

# Utah Health Status Update: Prescription Opioid Deaths

September 2014

Drug poisoning deaths,<sup>1</sup> which account for 89% of all poisoning fatalities, remain a significant public health problem. A leading cause of injury deaths in Utah, they outpace those due to firearms, falls, and motor vehicle crashes (Figure 1).<sup>2</sup> Utah ranks 5th in the nation for drug poisoning deaths (22 per 100,000 population)<sup>3</sup> (Figure 1), which is one of the indicators used to measure the Utah Department of Health's strategic plan goal of becoming the healthiest people in the nation (Figure 2).

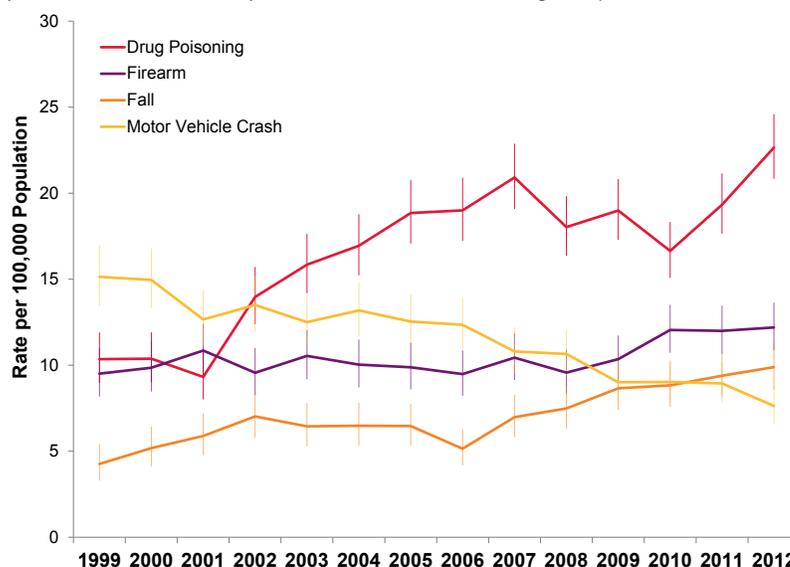
Every month, 49 Utahns die as a result of a drug poisoning, 82% of which are accidental or of undetermined intent, and of these, 75% involve opioids. The majority of deaths (74%) involving opioids had at least one prescription pain medication (non-illicit opioid) as an underlying cause of death; these include medications such as oxycodone, methadone, or hydrocodone.<sup>4</sup> There were a total of 268 deaths with a prescription opioid as an underlying cause in 2012, accounting for 46% of all drug poisoning fatalities (Figure 2).<sup>4</sup>

The overall age-adjusted prescription opioid death rate in 2012 was 10 per 100,000 population. There were no significant differences found between males and females (11 and 10 per 100,000 population respectively), and

Hispanic persons had a significantly lower prescription opioid death rate compared to non-Hispanic persons (4.5 and 10.1). Utahns ages 18 to 24 and 65 and older had significantly lower prescription opioid death rates compared to Utahns ages 25 to 64. Persons between the ages 45 and 54 had the highest prescription opioid death rate at 25 per 100,000 population (Figure 3).<sup>4,5</sup>

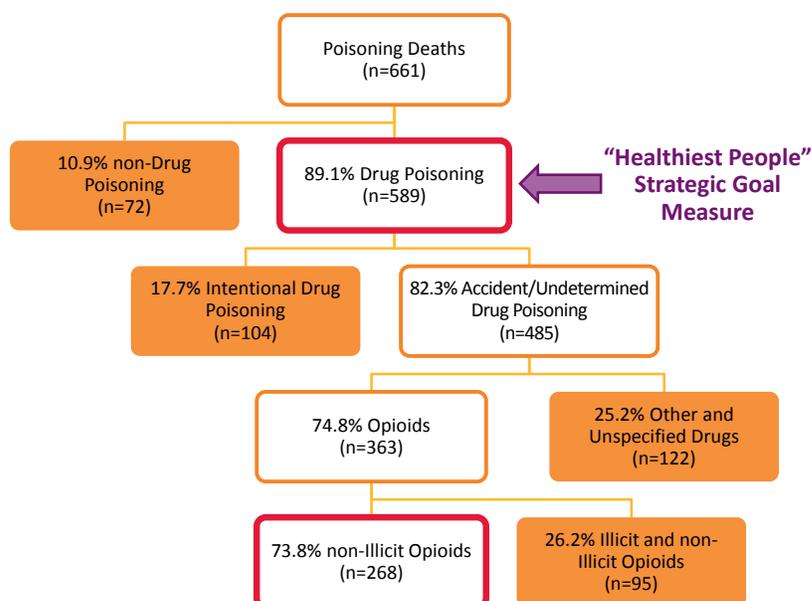
## Leading Causes of Injury Death

Figure 1. Rate of leading causes of injury death per 100,000 population by cause of death and year, Utah, 1999–2012 (age-adjusted)<sup>1</sup>



## How a Case is Determined to Be a Non-Illicit Opioid

Figure 2. Flow chart of non-illicit opioid case ascertainment, Utah, 2012<sup>4</sup>



- Every month, 49 Utahns die as a result of a drug poisoning, 82% of which are accidental or of undetermined intent, and of these, 75% involve opioids.
- There were a total of 268 deaths with a prescription opioid as an underlying cause in 2012, accounting for 46% of all drug poisoning deaths.
- Persons between the ages 45 and 54 had the highest prescription opioid death rate at 25 per 100,000 population (Figure 3).<sup>4,5</sup>
- In 2012, 820 Utahns were hospitalized as a result of prescription opioid misuse and abuse. Total hospitalization charges exceeded \$15 million.<sup>1</sup>

The availability of prescription opioids has dramatically increased over the last decade. Utah oxycodone prescriptions jumped 87% from 2004 to 2013.<sup>6</sup> National survey data indicate that 1 in 23 Utahns aged 12 or older reported having used prescription opioids non-medically in the past year; however, significant declines were reported among 18- to 25-year-old Utahns.<sup>7</sup> The prescription opioids most commonly used include methadone, fentanyl, oxycodone, and hydrocodone.<sup>6,8</sup> Deaths per 100,000 from methadone and hydrocodone prescriptions decreased by 16% and 29%, respectively, from 2009 to 2012, while deaths per 100,000 for fentanyl and oxycodone prescriptions increased by 21% and 9%, respectively.<sup>6,8</sup>

In 2012, 820 Utahns were hospitalized as a result of prescription opioid misuse and abuse. Total hospitalization charges exceeded \$15 million.<sup>1</sup> Motivations to misuse and abuse prescription opioids include anxiety, pain, sleep problems, and for euphoric effects. The top Utah circumstances observed in prescription opioid deaths include problems with substance abuse, physical health, and mental health.<sup>8</sup> More information regarding the safe use, storage, and disposal of prescription opioids can be found on the Use Only as Directed website ([www.useonlyasdirected.org](http://www.useonlyasdirected.org)).

Prescription opioid deaths are preventable through targeted interventions and stakeholder coordination. Promising approaches include:

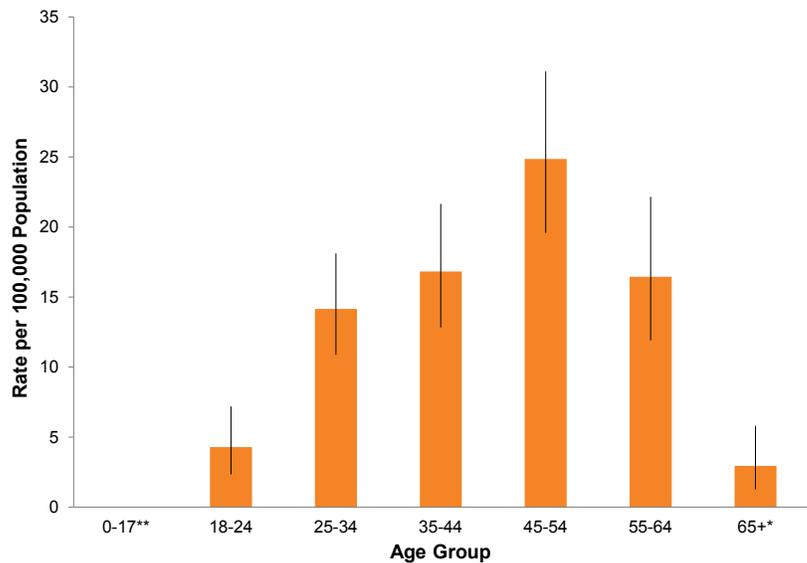
- conducting surveillance to monitor trends and identify risk factors;
- enhancing coordination of and developing targeted patient, public, and provider education programs;
- leveraging health information technology to improve clinical care and coordination; and
- preventing opioid overdose deaths with naloxone.

The Utah Pharmaceutical Drug Community Project Advisory Committee, a multi-agency coalition, recently developed a Utah-specific strategic plan encompassing these initiatives. These efforts hold great potential for the prevention of prescription opioid misuse, abuse, and deaths in Utah.

Utah is one of five states in the country to receive more than \$1 million from the Centers

## Prescription Opioid Overdose Deaths by Age Group

Figure 3. Rate of prescription opioid overdose deaths per 100,000 by age group, Utah, 2012<sup>4,5</sup>



\*Insufficient number of cases to meet UDOH standards for data reliability, interpret with caution.  
 \*\*The rate has been suppressed because the observed number of events is <5 or the estimate is unreliable.

for Disease Control and Prevention over the next three years to help prevent prescription drug overdoses and address the patient and prescribing behaviors that drive them.

### References

1. Drug poisoning deaths are defined by ICD-10 codes X40–X44, X60–X64, X85, Y10–Y14.
2. Utah Death Certificate Database. Retrieved Aug 2012 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website: <http://ibis.health.utah.gov/>.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2011). Available from URL: [www.cdc.gov/injury/wisqars](http://www.cdc.gov/injury/wisqars).
4. Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health, 2012.
5. National Center for Health Statistics (NCHS) through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2012.
6. Division of Occupational and Professional Licensing, Controlled Substance Database.
7. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011.
8. Utah Department of Health Violence and Injury Prevention Program, Utah Violent Death Reporting System 2012.

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## Breaking News, September 2014

### New Law Prohibits Use of Cell Phone While Driving

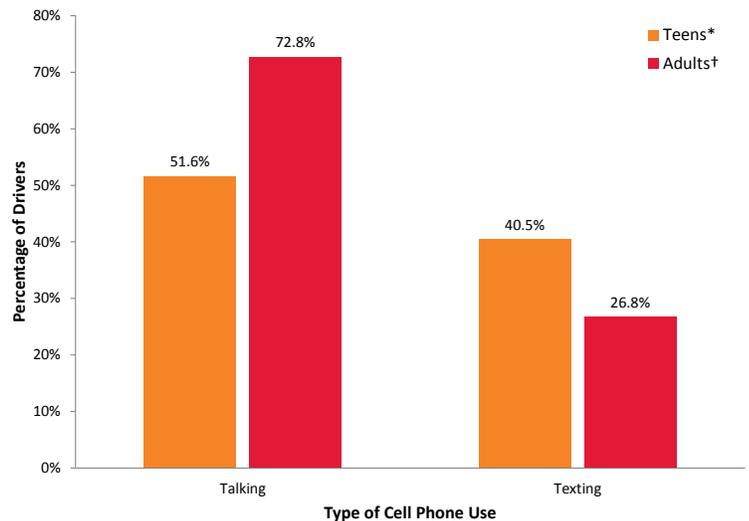
A new law, effective May 13, 2014, makes it illegal to do the following actions using a handheld phone, laptop, or other electronic device while driving<sup>1</sup>:

- Sending an instant message
- Emailing
- Dialing a phone number
- Accessing the Internet
- Viewing or recording a video or picture
- Texting (effective July 1, 2009)

Those caught breaking the law can receive a fine of up to \$100. The law does allow for drivers to talk on their phones while driving only when done through Bluetooth® or voice command (like Siri®). However, numerous studies have shown that drivers who talk on handheld or hands-free phones are just as impaired as drunk drivers<sup>2-4</sup>. While 65% of Utahns support laws banning the use of a cell phone while driving, data show nearly 60% of these same drivers admit to talking on their phones.

Another 27% of Utah adults reported they have sent a text message while driving during the past week. Adults were significantly more likely to talk on a cell phone while driving than teens (see figure). Despite the law allowing for use of hands-free devices, the best practice is to stop and pull over to make a call.

**Percentage of Utah Drivers Who Used a Cell Phone While Driving, Teens and Adults**



\*Cell phone use while driving occurring in the past 30 days; Youth Risk Behavior Survey, 2013.

†Cell phone use while driving occurring in the past week; Behavioral Risk Factor Surveillance System, 2012.

1. S.B. 253 Distracted Driver Amendments. Available at URL: <http://le.utah.gov/~2014/bills/static/SB0253.html>.

2. Strayer, DL, et al. A comparison of the cell phone driver and the drunk driver. *Human Factors*, 2006: 48; 381-391.

3. Just, MA, et al. Decrease in brain activation associated with driving when listening to someone speak. *Brain Research*, 2008: 1205; 70-80.

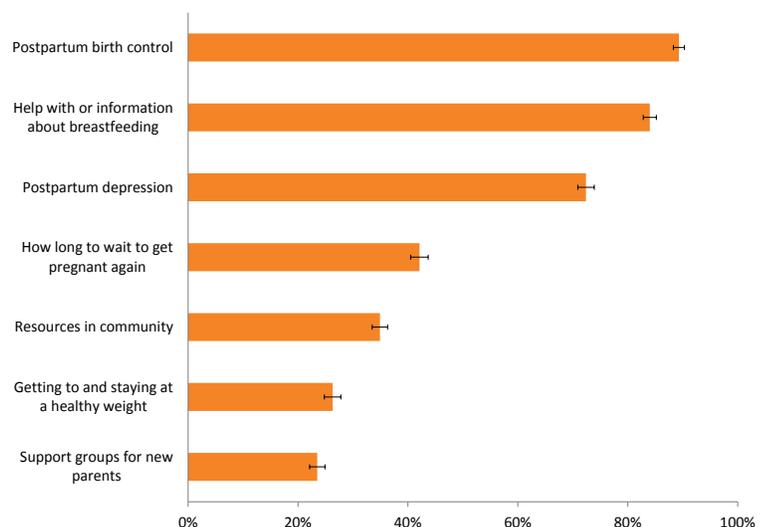
4. Strayer, DL, Drews FA. Profiles in Driver Distraction: Effects of Cell Phone Conversations on Younger and Older Drivers. *Human Factors*, 2004: 46(4); 640-649.

## Community Health Indicators Spotlight, September 2014

### Postpartum Counseling

The postpartum period is not only a time for supporting a new mother; it is also an opportune time to begin counseling for her next pregnancy. The Association of Reproductive Health Professionals recommends that all postpartum women have a physical exam that includes: discussions about nutrition and exercise; status of breastfeeding; weight loss; postpartum mental health; resources and support; and sexuality and contraception<sup>1</sup>. To assess the impact of counseling Utah women are receiving after delivery of their newborns, the Utah Pregnancy Risk Assessment Monitoring System (PRAMS) asks new mothers if any health care worker talked with them about various topics. The figure to the right illustrates how many women reported having these discussions in the 2–4 months post-delivery. The data show that while women have high rates of counseling about postpartum birth control, that discussion doesn't always include advice on how long a woman should wait before conceiving again. The data also show that women are least likely to be counseled about support groups for new parents, healthy postpartum weight, and community resources.

**Postpartum Counseling by a Health Care Worker, Utah PRAMS, 2009–2011**



1. Association of Reproductive Health Professionals. A Quick Reference Guide for Clinicians: Postpartum Counseling. Accessed August 25, 2014, <http://www.arhp.org/publications-and-resources/quick-reference-guide-for-clinicians/postpartum-counseling>.

# Monthly Health Indicators Report

(Data Through July 2014)

Monthly Report of Notifiable Diseases, July 2014	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	48	58	323	262	1.2
Shiga toxin-producing Escherichia coli (E. coli)	14	22	42	54	0.8
Hepatitis A (infectious hepatitis)	0	1	5	5	1.0
Hepatitis B, acute infections (serum hepatitis)	0	1	3	6	0.5
Meningococcal Disease	0	0	1	4	0.3
Pertussis (Whooping Cough)	36	79	584	459	1.3
Salmonellosis (Salmonella)	25	38	217	189	1.1
Shigellosis (Shigella)	2	3	16	19	0.8
Varicella (Chickenpox)	3	5	130	234	0.6
West Nile (Human cases)	0	1	0	1	0.0

Quarterly Report of Notifiable Diseases, 2nd Qtr 2014	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV/AIDS†	23	28	50	56	0.9
Chlamydia	2,000	1,684	4,114	3,466	1.2
Gonorrhea	318	102	633	196	3.2
Syphilis	13	13	21	22	0.9
Tuberculosis	9	10	14	19	0.8

Medicaid Expenditures (in Millions) for the Month of July 2014	Current Month	Expected/Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ (7.3)	\$ 1.3	\$ 144.8	\$ 147.5	\$ (2.8)
Inpatient Hospital	\$ 28.7	\$ (5.1)	\$ 143.8	\$ 142.9	\$ 0.9
Outpatient Hospital	\$ 2.9	\$ (12.3)	\$ 59.9	\$ 59.9	\$ 0.0
Long Term Care	\$ 9.6	\$ (6.8)	\$ 180.2	\$ 176.6	\$ 3.6
Pharmacy	\$ (4.5)	\$ (34.4)	\$ 107.4	\$ 111.0	\$ (3.6)
Physician/Osteo Services	\$ 5.7	\$ (23.0)	\$ 62.6	\$ 59.8	\$ 2.8
TOTAL HCF MEDICAID	\$ 31.3	\$ 27.3	\$ 2,263.8	\$ 2,262.5	\$ 1.3

Program Enrollment for the Month of July 2014	Current Month	Previous Month	% Change‡ From Previous Month	1 Year Ago	% Change‡ From 1 Year Ago
Medicaid	276,382	276,879	-0.2%	259,684	+6.4%
PCN (Primary Care Network)	14,091	12,229	+15.2%	16,117	-12.6%
CHIP (Children's Health Ins. Plan)§	15,473	15,563	-0.6%	34,823	-55.6%

Health Care System Measures	Annual Visits			Annual Charges	
	Number of Events	Rate per 100 Population	% Change‡ From Previous Year	Total Charges in Millions	% Change‡ From Previous Year
Overall Hospitalizations (2012)	281,605	9.2%	-1.2%	\$ 6,146.4	+5.6%
Non-maternity Hospitalizations (2012)	177,753	5.7%	-0.3%	\$ 5,208.7	+6.1%
Emergency Department Encounters (2012)	679,926	22.6%	+0.6%	\$ 1,447.3	+10.5%
Outpatient Surgery (2011)	376,054	12.7%	+2.5%	\$ 1,878.5	+6.5%

Annual Community Health Measures	Current Data Year	Number Affected	Percent/ Rate	% Change‡ From Previous Year	State Rank¶ (1 is best)
Obesity (Adults 18+)	2012	476,400	24.3%	-0.5%	10 (2012)
Cigarette Smoking (Adults 18+)	2012	207,300	10.6%	-10.8%	1 (2012)
Influenza Immunization (Adults 65+)	2012	147,100	56.0%	-1.5%	40 (2012)
Health Insurance Coverage (Uninsured)	2012	376,600	13.2%	-1.5%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2012	205	7.2 / 100,000	-16.8%	19 (2010)
Poisoning Deaths	2012	661	23.1 / 100,000	+15.6%	45 (2010)
Suicide Deaths	2012	545	19.1 / 100,000	+9.3%	45 (2010)
Diabetes Prevalence (Adults 18+)	2012	141,100	7.2%	+7.5%	14 (2012)
Poor Mental Health (Adults 18+)	2012	307,800	15.7%	-3.7%	12 (2012)
Coronary Heart Disease Deaths	2012	1,580	55.3 / 100,000	-3.4%	3 (2010)
All Cancer Deaths	2012	2,861	100.2 / 100,000	+3.3%	1 (2010)
Stroke Deaths	2012	793	27.8 / 100,000	+0.6%	17 (2010)
Births to Adolescents (Ages 15-17)	2012	668	10.4 / 1,000	-6.6%	11 (2011)
Early Prenatal Care	2012	38,829	75.5%	+1.0%	n/a
Infant Mortality	2012	248	4.8 / 1,000	-12.6%	10 (2010)
Childhood Immunization (4:3:1:3:3:1)	2012	40,000	74.9%	+5.3%	15 (2012)

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ % Change could be due to random variation.

§ The 55.6% reduction in CHIP enrollment from 15,473 in the current month to 34,823 in CHIP monthly enrollment a year ago is due to the "ACA federal mandate ruling" allowing a large percentage of CHIP kids to qualify and transfer to the Medicaid program for expanded medical services.

¶ State rank based on age-adjusted rates.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance has ended for influenza until the 2014-2015 season.