

Overdose Fatality Review in Maryland

June 26, 2019

Brooke G. Holmes, M.A., Administrator-OFR Manager
Costella M. Davis, M.H.A., OFR Coordinator
Office of Population Health Improvement

Public Health Approach



Overdose Fatality Review (OFR)

- State-supported, it is an in-depth review of OD deaths by local-level stakeholders
- Modeled after other mortality review teams such as Child Fatality Review and Fetal and Infant Mortality Review
- Provides a framework for analyzing deaths, understanding causes, and identifying prevention for future similar deaths
- Allows for data or information sharing within a protected space
- 3 approaches: provider, medical, community-based



Legal Authority

Health General Article, Title 5, Subtitle 9, Annotated Code of Maryland (OFR Law)



- In Health General § 5-903 teams are granted authority to conduct case review
- On request of the team chair, agencies are obligated to provide information about the case under review
- Teams may review people that have died of a drug and/or alcohol overdose, their family members, and anyone convicted of a crime that led to the death
- 42 C.F.R. § 2.15(b) allows for non-consented disclosures of patient information relating to the death of the patient pursuant to “laws ... permitting inquiry into the cause of death,” as does HIPAA (42 CFR section 164.512.)
- The team’s investigatory function allows patient-identifying information about a deceased patient to be disclosed to the team as part of a case review without consent or a court order.
- Establishes confidentiality expectations

Overdose Fatality Review Goals

- Identify overdose risk factors to improve local prevention planning
- Identify missed opportunities for prevention/intervention
- Make recommendations to law/policies/programs to prevent *future* deaths
- In addition to identify risk factor trends and outcomes across various demographic characteristics and counties.
- *Increase inter-agency communication/collaboration, trust and buy-in around overdose issue*



Overdose Fatality Review Method (OFR)

Method

- Local OFR teams conduct confidential reviews on a monthly, bi-monthly, or quarterly basis of resident drug and alcohol overdose deaths. Examination of collected quantitative and qualitative data.

Case Management System

- Chesapeake Regional Information System for our Patients (CRISP) houses the OFR Database
 - A means to provide teams with detailed information on overdose decedents and the circumstances of death.
 - MDH Office of the Chief Medical Examiner (OCME)
 - Vital Statistics Administration (VSA)
 - Prescription Drug Monitoring Program (PDMP)
 - Additional clinical data



Overdose Fatality Review

Teams

- Operational in 19 of 24 jurisdictions
- **Funded Teams Activities: Provider Outreach & Family Overdose Outreach**
 - Through Harold Rogers Grant:
 - Baltimore Co.
 - Carroll Co.
 - Through CDC Grant:
 - Worcester Co.
 - Frederick Co.



Overdose Fatality Review



OFR Team members consists of:

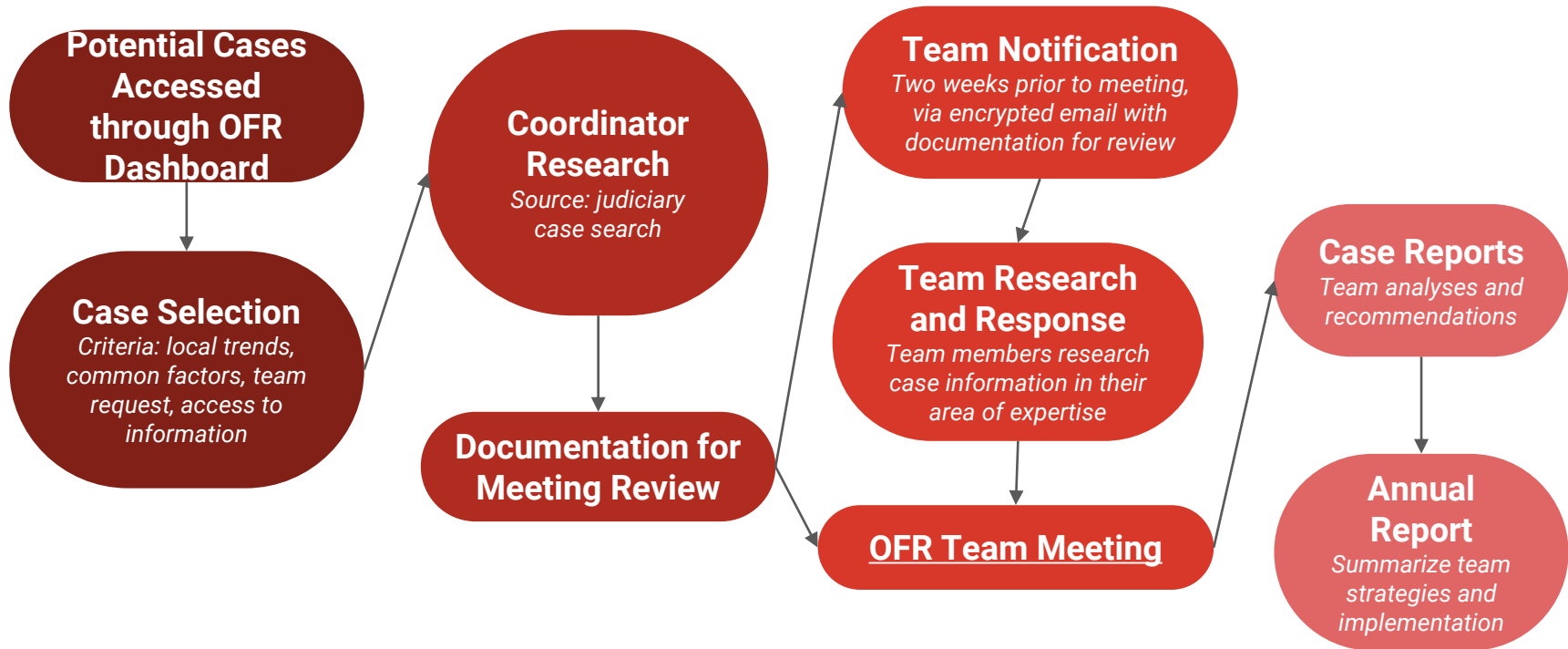
Local Health Department	Hospitals
Department of Social Services	Prevention Office
Local Law Enforcement	Juvenile Services
Emergency Medical Services	Parole and Probation
Public Education	Crisis Services
Harm Reduction Services	Pharmacy

Team Collaboration



- We encourage teams to provide case information two weeks prior to meeting that allows time to adequately research case data and consider contributing factors
- Case information is shared electronically via secured email - password protected documents or encrypted email service
- Local OFR Coordinator facilitates meeting and collects data for reporting, solicits information from members re: team changes, new members, processes
- Team members report their own case information- contributions may raise questions that lead to further insight
- Open dialogue allows all stakeholders to verbally explore relationships between community resources and contributing factors, leading to more creative problem-solving and greater synergy

Local OFR Team Workflow

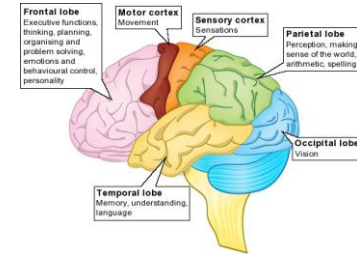


Case Reporting

- Case reporting form is based on
 - Maryland Violent Death Reporting System (MVDRS), suggestions of LOFRTs, recent overdose research, and gaps identified in OFR data.
 - New questions have been added
 - identify history of acquired brain injury
 - history of employment
 - identification of minor and/or adult children
 - pregnancy status
- Ability to access and download aggregate information, filterable by date range, from previously submitted case report forms for analysis at the local level.

Traumatic Brain Injury and the Opioid Crisis

- People who have a history of a moderate to severe traumatic brain injury (TBI) are 11 times more likely to die from an overdose than those without a history of TBI.
- Researchers report that people with TBI are at a significantly greater risk for opioid misuse and overdose
- Contributing to this risk, 70-80% of people with TBI are discharged from inpatient rehabilitation with an opioid prescription
- If the brain is starved of oxygen for more than 5-6 minutes due to an overdose, people who survive their overdose may sustain an Acquired Brain Injury (ABI)



[Filter](#)
[User Access](#)
[Resource Center](#)
[Upload OCME](#)
[Decedent Census Download](#)
[Case Report Download](#)
[Show Only Flagged Cases](#)

Open Cases

1 2 3 ... 25 Next »

OCME #	Resident County	Date Of Death	Cause of Death	Incident Jurisdiction	Case Action
[REDACTED]	Washington	[REDACTED]	ACUTE ALCOHOL INTOXICATION	Washington	Flag Close Edit
[REDACTED]	Frederick	[REDACTED]	COMBINED FENTANYL AND COCAINE INTOXICATION	Frederick	Flag Close Edit
[REDACTED]	Frederick	[REDACTED]	ALCOHOL INTOXICATION COMPLICATED BY DROWNING	Frederick	Flag Close Edit
[REDACTED]	Washington	[REDACTED]	OXYMORPHONE AND TRAZODONE INTOXICATION WITH COCAINE USE	Washington	Flag Close Edit
[REDACTED]	Washington	[REDACTED]	FENTANYL INTOXICATION COMPLICATING HYPERTENSIVE CARDIOVASCULAR DISEASE	Washington	Flag Close Edit

Available to Review

1 2 3 4 5 6 ... 797 Next »

OCME #	Resident County	Date Of Death	Cause of Death	Incident Jurisdiction	Case Action
[REDACTED]	Cecil	[REDACTED]	COMBINED EFFECTS OF HEROIN AND FENTANYL	Cecil	Check Flag Close
[REDACTED]	Cecil	[REDACTED]	METHADONE AND FENTANYL INTOXICATION	Cecil	Check Flag Close
[REDACTED]	Cecil	[REDACTED]	HEROIN FENTANYL AND ALCOHOL INTOXICATION	Cecil	Check Flag Close
[REDACTED]	Cecil	[REDACTED]	COMBINED EFFECTS OF HEROIN FENTANYL AND ALCOHOL	Cecil	Check Flag Close
[REDACTED]	Allegany	[REDACTED]	MIXED DRUG (HEROIN COCAINE METHADONE; FURANYL 4-	Allegany	Check Flag Close

Health-General Article 5 5-906, Annotated Code of Maryland, establishes that, with certain exceptions, the proceedings, records, and files of a LOFRT are confidential and not discoverable or admissible as evidence in any civil action. Much of the information provided to the LOFRT by the Maryland Department of Health, including investigative records of the Office of the Chief Medical Examiner, is confidential, privileged and protected from or limited in disclosure under state and federal laws and regulations.


Overdose Fatality Review Dashboard Cont:

Details

OCME Details

INCIDENT_ZIP	[REDACTED]
CASE_TYPE	Autopsy
MANNER	Undetermined
CODICD	METHADONE AND FENTANYL INTOXICATION
COD_4_FLUOR_FENT	No
COD_ACETYL_FENT	No
COD_ACRYL_FENT	No
COD_ALCOHOL	No

Actions

✓ ✕  [Clinical Data](#)

Case Attributes

2017 Trends Observed in 518 Cases	2018 Trends Observed in 415 Cases
Mental Health Diagnoses or treatment history	Mental Health Comorbidity
Previous Overdose	Cause of Death Fentanyl Combination
Somatic Health Condition	Caucasian Males
Pain Management	Criminal Justice History
Intimate Partner Violence	Homelessness
Recent time of abstinence	Visit the Emergency Room

Emerging trends

- Overdose deaths occurring in a hotel or motel
- History of traumatic brain injury
- History of childhood trauma

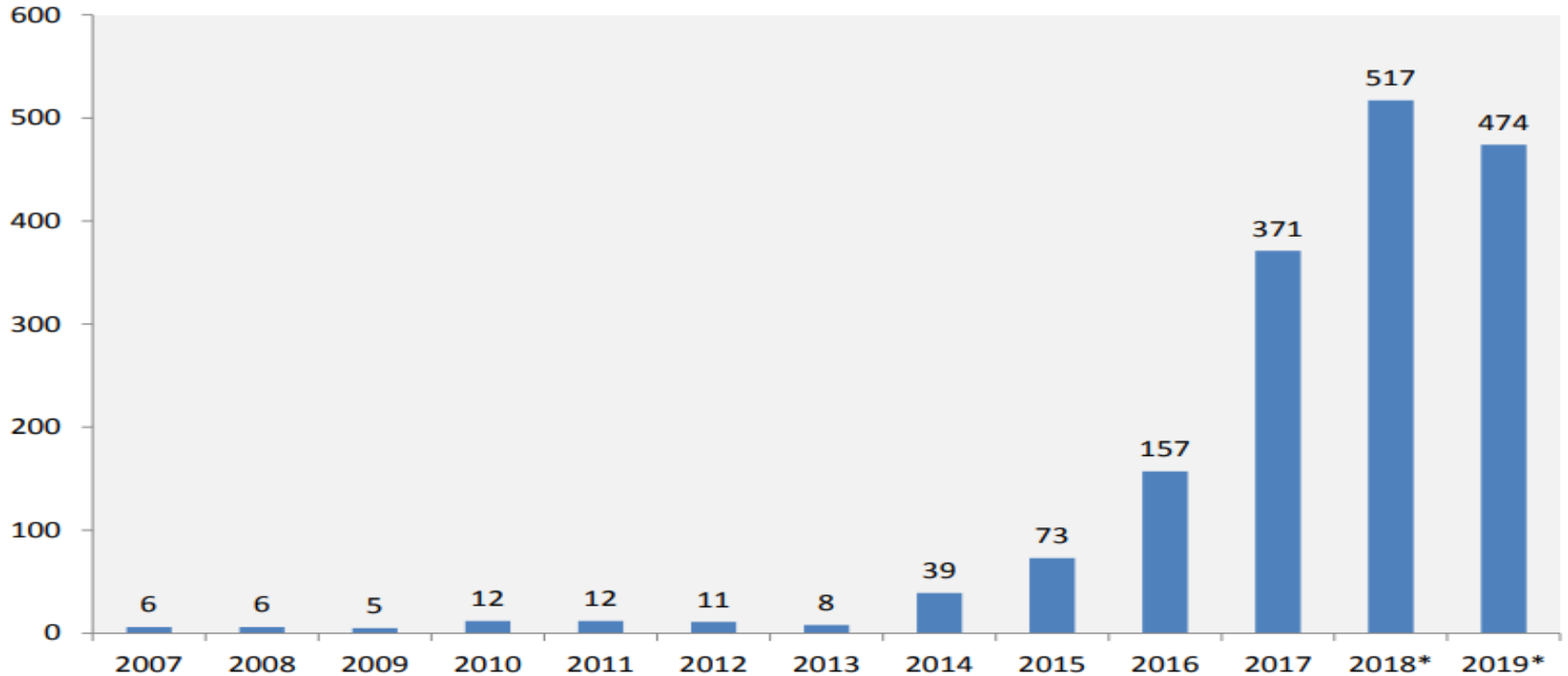


OFR 2018 Annual Report Data by County

County	# of Reviewed Cases	Average age or age range of Decedent	Substance Used	Gender of Majority of Decedent	Race of majority of decedent
Allegany Co	22	40yrs	92% Fentanyl	Male	Caucasian
Anne Arundel Co	23	20-35yrs	40% Fentanyl	Male	Caucasian
Baltimore City	15	35yrs	Fentanyl or a Fentanyl analogue	Male	African American
Baltimore Co	41	23-73yrs	Fentanyl	Male	Caucasian
Calvert Co	12	19-59yrs	Fentanyl	Male	Caucasian
Carroll Co	12	39yrs	Fentanyl	Male	Caucasian
Cecil Co	42	38yrs	Mixed Drugs	Male	Caucasian
Charles Co	25	38yrs	Fentanyl	Male	Caucasian
Frederick Co	30	24-34yrs	81% Fentanyl	Male	Caucasian
Garret Co	5	37yrs	Mixed Drugs involving Fentanyl	Male	Caucasian
Harford Co	14	40yrs	Fentanyl	Male	Caucasian
Howard Co	38	31-40yrs	Fentanyl	Male	Caucasian
Montgomery Co	17	22-59%	71% Fentanyl	Male	Caucasian
Prince George's Co	7	28-75yrs	43% Fentanyl	Male	African American
Somerset Co	8	35yrs	75% Fentanyl	Male	Caucasian
St. Mary's Co	30	24-60yrs	70% Fentanyl	Male	Caucasian
Washington Co	24	20-66yrs	Mixed Opioids	Male	Caucasian
Wicomico Co	33	38yrs	85% Fentanyl	Male	Caucasian
Worcester	17	42yrs	82% Fentanyl	Male	Caucasian

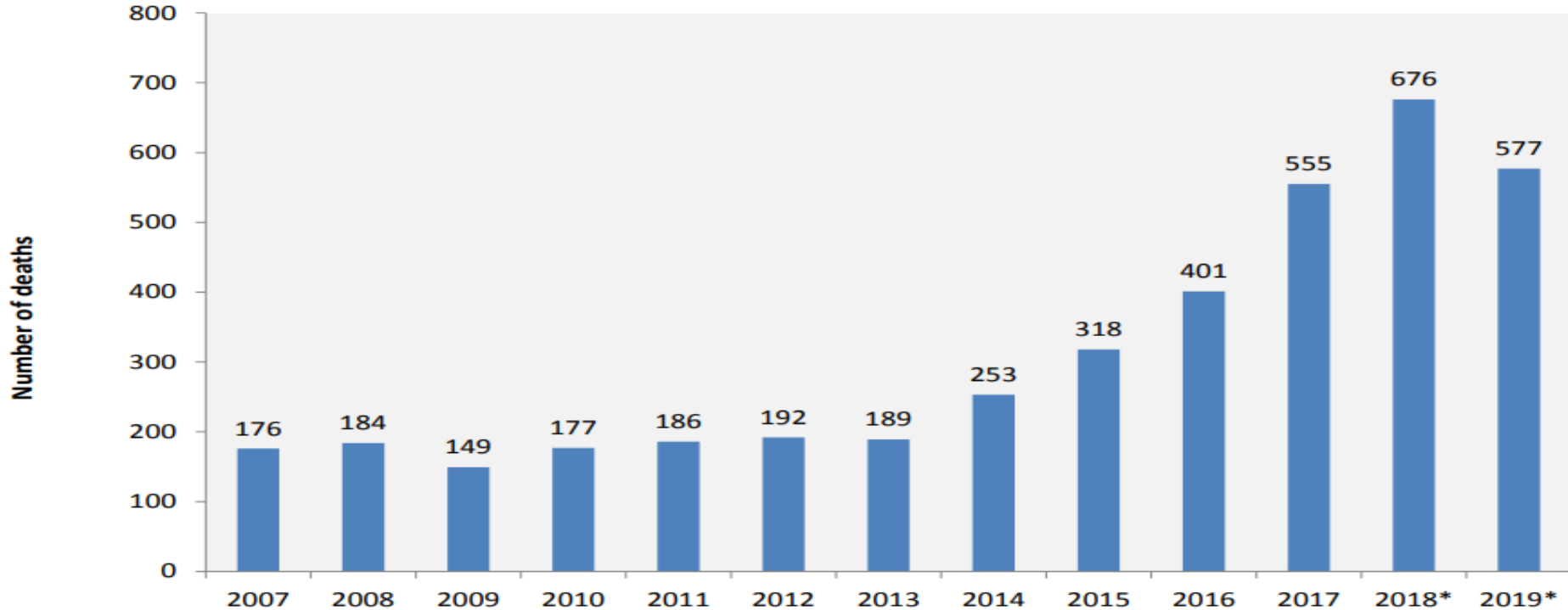


Number of Fentanyl-Related Deaths Occuring in Maryland from January-September of Each Year



* 2018, 2019 counts are preliminary.

Total Number of Unintentional Intoxication Deaths Occuring in Maryland from January-March of Each Year. *



* 2018, 2019 counts are preliminary.

Top Gaps in Services OFR Teams Observed

- Access to treatment for substance use
- Education to families and concerned others regarding Naloxone
- Access to Co-occurring treatment
- Communication between agencies
- Re-entry services/linkage to care
- Harm Reduction referrals



Local Recommendations



Case Attribute	Recommendation	Implementation
Fatal overdoses occurring in local hotel	Train hotel staff to administer Naloxone	Opioid Prevention Coalition coordinator reached out to hotel manager, Overdose Response Program coordinator conducted Naloxone training
Prescribed medications were contributors to overdose fatalities in majority of cases	Train prescribers of risks and consequences of prescription drug misuse; encourage prescribers to follow best practices	Opioid Misuse Prevention Program coordinator organized training programs and distributed CDC prescribing guidelines
Decedent was found by a family member in a majority of cases	Develop targeted outreach protocol and family support information materials	OFR Coordinator and Overdose Prevention Peer Support Specialist developing resource materials for distribution to family of overdose victims

Macro Recommendations



- Prevention Education: Drug education and outreach to families
- Integrated Care: Increase use of peer support counselors
- Harm Reduction: Good Samaritan Law Education/Naloxone education
- Criminal Justice Institution: Judge education and outreach
- Underserved population: Support for children of overdose patients
- Services enhancing: More accessible to trauma counseling
- Information sharing: Focus on communication among agencies
- Standardization: Need for standardized shelter services
- Law Enforcement and Forensic Intervention: Police with mental health focus

Lessons learned – 4 years of OFR

Lessons Learned



- Find balance between data collection function and maintaining space for open dialogue and conversation.
- Make connections with local and statewide programs. In Maryland, this has included primary prevention, the Opioid Misuse Prevention Program, naloxone and the Overdose Response Program, expansion of sterile syringe programs, and the work of the Opioid Intervention Teams.
- Create space for local jurisdictions to make the program useful for them through case selection, data analysis capacity, and meeting structure.
- Provide opportunities for learning through presentations on calls and in-person.
- Acknowledge and find ways to address team member fatigue as they review overdose cases.

Special Thanks

Anastasia Edmonston, MS CRC

Coordinator, Traumatic Brain Injury Partner Grant

Maryland Behavioral Health Administration



Thank you!

Brooke G. Holmes, MA

Brooke.holmes@maryland.gov

Administrator-Overdose Fatality Review Manager

Costella M. Davis, MHA

Costella.davis@maryland.gov

Overdose Fatality Review Coordinator

Office of Population Health Improvement
Maryland Department of Health-Public Health Services

References

- Haas, E., Truong, C., Bartolomei-Hill, L., Baier, M., Bazron, B., & Rebbert-Franklin, K. (2018). Local Overdose Fatality Review Team Recommendations for Overdose Death Prevention. *Health Promotion Practice*, 152483991879761. doi:10.1177/1524839918797617
- FN, K. (2019, January 22). "Everything you need to know about fentanyl." Medical News Today. Retrieved from Maryland Drug Rehab And Addiction Treatment Options. (2018, July 9). Retrieved from <https://www.addictioncampuses.com/maryland/>
- Opioids and Brain Injury Fact Sheet, (2019). This fact sheet is a collaboration of the Brain Injury Association of Maryland Traumatic Brain Injury Partner Grant, and is supported in part by grant number 90TBSG0027-01-00, FROM THE U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Point of view or opinions do not, therefore, necessarily represent official ACL policy. <https://www.medicalnewstoday.com/articles/308156.php>.
- Spencer, M. R., Warner, M., Bastian, B., Trinidad, J., & Hedegaard, H. (2019). Drug overdose death involving fentanyl, 2011-2016. National Vital Statistics Report, 68(3), 19. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_03-508.pdf