California Department of Public Health
Director and State Public Health Officer
Karen Smith, MD, MPH

On March 23, 2015, Karen Smith, MD, MPH, was sworn in as director of the California Department of Public Health and state public health officer. Dr. Smith is a physician specializing in infectious disease and public health. Prior to her appointment, Smith served as public health officer and deputy director at the Napa County Health and Human Services Agency beginning in 2004. She was also on medical staff for infectious disease at Queen of the Valley Medical Center in Napa from 2012 to 2014.

She served as clinical faculty at the Santa Clara County Valley Medical Center Division of Infectious Diseases from 1997 to 2004. Smith served as assistant section chief at the California Department of Health Services Tuberculosis Control Branch from 2000 to 2001 and was a faculty consultant for the Francis J. Curry International Tuberculosis Center at the University of California, San Francisco from 1997. Dr. Smith held several positions at the Stanford University School of Medicine from 1992 to 2004, including resident, fellow and international health course director. Smith also served as TB Controller and Deputy Health Officer for Santa Clara County from 1997 to 2004.

Dr. Smith completed her medical training and infectious diseases fellowship at Stanford University after having obtained a Master of Public Health degree at Johns Hopkins School of Hygiene and Public health. Prior to her medical training, Smith served in the Peace Corp as Public Health Laboratory Director for the Marrakesh Province in Morocco and at the Wichienburi Regional Hospital in Thailand.

Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup

Presented to:

The Medical Board of California

January 27, 2017

Karen L. Smith, MD, MPH

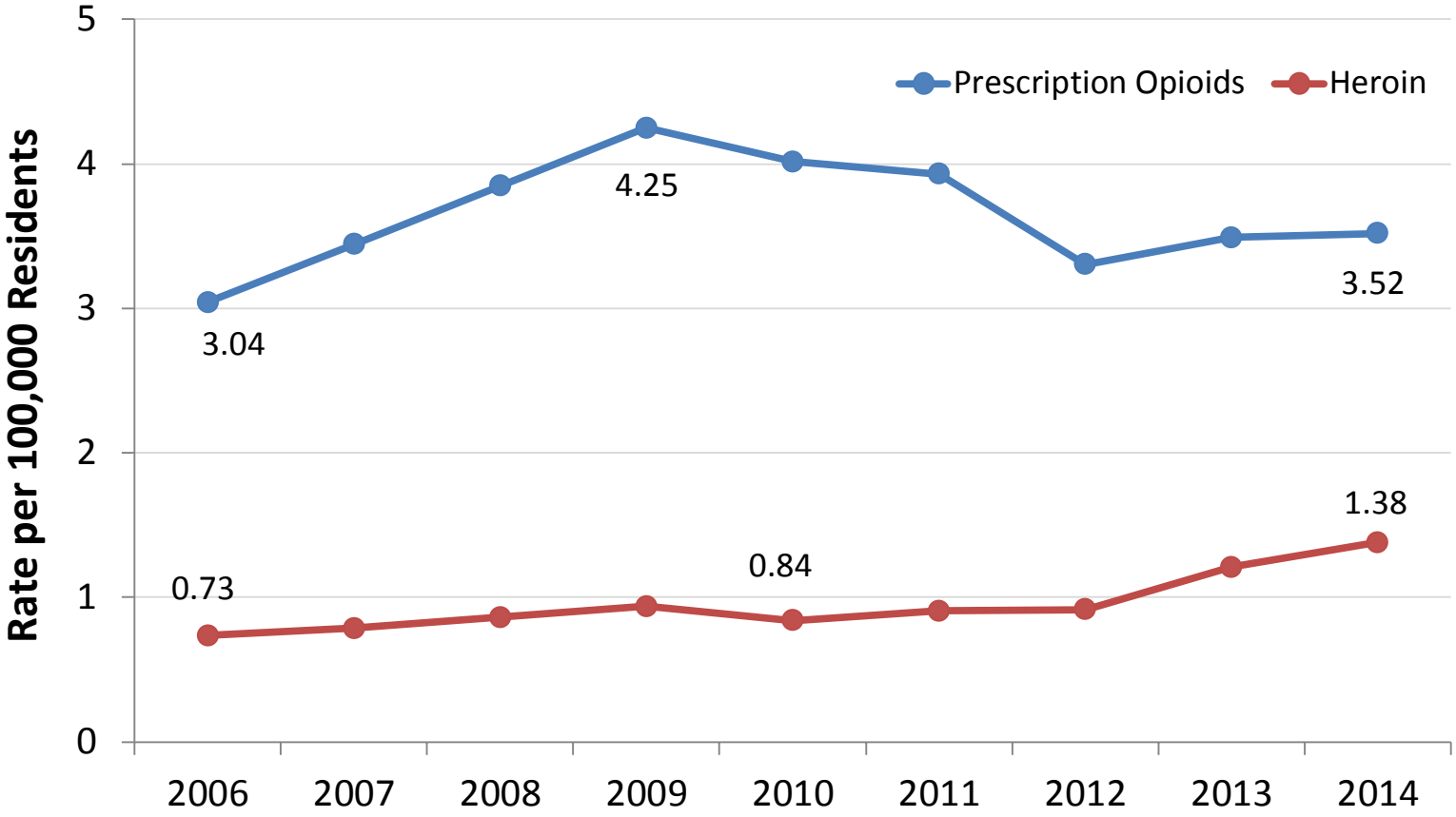
Director & State Public Health Officer

California Department of Public Health

CDPH California Department of PublicHealth

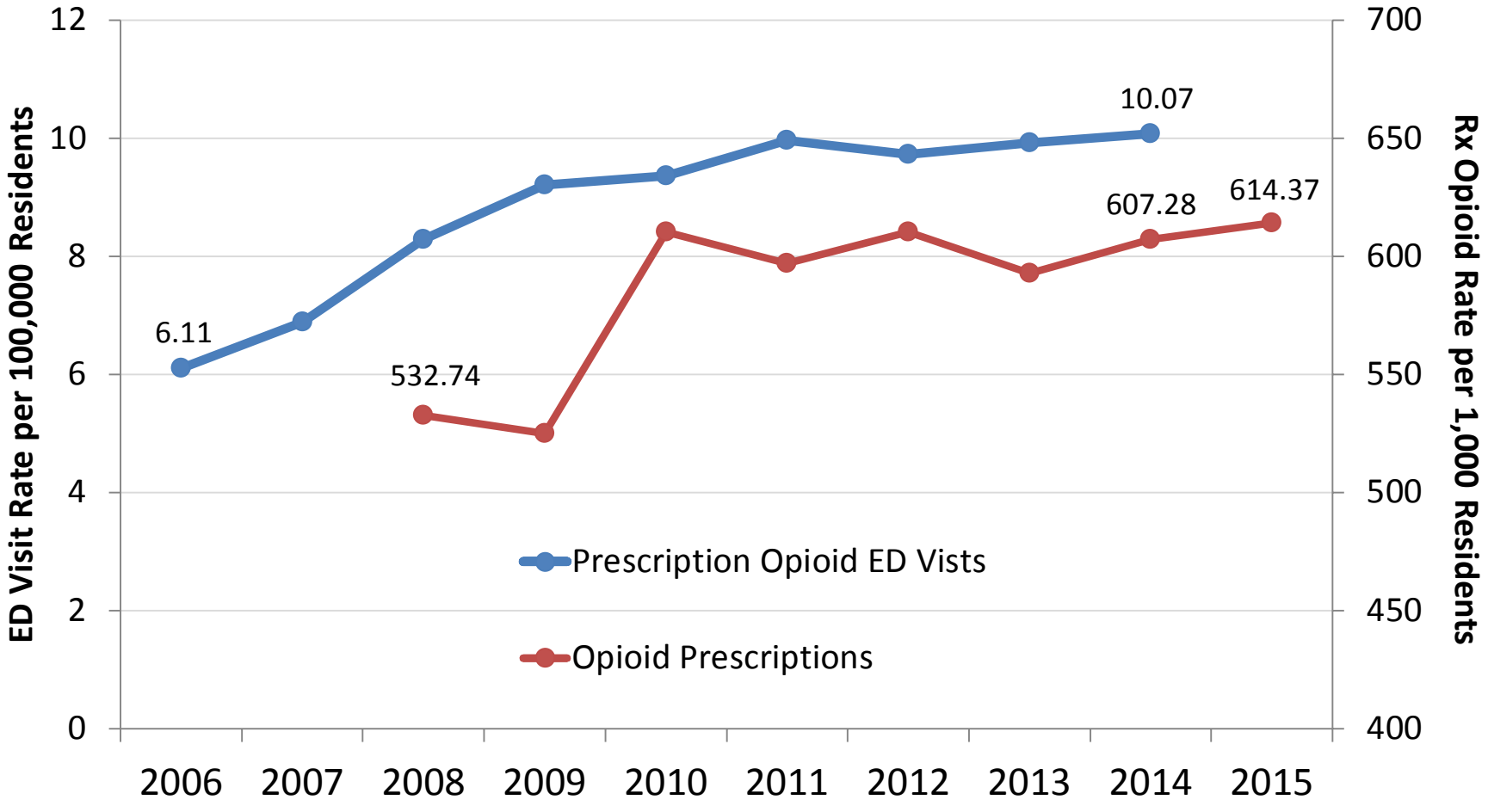
Prescription Opioid and Heroin Overdose Mortality Rates

(per 100k)



Sources: California Department of Public Health, Vital Statistics Death Statistical Master File
Office of Statewide Health Planning & Development, Emergency Dept. Visit File

Opioid Prescriptions and Related Emergency Department Visits



Sources: California Controlled Substance Utilization Review & Evaluation System (CURES)
Office of Statewide Health Planning & Development, Emergency Dept. Visit File

Prescription Opioid Misuse and Overdose Prevention Workgroup: Background

- 2013: CDC declares prescription drug misuse "a nationwide epidemic"
- Spring 2014: CDPH and state partners convene "Prescription Opioid Misuse and Overdose Prevention Workgroup"

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Multi-Sector Collaboration

A State of California **multi-sector collaboration** at state and local level to build a **comprehensive** approach to address the Opioid Epidemic.

- Safe Prescribing
- Access to Treatment
- Naloxone Distribution
- Public Education Campaign
- Data Informed

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Statewide Workgroup

Twenty plus member organizations

Collaborative prevention strategies to decrease opioid misuse, overdose and death

4 task forces, 4 action plans:

1) **Integrated health care and policy**
2) **Communication and outreach**
3) **Treatment**
4) **Data gathering and sharing**

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Current Workgroup Activities

- **Statewide Provider Meeting:** Co-sponsoring educational summits/forums
- **Academic Detailing:** Creating academic detailing curriculum for physicians and pharmacists

Task Force Activities

- **Communications:** Developing a statewide media education campaign for CA patients and consumers
- **Integrated HealthCare and Policy:** Conducting a "Policy" Environmental Scan to identify current laws, regulations, and policies for promoting opioid overdose and addiction prevention
- **Treatment:** Tracking Medicine-Assisted Treatment (MAT) initiatives and naloxone distribution sites
- **Data:** Setting standard data measures in California

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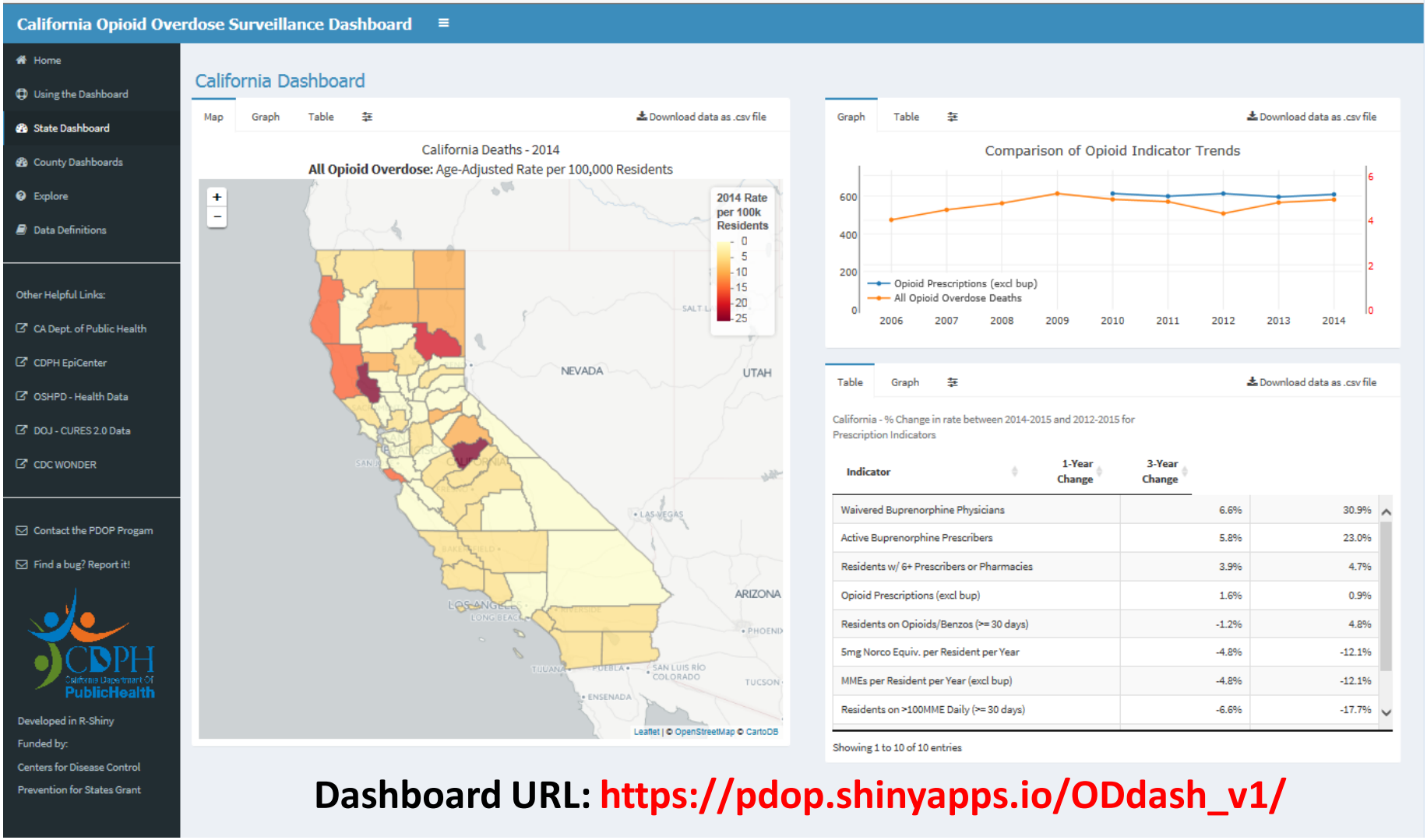
CA Opioid Overdose Surveillance Dashboard

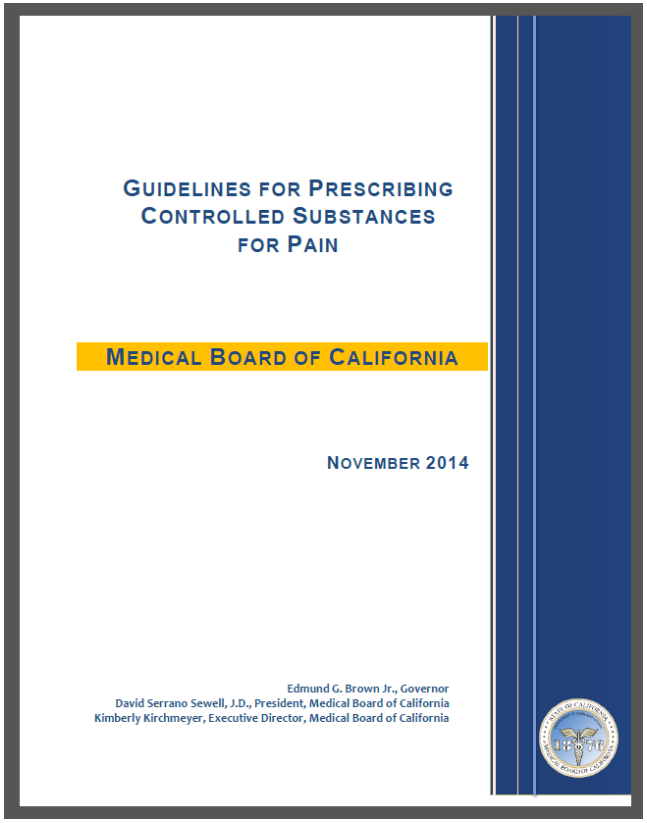


Dashboard URL: https://pdop.shinyapps.io/ODdash_v1/

Medical Board of California Release of Revised Guidelines

- Established a messaging sub-team
- Initiated a collective awareness effort using existing channels and tools from each partner department, including:

  - Joint news release
  - Stakeholder emails
  - Media coverage
  - Workgroup webpage
  - Linked webpages w/ common content



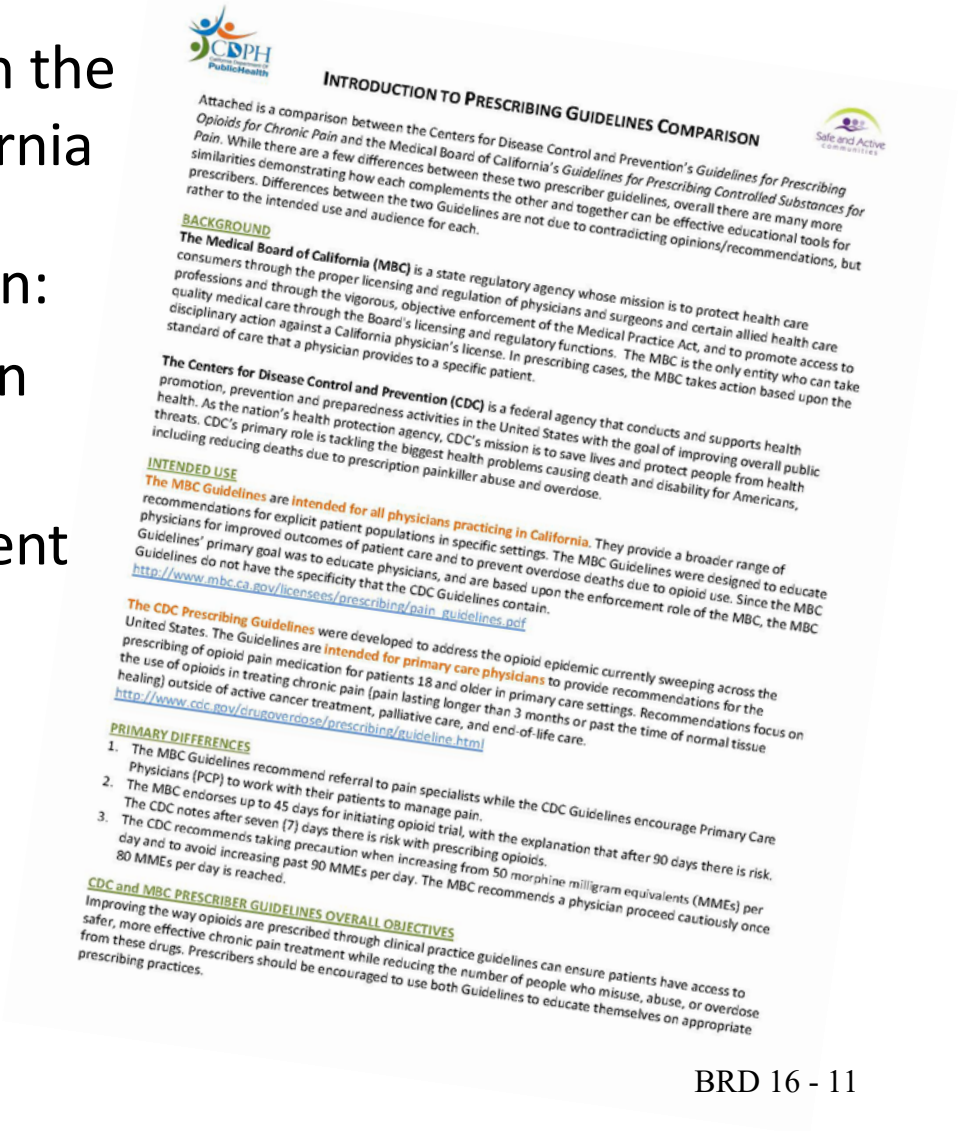
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

Comparison of Prescribing Guidelines

Close collaboration with the Medical Board of California

Summary of Comparison:

- more similarities than differences
- guidelines complement each other
- together effective educational tools for prescriber



INTRODUCTION TO PRESCRIBING GUIDELINES COMPARISON

Attached is a comparison between the Centers for Disease Control and Prevention's *Guidelines for Prescribing Opioids for Chronic Pain* and the Medical Board of California's *Guidelines for Prescribing Controlled Substances for Pain*. While there are a few differences between these two prescriber guidelines, overall there are many more similarities demonstrating how each complements the other and together can be effective educational tools for prescribers. Differences between the two Guidelines are not due to contradicting opinions/recommendations, but rather to the intended use and audience for each.

BACKGROUND

The Medical Board of California (MBC) is a state regulatory agency whose mission is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions. The MBC is the only entity who can take disciplinary action against a California physician's license. In prescribing cases, the MBC takes action based upon the standard of care that a physician provides to a specific patient.

The Centers for Disease Control and Prevention (CDC) is a federal agency that conducts and supports health promotion, prevention and preparedness activities in the United States with the goal of improving overall public health. As the nation's health protection agency, CDC's mission is to save lives and protect people from health threats. CDC's primary role is tackling the biggest health problems causing death and disability for Americans, including reducing deaths due to prescription painkiller abuse and overdose.

INTENDED USE

The MBC Guidelines are intended for all physicians practicing in California. They provide a broader range of recommendations for explicit patient populations in specific settings. The MBC Guidelines were designed to educate physicians for improved outcomes of patient care and to prevent overdose deaths due to opioid use. Since the MBC Guidelines' primary goal was to educate physicians, and are based upon the enforcement role of the MBC, the MBC Guidelines do not have the specificity that the CDC Guidelines contain.
http://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf

The CDC Prescribing Guidelines were developed to address the opioid epidemic currently sweeping across the United States. The Guidelines are **intended for primary care physicians** to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.
http://www.cdc.gov/drugoverdose/prescribing/guideline.html

PRIMARY DIFFERENCES

1. The MBC Guidelines recommend referral to pain specialists while the CDC Guidelines encourage Primary Care Physicians (PCP) to work with their patients to manage pain.
2. The MBC endorses up to 45 days for initiating opioid trial, with the explanation that after 90 days there is risk. The CDC notes after seven (7) days there is risk with prescribing opioids.
3. The CDC recommends taking precaution when increasing from 50 morphine milligram equivalents (MMEs) per day and to avoid increasing past 90 MMEs per day. The MBC recommends a physician proceed cautiously once 80 MMEs per day is reached.

CDC and MBC PRESCRIBER GUIDELINES OVERALL OBJECTIVES

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs. Prescribers should be encouraged to use both Guidelines to educate themselves on appropriate prescribing practices.

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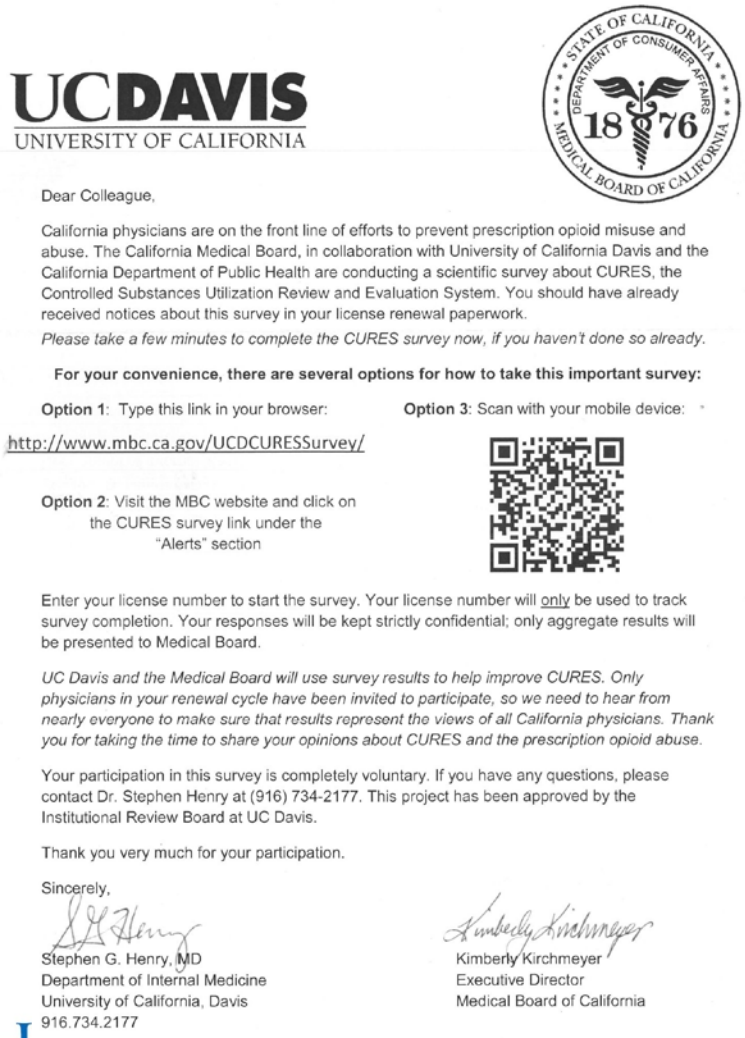
CURES USER/ATTITUDE SURVEY



UCDAVIS
UNIVERSITY OF CALIFORNIA

STATE OF CALIFORNIA · DEPARTMENT OF CONSUMER AFFAIRS · 18 76 · MEDICAL BOARD OF CALIFORNIA

Dear Colleague,

California physicians are on the front line of efforts to prevent prescription opioid misuse and abuse. The California Medical Board, in collaboration with University of California Davis and the California Department of Public Health are conducting a scientific survey about CURES, the Controlled Substances Utilization Review and Evaluation System. You should have already received notices about this survey in your license renewal paperwork.

Please take a few minutes to complete the CURES survey now, if you haven't done so already.

For your convenience, there are several options for how to take this important survey:

Option 1: Type this link in your browser:
http://www.mbc.ca.gov/UCDCURESSurvey/

Option 2: Visit the MBC website and click on the CURES survey link under the "Alerts" section

Option 3: Scan with your mobile device:

Enter your license number to start the survey. Your license number will only be used to track survey completion. Your responses will be kept strictly confidential; only aggregate results will be presented to Medical Board.

UC Davis and the Medical Board will use survey results to help improve CURES. Only physicians in your renewal cycle have been invited to participate, so we need to hear from nearly everyone to make sure that results represent the views of all California physicians. Thank you for taking the time to share your opinions about CURES and the prescription opioid abuse.

Your participation in this survey is completely voluntary. If you have any questions, please contact Dr. Stephen Henry at (916) 734-2177. This project has been approved by the Institutional Review Board at UC Davis.

Thank you very much for your participation.

Sincerely,

Stephen G. Henry, MD
Department of Internal Medicine
University of California, Davis
916.734.2177

Kimberly Kirchmeyer
Executive Director
Medical Board of California

Collaborated with our Initiative evaluation team (CDPH and UCDMC) to distribute our CURES user and attitude survey to physicians.

CDPH California Department of PublicHealth

ON-GOING WORKGROUP PARTICIPATION

The Medical Board of California staff continues to partner with the Workgroup

- Founding member in 2014
- Active Agenda Setting Team member
- Participate in multiple taskforces

CDPH California Department of PublicHealth

Questions?

Thank you!

California Department of Public Health

Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup

Workgroup web address is:
http://www.cdph.ca.gov/Pages/OpioidMisuseWorkgroup.aspx

CDPH California Department of PublicHealth

The Office Health Equity

"Health equity" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Source: California Health and Safety Code Section 131019.5

OFFICE OF HEALTH EQUITY MISSION

Promote equitable social, economic and environmental conditions to achieve optimal health, mental health and well-being for all.

Office of Health Equity's Purpose

California Health and Safety Code Section 131019.5

Established to align state resources, decision making, and programs to accomplish the following:

- Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice…
- Work collaboratively with the Health in All Policies (HiAP) Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health
- Advise and assist other state departments in their mission to increase access to and quality of …health and mental health services
- Improve health status of all populations…priority on eliminating health and mental health disparities and inequities.

CDPH California Department of PublicHealth

OHE Key Duties

- Conduct policy analysis & develop strategic policies and plans…..to increase positive health & mental health outcomes…focus on vulnerable communities
- Establish comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities.
- Build upon and inform the work of the HiAP Task Force.
- Assist and consult with state and local governments, health and mental health providers, community-based organizations and advocates, and various stakeholder communities to advance health equity.

OFFICE OF HEALTH EQUITY STRUCTURE

COMMUNITY DEVELOPMENT AND ENGAGEMENT UNIT (CDEU)

&

POLICY UNIT

&

HEALTH RESEARCH AND STATISTICS UNIT (HRSU)

Community Development
&
Engagement Unit

CDEU Mission

Strengthen CDPH's focus and ability to advise and assist other state departments in their mission to increase access to, and quality of, culturally and linguistically competent mental health care and services.

CDEU responsibilities

- California Reducing Disparities Project (CRDP)
- Mental Health Services Act (MHSA) Translation
- Cultural Competency Consultants
- Cultural Competence Plans
- Technical Assistance
- Outreach/Education

POLICY UNIT

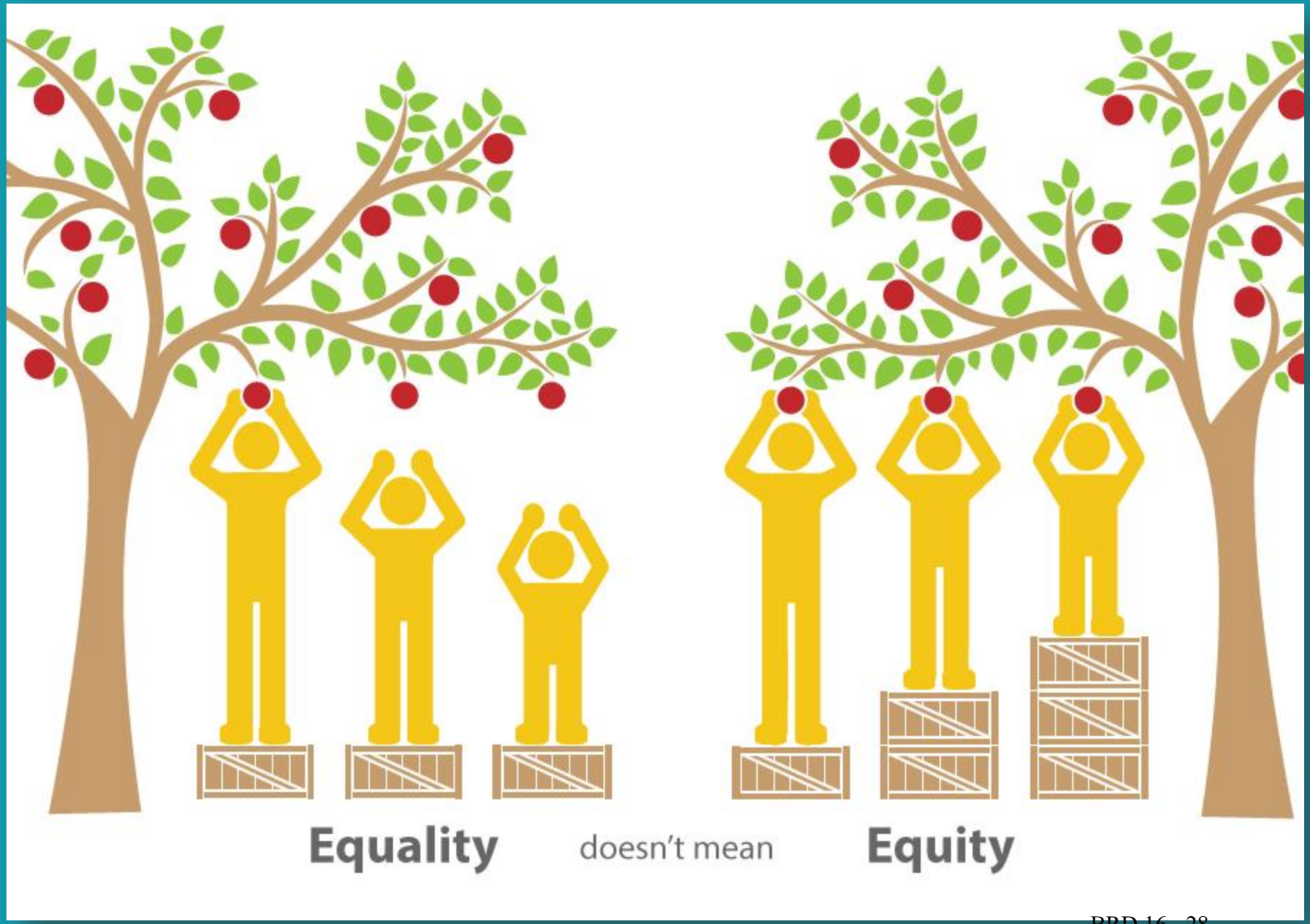
Policy Unit Sections

- Climate Change and Public Health
- California Health in All Policies Task Force
- Healthy Communities Data and Indicator Project

Health Research and Statistics Unit

HRSU supports research that seeks to:

- reduce health, health care, and mental health disparities and achieve equity among "Vulnerable communities" in California.
- understand a broadened array of social, economic, and environmental determinants of disparities/inequalities in health, health care, and mental health.


Equality
doesn't mean
Equity

CALIFORNIA HEALTH AND SAFETY CODE SECTION 131019.5

(a) For purposes of this section, the following definitions shall apply:

(1) “Determinants of equity” means social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

(2) “Health equity” means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

(3) “Health and mental health disparities” means differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

(4) “Health and mental health inequities” means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

(5) “Vulnerable communities” include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations.

(6) “Vulnerable places” means places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

(b) The State Department of Public Health shall establish an Office of Health Equity for the purposes of aligning state resources, decisionmaking, and programs to accomplish all of the following:

(1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.

(2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.

(3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.

(4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

(c) The duties of the Office of Health Equity shall include all of the following:

(1) Conducting policy analysis and developing strategic policies and plans regarding specific issues affecting vulnerable communities and vulnerable places to increase positive health and mental health outcomes for vulnerable communities and decrease health and mental health disparities and inequities. The policies and plans shall also include strategies to address social and environmental inequities and improve health and mental health. The office shall assist other departments in their missions to increase access to services and supports and improve quality of care for vulnerable communities.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan shall be developed in collaboration with the Health in All Policies Task Force. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. This plan shall be included in the report required under paragraph (1) of subdivision (d). The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Building upon and informing the work of the Health in All Policies Task Force in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development to ensure the implementation of goals and objectives that close the gap in health status. The Office of Health Equity shall work collaboratively with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health impacts in all of the following ways, within the resources made available:

(A) Develop intervention programs with targeted approaches to address health and mental health inequities and disparities.

(B) Prioritize building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

(C) Work with the advisory committee established pursuant to subdivision (f) and through stakeholder meetings to provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, interrelated, and multisectoral strategies.

(D) Provide technical assistance to state and local agencies and departments with regard to building organizational capacity, staff training, and facilitating communication to facilitate strategies to reduce health and mental health disparities.

(E) Highlight and share evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities.

(F) Work with local public health departments, county mental health or behavioral health departments, local social services, and mental health agencies, and other local agencies that address key health determinants, including, but not limited to, housing, transportation, planning, education, parks, and economic development. The Office of Health Equity shall seek to link local efforts with statewide efforts.

(4) Consult with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assist in coordinating projects funded by the state that pertain to increasing the health and mental health status of vulnerable communities.

(6) Provide consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze, and report disparities and to identify strategies to address health and mental health disparities.

(7) Provide information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to vulnerable communities and that address community environments to promote health. This information shall identify unnecessary duplication of services.

(8) Communicate and disseminate information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in vulnerable communities and to share strategies that address the social and environmental determinants of health.

(9) Provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the health and mental health status of vulnerable communities.

(10) Seek additional resources, including in-kind assistance, federal funding, and foundation support.

(d) In identifying and developing recommendations for strategic plans, the Office of Health Equity shall, at a minimum, do all of the following:

(1) Conduct demographic analyses on health and mental health disparities and inequities. The report shall include, to the extent feasible, an analysis of the underlying conditions that contribute to health and well-being. The first report shall be due July 1, 2014. This information shall be updated periodically, but not less than every two years, and made available through public dissemination, including posting on the department's Internet Web site. The report shall be developed using primary and secondary sources of demographic information available to the office, including the work and data collected by the Health in All Policies Task Force. Primary sources of demographic information shall be collected contingent on the receipt of state, federal, or private funds for this purpose.

(2) Based on the availability of data, including valid data made available from secondary sources, the report described in paragraph (1) shall address the following key factors as they relate to health and mental health disparities and inequities:

(A) Income security such as living wage, earned income tax credit, and paid leave.

(B) Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.

(C) Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.

(D) Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.

(E) Environmental quality, including exposure to toxins in the air, water, and soil.

(F) Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting.

(G) Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.

(H) Prevention efforts, including community-based education and availability of preventive services.

(I) Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.

(J) Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.

(K) The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.

(L) Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.

(M) Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.

(N) Accessible, affordable, and appropriate mental health services.

(3) Consult regularly with representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQQ communities, women's health advocates, mental health advocates, health and mental health providers, community-based organizations and advocates, academic institutions, local public health departments, local government entities, and low-income and vulnerable consumers.

(4) Consult regularly with the advisory committee established by subdivision (f) for input and updates on the policy recommendations, strategic plans, and status of cross-sectoral work.

(e) The Office of Health Equity shall be organized as follows:

(1) A Deputy Director shall be appointed by the Governor or the State Public Health Officer, and is subject to confirmation by the Senate. The salary for the Deputy Director shall be fixed in accordance with state law.

(2) The Deputy Director of the Office of Health Equity shall report to the State Public Health Officer and shall work closely with the Director of Health Care Services to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

(f) The Office of Health Equity shall establish an advisory committee to advance the goals of the office and to actively participate in decisionmaking. The advisory committee shall be composed of representatives from applicable state agencies and departments, local health departments, community-based organizations working to advance health and mental health equity, vulnerable communities, and stakeholder communities that represent the diverse demographics of the state. The chair of the advisory committee shall be a representative from a nonstate entity. The advisory committee shall be established by no later than October 1, 2013, and shall meet, at a minimum, on a quarterly basis. Subcommittees of this advisory committee may be formed as determined by the chair.

(g) An interagency agreement shall be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the Office of Health Equity, including responsibilities, scope of work, and necessary resources.