Overdose Fatality Review

Melissa Heinen, RN, MPH
Institute for Intergovernmental Research
mheinen@iir.com
Overdose Fatality Review Team

Melissa Heinen, RN, MPH
Senior Research Associate
mheinen@iir.com

Chris Morgan
Senior Research Associate
cmorgan@iir.com

Lauren Savitskas, MPH
Senior Research Associate
lsavitskas@iir.com

Cat Gangi, MPH, CHES
Senior Program Specialist
cgangi@iir.com

Mallory O'Brien Ph.D., M.S.,
Consultant, IPA Overdose
Fatality Reviews, CDC, Senior
Science Advisor, IPA, BJA
COSSAP
Mallory.O'Brien@usdoj.gov
OFR Purpose and Value

- Overdoses are preventable
- Identify system gaps: missed opportunities for prevention and intervention
- Design innovative community-specific prevention strategies
Overdose Fatality Review Overview

• OFRs involve analysis and **review of aggregate data** to understand overdose trends, select cases to review, and provide context for case findings and recommendations.

• OFRs involve a series of **confidential individual death reviews** by a multidisciplinary team to effectively **identify system gaps and innovative community-specific** overdose prevention and intervention strategies.

• These recommendations are presented to a **governing committee** that supports and provides resources for an implementation framework for accountability for action.
OFR Structure

**Lead Agency:** Oversees the OFR team coordination and provides administrative support

**Governing Committee:** Supports and provides resources to implement recommendations generated by case reviews

**OFR Team:** Multidisciplinary team that reviews a series of individual deaths to identify system-level missed opportunities for prevention and intervention

**Subcommittees:** Focus attention on a recommendation or need, such as case selection
## The “SOS” Process

<table>
<thead>
<tr>
<th>Shared Understanding</th>
<th>OFRs increase members’ understanding of area agencies’ roles and services as well as the community’s assets and needs, substance use and overdose trends, current prevention activities, and system gaps.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimized Capacity</td>
<td>OFRs increase the community’s overall capacity to prevent future overdose deaths by leveraging resources from multiple agencies and sectors to increase system-level responses.</td>
</tr>
<tr>
<td>Shared Accountability</td>
<td>OFRs continually monitor local substance use and overdose death data as well as recommendation implementation activities. Status updates on recommendations are shared at each OFR team meeting and with a governing committee, reinforcing accountability for action.</td>
</tr>
</tbody>
</table>
Aggregate Data Discussion

• Purpose
• Examples
• Mechanism
Data Collection: Confidentiality

- Confidentiality is essential
- Data sharing agreements
- Confidentiality agreements
- State legislation
Information and Data Sharing

How can an OFR team obtain Prescription Drug Monitoring Program records after a person dies?

• In the absence of a specific state statute or regulation authorizing the release of Prescription Drug Monitoring Program (PDMP) records to an OFR team, it is unlikely the team can directly receive prescription information from the state PDMP. However, OFR teams should contact the administrator of their state PDMP to determine if other avenues exist through which one or more team members can obtain PDMP records in the absence of direct authority, such as via the decedent’s medical file or a next of kin request.

Legislative Analysis and Public Policy Association (LAPPA) – information sharing guidance documents
Sample Timeline of Decedent’s Life Events

9 April 2020
EMS responds to nonfatal overdose

18 August 2020
9-1-1 call related to a domestic assault

1 September 2020
Decedent released from county jail

7 September 2020, 5:00 p.m.
Decedent found dead of an overdose
Case Data Discussion - Timeline

• Purpose
• Examples
• Mechanism
Problem-Solving Process to Identify Recommendations

- What are the missed opportunities?
- What are the system gaps?
- What can be done to improve service delivery or intervention?
- How would this be implemented and in what settings?
What Makes a Good Recommendation?

- Specific
- Measurable
- Actionable
- Assigned to a specific agency
- Time-bound
- Data-informed
Example: All these cases missed their first substance use disorder (SUD) treatment appointment after release from local jail. How often do people connect with community treatment after release?
Resources
Overdose Fatality Review: A Practitioner’s Guide to Implementation
1. Case Information
   - OFR Administration
   - Decedent Demographic Information
   - Cause of Death
   - Scene of Overdose and Death
   - Drugs at the Scene of Death
   - Death Investigation and Toxicology Information
   - Interventions Following Overdose
   - Life Stressors
   - Health History and Health Care Access
   - Prescription Drug Monitoring Program Summary Indicators
   - Mental Health History
   - Substance Use History
   - Trauma History
   - Criminal Justice History
   - Social Services History
   - Education History
   - Recommendations
   - Site-specific Community Context Variables
   - Site-specific Variables
   - Narrative Section

2. County Profile

3. Recommendation Monitoring

4. Next-of-Kin Interview
<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decedent had medications entered in the PDMP within two years prior to death</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the decedent prescribed opioids in the 24 months prior to death?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the decedent prescribed benzodiazepines in the 24 months prior to death?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the decedent prescribed benzodiazepines and opioids concurrently in the 24 months prior to death?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the decedent prescribed gabapentinoid in the 24 months prior to death?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Did the decedent have overlapping opioid prescriptions in the 24 months prior to death?</td>
<td>No</td>
<td>Yes</td>
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</table>
### Example: PDMP Summary

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the decedent have multiple prescribers in the 24 months prior to death?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the decedent have multiple pharmacies in the 24 months prior to death?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the decedent receive long-acting opioids at some point in the 24 months prior to death?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the decedent opioid naïve (not receiving opioids for a period of 6 months or greater) and then received long-acting opioids at some point in the 24 months prior to death?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the decedent ever prescribed greater than 90 morphine milligrams equivalent (MME) in the 24 months prior to death?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**
1. OFR Administration

1.1) Case-unique identifier (REDCap generated)

Variable: case_id

Question type: Automatically generate by REDCap

Definition: REDCap will generate a unique case ID.

Guidance: None

Reference: None

1.2) Name of person completing this form

Variable: contact_name

Question type: Text entry

Definition: First and last name of the person completing this case record information.

Guidance: These are the first and last names of the person entering the data for this case.

Reference: None

Section Tables

<table>
<thead>
<tr>
<th>Section</th>
<th>OFR Administration</th>
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</thead>
<tbody>
<tr>
<td>Variable</td>
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<tr>
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</tr>
<tr>
<td>contact_name</td>
<td>text</td>
</tr>
<tr>
<td>contact_email</td>
<td>text [email]</td>
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<tr>
<td>start_date</td>
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<tr>
<td>review_date</td>
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<tr>
<td>data_type_3</td>
<td>binary</td>
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</tbody>
</table>
OFR Resources
Training and Technical Assistance
OFR Email Exchange

Great way to network with your peers

• Send an email to the group (OFR@cossapresources.org) and every member of the list will get the email. That is all there is to it.

• Sign up by emailing COSSAP@iir.com requesting to be added to the COSSAP OFR Email Exchange
Questions?

Melissa Heinen
mheinen@iir.com