Heroin and Opiate Use in Rural Pennsylvania

Comments Provided to the
Center for Rural Pennsylvania

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Thank you for the opportunity to participate in the Center for Rural Pennsylvania's Public Hearing on the Heroin Crisis Facing Pennsylvania. My name is Lisa Davis and I am the director of the Pennsylvania Office of Rural Health, one of 50 state offices of rural health in the nation dedicated to ensuring access to high quality, affordable healthcare services in rural areas and to enhancing the health status of rural residents. My office appreciates the concerted effort that the Center for Rural Pennsylvania and members of the Pennsylvania General Assembly are devoting to the issue of heroin and opiate use in rural Pennsylvania. This is significant community and public health issue that impacts individuals and families, regardless of their geographic location or socio-demographic status.

1. Introduction

According to Trust for America's Health (2013), Pennsylvania has the 14th highest drug overdose mortality rate in the country. The rate of drug-induced deaths in the state is higher than the national average, with heroin being the most commonly cited drug among primary drug treatment admissions (Office of National Drug Control Policy, 2013). For more detailed information on Pennsylvania's 2010 treatment admissions data sorted by primary drug, please see Table 1 in Appendix A. Heroin is steadily rising as a primary substance being abused, growing by 3.5 percent since state Fiscal Year 2009-2010 (Pennsylvania Department of Drug and Alcohol Programs, 2013) and the use of opiates is also of growing concern across the state. Pennsylvania's 48 rural counties are not exempt from these issues.

The issue of heroin and opiate use in rural areas has been highlighted in the news. For example, a January 2014 article in the *Pittsburgh Post-Gazette* notes that Fayette County now ranks among the highest counties in the U.S. for death rates from drug overdoses, with 33.5 deaths per 100,000 residents (Crompton, 2014). The article references several bills that have been introduced by the Pennsylvania General Assembly to create stronger prescription drug monitoring programs with opioids listed as one of the commonly abused medications. The article noted that officials fear that as the state cracks down on prescription drug abuse, reports of heroin will rise as a result of patients seeking other forms of drugs to supplant the use of prescription drugs.

2. Expanding Heroin Use from Cities to Rural Communities

Drug dealers in Pennsylvania have expanded their territory, moving out of their original source cities to rural areas to gain new customer bases and to continue to keep heroin widely available throughout the state (Friends of Narconon, 2014). The greater Philadelphia area has long been known as a large marketplace for heroin, but inexpensive, "high-purity heroin," is becoming quickly available in rural southwestern and northeastern areas of the state, which had been dominated by the distribution of cocaine. Cities such as Allentown, Bethlehem, Reading, and Easton are now considered to be lower-level distribution points for heroin dealers and users who then spread to other smaller cities and towns. These locations are not only a short distance from Philadelphia, but are also quick day trips to New York City, the prime source city for heroin distribution. Increased access to less expensive, but still highly pure heroin, is contributing to the growing problem (Friends of Narconon, 2014).

3. Heroin-related Deaths in Rural Pennsylvania

The Pennsylvania State Coroners Association released a *Heroin Death Overdose Report* spanning the years 2009-2013. In 2013, of the 124 "Heroin Only" deaths reported, 23 percent occurred in rural counties in Pennsylvania: one in Adams County, two in Blair, three in Clarion, two in Huntingdon, three in Monroe, four in Northampton, one in Susquehanna, and 13 in Washington County.

A second set of data highlighted the Multi Drug Toxicity deaths per county. According to the Pennsylvania State Coroners Association (2013), Multi Drug Toxicity is referring to a mixture of Heroin plus one or more "other opiates, illicit drugs, or prescription drugs found through toxicology" (p. 2). The most common substances found, in addition to heroin, are Alprazolam, Citalopram, Mirtazapine, Primidone, Cocaine, Phentermine, Hydrocodone, Ethanol/Alcohol, Codeine, Diazepam, Temazepam, Trazadone, Chlordiazepoxide, Venlafaxine, Amitriptyline, Oxycodone, Clonazepam, Nordiazepam, Methadone, Doxepin, Lamotrigine, Flurazepam, Fentanyl, Tramadol, Sertraline, Oxymorphone, Cyclobenzaprine, Morphine, Prozac, and Marijuana/THC. In 2013, of the state's 444 Multi Drug Toxicity deaths, 12 percent occurred in the state's rural counties: Armstrong (3), Blair (1), Butler (6), Franklin (1), Greene (3), Lycoming (1), Monroe (11), Northampton (22), Pike (1), and Washington (6).

4. Efforts to Improve Drug Monitoring Programs

The state has an opportunity to improve efforts to regulate and track the use of prescription drugs. In 2013, the Centers for Disease Control and Prevention (CDC) released a *Prevention Status Report* which indicated that Pennsylvania lags behind other states in the passage of state pain clinic laws and Prescription Drug Monitoring Programs (PDMP). The CDC noted that as of July 2013, Pennsylvania did not have a pain clinic law, which attempts to stop most, "egregious overprescribing practices" (p. 3). To elevate the state's rating by the CDC, Pennsylvania will need to establish a law requiring state oversight and implement requirements for owning and operating pain management clinics, facilities, or practice locations (CDC, 2013). Further, the CDC noted that as of July 2013, Pennsylvania's PDMP does not follow any of the selected best practice guidelines. The CDC (2013) cited selected best practices as providing, "prescribers and dispensers access to PDMPs, interoperability with the PDMP of at least one other state or the District of Columbia, and proactively reporting findings to law enforcement and regulatory agencies" (p. 3).

5. Heroin and Opiate Use in Other States

To get a sense of the issue in other states, I solicited information from other state offices of rural health. The timeframe for receiving the information was short, and I was able to hear from a few states that are experiencing significant problems with heroin and opiate use and who provided information on programs initiated to address this public health concern.

The **Arizona** Department of Health Services (ADHS) has contracted with the Arizona Center for Rural Health to develop online training modules that guide prescribers and pharmacists about the risks and alternatives to prescription opioid medications; assess the need for education and

training regarding the prescription of controlled substances; develop a dissemination strategy to ensure that prescribers are aware of and participate in the training; and provide a demonstration of the education and training to the Prescription Drug Core Group, the Arizona Substance Abuse Partnership, and other entities or groups. ADHS convened a well-attended stakeholder summit in the spring of 2014, drafted prescribing guidelines for the treatment of acute and chronic pain, and will present the guidelines and two training modules at the annual rural health conference this month. They also are working with state and county medical societies and licensing boards to create tools such as electronic health record templates, contracts/agreements, and patient education.

The problem is significant in **Connecticut**. A task force was formed is a result of opiate and heroin abuse in Litchfield County and the governors from the New England states have held a few summits to address the issue. This subject is the main theme for the New England Rural Health Roundtable annual symposium this year. Connecticut passed legislation to allow for easier access to and administration of Narcan by EMTs and lay persons. However, the supply of Narcan kits is not as readily available to dispense in more rural areas. In Connecticut so far, there have not been any issues with health insurers. In fact, if a family member of a known drug user wants to have a Narcan kit, their private insurance will cover the cost and a private physician can write the prescription.

Delaware's Health and Human Services Secretary says that heroin use is an epidemic and that by all accounts, the latest spike in heroin use is a result of a successful crackdown on the abuse of prescription painkillers such as Percocet and Oxycontin. Doctors began to prescribe the drugs less and manufacturers made the tablets harder for addicts to crush so they could snort or inject them. The heroin market responded with a drug that is more plentiful, purer, and cheaper than ever before. Twenty years ago, heroin was 17 percent pure and cost $10 a bag. Today, it's around 67 percent pure and can be purchased in Wilmington for as little as $3 a bag. Even novice users from the suburbs know which parts of the city to visit to find a willing seller. At least 1,990 people who sought treatment from 1998 to 2009 cited heroin as their primary drug. The Wilmington police chief notes that record-setting heroin seizures are a drop in the bucket of the product that's on the street and that another substance would replace it anyway.

Heroin is the major culprit for overdose in **Indiana**'s rural emergency departments (EDs). Heroin is cheap and can be purchased almost more easily than marijuana. No one seems to stop the suppliers coming to their rural areas, particularly those areas where interstates are located. In response to overprescribing or monitoring drug seekers, Indiana instituted a prescription monitoring program last year where practitioners can access a statewide database to find information on narcotics prescribed to patients and to help prevent drug seekers visiting the ED. However, this database is updated on a daily basis, resulting in some patients leaving one ED seeking medication and traveling 30 minutes to another ED for the same condition. The other issue is the disposal of opiate patches and Vicodin and Oxycodone. To answer that, a growing number of communities, through law enforcement and the local health department and hospitals, are sponsoring central drop-off spots for the disposal of old medication or medication that is no longer being used. Some communities have collected hundreds of pounds of medication which has been destroyed, preventing contamination of the water supply and getting the drugs out of circulation.

In **Louisiana**, the death rate from heroin increased by 975 percent in five years, from 12 in 2008 to 117 in 2103.

Recent data from **North Carolina** indicated that the state is ranked 22nd in the nation for deaths by unintentional poisonings. In the past year, there were 3,120 visits to North Carolina emergency departments (EDs) with a primary diagnosis of opioid poisoning or overdose for an estimated cost of $10.1M. Rates of hospitalizations associated with drug withdrawal syndrome in newborns increased 278 percent between 2004 and 2010. State Medicaid data reveal that 60 percent of ED visits involve a "pain complaint." The rate of prescription drug opioid deaths was 68.9 cases per 100,000 person-years in North Carolina during 2012, compared to 16.3 cases for heroin deaths. The state has contracted with North Carolina Community Care Networks, Inc. (CCNC) to address this growing problem as part of a Medicaid matching grant with the Kate B. Reynolds Charitable Trust. Total funding is $2.6M for each of two years. North Carolina also has been funded to implement the Project Lazarus Model, a public health model based on the twin premises that drug overdose deaths are preventable and that all counties are ultimately responsible for their own health. NC Project Lazarus: Chronic Pain Initiative was developed as a series of educational activities, training, and strategies to help primary care providers, ED staff and CCNC care managers address opioid misuse and abuse.

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Appendix A

Table 1