

## Utah Health Status Update:

# Opiate Antagonist: Naloxone Awareness in Utah

July 2016

Drug poisoning deaths are a preventable public health problem that have outpaced deaths due to firearms, falls, and motor vehicle crashes in Utah.<sup>1</sup> In 2014, an average of 24 Utah adults died as a result of prescription opioids each month (13.9 per 100,000 population).<sup>2</sup> Opioid overdoses can be reversible through the timely administration of an opioid antagonist, such as naloxone. The Emergency Administration of Opiate Antagonist Act, passed during Utah's 2014 legislative session, authorizes:

- Prescribing and dispensing of naloxone to “third parties” such as family members or friends of someone who is at risk for opioid overdose;
- Creates immunity from criminal, civil, and health care liability for prescribing, dispensing, and administering naloxone to treat a suspected opioid overdose; and

### KEY FINDINGS

- In 2014, an average of 24 Utah adults died as a result of prescription opioids each month (13.9 per 100,000 population).<sup>2</sup>
- Survey results indicated that pharmacists were more likely to know about the strategy of prescribing naloxone and be aware of the Emergency Administration of Opiate Antagonist Act compared to prescribers.
- Half of providers and 80% of pharmacists felt comfortable prescribing/dispensing naloxone to patients at high risk for opioid abuse, as well as to third parties.
- Nearly half (47%) of focus group participants reported personal misuse or abuse of opioids, 85% reported having a friend or family member who has misuses or abuses opioids, more than 90% reported knowing someone who has overdosed from opioids, and 19% reported personally overdosing from opioids.

- Requires prescribers and dispensers to advise a person to seek medical evaluation after experiencing a drug overdose and taking naloxone.<sup>3</sup>

In March 2015, a survey<sup>4</sup> was administered and completed by 630 prescribers and 213 pharmacists in Utah to understand their knowledge, awareness, and beliefs regarding naloxone. Survey results showed that the majority of both groups practiced in urban areas (Table 1). Survey results indicated that pharmacists were more likely to know about the strategy of prescribing naloxone and be aware of the Emergency Administration of Opiate Antagonist Act compared to prescribers (Figure 1). Only 13% of providers said they currently prescribe naloxone, while 38% of pharmacists have filled naloxone prescriptions in the past. Among providers who currently prescribe naloxone, 20% reported that they prescribe to third parties, and among pharmacists, 22% reported that their pharmacy currently stocks naloxone.

Half of providers felt uncomfortable prescribing naloxone to patients at high risk for opioid abuse, as well as to third parties while 80% of pharmacists felt comfortable dispensing naloxone to patients at high risk for opioid abuse, as well as to third parties. The majority of providers and pharmacists felt comfortable educating patients and their family members on the signs and symptoms of opioid overdose, as well as when to seek medical attention for opioid overdose. Providers and pharmacists were less likely to report feeling comfortable educating patients or their family members on how to administer naloxone (56.7% and 65.1%, respectively) (Figure 2).

In September 2015, a total of eight focus groups were held in areas of increased burden of drug poisoning deaths across the state.<sup>5</sup> A total of 47 people participated, in which nearly half (47%) reported personal misuse or abuse of opioids, 85% reported having a friend or family

### Naloxone Awareness Survey Demographics

Table 1. Naloxone awareness survey demographics, health care providers and pharmacists, Utah, March 2015

Health Care Providers			Pharmacists		
	N	%		N	%
<b>Medical Credentials</b>			<b>Pharmacy Type</b>		
Doctor of Medicine	391	62.3%	Independent/Community	112	52.8%
Advanced Practice Registered Nurse	152	24.2%	Clinic	29	13.7%
Physician Assistant	71	11.3%	Hospital	52	24.5%
Certified Nurse Midwife	14	2.2%	Other	19	9.0%
Total	628	100.0%	Total	212	100.0%
<b>Primary Place of Business</b>			<b>Primary Place of Business</b>		
Urban	537	85.2%	Urban	175	82.2%
Rural/Frontier	93	14.8%	Rural/Frontier	38	17.8%
Total	630	100.0%	Total	213	100.0%
<b>Age Group</b>			<b>Age Group</b>		
44 years or younger	217	36.9%	44 years or younger	120	62.2%
45 years or older	371	63.1%	45 years or older	73	37.8%
Total	588	100.0%	Total	193	100.0%

member who misuses or abuses opioids, more than 90% reported knowing someone who has overdosed from opioids, and 19% reported personally overdosing from opioids. One-third of participants were aware of the Emergency Administration of Opiate Antagonist Act.

Insights from this evaluation were reviewed during the 2016 Utah State Legislative Session, providing an evidence base during the development of three House Bills that became law. The Opiate Overdose Response Act amends definitions and civil liability provisions and includes the following:

- HB 192 Opiate Overdose Outreach Pilot Program - Utah Department of Health will provide grants to persons that are in a position to assist individuals at increased risk of experiencing opiate-related drug overdose events.
- HB 238 Overdose Outreach Providers - May furnish naloxone without civil liability and includes a requirement to furnish instruction on how to recognize and respond appropriately to opiate-related drug overdose events.
- HB 240 Standing Orders - Authorizes the use of standing prescription drug orders issued by physicians to dispense naloxone.

Recent legislation provides many opportunities to decrease overdose deaths, including promoting naloxone awareness efforts, conducting follow-up surveys and community focus groups to document changes in awareness, pilot program planning and implementation, and naloxone distribution and overdose reversals.

1. Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health: 1999–2014 data queried via Utah’s Indicator-based Information System for Public Health (IBIS-PH) [cited 2016 January], IBIS Version 2014.

2. Utah Department of Health Violence & Injury Prevention Program, Utah Violent Death Reporting System 2000–2014.

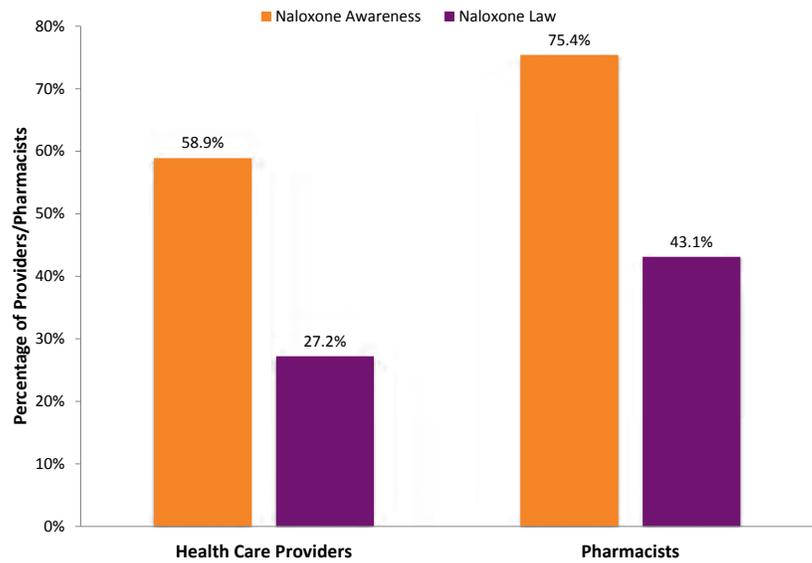
3. House Bill 119, Opiate Emergency Treatment, Utah State Legislature (2014).

4. Beletsky, L., Ruthazer, R., Mecalino, G., Rich, J., Tan, L., Burris, S. (2006). Physicians’ Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 84, No. 1, 126–136.

5. Opioid Overdose Focus Group Report. Lighthouse Research & Development, Inc. September 2015.

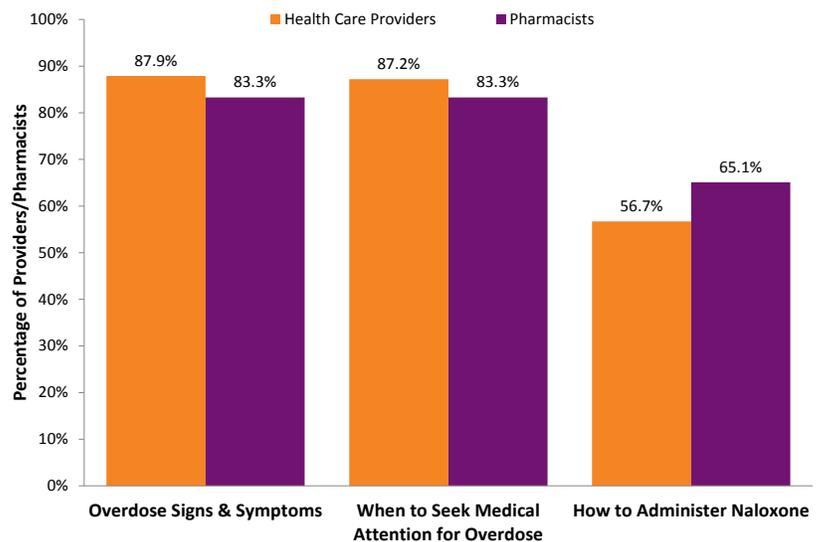
## Naloxone Awareness

Figure 1. Naloxone awareness among health care providers and pharmacists, Utah, 2015



## Comfort in Educating Patients or Family Members

Figure 2. Comfort in educating patients or family members among health care providers and pharmacists, Utah, 2015



For additional information about this topic, contact Meghan Balough, Utah Department of Health, (801) 538-6183, email: [mbalough@utah.gov](mailto:mbalough@utah.gov) or the Office of Public Health Assessment, Utah Department of Health, (801) 538-9191, email: [chdata@utah.gov](mailto:chdata@utah.gov).

### UDOH ANNOUNCEMENT:

The Bridging Communities and Clinics (BCC) Outreach Program was designed by the Office of Health Disparities to address known inadequacies and inefficiencies of the “traditional” health fair approach to community health outreach. For more information, visit <http://www.health.utah.gov/disparities/current-projects.html>.

## Breaking News, July 2016

### Zika Virus

Before 2015, Zika virus outbreaks were reported in tropical Africa, Southeast Asia, and the Pacific Islands. Since 2015, outbreaks have been identified in the Americas. For information on countries where outbreaks are occurring, visit <http://wwwnc.cdc.gov/travel/page/zika-information>.

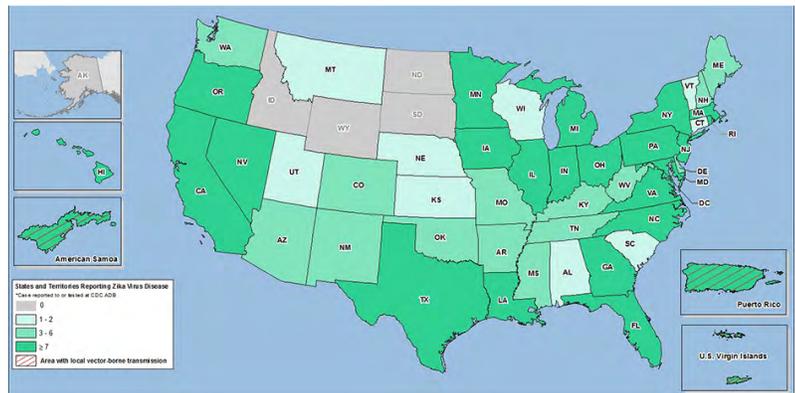
Zika virus is spread to people primarily through the bite of an infected *Aedes* mosquito. This species is not endemic in Utah; however, officials have increased surveillance for it. Zika virus can be transmitted from a mother to her fetus during pregnancy, through sexual contact, blood transfusion, or laboratory exposure. Zika virus infection during pregnancy can cause a serious birth defect called microcephaly, a sign of incomplete brain development. Therefore, pregnant women are being advised to avoid travel to Zika virus-affected areas and avoid sexual contact with anyone who has traveled to those areas. To date, three pregnant females and one non-pregnant person tested positive for Zika virus in Utah; none of the infants born to these mothers have been found to have complications. All confirmed cases traveled to Zika-endemic areas.

Minimizing mosquito bites is the key to preventing infection with mosquito-borne diseases, including West Nile and Zika viruses. It is recommended that people:

- Use insect repellent with 20%–30% DEET
- Cover arms and legs when outside
- Reduce standing water around their home

For more information regarding Zika virus, visit <http://health.utah.gov/epi/diseases/zika/>.

### Laboratory-confirmed Zika virus disease cases reported to ArboNET by state or territory — United States, 2015–2016 (as of June 22, 2016)



Source: Zika Virus in the United States. CDC. Downloaded 6/28/16 from <http://www.cdc.gov/zika/geo/united-states.html>.

## Community Health Indicators Spotlight, July 2016

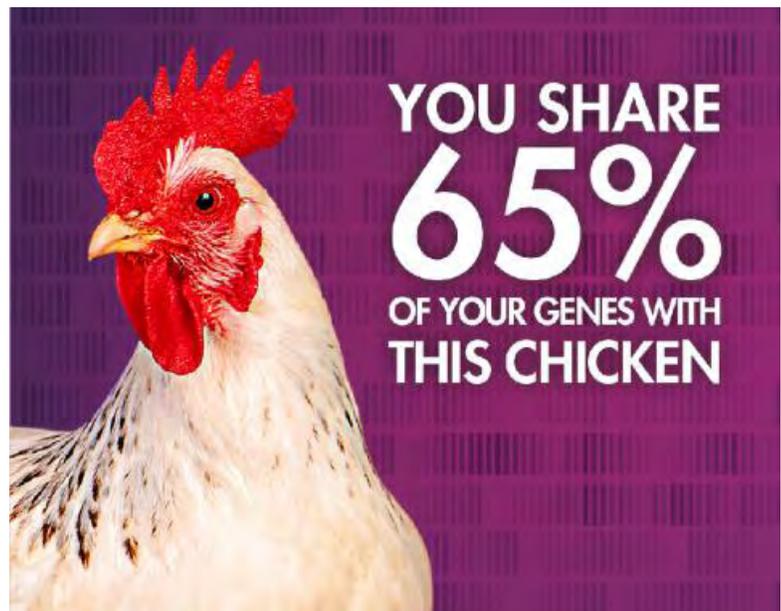
### Utah Cancer Genomics Program

Most cancer comes from lifestyle choices, such as smoking or diet and exercise, or environmental causes; however, some cancers are hereditary. Cancer genomics is the study of genes with the hope of preventing cancers that may be inherited. Utah's large families and interest in genealogy make it an ideal place for genomics cancer research. Utah is one of only five states to receive a genomics grant from the Centers for Disease Control and Prevention (CDC).

The Utah Department of Health's Cancer Control Program partners with the Huntsman Cancer Institute, Intermountain Healthcare, Utah Cancer Registry, and the Utah Population Database for this genomics project with a focus on BRCA I and II and Lynch Syndrome. BRCA (from **B**Reast **C**ANcer) is one of several genetic mutations linked to breast cancer and ovarian cancer. By age 80, a woman with a BRCA mutation has about an 80% chance of getting breast cancer. Lynch syndrome

is an inherited disorder that increases the risk for many types of cancer, particularly cancers of the colon (large intestine) and rectum, which are known as colorectal cancer. The Utah Cancer Genomics Program also works with the Museum of Natural History on their Genome Exhibit. Through education, tracking, and policy changes, the Utah Cancer Genomics Program is working to save lives of Utahns by helping find genetic cancers early when they can be treated more successfully.

If you would like information or are interested in your family health history, visit <http://cancerutah.org/genomics/>.



# Monthly Health Indicators Report

(Data Through May 2016)

Monthly Report of Notifiable Diseases, May 2016	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis ( <i>Campylobacter</i> )	31	50	141	162	0.9
Shiga toxin-producing <i>Escherichia coli</i> ( <i>E. coli</i> )	4	5	16	17	0.9
Hepatitis A (infectious hepatitis)	0	1	4	4	1.1
Hepatitis B, acute infections (serum hepatitis)	0	0	0	3	0.0
Influenza*	Weekly updates at <a href="http://health.utah.gov/epi/diseases/influenza">http://health.utah.gov/epi/diseases/influenza</a>				
Meningococcal Disease	0	0	2	3	0.8
Pertussis (Whooping Cough)	2	99	73	461	0.2
Salmonellosis ( <i>Salmonella</i> )	22	33	143	125	1.1
Shigellosis ( <i>Shigella</i> )	7	2	33	13	2.6
Varicella (Chickenpox)	19	25	136	148	0.9

Quarterly Report of Notifiable Diseases, 1st Qtr 2016	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†	32	30	32	30	1.1
Chlamydia	2,412	1,981	2,412	1,981	1.2
Gonorrhea	513	197	513	197	2.6
Syphilis	11	11	11	11	1.0
Tuberculosis	5	8	5	8	0.7

Medicaid Expenditures (in Millions) for the Month of May 2016	Current Month	Expected/Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 15.9	\$ 16.3	\$ 158.7	\$ 159.1	\$ (0.4)
Inpatient Hospital	\$ 13.0	\$ 13.6	\$ 112.9	\$ 114.4	\$ (1.5)
Outpatient Hospital	\$ 6.0	\$ 4.8	\$ 41.0	\$ 41.3	\$ (0.3)
Long Term Care	\$ 22.3	\$ 21.5	\$ 180.4	\$ 180.5	\$ (0.1)
Pharmacy	\$ 2.3	\$ 1.8	\$ 93.6	\$ 94.1	\$ (0.5)
Physician/Osteo Services	\$ 3.6	\$ 4.8	\$ 39.0	\$ 45.9	\$ (6.8)
<b>TOTAL MEDICAID</b>	<b>\$ 206.2</b>	<b>\$ 205.1</b>	<b>\$ 2,253.5</b>	<b>\$ 2,255.6</b>	<b>\$ (2.2)</b>

Program Enrollment for the Month of May 2016	Current Month	Previous Month	% Change‡ From Previous Month	1 Year Ago	% Change‡ From 1 Year Ago
Medicaid	293,949	294,796	-0.3%	287,732	+2.2%
PCN (Primary Care Network)	17,592	18,036	-2.5%	14,587	+20.6%
CHIP (Children's Health Ins. Plan)	17,979	17,886	+0.5%	16,338	+10.0%

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 (2014)	281,302	8.9%	-0.8%	\$ 7,281.6	+11.8%
Non-maternity Hospitalizations (2014)	177,881	5.5%	-1.1%	\$ 6,200.8	+11.6%
Emergency Department Encounters (2014)	710,266	22.9%	+2.6%	\$ 1,760.5	+13.2%
Outpatient Surgery (2013)	404,303	13.1%	+7.3%	\$ 2,167.9	+11.5%

Annual Community Health Measures	Current Data Year	Number Affected	Percent/Rate	% Change‡ From Previous Year	State Rank§ (1 is best)
Obesity (Adults 18+)	2014	524,000	25.7%	+6.5%	8 (2014)
Cigarette Smoking (Adults 18+)	2014	197,800	9.7%	-6.1%	1 (2014)
Influenza Immunization (Adults 65+)	2014	171,300	58.0%	+1.0%	36 (2014)
Health Insurance Coverage (Uninsured)	2014	303,100	10.3%	-11.2%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2014	234	8.0 / 100,000	+20.2%	17 (2014)
Poisoning Deaths	2014	641	21.8 / 100,000	+0.4%	45 (2014)
Suicide Deaths	2014	555	18.9 / 100,000	-4.0%	41 (2014)
Diabetes Prevalence (Adults 18+)	2014	144,800	7.1%	-0.1%	8 (2014)
Poor Mental Health (Adults 18+)	2014	324,200	15.9%	-3.0%	19 (2014)
Coronary Heart Disease Deaths	2014	1,574	53.5 / 100,000	+2.5%	3 (2014)
All Cancer Deaths	2014	3,033	103.1 / 100,000	+1.0%	1 (2014)
Stroke Deaths	2014	854	29.0 / 100,000	+1.4%	31 (2014)
Births to Adolescents (Ages 15-17)	2014	537	7.9 / 1,000	-8.8%	12 (2014)
Early Prenatal Care	2014	39,005	76.2%	-0.2%	n/a
Infant Mortality	2014	251	4.9 / 1,000	-4.7%	13 (2013)
Childhood Immunization (4:3:1:3:3:1)	2014	36,700	74.6%	n/a#	24 (2014)

\* Influenza-like illness activity is minimal in Utah. As of May 21, 2016, 1,190 influenza-associated hospitalizations have been reported to UDOH since the start of the influenza season on October 4, 2015. More information can be found at <http://health.utah.gov/epi/diseases/influenza/surveillance/index.html>.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ Relative percent change. Percent change could be due to random variation.

§ State rank based on age-adjusted rates where applicable.

# In 2014, NIS analysis for the complete 4:3:1:3:3:1 series was updated to provide a more accurate assessment of Haemophilus influenzae type B vaccination. Due to this change, the 2014 results for 4:3:1:3:3:1 coverage are not comparable to prior years.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile Virus will start in June for the 2016 season.