Overdose Fatality Review
Presentation of Annual Reports

Erin Haas and Laura Bartolomei-Hill
Maryland Department of Health

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Agenda

- Introductions
- Overview of Overdose Fatality Review in Maryland
  - Background
  - Social-Ecological model
  - Case review example
- Recommendations
- Discussion
OFR in Maryland

• Operational in 19 of 24 jurisdictions
• Established as a pilot in 3 jurisdictions with the support of a Harold Rogers 2013 grant
• Local OFR teams meet at least quarterly to review cases
• Teams have met over 205 times and reviewed over 518 cases
• Teams include representatives from:
  - Local Health Dept
  - Law Enforcement
  - EMS
  - Local Hospital
  - Treatment providers
  - Prevention Office
  - Dept of Social Services
  - Public Education
  - Parole and Probation
  - Detention Center
  - Crisis Services
  - Community Colleges
Overdose Fatality Review Background

• 2011-2012: State tracks significant rise in OD deaths (Rx opioid & heroin-related)

• Jan. 2013: Maryland Opioid Overdose Prevention Plan
  o Implement Prescription Drug Monitoring Program
  o Surveillance of problematic prescribing/dispensing
  o Overdose education & naloxone distribution
  o Continue access expansion for opioid replacement therapy (methadone & buprenorphine)
  o Local overdose prevention plans
  o **Pilot local overdose fatality review teams (LOFRT)**
Supply Monitoring
- Prescription Drug Monitoring Program
- Heroin availability
- Fentanyl tracking
- Naloxone availability

Overdose Response
- Naloxone in the hands of high-risk individuals and those likely to witness and overdose
- Overdose response training/Community preparedness
- EMS and ED readiness

Engagement
- People who use drugs:
  - Screening and referral to treatment
  - Medication Assisted Treatment
  - Peer support and follow up
  - Care coordination
  - Harm Reduction programs: syringe services, safer injection facilities
- Physicians:
  - Prescribing guidelines
  - Provider alerts
  - OFR Team Communication

Supply Monitoring
Overdose Fatality Review Overview

• Modeled after existing mortality review programs (Child Fatality Review)

• Multi-agency/multi-disciplinary team assembled at local (county/Balt. City) level to conduct confidential reviews of overdose death cases

• Goal to prevent *future* deaths by:
  o Identifying missed opportunities for prevention and gaps in system
  o Building working relationships b/t local stakeholders on OD prevention
  o Recommending policies, programs, laws, etc. to prevent OD deaths
  o Informing local overdose prevention strategy
Goals of OFR - H-G § 5-903

• Promote cooperation and coordination among agencies involved in investigations of drug overdose deaths or in providing services to surviving family members

• Develop an understanding of the causes and incidence of drug overdose deaths in the county

• Develop plans for and recommend changes within the agencies represented on the local team to prevent drug overdose deaths

• Advise the Department on changes to law, policy, or practice, including the use of devices that are programmed to dispense medications on a schedule or similar technology, to prevent drug overdose deaths
Social-Ecological Model

Policy inputs
Commentaries on government programs or agencies, regulations, laws, and taxes

Neighborhood/community physical and social environments
References to physical and social environments, including commercial or retail establishments, parks, playgrounds, and streets, and the social exchanges that occur in those settings

School and work environments
References to environments and policies in school or work settings

Interpersonal and household environments
References to social interactions, including those that occur within households, families, or close peer groups

Individual choice
References to personal choices or behaviors (e.g., personal decisions to smoke or not to smoke)
Coalition Impact

• Establishment of ‘safe space’
  – Allows for theory testing
  – Encourages increased community participation
  – Provides quicker, real-time feedback on effectiveness of changes
  – Encourages cross-specialty collaboration
• Facilitates a person-centered approach across multiple systems
• Relationship to other coalitions (Opioid Misuse Prevention Program coalition, Local Drug and Alcohol Abuse Council, and local strategic planning efforts)
  – OMPP offers the potential to create new programs, systems, and opportunities based on the information gathered by LOFRT case reviews
  – Strong focus on prevention and systemic improvement
  – Allows and encourages LOFRT group members to see more “tangible” outcomes for their efforts and be involved from the start
Sample Case: Mr. Leighman

- OCME Data:
  - 48 AA Male
  - DOD: 10/1/2015
  - COD: Heroin Intoxication
  - Autopsy? Yes
  - Other substances in toxicology screen: Benzoyle, Cocaine, Codeine, Freemorphine, Morphine
  - Manner of death: undetermined
  - Location of residence: Somerset County
  - Location of incident: Wicomico County
Stewart Leighman, black, male, DOB 7/29/1967, lives in a wooded area in a small tent near Salisbury, Wicomico County, Maryland. On 10-1-15 at 0830 hrs. He met his girl friend in Salisbury, Md. and they walked to the local hospital where she visited with her mother and apparently borrowed some money from her, thirty dollars of which she gave to Mr. Leighman. The two parted ways at 1200 pm and Mr. Leighman said he would see her back at the tent. The girlfriend did not return to the tent because of the heavy rain, instead, she called Robert Lewis, Mr. Leighman’s cousin, to check on him. Mr. Lewis went to the tent at 1845 hrs. And discovered Mr. Leighman lying on his back in the tent with just his shorts on, he was unresponsive and Mr. Lewis could not awaken him. Mr. Lewis called 911 and he says he started CPR. Arriving EMS found him in asystole and transported him to the ED. He was given life saving treatment to no avail. He was determined dead at 1942 hrs. Mr. Leighman has a history of Diabetes and stomach problems. He has a history of Cocaine use and Heroin use. The family requested a funeral home and they were called and agreed to respond. OCME was notified of this case and autopsy was ordered by the F.I.
Investigation Questions

- Were other investigations conducted besides the Office of the Chief Medical Examiner (Law Enforcement, Drug Task Force)?
- What were the key findings of the investigation(s)?
- Does the team feel the investigation was adequate?
  - Is the investigation complete?
  - What more do we need to know?
- Does the team have suggestions to improve the investigative system?
Sample Case: Mr. Leighman

- EMS: day of death only
- Hospital: Yes (multiple ER visits for stomach pain)
- Social Services: Yes (food stamps and MA)
- Sherriff's Office: Yes
- State’s Attorney’s Office: Yes
- Court System: Yes (3 open cases, all drug related)
- Community supervision: Yes
- Drug Treatment: Yes
- Pain Management: Yes
- Pharmacy records: PDMP
Service Delivery Questions

• Were there any services that the deceased was accessing or agencies he or she was involved with at the time of death?
• Were services provided to family members? If so, what can we learn about the person’s life through the agency’s interaction with the family members?
• Did the deceased transition between service providers or experience an extended gap of service? Were adequate referrals made, and was there sufficient communication among providers?
• Were there missed opportunities to provide services?
• Could the individual have been better engaged in services?
• Does the team have suggestions to improve service delivery systems?
## Conclusions: Mr. Leighman

### Risk factors:
- transience/homelessness
- history of addiction
- co-occurring chronic illness
- older adult
- possible long period of abstinence
- pain management

### System-level implications:
- need for improved coordination of healthcare services for transient population
- overdose prevention and substance use disorder treatment access for incarcerated individuals
- community naloxone trainings targeting homeless population
- pain management co-prescription for naloxone
OFR Outcomes: Trend Identification

• 883 trends observed in 518 cases
  o Mental Health diagnosis or treatment history (135)
  o Previous overdose (92)
  o Somatic Health Condition (78)
  o Pain management (37)
  o Intimate Partner Violence (35)
  o Recent time of abstinence (34)

• Emerging trends
  o Overdose deaths occurring in a hotel or motel
  o History of traumatic brain injury
  o History of childhood trauma
Team Accomplishments

- The Bureau of Behavioral Health, in response to this recommendation by the DOLRT, moved to a system of “walk-in” substance use screenings at Eastern Family Resource Center in May of 2016 (Baltimore County).
- Last year, the team recommended for there to be community based Naloxone training sessions, rather than locations at the Garrett County Health Department Centers. In 2016 the Garrett County Center for Behavioral Health held 8 community Opioid Overdose Response Trainings.
- The Harford OFR team identified family members also at-risk for a drug overdose. The Chair reached out to these individuals and encouraged them to access community resources.
Recommendation Review and Discussion

- Methodology for recommendation review and categorization
- Discussion for each category:
  - What services are you aware of that contribute to the recommendations in this category?
  - Are you currently working on a project that addresses any recommendations in this category?
  - Do any recommendations catch your eye that you think inspires future policy or program changes?
Family Support and Outreach

Ten OFR teams recommended enhancing support and outreach for family members of overdose decedents and overdose survivors.

- Assess needs of surviving family members
- Connect to SUD treatment if needed
- Prioritize family members in Naloxone outreach
- Make trauma and grief services available to families
- Engage school-aged children and connect to counseling and services

“A family member found the decedent in 83% of cases”

— Carroll County
Seven OFR teams recommended engaging prescribers and other health care providers

- Promote awareness of the Prescription Drug Monitoring Program and CRISP
- Increase the number of prescribers following best practices when prescribing opioids
- Train providers to screen for substance use disorder and offer recovery-supportive services

“4 of the 13 FORT cases reviewed had chronic somatic health conditions that require pain management”

- Anne Arundel
Enhanced services to people who use drugs

Seven OFR teams recommended engagement of people who use drugs, including overdose survivors.

- Provide all overdose survivors with Naloxone
- Employ peer-recovery specialists to connect overdose survivors and individuals with a Substance Use Disorder to treatment services via law enforcement and local hospitals
- Establish syringe service programs
- Harm reduction education for high-risk individuals

“Our case reviews show many decedents used intravenous route of administration...which shows a need for the service”

- Howard
Treatment system improvement

Five OFR teams recommended treatment system improvements.

– Move toward a system of “treatment on demand”
– Educate mental health providers on overdose risk and prevention
– Change criteria for admittance into residential facilities, particularly upon release from incarceration
– Increase availability of MAT for alcohol use disorders

“**Given the prevalence of alcohol contributing to overdose deaths, it remains important to promote prevention and treatment efforts, including MAT for alcohol abuse as well as opioids.**”

- Worcester
Fentanyl

Three OFR teams recommended action on fentanyl.
– Implement a statewide education campaign about fentanyl and heroin overdose risks
– Improve surveillance of fentanyl and other highly potent opioids to obtain real-time awareness of increased overdose activity in Baltimore and respond with outreach and education.
– Fentanyl alerts

“Fentanyl has become more pervasive on the street and involved in rising numbers of overdose deaths”

- Baltimore City
Eight OFR teams recommended strategic expansion of Naloxone distribution and overdose prevention education.

- Engage judges on sentencing, including ordering SUD evaluation and assessing previous
- Increase community-based Naloxone trainings
- Reach more people at highest risk of experiencing or witnessing an overdose.

“In all of the cases reviewed, there is NO indication that anyone close to the deceased had received Naloxone training”  
- Wicomico
Six OFR teams recommended changes to the criminal justice system.

- Promote consideration and assessment of SUD history in sentencing
- Increase MAT, SUD treatment, and Naloxone distribution in detention centers and upon release
- Provide up-to-date drug trend briefing to first responders

“In some cases, probationers were not court ordered for treatment, despite evidence of having a substance use disorder”

- Baltimore County
Public Awareness

Three OFR teams recommended expansion of public awareness campaigns
- Tailor public education efforts to include bars and restaurants, central booking, Emergency Departments, treatment providers
- Community outreach and education on overdose prevention and treatment resources
- Increase awareness of the Good Samaritan Law

“Law enforcement suspects the family had cleaned up all evidence of drug use before calling 911 to report a suspected heart attack”

- Garrett
OFR Expansion and Innovation

• Develop protocols for and pilot team coordination of services provided to surviving family members and outreach activities to prescribers and other healthcare providers associated with decedents selected for case review
  – Beginning in Year 2, two local OFR teams will begin writing protocols for and conducting outreach to surviving family members and health care providers

• Create an integrated online portal for overdose fatality review data transmission and reporting through CRISP
  – Streamline access to PDMP, CRISP, OCME, and OFR reporting data
  – Improve capacity for local and statewide analysis
OFR Expansion and Innovation

• **Enhance PDMP-related technical assistance to teams**
  – Expand technical assistance and training for PDMP data to improve its use during case review and inform outreach activities
  – Create PDMP guidance document
  – Develop PDMP web-based training for Local OFR teams

• **Conduct program and grant activity evaluation**
  – University of Maryland Systems Evaluation Center will evaluate grant activities by attending selected team meetings, analyzing OFR data, and conducting stakeholder interviews
OFR Staff

Laura Bartolomei-Hill, LGSW
Overdose Fatality Review Coordinator
Office: 410-402-8491
Email: laura.bartolomei-hill@maryland.gov

Maryland Department of Health
Behavioral Health Administration
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, MD 21228