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
Isavitskas@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

Shared Understanding

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.

Optimized Capacity

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.

Shared Accountability

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.

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



EMS responds to nonfatal overdose



1 September 2020

Decedent released from county jail

9-1-1 call related to a domestic assault



Decedent found dead of an overdose



Case Data Discussion - Timeline

- Purpose
- Examples
- Mechanism

Problem-Solving
Process to Identify
Recommendations







Specific



Measurable



Actionable



Assigned to a specific agency

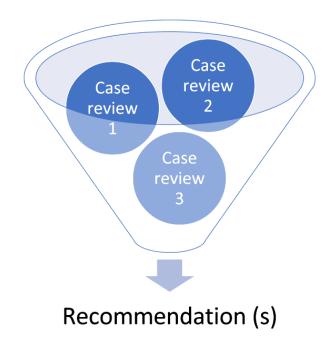


Time-bound



Data-informed

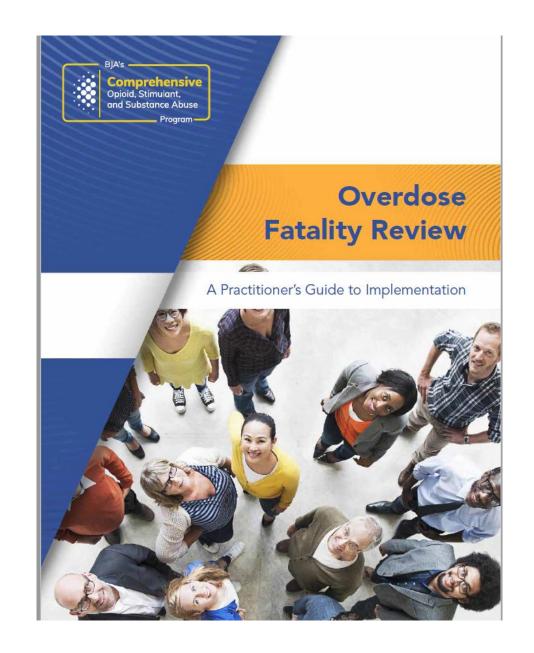
Case Review→ Recommendations → Action



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



Modules



Recruit

Recruit Your OFR Members



Plan

Plan Your OFR Meeting



Facilitate

Facilitate Your OFR Meeting



Collect

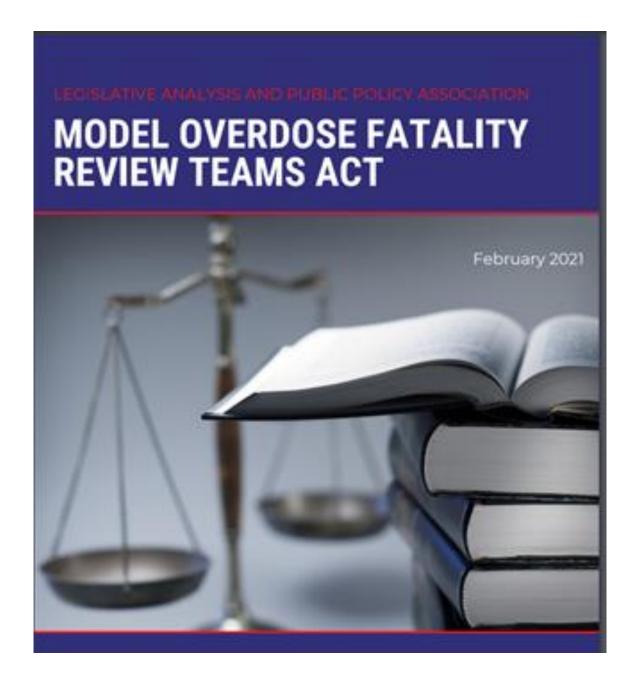
Collect Your OFR Data



Build

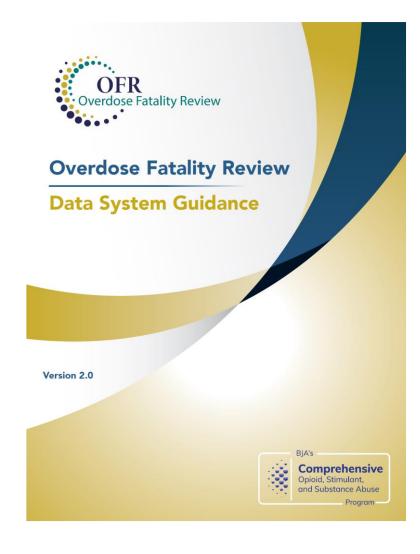
Build a Recommendation Plan

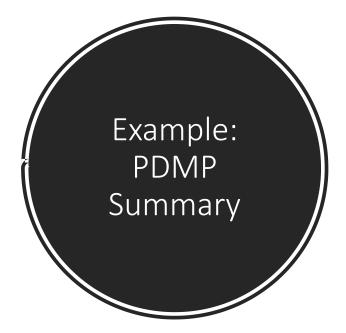
OFR Model Law



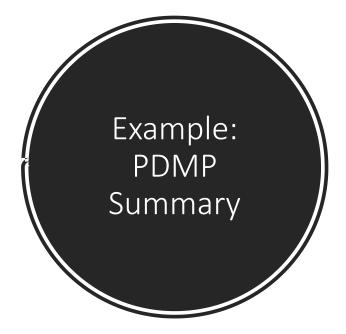
OFR Database Version 2.0

- 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





Decedent had medications entered in the PDMP within two years prior to death
○ No
Was the decedent prescribed opioids in the 24 months prior to death?
○ No ○ Yes
Was the decedent prescribed benzodiazepines in the 24 months prior to death?
○ No ○ Yes
Was the decedent prescribed benzodiazepines and opioids concurrently in the 24 months prior to death?
○ No ○ Yes
Was the decedent prescribed gabapentinoid in the 24 months prior to death?
○ No ○ Yes
Did the decedent have overlapping opioid prescriptions in the 24 months prior to death?
○ No ○ Yes



Did the decedent have multiple prescribers in the 24 months prior to death?
○ No ○ Yes
Did the decedent have multiple pharmacies in the 24 months prior to death?
○ No ○ Yes
Did the decedent receive long-acting opioids at some point in the 24 months prior to death?
○ No ○ Yes
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?
O No
○ Yes
Was the decedent ever prescribed greater than 90 morphine milligrams equivalent (MME) in the 24 months prior to death?
○ No
○ Yes
Notes

OFR Data System Guidance Documents

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

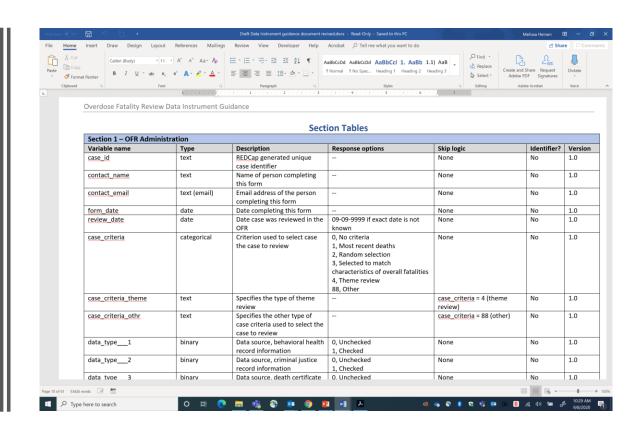
Variable: contact_name

Question type: Text entry

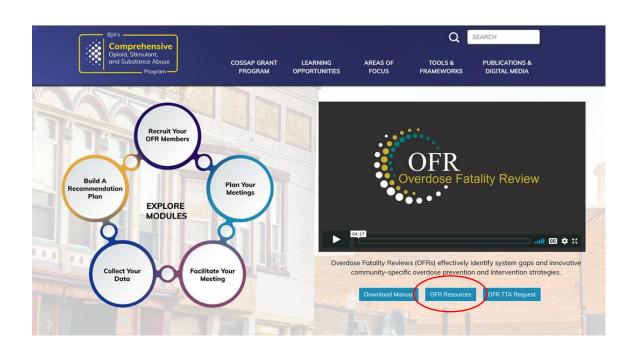
Definition: First and last name of the person completing this case record information.

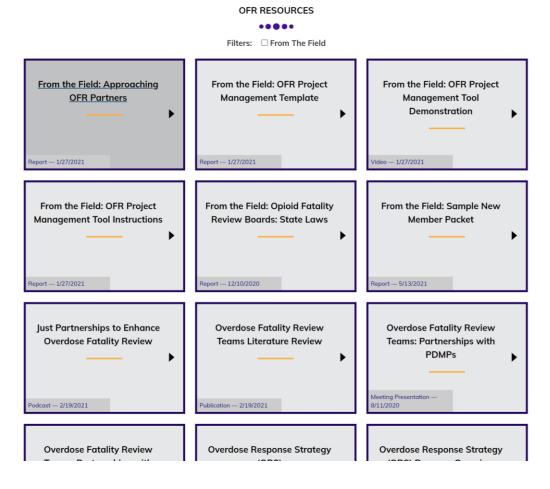
Guidance: These are the first and last names of the person entering the data for this case.

Reference: None



OFR Resources





Training and Technical Assistance

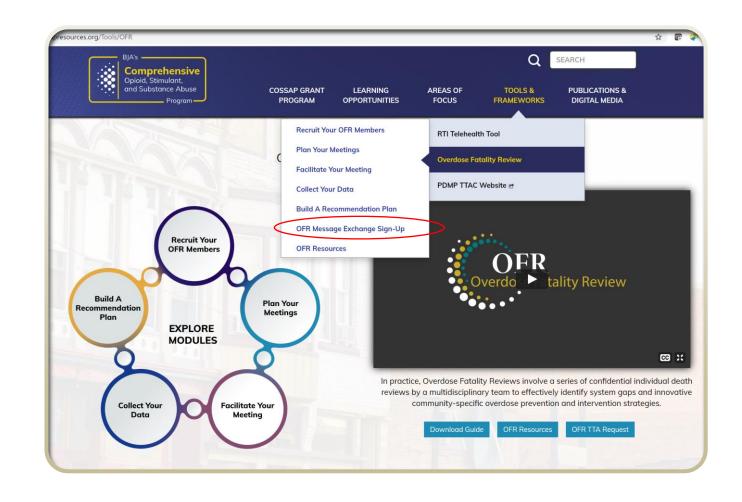


Tools & Frameworks OFR	
	TRAINING AND TECHNICAL ASSISTANCE REQUEST
The fields marked with the * are required	1.
Name *	
Agency *	
Current Grant Funding Source	
Γitle *	
City *	
uty	
State/Territory *	
Select State/Territory	
Email *	
Phone Number *	
∏A Type *	
Overdose Fatality Review	

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 <u>COSSAP@iir.com</u> requesting to be added to the COSSAP OFR Email Exchange



Questions?

Melissa Heinen mheinen@iir.com