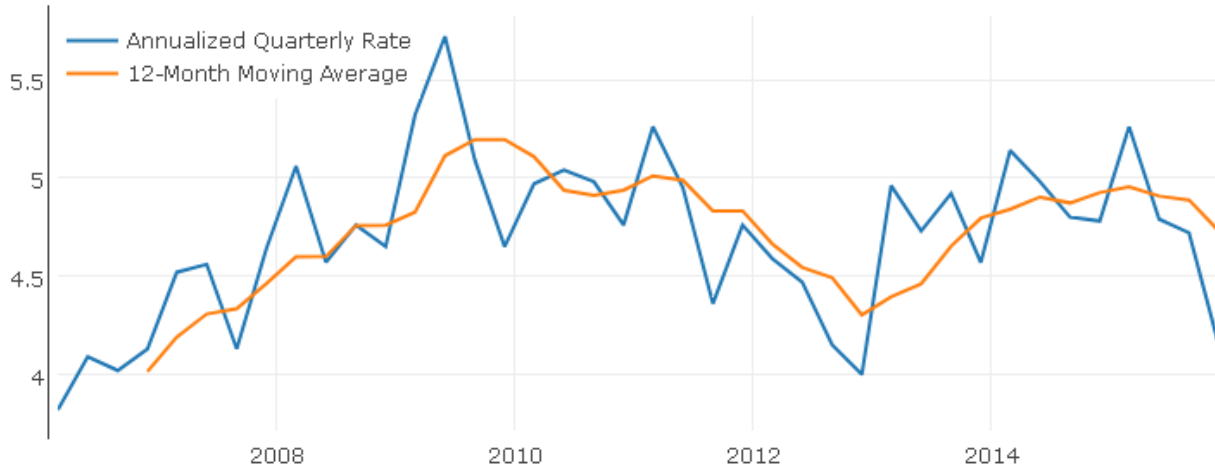
Data Source: California Opioid Overdose Surveillance Dashboard

Section II: Summarize the most recent annual data available for Opioid-involved Overdose Deaths

Number of Opioid Involved Overdose Deaths by State and County

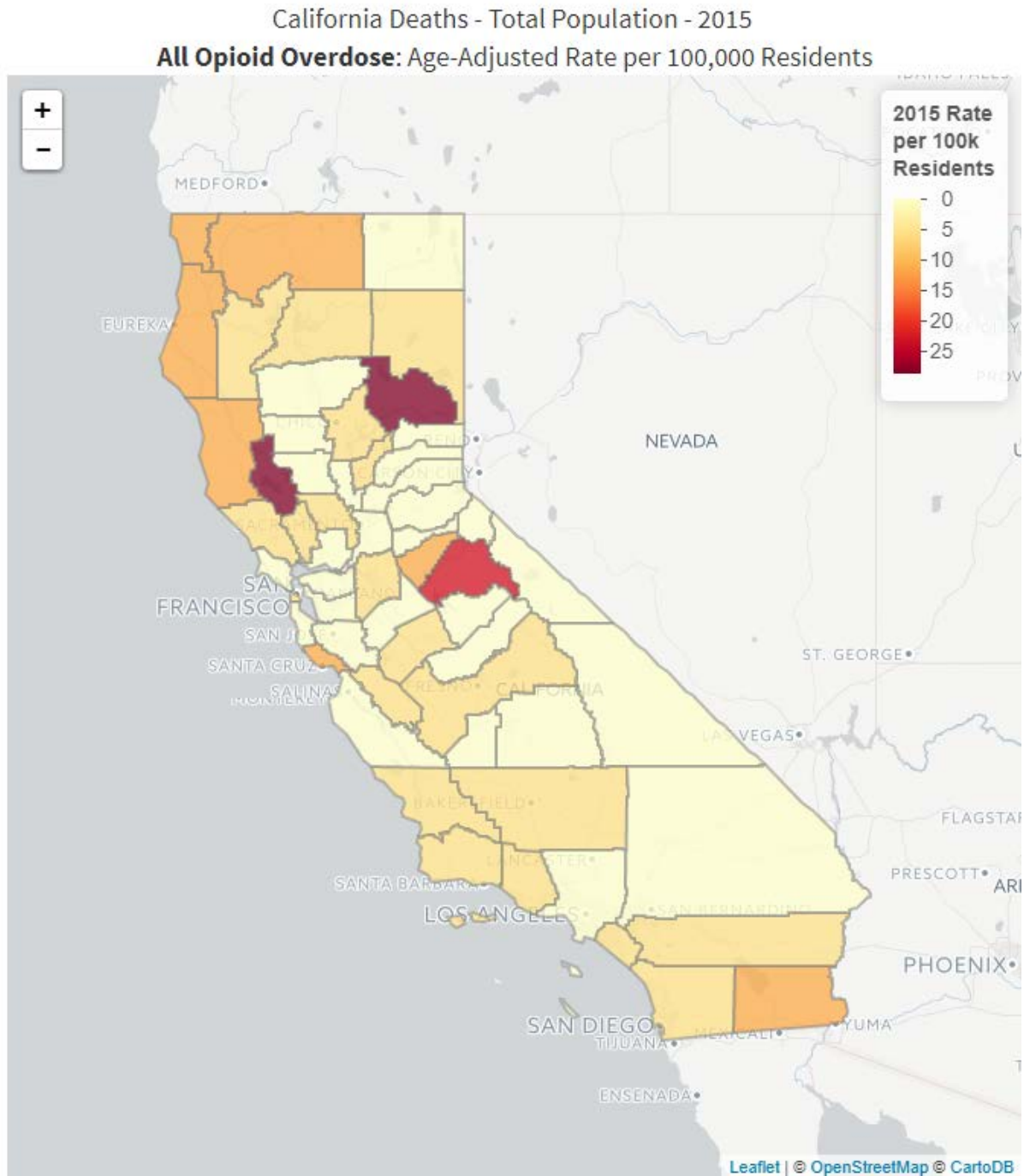
Opioid overdose death rates were at a 12-month moving average of 4.7 per 100,000 in 2015 Q4. (See Fig 2.1 and Map 2.1).

Figure 2.1 All California Opioid Overdose Deaths over Time: Age-Adjusted Rate per 100k Residents



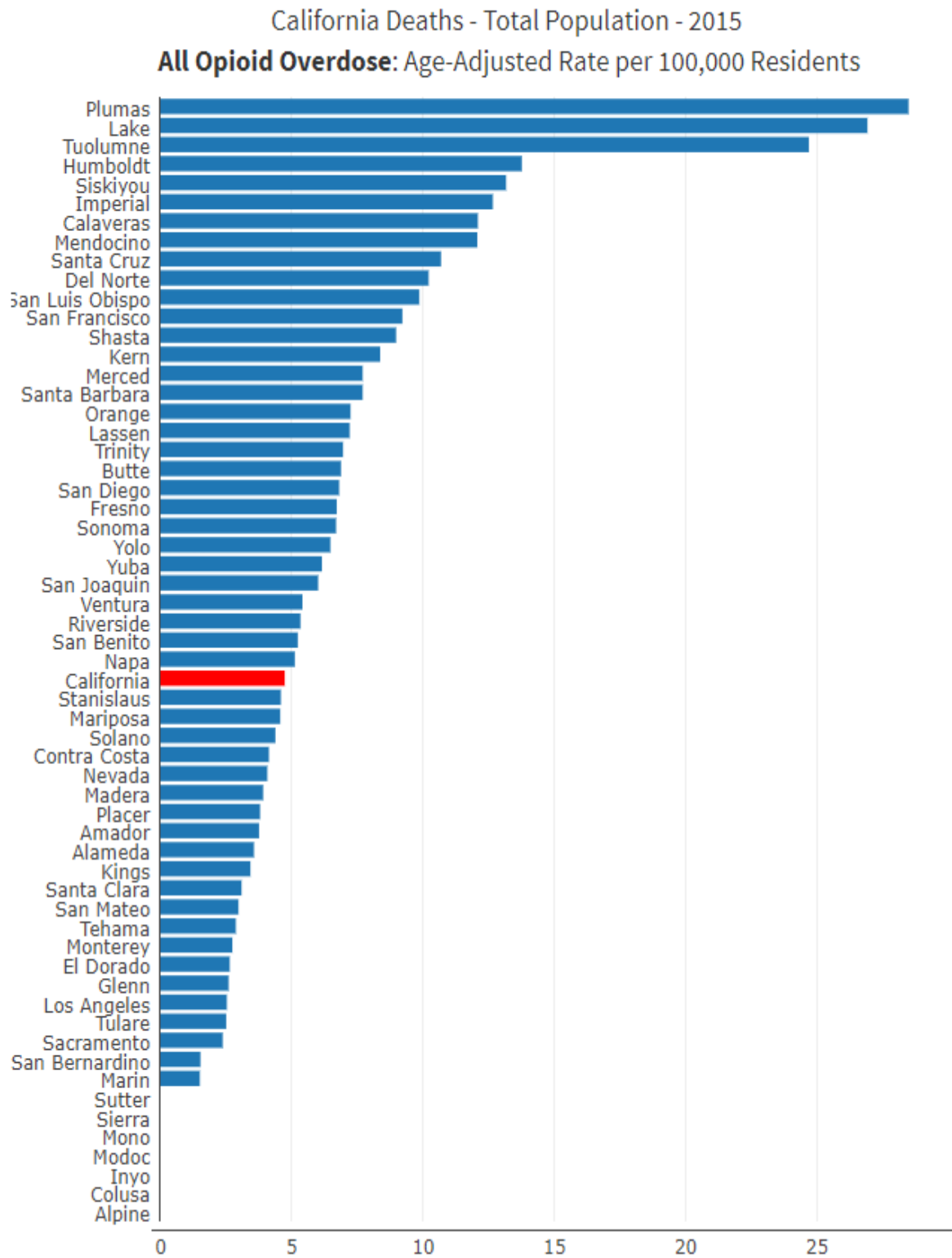
Data source: CDPH Vital Statistics Multiple Cause of Death Files via the California Opioid Overdose Surveillance Dashboard

Map 2.1



Three counties in California, namely Plumas, Lake, and Tuolumne had the highest rate of age-adjusted opioid related overdose deaths per 100,000 residents.

Fig 2.2



Analysis of data and identification of counties and municipalities at highest risk for opioid-involved overdose

Using a variety of data sources, the State Epidemiology and Outcome Workgroup (SEOW), with assistance from the California Prescription Drug Overdose Prevention Initiative, has identified and continues to monitor the counties most impacted by the prescription drug epidemic based on self-report of consumption, prescribing and dispensing data, and opioid pharmaceutical and heroin deaths. There is a clear geographic pattern identifying the highest burden areas for the prescription drug epidemic in California.

- Past year non-medical use of prescription drugs is highest in northern California rural regions [National Survey on Drug Use and Health (NSDUH) - Region 1R (Humboldt, Lake, Mendocino, Plumas, Shasta) = 5.71%; Region 12R (Tuolumne) = 5.59%.]
- The number of opioid prescriptions per 1,000 residents is highest in the rural northern counties of California (see Map 1.1) and
- The rate of prescription opioid related deaths per resident is highest in these same rural northern California counties, where there are sufficient numbers to map (see Map 2.1).

In 2015, California's opioid related age adjusted death rate per 100,000 persons was 6.4 with wide variation between regions. For rural counties the death rate was 7.3,, for small to medium metropolitan counties the rate was 6.3, and for large metropolitan counties the rate was 5.7 (See Table 2.1).

Table 2.1 - Opioid Related Age Adjusted Death Rate Per 100,000 Persons by Rural/Metropolitan Classification in California - 2015

	Mean	SD	95% Confidence Interval	Median
Rural (N = 21)	7.3	8.0	3.5 – 11.0	4.4
Small to medium metropolitan (N = 21)	6.3	3.0	4.9 – 7.6	6.1
Large metropolitan (N = 16)	5.7	6.3	2.5 – 8.9	3.8
California	6.4	6.0	4.8 - 8.0	5.2

Data Source: California Opioid Overdose Surveillance Dashboard, California Department of Public Health

Section III: Summarize the current availability of MAT

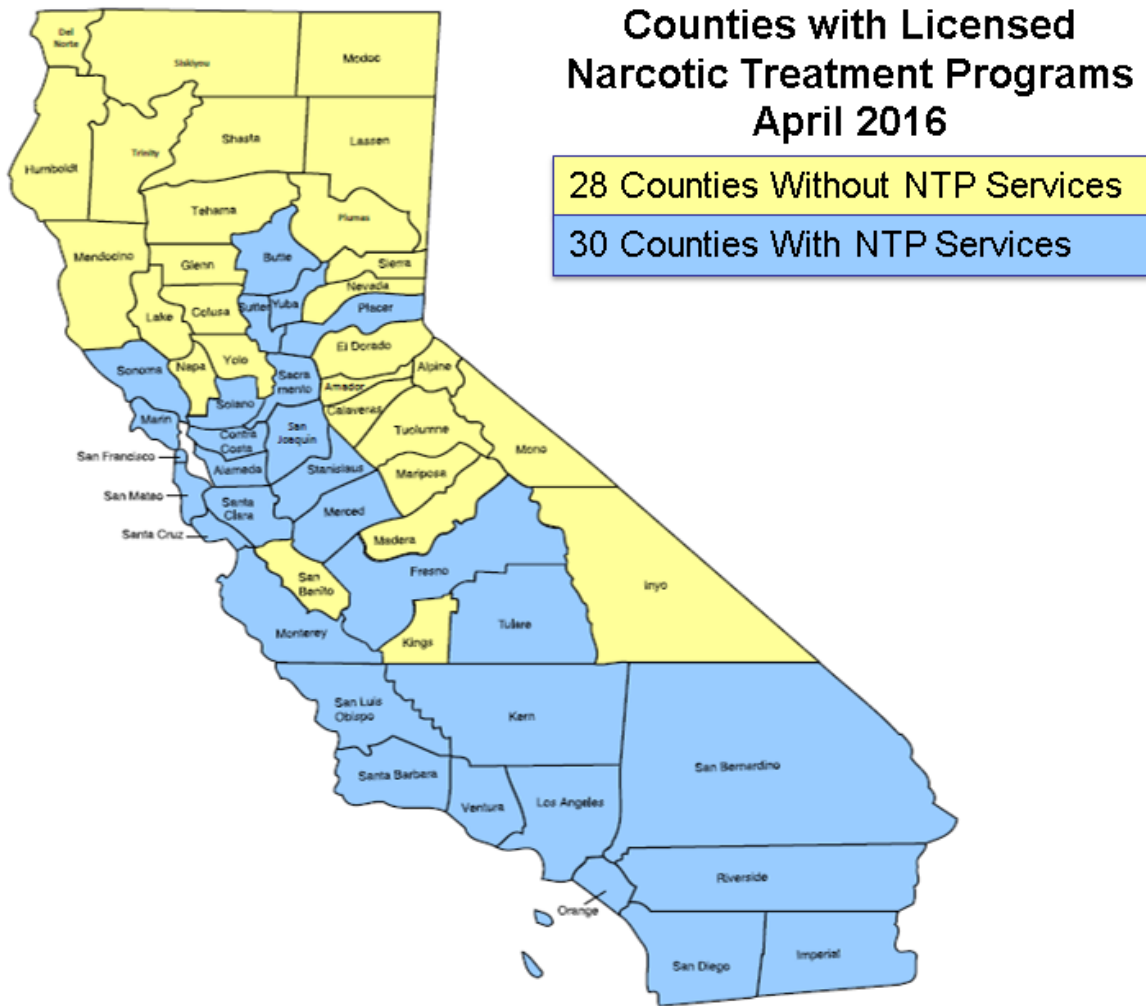
Number of certified Opioid Treatment Programs (OTPs), their location by county and average patient capacity

In 2016, 48% of the counties in California did not have Narcotic Treatment Programs (NTP). The top eight counties in terms of opioid overdoses have zero NTPs. These counties are located in Northern California and Central Eastern California (see Map 3.1).

In California, an estimated 70.8% of NTPs operate at 80% of capacity or higher.⁴

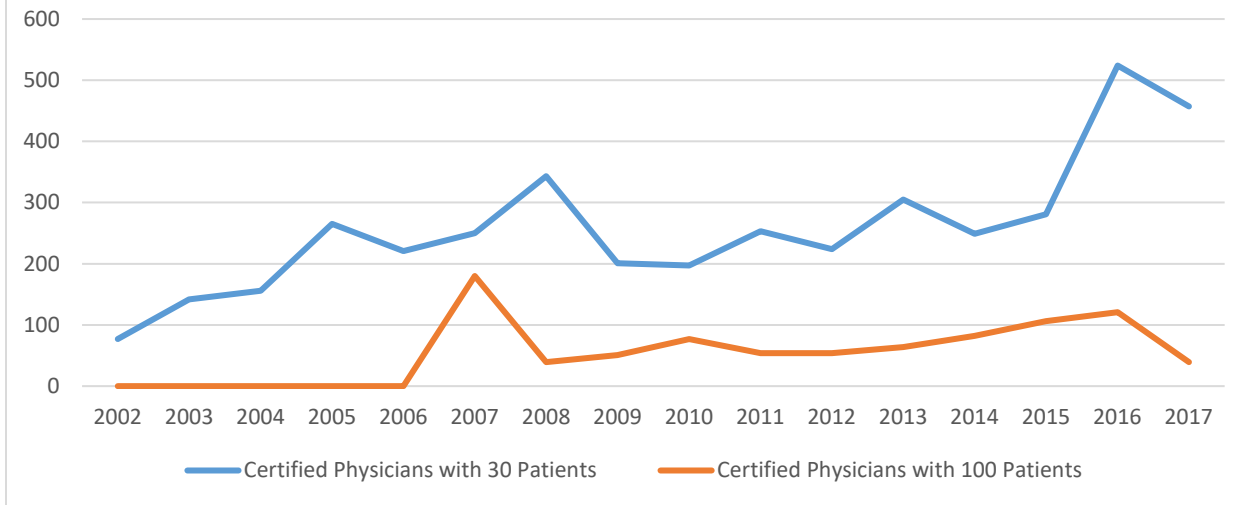
⁴ Jones, C.M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment, 105(8), e55-e63.

Map 3.1



Number of Office-based Opioid Treatment (OBOT) certified providers (including MDs, DOs, PAs and NPs)

Table 3.1: Number of DATA Certified Physicians in California Eligible to Provide Buprenorphine Treatment for Opioid Dependency: 2002-2017

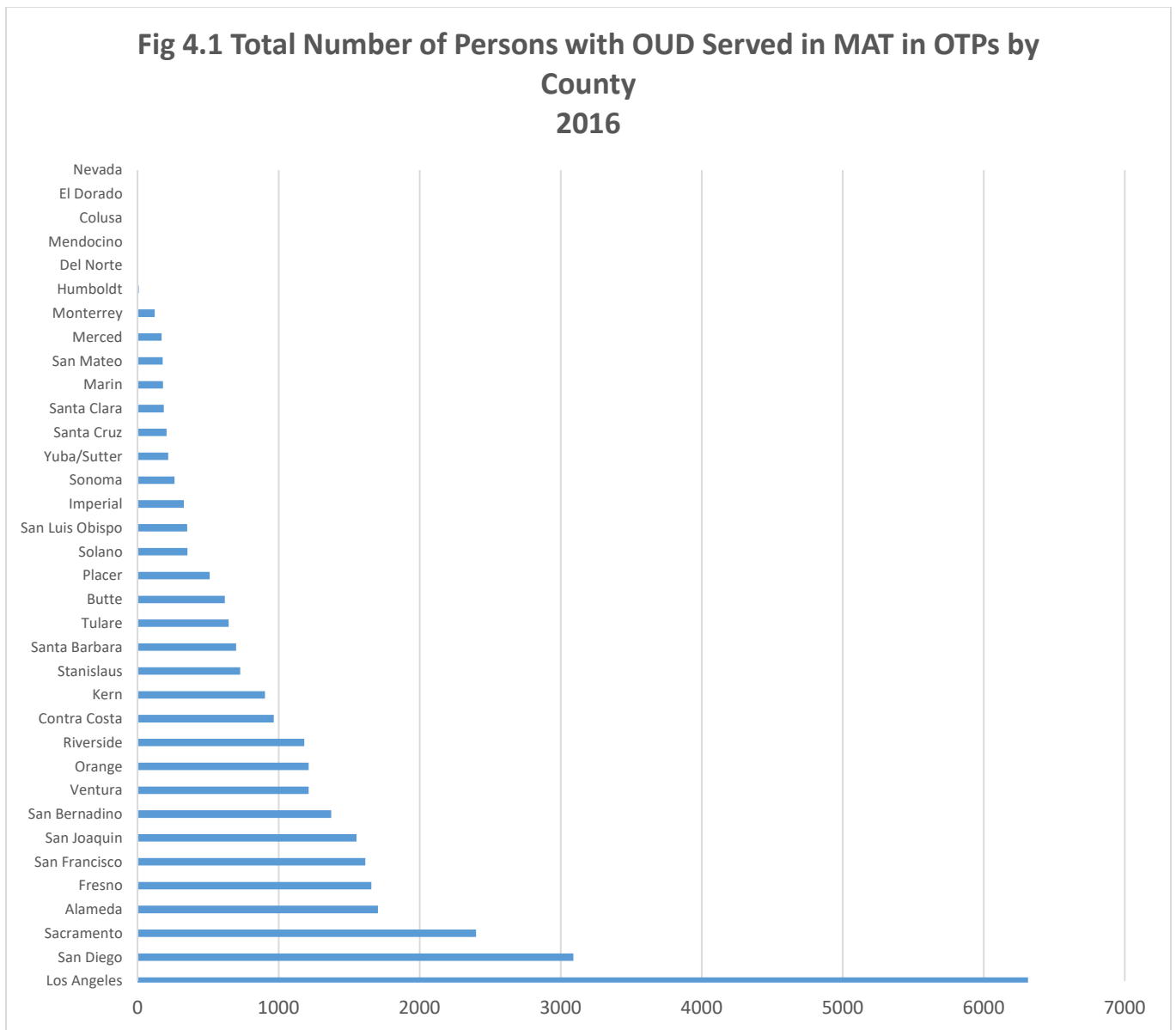


Data Source: SAMHSA

According to SAMHSA,⁵ in California the number of physicians eligible to provide buprenorphine treatment for opioid dependency has gone up significantly by 493% for certified physicians with 30 patients from 77 in 2002 to 457 in 2017. However for certified physicians with 100 patients the numbers have remained relatively low and stable. Between 2002 and 2006 there were no certified physicians to provide buprenorphine treatment for opioid dependency. In 2007, there were 180 certified physicians with 100 patients, and declined to 39 in 2006. Between 2009 and 2014, the number of certified physicians with 100 patients was between 39 and 82, increasing to 106 in 2015, 121 in 2016 and declining to 39 in 2017.

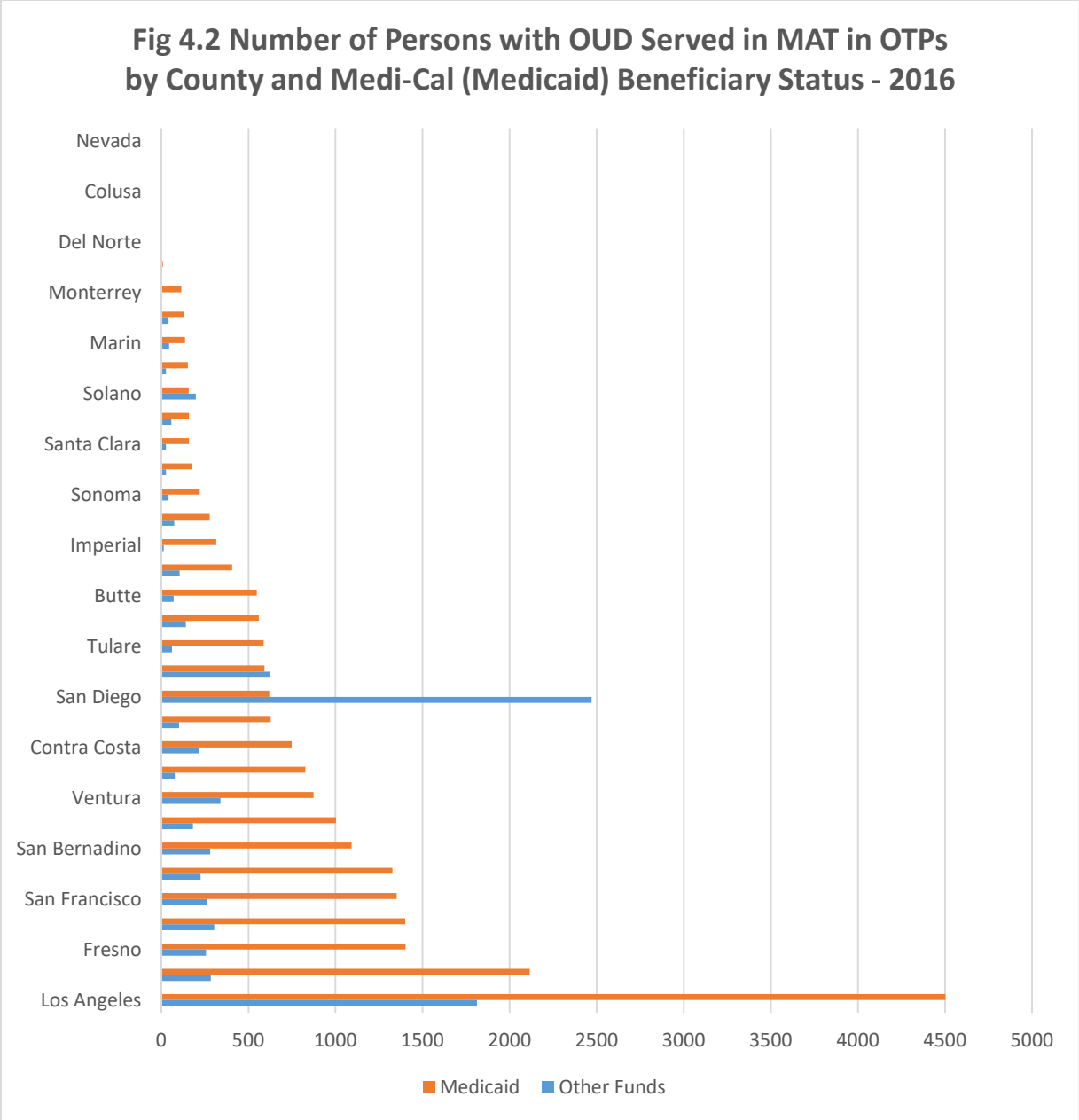
⁵ https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=CA

Section IV: Current Programmatic Capacity



Data Source: CalOMS-Tx, 2016.

Los Angeles County had the highest number of OUD persons served in MAT in OTPs in 2016 with 6,314 persons while Nevada, El Dorado, Colusa, Mendocino, Del Norte and Humboldt counties served less than 10 clients.



Data Source: CalOMS-Tx, 2016.

While Los Angeles County had the highest number of OUD persons with Medicaid served in MAT in OTPs at 4,502 persons, San Diego had the highest number of OUD persons in OTPs who were not reported as Medicaid beneficiaries at 2,471 persons. It is unclear why San Diego is an outlier on this variable, and it is possible that data collection and reporting issues could play a role.

Describe the current prevention system to address the opioid crisis in your state. Identify any strengths or gaps in services

Please see Section VII

Section V: Locations of existing prevention & recovery initiatives

A number of initiatives are underway, some of which are discussed in sections VII and XI. Many of these efforts are statewide and difficult to map, however. One example that has been mapped, however, is described below.

California Opioid Safety Coalitions Network⁶

Opioid safety coalitions bring together a broad group of stakeholders committed to decreasing opioid overuse and overdose deaths. Advocates and community leaders from public health, hospitals, addiction treatment, medical societies, law enforcement, health plans, and others come together to find creative ways to solve the opioid epidemic in their communities. CHCF is providing technical assistance to 16 of these coalitions in 24 counties across California. The map below shows active coalitions statewide.

Map 5.1



⁶ <http://www.chcf.org/oscn/about>

Section VI: Policy legislation proposed or enacted within your state/jurisdiction related to the opioid overdose crisis including the overall socio-political environment that is supportive of MAT

Legislative, Regulatory and Policy Barriers

California has been making strides in removing the state regulatory and policy barriers that unnecessarily reduce MAT access. In 2015, DHCS removed the treatment authorization request required for buprenorphine, allowing streamlined access for Medi-Cal patients. DHCS is also midway through a regulations package for NTPs that will remove capacity barriers, assist with the expansion of buprenorphine within the NTP setting, and establish additional guidance around the use of MUs and other changes to reduce regulatory and policy barriers to NTP services. These regulations are due to be released for public comment by Summer 2017.

- Good Samaritan laws – AB 635 (passed in 2013) removed liability from prescribers of naloxone.
- Mandatory participation in PDMP SB 482 (passed in 2016) requires mandated use of CURES. However, it won't go into effect until six months after DOJ certifies that they are ready both technologically (interfacing with hospital software programs) and hiring new DOJ staff. DOJ is reportedly ready technologically, and are in process of hiring 8 new staff, so six months later that this mandate will require all prescribers of controlled substances to use CURES 2.0 (CA's PDMP). Laying the groundwork for this mandate, California Health and Safety Section 11165.1 already requires all physicians to register on CURES 2.0.
- Open prescription for Naloxone – In California Pharmacists can provide naloxone without a prescription – AB 1535 (2013-14). Many programs across the state also have standing orders in place that allow direct access to naloxone (e.g. needle exchanges). First responders across the state also often carry and administer naloxone.
- New dedicated funding for MAT (methadone, buprenorphine and naltrexone). Methadone is covered under Drug Medi-Cal, and use of MAT is being expanded under California's Drug Medi-Cal Organized Delivery System Waiver.
- New dedicated state funding for naloxone – SB 833 – 2016 provided \$3 Million “to award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations, regional opioid prevention coalitions, or both, to support or establish programs that provide Naloxone to first responders and to at-risk opioid users through programs that serve at-risk drug users, including, but not limited to, syringe exchange and disposal programs, homeless programs,

and substance use disorder treatment providers.” This was a one-time allocation of funds – the distribution of naloxone is in process currently.

- Public regulatory agency developments and practices (i.e. siting of programs, laws and policies that impede persons struggling with OUD from obtaining treatment). AB 395 is current legislation that would expand the definition of MAT. It is still going through the legislative process: Assembly Bill (AB) 395 would expand medications authorized by licensed Narcotic Treatment Programs (NTPs) for individuals with substance use disorders (SUDs). The bill would authorize NTPs to provide any medication that is approved by the Food and Drug Administration (FDA) for the purpose of medication-assisted treatment (MAT). AB 395 would remove the maximum allowance of 20 patients per physician in an office-based narcotic treatment program (OBNTP) to instead allow for an appropriate number of patients as defined under the physician’s Drug Enforcement Administration (DEA) registration. The bill would also require all Drug Medi-Cal (DMC) Treatment Program providers to submit billings no later than six months from the date of service.
- Standing orders for Naloxone – Of the 55 counties who applied for naloxone under “new dedicated state funding for naloxone” described above, 18 health officers have already signed standing order for their counties, and another 18 indicated that they plan to sign standing orders in the future.
- The creation of governor’s-task forces, advisory councils, or work groups to address the opioid crisis – California’s Statewide Opioid Safety Workgroup reports activities to the Governor’s office.

Section VII: Provide a description of the current evidence-based, evidence-informed and promising practices in place for prevention efforts

Media campaigns, include intended audiences and messages

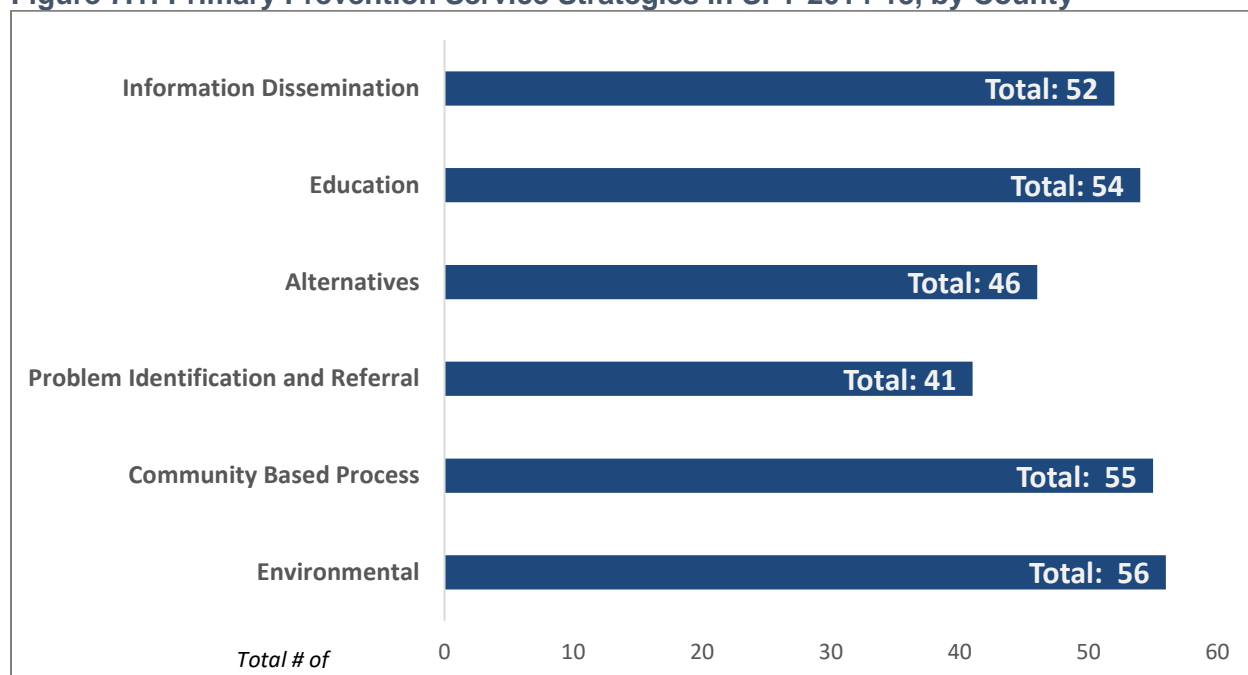
California is currently working through the communications task force of the Statewide Opioid Safety Workgroup to implement a media campaigns for youth and youth influencers such as teachers and parents.

School and community education programs

The following prevention activities are occurring statewide:

The six prevention service strategies, as defined by SAMHSA’s Center for Substance Abuse Prevention are Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental. Each of these strategies has multiple related services/activities that are quantifiably reported into CalOMS Pv by counties and prevention service providers (see Figure 3).

Figure 7.1: Primary Prevention Service Strategies in SFY 2014-15, by County



Source: CalOMS Pv

With the exception of Information Dissemination, five strategies capture demographic data on participants that includes gender, age, and race/ethnicity.

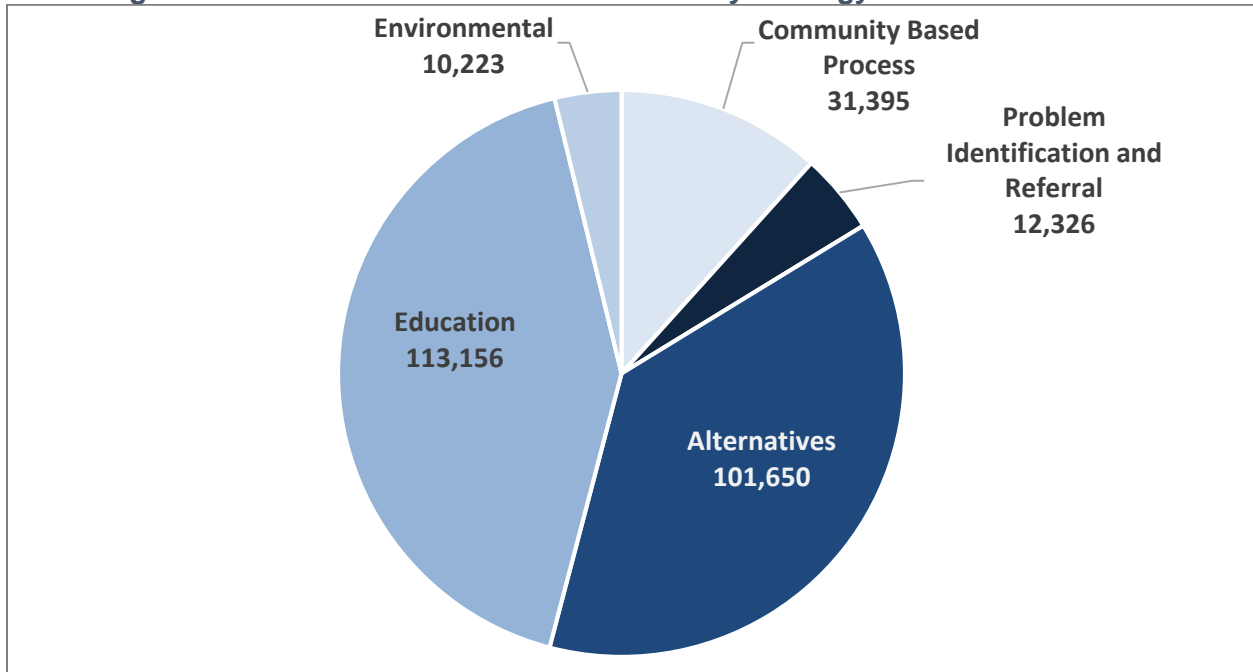
Information Dissemination

Information Dissemination activities reported into CalOMS Pv include audio and visual material development and dissemination, conference/fair planning and attendance, media campaign development and implementation, resource directory development and dissemination, speaking engagements, and similar multi-media generating activities. Demographic data is available by age groups, race, or gender. In SFY 2014-15, the highest totals reported by service frequency activity statewide were as follows (number of individuals served is not captured in these strategy descriptions):

- Printed Materials Disseminated = 6,885
- Printed Materials Developed = 4,159
- Speaking Engagements = 3,612
- Brochures/Pamphlets Disseminated = 3,179
- Health Fair/Promotion Planning = 1,471
- Figure 7.2 below displays the total individuals served by each strategy, with the exception of Information Dissemination. Publicly funded providers reported that 268,750 Californians received some type of SUD prevention service. Education and Alternatives strategies are provided to the largest number of prevention recipients, while Environmental strategies serve the fewest individuals. Environmental and Community-Based Process strategies capture some individuals-served data. However, many activities in these strategies are

planning/coordination and occur at an organizational level, rather than involving direct prevention services to individuals, as reflected in the other strategies' data.

Figure 7.2: Number of Beneficiaries Served by Strategy for SFY 2014-15



Source: CalOMS Pv

Education

Prevention service activities reported as Education include SUD prevention classroom and educational services for youth and adult groups, mentoring, parenting and family management services, peer leader and preschool prevention programs, theatre troupes, and groups for children of substance abusers. The five activities with the highest number of individuals served were:

- Classroom Educational Services = 56,398
- Small Group Sessions = 15,793
- Educational Services for Youth Groups = 14,373
- Educational Services for Adult Groups = 12,843
- Parenting/Family Management Services = 10,719

Alternatives

Activities reported within Alternatives in CalOMS Pv include community center activities and operation, substance use-free social events, community service, youth and adult leadership, and Outward Bound. The highest numbers of individuals served through alternative activities are:

- Substance Use-Free Social/Recreational Events = 44,344
- Youth/Adult Leadership Activities = 43,642
- Community Service Activities = 6,831
- Community Drop-in Center Activities = 4,457

- Recreational Activities = 2,376

Problem Identification and Referral

This strategy contains the fewest types of activities ranging from Alternatives to Violence to Student Assistant Programs.

- Prevention Screening and Referral Services = 9,109
- Student Assistance Programs = 3,137

Community-Based Process

This strategy predominantly reflects activities in planning and coordination of prevention services along with technical assistance and training. The community-based process strategy includes serving and providing guidance to individuals who are “Intermediaries” (social workers, beverage servers, policy makers, law enforcement, etc.). The secondary impact on these participants is delivered through later actions of their agencies/services; however, the quantity/demographics of these actions are outside the view of a prevention data system and are not captured in CalOMS Pv. The data below reflects the three activities that report individuals served.

- Technical Assistance = 15,549
- Community/Volunteer Training = 8,188
- Training Services = 7,658

Not all of the activities under this strategy capture the number of individuals served, as many are indirect services rather than services provided to individuals. The remaining Community-Based Process activities are reported as count-of-service types or the frequency of occurrence. The most reported activities are as follows:

- Multi-Agency Coordination/Collaboration = 23,807 services
- Assessing Community Needs/Assets = 4,404 services
- Evaluation Services = 2,909 services

Environmental

As with the Community-Based Process strategy, service frequency is reported for all environmental activities, but not all environmental activities collect data for individuals served. The Compliance Training sub-categories report the most individuals served as follows:

- Compliance: Training – Commercial Host and Management = 4,083
- Compliance: Training – Social Host and Management = 3,198
- Compliance: Retailer/Vendor Education = 1,406

The highest service frequencies reported for this strategy are:

- Environmental Other = 6,537 services
- Policies and Regulations = 3,082 services
- Media Strategies = 2,297 services
- Efforts with City and/or County Officials = 1,980 services

Summarize location of prevention efforts (i.e. geographic locations, institutions and areas of unmet need/underserved)

Funding from the Substance Abuse Prevention and Treatment Block Grant is allocated to all 58 counties using a population-based allocation method. Each county is required by contract to submit a strategic prevention plan (SPP) using SAMHSA's Strategic Prevention Framework (SPF). Each SPP contains a county needs assessment that assess risk and protective factors and community resources and readiness. Through the SPF process, counties also examine community problems and related behaviors.

Section VIII: Summarize the existing recovery support initiatives including a description of their current involvement and capacity for addressing the opioid crisis

Recovery support services are being expanded under California's Drug Medi-Cal Organized Delivery System (DMC-ODS), which is part of California's Medicaid 1115 waiver ("Medi-Cal 2020"). Recovery services are important to the Drug Medi-Cal beneficiary's recovery and wellness. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

a. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse.

b. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

c. The components of Recovery Services are:

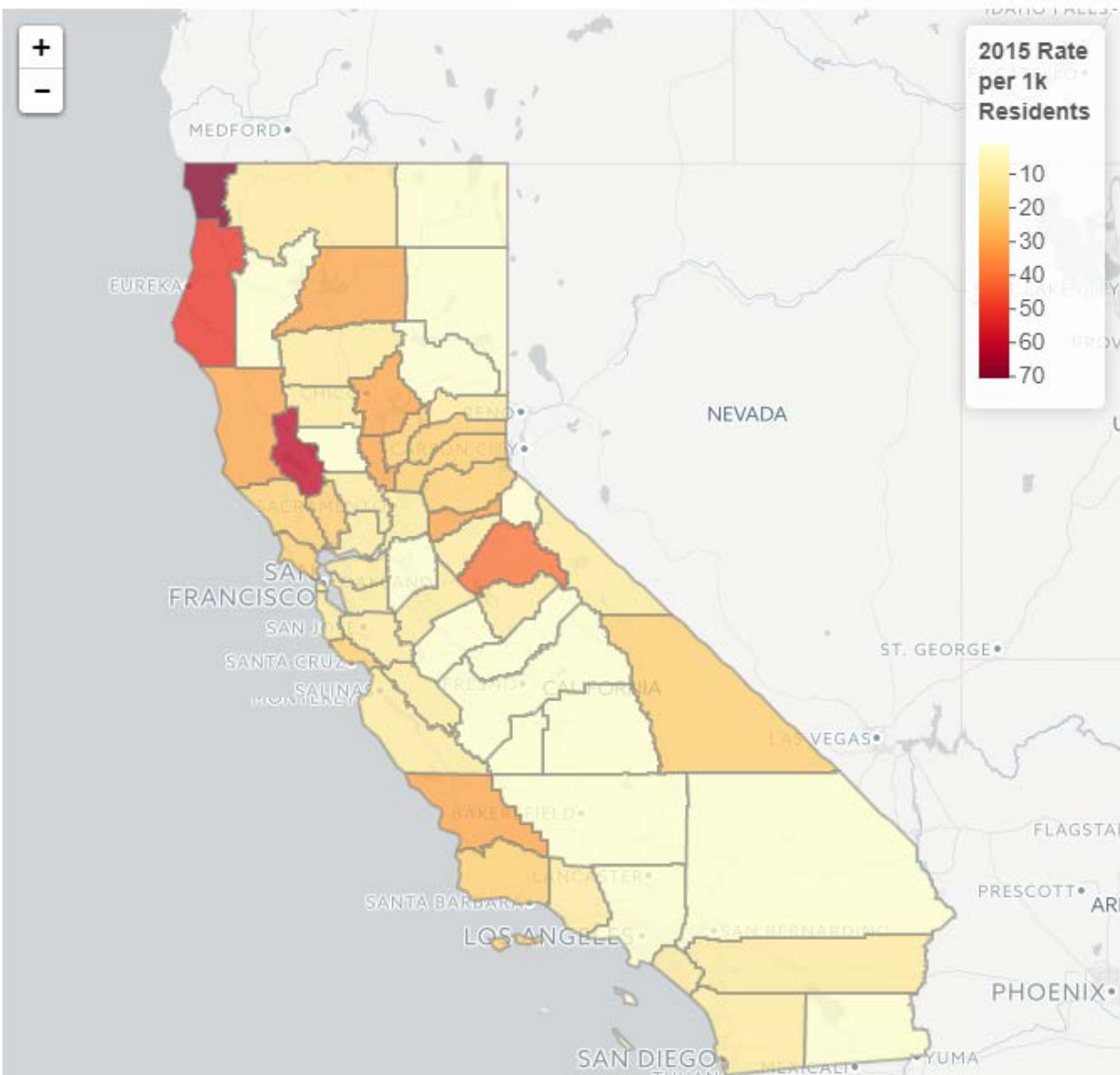
- Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
- Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

- Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
- Support Groups: Linkages to self-help and support, spiritual and faith-based support;
- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

Section IX: Provide a summary of persons served with public and private funds in DATA 2000 Buprenorphine Waiver Provider Practices (including FQHCs) by state and county (from most recent annual data available)

Map 9.1

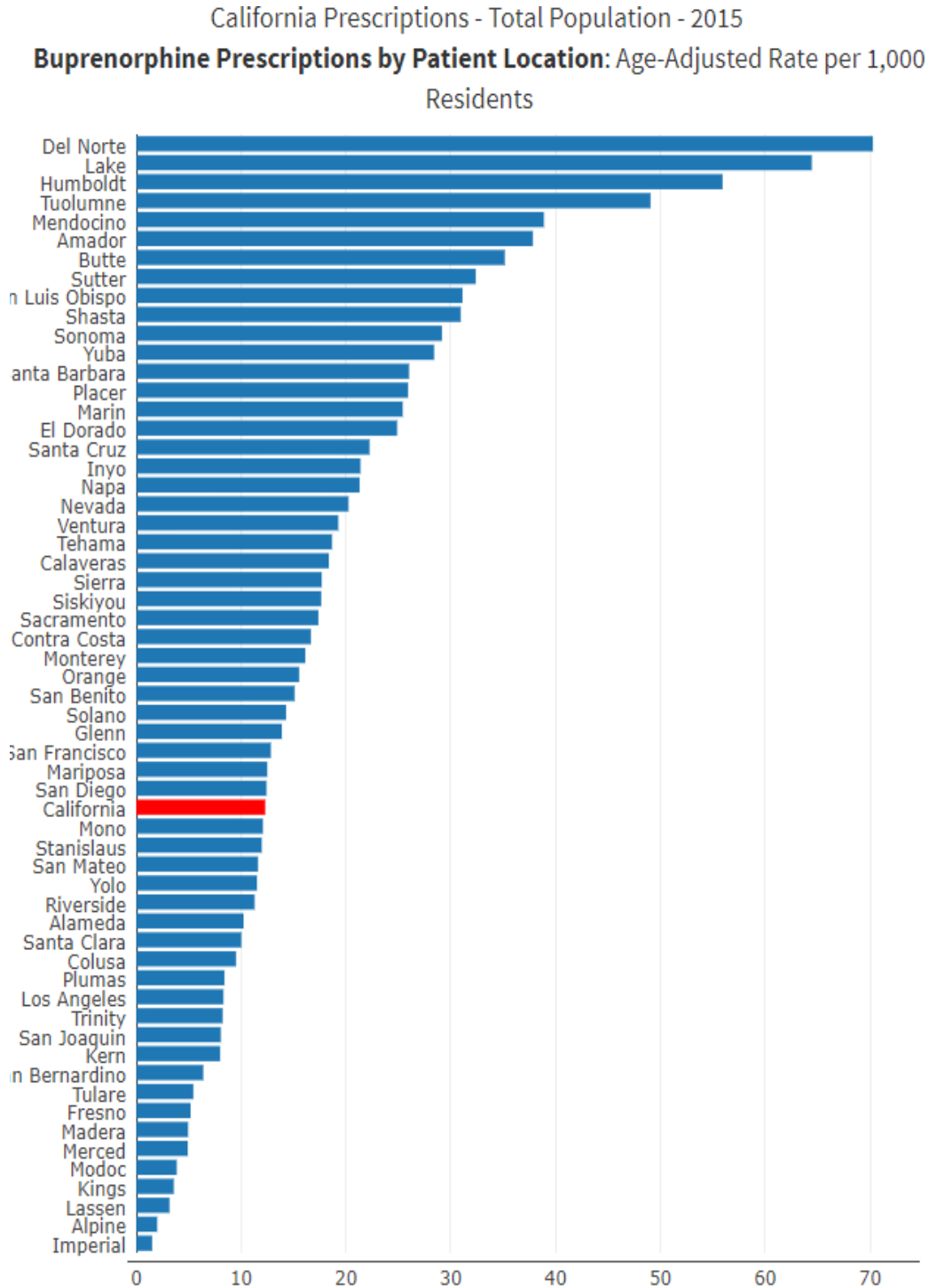
California Prescriptions - Total Population - 2015
Buprenorphine Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents



Data Source: California Opioid Overdose Surveillance Dashboard, California Dept of Public Health

In 2015, the number of Buprenorphine prescriptions per 1,000 residents were the highest in three counties, Del Norte at 70.28, Lake at 54.4 and Humboldt at 54.6. Imperial, Alpine and Lassen had the lowest rate of Buprenorphine prescriptions.

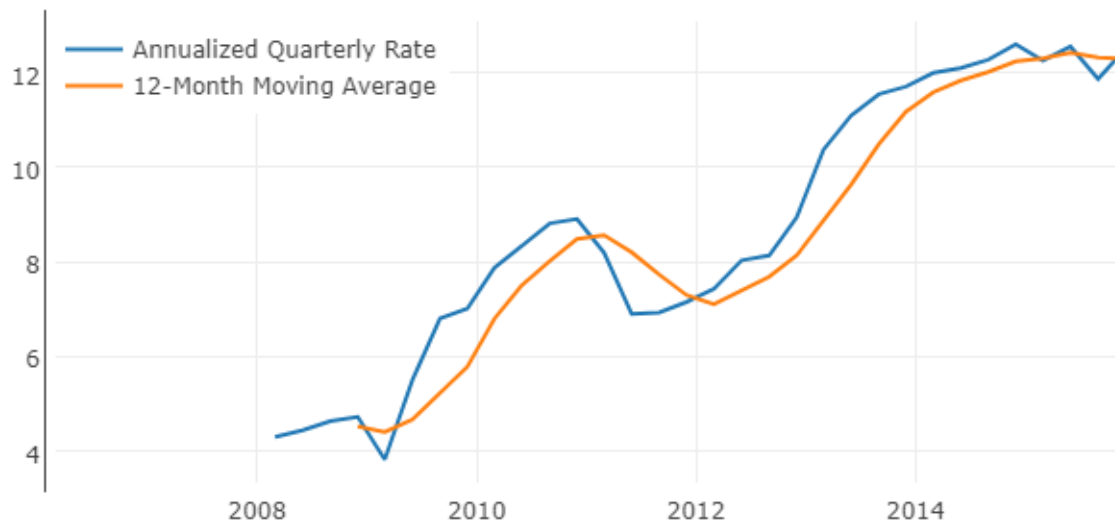
Fig 9.1



Data Source: California Opioid Overdose Surveillance Dashboard, California Dept of Public Health

Fig 9.2

Total Population : **Buprenorphine Prescriptions** : Age-Adjusted Rate per 1k Residents



Data Source: California Opioid Overdose Surveillance Dashboard, California Department of Public Health

As shown in Figure 9.2, In California the number of Buprenorphine prescriptions increased by 191% from 168,552 in 2008 to 490,551 in 2015.

Section X. Estimated current treatment need

Jones, Campopiano, Baldwin, & McCance-Katz (2015)⁷ used NSDUH data to calculate need based on past year opioid abuse or dependence. This study estimated California's rate at 7.5 per 1,000 persons age 12 or over, compared to 8.5 per 1,000 persons for the United States as a whole. The California population for 12+ was not readily available at the time this report was submitted, but based on the population that is 15 and above based on estimates from the California Department of Finance,⁸ this would conservatively translate into at least 240,281 Californians in need of treatment.

⁷ Jones, Campopiano, Baldwin, & McCance-Katz (2015) "National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment," American Journal of Public Health, 105(8):e55-63.

⁸ http://www.dof.ca.gov/Forecasting/Demographics/Projections/documents/P1_Sex_Age_1yr.xlsx

Section XI. Any other existing activities and their funding sources in the state that address opioid use prevention, treatment and recovery activities.

Prescription Opioid Misuse and Overdose Prevention Workgroup⁹

California convened a Prescription Opioid Misuse and Overdose Prevention Workgroup in spring 2014. The goals for the Workgroup are to:

1. Promote safe and effective prescribing and dispensing policies and practices.
2. Guide appropriate patient use, storage and disposal of prescription drugs.
3. Support proper pain management methods.
4. Minimize the unintended consequence of increased heroin use.
5. Promote the expansion of medically assisted treatment opportunities.

Workgroup membership is representative of many agencies and disciplines, bringing diverse perspectives and valued content expertise.

Smart Care California¹⁰

Smart Care California is a public-private partnership working to promote safe, affordable health care in California. The group currently focuses on three issues, one of which is opioid overuse. Collectively, Smart Care California participants purchase or manage care for more than 16 million Californians—or 40 percent of the state. Smart Care California is co-chaired by the state’s leading health care purchasers: DHCS, which administers Medi-Cal; Covered California, the state’s health insurance marketplace; and CalPERS. IHA convenes and coordinates the partnership with funding from the California Health Care Foundation.

Treating Addiction in Primary Care learning collaborative¹¹

The Center for Care Innovations, in partnership with the California Health Care Foundation, created the Treating Addiction in the Primary Care Safety Net (TAPC) program. The TAPC program provides tailored technical assistance on addiction treatment and change management topics to a group of 25 community health center awardees.

Testing Tracking of the Opioid Crisis with Google Trends

In an effort to find creative ways to approach the opioid crisis, UCLA (under contract with DHCS) is examining the use of Google Trends (<https://trends.google.com/trends/>), which reports near-real-time data on Google web searches. This tool has the potential to provide supplementary surveillance on opiate and other drug trends that is more immediate (down

⁹ <https://archive.cdph.ca.gov/Pages/OpioidMisuseWorkgroup.aspx>

¹⁰ <http://www.iha.org/our-work/insights/smart-care-california/focus-area-opioids>

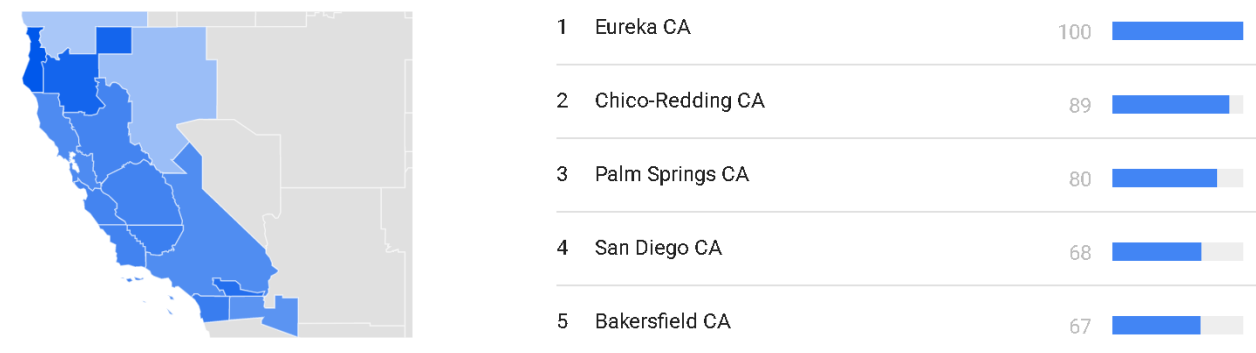
¹¹ <http://www.careinnovations.org/programs-grants/treating-addiction>

to “past hour”) and granular (city level) than other epidemiological tools. Google Trends is not a replacement for other methods (efforts to track influenza with it have been mixed), but it may be useful as a tool in the state’s toolbox.

Examples of Google Trend data are below. Values are calculated on a scale from 0 to 100, where 100 is the location where the search term had the most popularity as a fraction of total searches in. A higher value means a higher proportion of all queries, not a higher absolute query count.

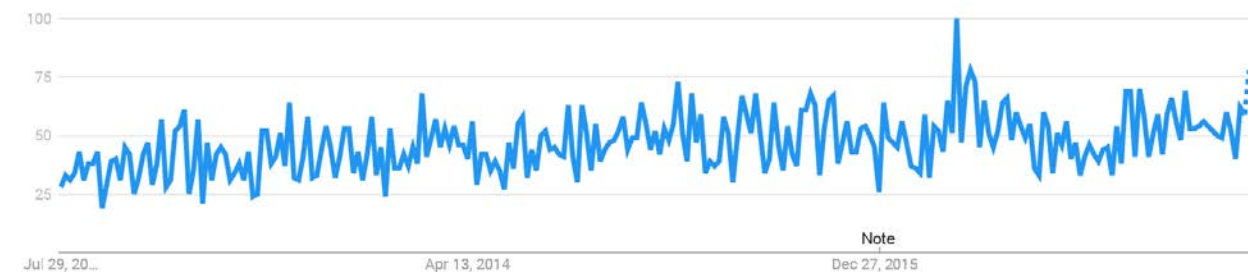
Searches for opiate-related terms tend to be highest in the far northern areas of the state where opiate use is the highest.

Fig 11.1: Google Trends: Searches for “Oxycodone” (July 29, 2016-July 29, 2017)



Trends can also be graphed over time. For example, the following graph suggests a slowly increasing trend of searches for “buprenorphine” from 2012 to 2017. In addition to monitoring searches for different substances, as California’s STR project is implemented UCLA will monitor whether searches increase as a potential signal of increased awareness and availability of buprenorphine.

Fig 11.2: Google Trends: California Searches for Buprenorphine over 5 years (July 29, 2012-July 29, 2017)



Conclusion

The data reviewed for this needs assessment suggests elevated need in Northern California, in rural areas, and in areas without current access to MAT. California's MAT expansion project will seek to address these needs by strategically focusing on populations with limited or no MAT access (including rural areas), American Indian and Native Alaskan (AI/NA) tribal communities, and expanding statewide access to buprenorphine. Many of the data sources used for this needs assessment will also be used in an ongoing evaluation of California's efforts. This report therefore provides a baseline snapshot of California needs that will be built upon as the project proceeds.