COUNTY of VENTURA
Medical Examiner's Office

Medical Examiner's Office
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Dear _____(name prescriber),

This is a courtesy notification to inform you that your patient(name) (Date of Birth) died on _____. The use of prescribed medication(s) was either the primary cause of death or contributed to the death.

The Ventura County Medical Examiner's Office sees between 150 and 160 overdose deaths each year. These numbers continue to rise. In 2020 our office saw 217 overdose deaths: 45.6% increase from 2019. A significant proportion of deaths are due to the combination of multiple prescription medications. Patients may obtain legitimate prescriptions for opioids, benzodiazepines, muscle relaxants, and sleep aids from more than one prescriber. When taken in any combination, these medications put patients at greater risk of death. We also see many deaths that are a result of when prescription medications are used in combination with alcohol or other illicit substances.

The Controlled Substance Utilization Review and Evaluation System (CURES) *helps prescribers who are dedicated to avoiding prescribing controlled substances when they are likely to do more harm than good.* CURES contains information about whether other clinicians had prescribed controlled substances to your patient. This type of information can help prescribers make informed decisions and avoid duplicate or additive types of medications from being provided to patients. The mandate to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II- IV controlled substance became effective on October 2, 2018..

The following evidence-based interventions also lower overdose death rates:

1. **Avoid co-prescribing an opioid and a benzodiazepine.** Nationally the number of opioid deaths involving benzodiazepine is increasing annually.

2. **Minimize opioid prescribing for acute pain**. According to the Centers for Disease Control and Prevention (CDC), clinicians should avoid opioids, and when necessary, start with the lowest effective dose of immediate-release opioids. Three days or less will often be sufficient. Opioids should not be considered first-line or routine therapy for chronic pain.

3. **Taper opioids to safer doses**. The CDC recommends that for patients already on long-term opioid high dose opioid therapy, taper to a dose that is lower than 50 milligrams of morphine equivalent and that slow opioid tapers as well as pauses in the taper may be needed for long-term users.

4. **Avoid "the 90-day cliff."** The CDC recommends opioids should be discontinued if benefits do not outweigh risks.

5. **The CDC recommends prescribing naloxone** to patients on higher than 50 milligrams of morphine equivalents daily. The mandate to offer a prescription for naloxone to a patient at high risk of overdose (see website for additional info) went into effect January 1, 2019.

Learning of your patient's death can be difficult. We hope that you will take this as an opportunity to join us in preventing future deaths from drug overdose. For more resources visit www.meo.ventura.org/letter

Sincerely,

Christopher Young, MD
Chief Medical Examiner

SCAN ME