MOTION BY SUPERVISORS JANICE HAHN AND HILDA L. SOLIS

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Prevention of Opioid-Related Deaths

Across the United States, drug overdoses are killing more people than both car accidents and firearms. Today, most accidental deaths are a result of fatal opioid overdoses, prescription painkillers, or heroin. Life expectancy in the United States dropped for the second consecutive year in 2016, something that has not happened since the influenza epidemic in the 1960's.

The opioid epidemic ravaging many communities across the nation is one of the major reasons why life expectancy across the nation has dropped, with high prescription rates for opioid pain medications serving as a key contributor. These opioid pain medications were pushed aggressively by the pharmaceutical companies that developed them, and doctors were encouraged to prescribe them for everything from acute low back pain to chronic pain from terminal cancer. While opioid medications serve an important role in pain management, there is a need to promote interventions to ensure that prescribers follow safe prescribing practices to mitigate the human and economic impacts of the opioid crisis.

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A recent study out of San Diego, California looked at the preventive value of awareness and education. This study examined whether a letter from the County Medical Examiner-Coroner to a prescribing physician informing them that one of their patients has died of an opioid overdose could reduce the future number of opioid prescription written by that physician. That letter would also encourage the prescribing physician to utilize CURES 2.0, the statewide Prescription Drug Monitoring Program (PDMP), and refer the prescribing physician to published prescribing guidelines for opioids. The PDMP enables a physician to determine whether or not a patient has already been prescribed pain medication by another physician, and if so, what kind.

WE, THEREFORE MOVE that the Board of Supervisors direct the Chief Medical Examiner-Coroner to work in conjunction with the Director of Public Health and the County Health Officer, among others, and report back in 30 days on the feasibility of notifying physicians and other medical professionals who prescribed opioids to a patient who has died of an opioid overdose.

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