Overdose Fatality Review in Maryland

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Overdose Deaths in Maryland, 2007-2013

95%
2013: State Overdose Prevention Plan

- Enhanced epidemiology
- Expand Medication Asst. Tx: methadone & bupe
- Reduce Rx abuse:
  - PDMP: within CRISP, state Health Info Exchange
  - DHMH investigative “fusion center” w/ licensing boards
  - CDS patient support following license suspensions
  - Standardize “lock-in” across Medicaid MCOs
  - Clinical education: FDA REMS
- Naloxone: 3rd party training/credentialing law
- Local: all jurisdictions required to create local overdose prevention plans
Overdose Fatality Review

• State-supported, in-depth review of OD deaths by local-level stakeholders

• Modelled on existing mortality review teams for children, fetal/infant, domestic violence, etc.

• Goals:
  o Identify OD risk factors to improve local prevention planning
  o Identify missed opportunities for prevention/intervention
  o Make recommendations to law/policies/programs to prevent future deaths
  o Increase inter-agency communication/collaboration, trust and buy-in around OD issue
Age-Adjusted Death Rates for Total Intoxication
Deaths by Place of Residence, Maryland, 2007-2012

Note: Since rates based on fewer than 20 deaths are considered unreliable, rates are only shown for jurisdictions with 20 or more intoxication deaths over a six-year period. The counties in white have fewer than 20 deaths. Homicides and Suicides are not shown in this map.

Legend
Age-Adjusted Death Rate Per 100,000 Population
- 4.40 - 6.00
- 6.01 - 10.10
- 10.11 - 13.30
- 13.31 - 17.10
- 17.11 - 27.90

Source: Maryland Department of Health and Mental Hygiene
Map Created: July 2013
Local Overdose Fatality Review Teams

- Est. by local health departments: Baltimore City, Cecil County & Wicomico County pilots

- Multi-agency, multi-disciplinary:
  - LHD
  - SUD/Mental Health coord.
  - Healthcare providers
  - EMS
  - Hospital
  - Social Services
  - Law enforcement
  - Prosecutors
  - Corrections
  - Juvenile services
  - Schools

- Confidential proceedings & records protected from discovery/subpoena in civil litigation

- Primarily review resident deaths
Office of Chief Medical Examiner: monthly OD death record query:

- Decedent info (name, DOB, sex, address, etc.)
- Incident info (COD & MOD, location)
- ME investigative notes (LE, witness, kin info)
- Toxicology results

Vital Statistics Admin: analyze & code OCME records for substances/classes, matches against death certificates

Behavioral Health Admin:

- Matches death records w/ SUD Tx records
- Formats all data in secure file & sends to LOFRTs
- LOFRT Data Use Manual
- LOFRT technical assistance

LOFRT: Team members must query agency systems for decedent info and bring to meetings
Recordkeeping Requirements

- Team coordinators must maintain notes from meetings
- Notes must include:
  - Demographic information
  - Substances involved in death
  - Time spent reviewing case
  - Systems with which the deceased interacted
  - Key observations from review
- List of meeting attendees
- Observation and recommendation tracking chart
LOFRTs & PDMP data

- MD PDMP law does not allow direct data disclosure to LOFRTs
- PDMP regulations changed to allow data re-disclosure to LOFRTs
- DHMH currently working w/ OCME to est. routine request & re-disclosure process
- Proposal to change PDMP law in 2015 to allow LOFRTs to request data directly
House Bill 1282, 2014

• Modelled on Child Fatality Review statute
• Est. OFR in law and gives local jurisdictions authority to create teams (voluntary)
• Gov. agencies & healthcare providers must provide decedent records at LOFRT request
• LOFRT members & people that provide info are immune from civil liability
• DHMH oversees LOFRTs and may require reports
Implementation to Date

• 2013 HRPDMP grant: funding for DHMH program coordinator
• First meetings February 2014
• Mostly monthly, 2 hour meetings
• 50 cases reviewed by 3 pilot jurisdictions
• No formal recommendations made yet, but…. 
Sample of Highlighted Issues

- SUD Tx program patient death reporting to DHMH: new investigative process established
- Lack of followup w/ aftercare on discharge SUD Tx
- Examine/improve OTP protocols for pregnant women
- Naloxone in recovery houses
- Improve referral to naloxone training through EMS, community outreach, housing partners
- Promote PDMP use by somatic providers and OTPs
- Develop PDMP provider alerts on dangerous drug combinations
- Access to care limited by insurance paneling
- Need better child/family services for addicted patients
- Large number of individuals w/ intimate partner violence: need for trauma-informed care
- Need to conduct outreach post EMS-treated non-fatal overdose