AGN. NO.____

MOTION BY SUPERVISORS JANICE HAHN AND HILDA L. SOLIS

October 2, 2018

Opioid Death Prescriber Notification

The Centers for Disease Control and Prevention have declared prescription drug abuse an epidemic in the United States. In the wake of continuing conversations on the topic, national attention has turned to the correlation of increased opioid-related deaths with increased opioid prescribing. It is now known that synthetic opioids were aggressively and misleadingly marketed by pharmaceutical representatives. Doctors were courted and encouraged to prescribe opioids to treat acute and chronic pain alike, and the possibility of addiction was downplayed. For many people who die from accidental opioid overdose, it began in their doctor's office with a complaint of pain; addiction soon followed. Doctor shopping, a strategy used by individuals to obtain multiple prescriptions, is not unique to opioid users, but results in increased numbers of prescriptions, a higher number of pills, and a higher number of morphine equivalents. As a result of this knowledge, prescribers are natural partners in the effort to decrease the numbers of people who die from unintended opioid overdoses.

A group of researchers in southern California sought to determine whether or not patterns or predictors could help find solutions to the epidemic. When a person died as

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a result of an opioid overdose, the researchers combed state databases to identify those patients' opioid prescribers. The researchers then wrote letters to the prescribers of the medications that caused or contributed to the cause of the patient deaths; and subsequently tracked the prescribing behavior of those medical professionals. There was a statistically significant change in prescribing practices: they either prescribed non-opioid pain relievers as an initial treatment protocol or utilized lower-dose opioids for pain relief.

In short, the letters had an effect, and time will tell whether or not the information conveyed to the prescribers continues to have an effect on the amounts and dosages of opioids prescribed, and consequently, the number of potential deaths to be averted.

In the wake of the study's published results, on August 14, 2018, the Los Angeles County Board of Supervisors (BOS) unanimously approved a motion directing the Department of Medical Examiner-Coroner, in conjunction with the Department of Public Health and County Counsel, to report back on the feasibility of implementing a notification protocol to medical prescribers in the wake of an opioid overdose-related death.

On September 13, 2018 that report was received by the BOS, along with a proposed notification letter and draft Prescriber Notification Process. The report makes it clear that notification is feasible and the sample letter provided complies with all requirements of controlling privacy laws.

WE, THEREFORE MOVE that the Board direct the Chief Medical Examiner-Coroner and the County Health Officer, in conjunction with the Chief Executive Officer, to:

1. Implement the Prescriber Notification Process described in the September 13th, 2018 report back on the prevention of opioid deaths;
2. Engage stakeholders including, but not limited to, the Los Angeles County Medical Association, local health plans, and Controlled Substance Utilization Review and Evaluation System (CURES) to notify them of the proposed notification process;
3. Evaluate the impact the notifications may have on prescription practices and overdose deaths.

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JH:dg