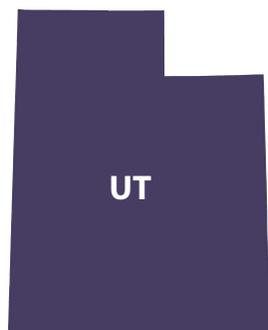


Public Health Practice Stories from the Field



Utah Takes Multipronged Approach to Respond to Prescription Drug Abuse

500% increase
in Utah residents dying from
prescription drug poisoning
(1991–2007)

83% increase
in methadone prescriptions
(2002–2006)

**Educational
campaigns**
target health care providers and
the public

25% decrease
in prescription drug overdose
deaths (2007–2011)

Someone dies every 19 minutes from an unintentional drug overdose in the United States. In Utah, deaths from all drug poisoning increased from 79 in 1991 to 391 in 2003. This increase was largely the result of overdoses of prescription painkillers. Prescription drug overdose deaths in Utah skyrocketed nearly 500% between 1991 and its peak in 2007 (55 to 326, respectively).

The increase in prescription drug overdose deaths corresponded with increases in prescriptions for opioid medications such as methadone, oxycodone, and hydrocodone. Between 2002, the first year in which prescribing data are available, and 2006, methadone prescriptions increased 83%. The average number of prescriptions per patient also increased by 13% during this time period.

The Utah Department of Health investigated the overdose deaths during 1996–2000 and found that most people had legitimate prescriptions for the medications, as determined by the medical examiner at the time of death.

To respond to this patient safety issue, the health department used a multipronged approach, targeting both the general public and health care providers. A year-long educational campaign coupled with new opioid-prescription practice guidelines raised public awareness of risks of prescription medication and appears to have contributed to a reduction in adverse events.

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What We Did

By linking prescription monitoring program data with adverse events data (1996–2000), the Utah Department of Health learned that

- Nearly half (17 of 35) of those who died of methadone poisoning had previous methadone prescriptions
- 14 had a valid methadone prescription at the time of death
- Of those with a valid prescription, 7 were taking methadone for the first time when they died, while the rest had previous prescriptions (ranging from 1 to 17 prescriptions)

The Utah Department of Health then developed an educational campaign targeted to both prescribers and the general public about safe use, storage, and disposal of medications. The health department also convened a panel to develop practice guidelines, which were disseminated in 2009 and subsequently published. In the guidelines, methadone was singled out as a drug that requires particular care to be safely prescribed. The health department evaluated the impact of the guidelines by surveying primary care physicians.

What We Accomplished

Since the interventions began, the annual number of prescription opioid-related deaths fell for the first time since 1991, resulting in a 25% decrease between 2007 and 2011 (326 to 246 deaths respectively). Methadone prescribing also dropped after the interventions began; after peaking in 2006, the number of methadone patients fell back to 2003 levels by 2010.

Analyses are in progress to determine whether providers have changed their prescribing practices and to examine the association between provider-level prescribing and adverse events. Given that the interventions occurred concurrently, observed changes in drug-related harm and prescribing practices cannot be credited conclusively to a particular intervention.

What We Learned

Utah learned a number of key lessons through this process:

- Prescription drug-related harms have affected thousands of Utah families, and the community must be part of intervention efforts.
- Providers desire more training about safe prescribing and tools to help assess risk, and prefer using tools that are easily available within electronic medical records rather than external tools.
- Linking prescription monitoring program data with adverse events data allows for more sophisticated analyses of patient- and provider-level exposures and outcomes.
- Adding patient diagnoses to the data set would help inform risk assessment efforts.
- Linking data about physician practice groups to the prescription monitoring program would help distinguish “doctor shoppers” from legitimate patients receiving prescriptions from multiple providers in the same group.

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