Overdose Fatality Review Annual Report: Empowering Community Action

February 2023

Overdose Fatality Review Team

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OFR Structure

Lead Agency: Oversees the OFR team coordination and provides administrative support, ideally a nonpolitical, neutral agency

Governing Committee/PHAST: 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

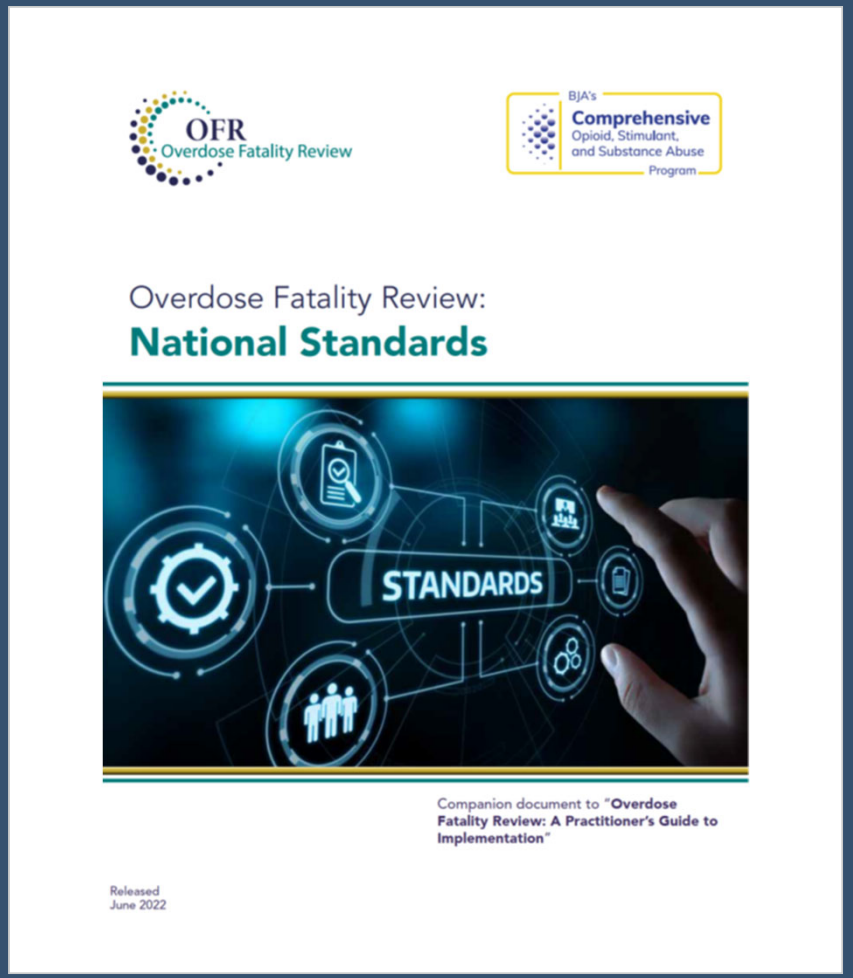
Subcommittees: Focus attention on a recommendation or need, such as case selection

Learning Objectives

- Explain the purpose and value of an annual report
- Provide an overview of collecting and summarizing data to include in an annual report
- Share examples of annual reports and dissemination strategies
- Highlight how to use an annual report to mobilize community and action

At least annually, draft a report to showcase progress, findings, and recommendations

National Standard



Purpose and Value

Communicate progress, findings, and recommendations

Ensure accountability and transparency

Mobilize community and OFR members to action

Offer hope to those impacted by substance use and related deaths

Audiences

OFR Members including Governing Committee/PHAST
Partners
Community leaders
State agencies
Elected officials
Funders
Community members
Loss survivors and recovery community

Methodology

Coconino County, AZ

[OFR-Annual-Report_2019-Final.pdf (tgcaz.org)]

METHODOLOGY FOR CASE REVIEW

Coconino County's OFR team utilizes the following procedure to conduct its case review.

1

STEP 1: CASE IDENTIFICATION

Identify cases through the Office of the Coconino County Medical Examiner (ME) on a quarterly basis.

2

STEP 2: OBTAIN RECORDS

Obtain all pertinent records from the ME, Law Enforcement, and Courts for overdose deaths.

3

STEP 3: CREATE CASE SUMMARIES

Prepare summary reports based on all the records obtained.

4

STEP 4: CONVENE QUARTERLY MEETINGS

Convene quarterly meetings in which select cases are reviewed and discussed in greater detail. The team's discussion focuses on understanding the medical, social and behavioral health circumstances surrounding each death in an effort to identify prevention measures. The team asks itself two key questions:

1) What possible changes could have been made in this person's life?
2) What points of contact, connection, systems changes, education, etc. could have prevented this death?

Methodology

Washington, DC

[OFRB 2020 Annual Report-FINAL WEB.pdf (dc.gov)]

OFRB
ACCOMPLISHMENTS AND HIGHLIGHTS

A LOOK INTO 2020 OFRB OBJECTIVES

- The development of the OFRB Case Summary Review Form adapted from the CDC Maternal Mortality Review Committee Decisions Form MMRIA.
- Conducting quarterly recommendation sub-committee meetings for the formal adoption of recommendations.

DC OCME was awarded funds as a sub-grantee from the Centers for Disease Control and Prevention (CDC): Overdose Data to Action (OD2A) grant to hire an additional Opioid Fatality Review Program Specialist. The specialist will be responsible for the planning coordination of case reviews as required by the OFRB.

Functions of the OFRB

The OFRB is tasked with the following functions:

1. EXAMINATION
The examination of deaths of District residents over the age of eighteen (18) years who died of a confirmed opioid (illicit and prescription) overdose.

2. IDENTIFICATION
Identifying the causes and circumstances contributing to an opioid overdose death, including socioeconomic risk factors, education, behavioral health, and public and private system contacts, including criminal justice and treatment.

3. REVIEW AND EVALUATION
Reviewing and evaluating services provided by public and private systems relevant to drug treatment and prevention specific to an opioid death or as part of a systemic evaluation of service providers.

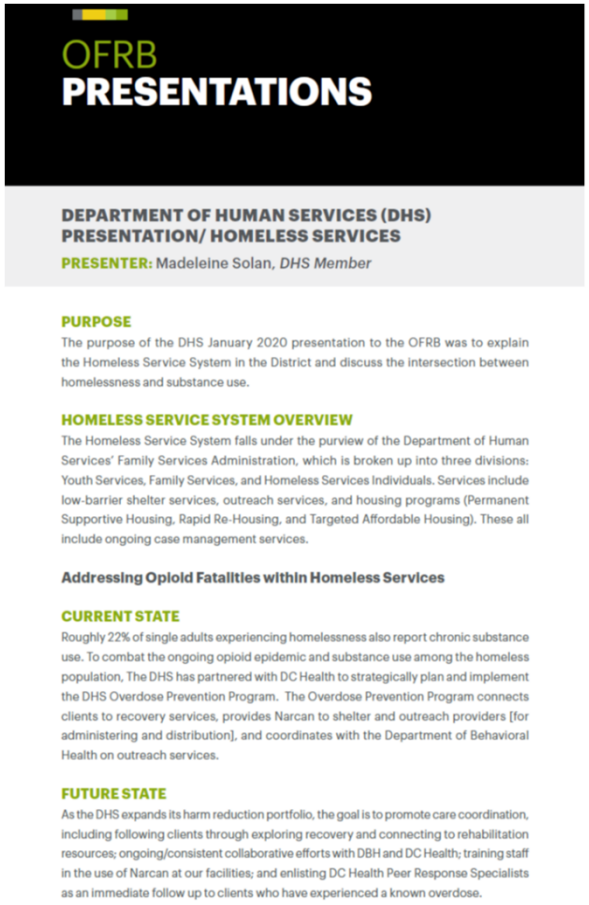
4. ADVISING
Advising the Mayor on findings and recommendations to reduce the number of preventable opioid overdose deaths and promote the improvement of public and private systems serving District residents with substance use disorders.

5. CONFIDENTIALITY
The confidentiality of the decedents is maintained through signed confidentiality agreements before each meeting and de-identification of the decedent and their families.

Methodology

Washington, DC

[OFRB 2020 Annual Report-FINAL WEB.pdf (dc.gov)]



OFRB
PRESENTATIONS

DEPARTMENT OF HUMAN SERVICES (DHS) PRESENTATION/ HOMELESS SERVICES

PRESENTER: Madeleine Solan, *DHS Member*

PURPOSE

The purpose of the DHS January 2020 presentation to the OFRB was to explain the Homeless Service System in the District and discuss the intersection between homelessness and substance use.

HOMELESS SERVICE SYSTEM OVERVIEW

The Homeless Service System falls under the purview of the Department of Human Services' Family Services Administration, which is broken up into three divisions: Youth Services, Family Services, and Homeless Services Individuals. Services include low-barrier shelter services, outreach services, and housing programs (Permanent Supportive Housing, Rapid Re-Housing, and Targeted Affordable Housing). These all include ongoing case management services.

Addressing Opioid Fatalities within Homeless Services

CURRENT STATE

Roughly 22% of single adults experiencing homelessness also report chronic substance use. To combat the ongoing opioid epidemic and substance use among the homeless population, The DHS has partnered with DC Health to strategically plan and implement the DHS Overdose Prevention Program. The Overdose Prevention Program connects clients to recovery services, provides Narcan to shelter and outreach providers [for administering and distribution], and coordinates with the Department of Behavioral Health on outreach services.

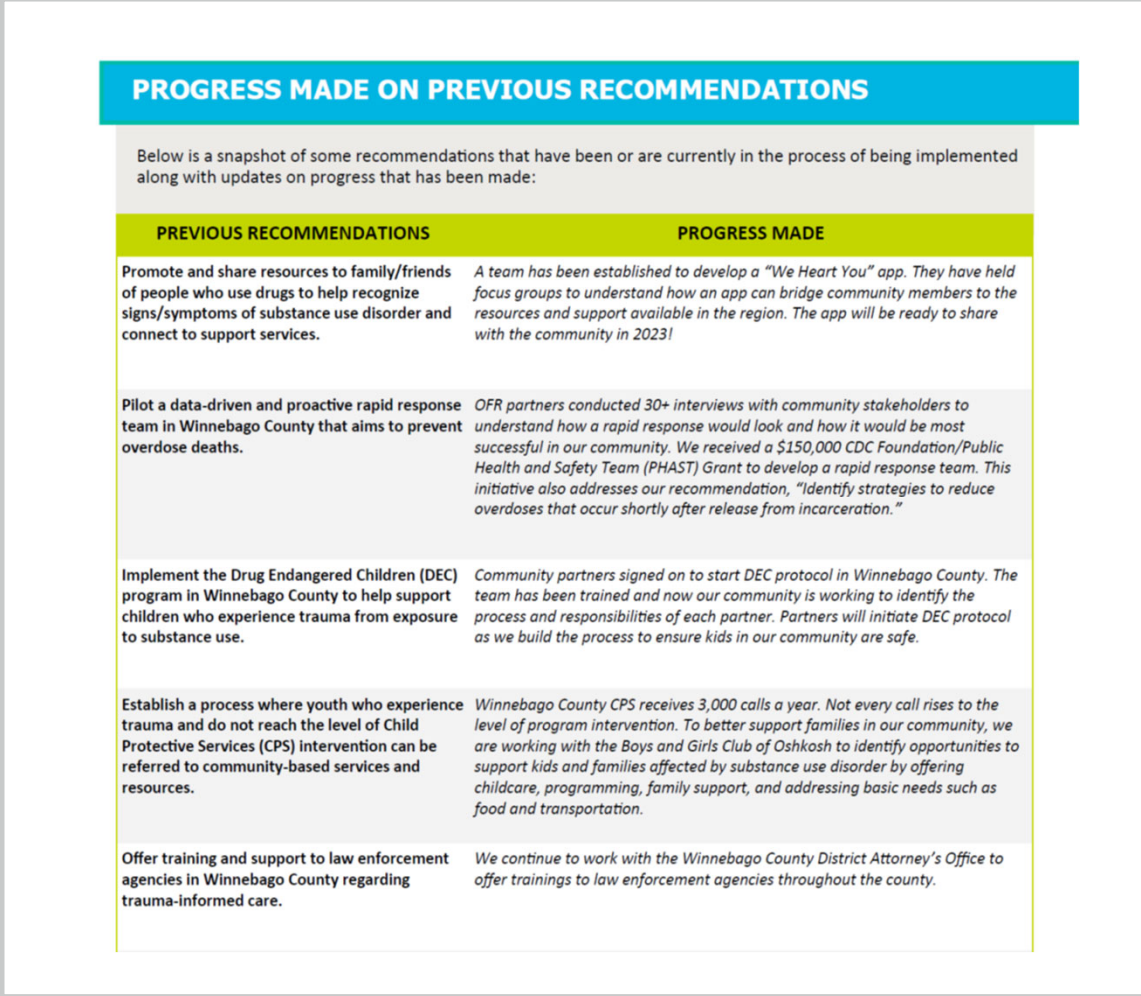
FUTURE STATE

As the DHS expands its harm reduction portfolio, the goal is to promote care coordination, including following clients through exploring recovery and connecting to rehabilitation resources; ongoing/consistent collaborative efforts with DBH and DC Health; training staff in the use of Narcan at our facilities; and enlisting DC Health Peer Response Specialists as an immediate follow up to clients who have experienced a known overdose.

Example: Accountability

Winnebago County, WI

https://www.co.winnebago.wi.us/sites/default/files/uploaded-files/2021-2022_winnebago_ofr_annual_report_final.pdf



PROGRESS MADE ON PREVIOUS RECOMMENDATIONS

Below is a snapshot of some recommendations that have been or are currently in the process of being implemented along with updates on progress that has been made:

PREVIOUS RECOMMENDATIONS	PROGRESS MADE
Promote and share resources to family/friends of people who use drugs to help recognize signs/symptoms of substance use disorder and connect to support services.	*A team has been established to develop a "We Heart You" app. They have held focus groups to understand how an app can bridge community members to the resources and support available in the region. The app will be ready to share with the community in 2023!*
Pilot a data-driven and proactive rapid response team in Winnebago County that aims to prevent overdose deaths.	*OFR partners conducted 30+ interviews with community stakeholders to understand how a rapid response would look and how it would be most successful in our community. We received a $150,000 CDC Foundation/Public Health and Safety Team (PHAST) Grant to develop a rapid response team. This initiative also addresses our recommendation, "Identify strategies to reduce overdoses that occur shortly after release from incarceration."*
Implement the Drug Endangered Children (DEC) program in Winnebago County to help support children who experience trauma from exposure to substance use.	*Community partners signed on to start DEC protocol in Winnebago County. The team has been trained and now our community is working to identify the process and responsibilities of each partner. Partners will initiate DEC protocol as we build the process to ensure kids in our community are safe.*
Establish a process where youth who experience trauma and do not reach the level of Child Protective Services (CPS) intervention can be referred to community-based services and resources.	*Winnebago County CPS receives 3,000 calls a year. Not every call rises to the level of program intervention. To better support families in our community, we are working with the Boys and Girls Club of Oshkosh to identify opportunities to support kids and families affected by substance use disorder by offering childcare, programming, family support, and addressing basic needs such as food and transportation.*
Offer training and support to law enforcement agencies in Winnebago County regarding trauma-informed care.	*We continue to work with the Winnebago County District Attorney's Office to offer trainings to law enforcement agencies throughout the county.*

Give Hope

Ocean County, NJ

[Ocean County Overdose Fatality Review Program Annual Report (naccho.org)]

Reflections on 2019

Successes

- A Chief's Opioid Response Committee was formed by bringing in the local Chiefs of Police to discuss the overdose epidemic and formalize strategies through a public safety and public health partnership.
- The executive committee of the OC-OFRP was expanded to help move the recommendations of the monthly fatality review committee into actionable steps
- In 2019, the National Association of County and City Health Officials (NACCHO) selected the OC-OFRP as a National Model Practice. This honor means that Ocean County implemented a program that "*demonstrates exemplary and replicable outcomes in response to an identified public health need.*"
- The First National Conference on Fatality Reviews was held Washington D.C. and Kimberly Reilly was invited to present on the OC-OFRP and the success of the sub-committees.
- In order to address the underlying stigma in Ocean County, a Share Your Story sub-committee was formed and a Share Your Story event was held on October 24, 2019 highlighting four stories of love, loss, and hope in the overdose epidemic.
- A partnership was formed with Brick Police Department in a program called, "Because We Care: Share Your Story" in which police officers outreach the homes of those reversed by narcan to conduct a questionnaire on their and their families experiences in the community, with law enforcement, the judicial system, and healthcare providers. The OCHD partnered to assist with questions and to provide navigation to treatment and recovery supports. This model expanded to Lacey Township Police Department in 2019. A CDC/NACCHO grant was secured to expand the project in 2020.
- In 2019, legislation to mandate fatality reviews to each county is reviewed.
- The first year-end conference was held focusing on the successes of the group along with a training on self-care during the overdose epidemic.

Above: Kimberly Reilly (OCHD) and Nava Bastola (NY/NJ HIDTA) presenting the fatality review poster at the NACCHO Annual Conference. Below: Same receiving the award for a 2019 Model Practice.

Below: The Share Your Story Invite for October 12, 2019.

Summary Data Included

- OFR members and structure
- Community aggregate data
- OFR reviewed cases
- Contextualize cases
- OFR findings
- OFR recommendations

Example: OFR Members and Structure

Salem County, NJ

[Overdose Fatality Review Salem County, New Jersey Annual Report 2020-2021 (salemcountynj.gov)]

Members, Participating Agencies, and Subcommittees

We have diligently worked to recruit a diverse, complete list of OFRT members. We have representatives from both the private and public sectors. Our recruitment efforts continue as our team identifies team members who may enhance our reviews.

Salem County Overdose Fatality Review Team Affiliated Agencies

- ACENDA Integrated Health
- Addiction Medicine Center for Healing/Cooper Health
- CDC Foundation and NY/NJ HIDTA
- Center for Family Services
- Department of Child Protection & Permanency
- Gloucester/Camden/Salem Medical Examiner's Office
- Healthcare Commons, Inc.
- Hendricks House, Inc.
- Inspira Health Network
- Maryville Addiction Treatment Centers of New Jersey
- New Hope IBHC
- New Jersey Department of Health, Office of Local Public Health
- New Jersey State Police Office of Drug Monitoring and Analysis
- Pennsville Police Department
- Pittsgrove School District Guidance Department
- Salem City Police Department
- Salem County Board of Social Services
- Salem County Correctional Facility
- Salem County Health and Human Services Health Officer
- Salem County Health and Human Services Mental Health Administrator
- Salem County Health and Human Services Alcohol and Drug Abuse Services Director
- Salem County Overdose Fatality Review Team Coordinator
- Salem County Prosecutors Office
- Salem Medical Center
- The Southwest Council

Executive Committee Members

- Director of the Salem County Department of Health and Human Services
- Salem County Office of Mental Health Administrator
- Salem County Department of Health and Human Services Health Officer
- Salem County Alcohol and Drug Abuse Services Director
- Salem County Overdose Fatality Review Team Coordinator

Example: OFR Members and Structure

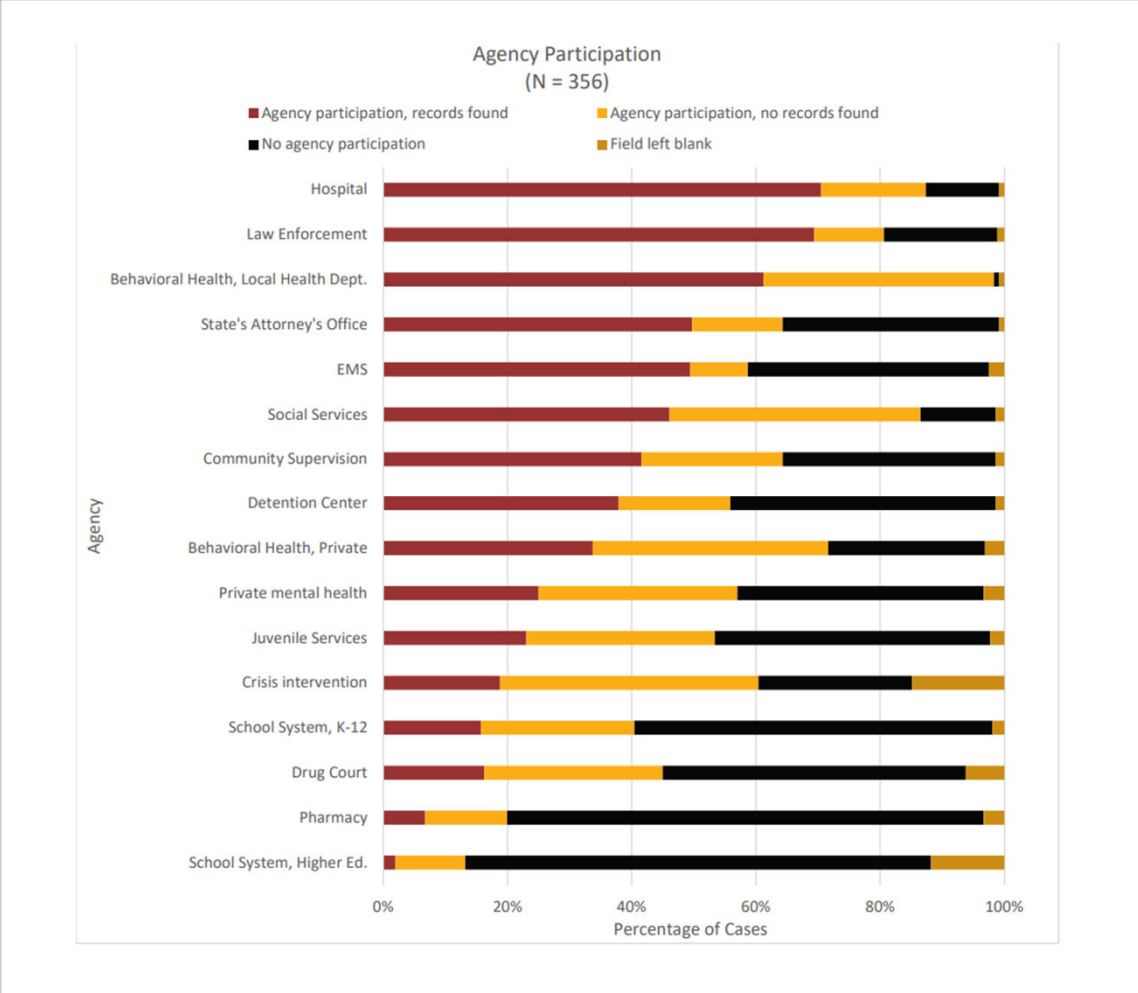
Coconino County, AZ

[OFR-Annual-Report_2019-Final.pdf (tgcaz.org)]

Example: OFR Members and Structure

Maryland State Report

[Microsoft Word - OFR Annual Report Synopsis 2019_FINAL REVISED 01.19.2022_v2 (maryland.gov)]



Example: Community Aggregate Data

Mercer County, NJ

[Overdose Fatality Review Report - Trenton Health Team]

Our Community

Mercer County, New Jersey

Demographics

- 367,922 population
- 62.9% White
- 20.7% African-American
- 17.5% LatinX
- 7.9% families living below the poverty line, with median household income of $81,057

Data reflects the most recent available ACS data, which is the 5 year estimate from 2015 - 2019

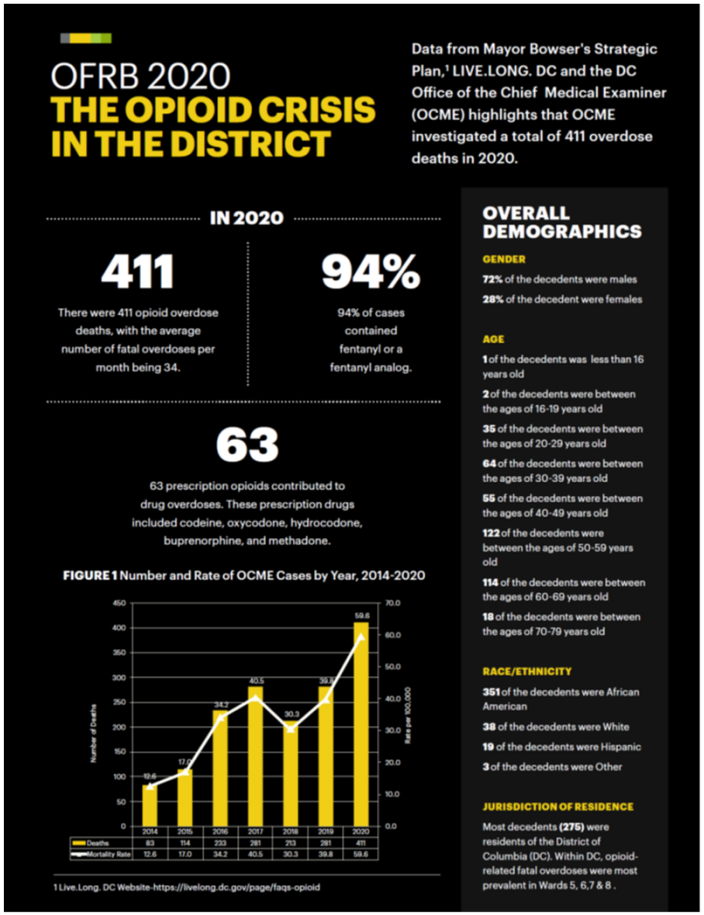
Healthcare Services

- 3 hospital systems
- 1 federally qualified health center
- 1 syringe exchange program

Example: Community Aggregate Data

Washington, DC:

[OFRB 2020 Annual Report-FINAL WEB.pdf (dc.gov)]



OFRB 2020
THE OPIOID CRISIS IN THE DISTRICT

Data from Mayor Bowser's Strategic Plan,[1] LIVE.LONG. DC and the DC Office of the Chief Medical Examiner (OCME) highlights that OCME investigated a total of 411 overdose deaths in 2020.

IN 2020

411
There were 411 opioid overdose deaths, with the average number of fatal overdoses per month being 34.

94%
94% of cases contained fentanyl or a fentanyl analog.

63
63 prescription opioids contributed to drug overdoses. These prescription drugs included codeine, oxycodone, hydrocodone, buprenorphine, and methadone.

FIGURE 1 Number and Rate of OCME Cases by Year, 2014-2020

	2014	2015	2016	2017	2018	2019	2020
Deaths	83	114	233	281	213	281	411
Mortality Rate	12.6	17.0	34.2	40.5	30.3	39.8	59.6

1 Live.Long. DC Website-https://livelong.dc.gov/page/faqs-opioid

OVERALL DEMOGRAPHICS

GENDER
72% of the decedents were males
28% of the decedent were females

AGE
1 of the decedents was less than 16 years old
2 of the decedents were between the ages of 16-19 years old
35 of the decedents were between the ages of 20-29 years old
64 of the decedents were between the ages of 30-39 years old
65 of the decedents were between the ages of 40-49 years old
122 of the decedents were between the ages of 50-59 years old
114 of the decedents were between the ages of 60-69 years old
18 of the decedents were between the ages of 70-79 years old

RACE/ETHNICITY
351 of the decedents were African American
38 of the decedents were White
19 of the decedents were Hispanic
3 of the decedents were Other

JURISDICTION OF RESIDENCE
Most decedents **(275)** were residents of the District of Columbia (DC). Within DC, opioid-related fatal overdoses were most prevalent in Wards 5, 6,7 & 8 .

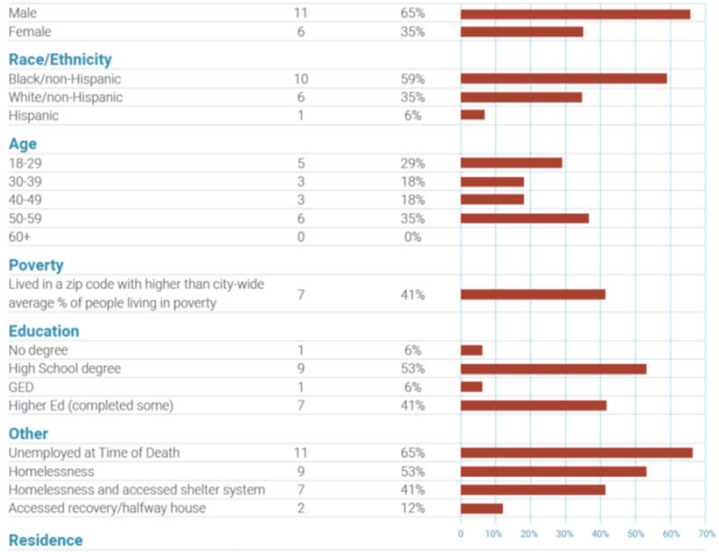
Example: OFR Cases

Philadelphia

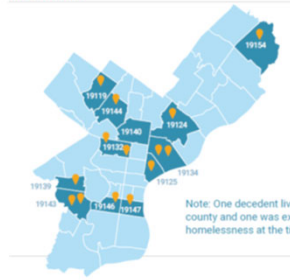
[OD-Stat-Annual-Report-2021-FINAL.pdf (phila.gov)]

Demographics of OD Stat Decedents Reviewed in 2021

	2021 OD Stat Decedents	% of Total Reviewed (17)
Sex		
Male	11	65%
Female	6	35%
Race/Ethnicity		
Black/non-Hispanic	10	59%
White/non-Hispanic	6	35%
Hispanic	1	6%
Age		
18-29	5	29%
30-39	3	18%
40-49	3	18%
50-59	6	35%
60+	0	0%
Poverty		
Lived in a zip code with higher than city-wide average % of people living in poverty	7	41%
Education		
No degree	1	6%
High School degree	9	53%
GED	1	6%
Higher Ed (completed some)	7	41%
Other		
Unemployed at Time of Death	11	65%
Homelessness	9	53%
Homelessness and accessed shelter system	7	41%
Accessed recovery/halfway house	2	12%



Residence



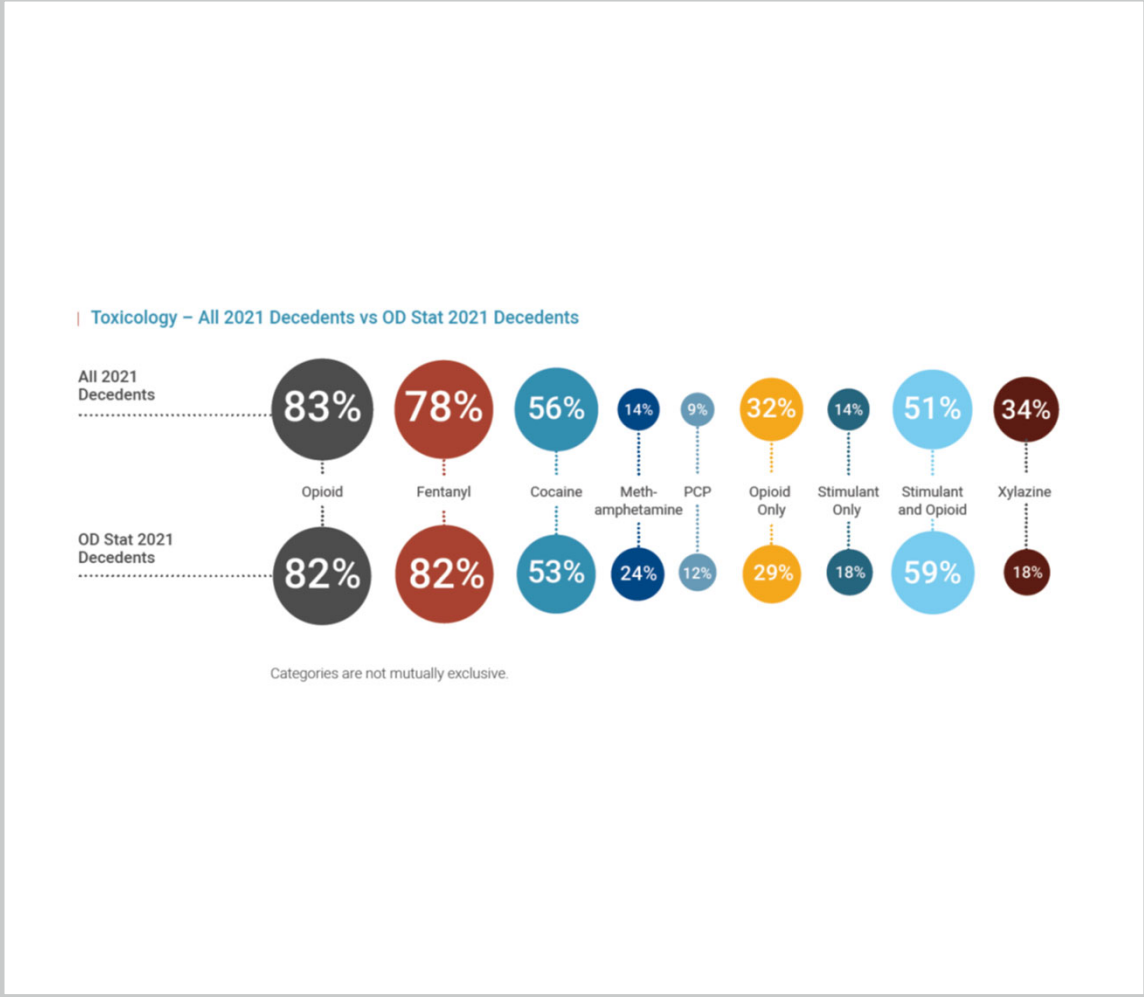
In 2021, by residence, the highest number of overdoses occurred in 19134, 19124, 19140, 19132, and 19144. At left is the map of the OD Stat decedent's resident zip codes reviewed in 2021.

Note: One decedent lived out of county and one was experiencing homelessness at the time of death.

Example: Contextualize Cases

Philadelphia

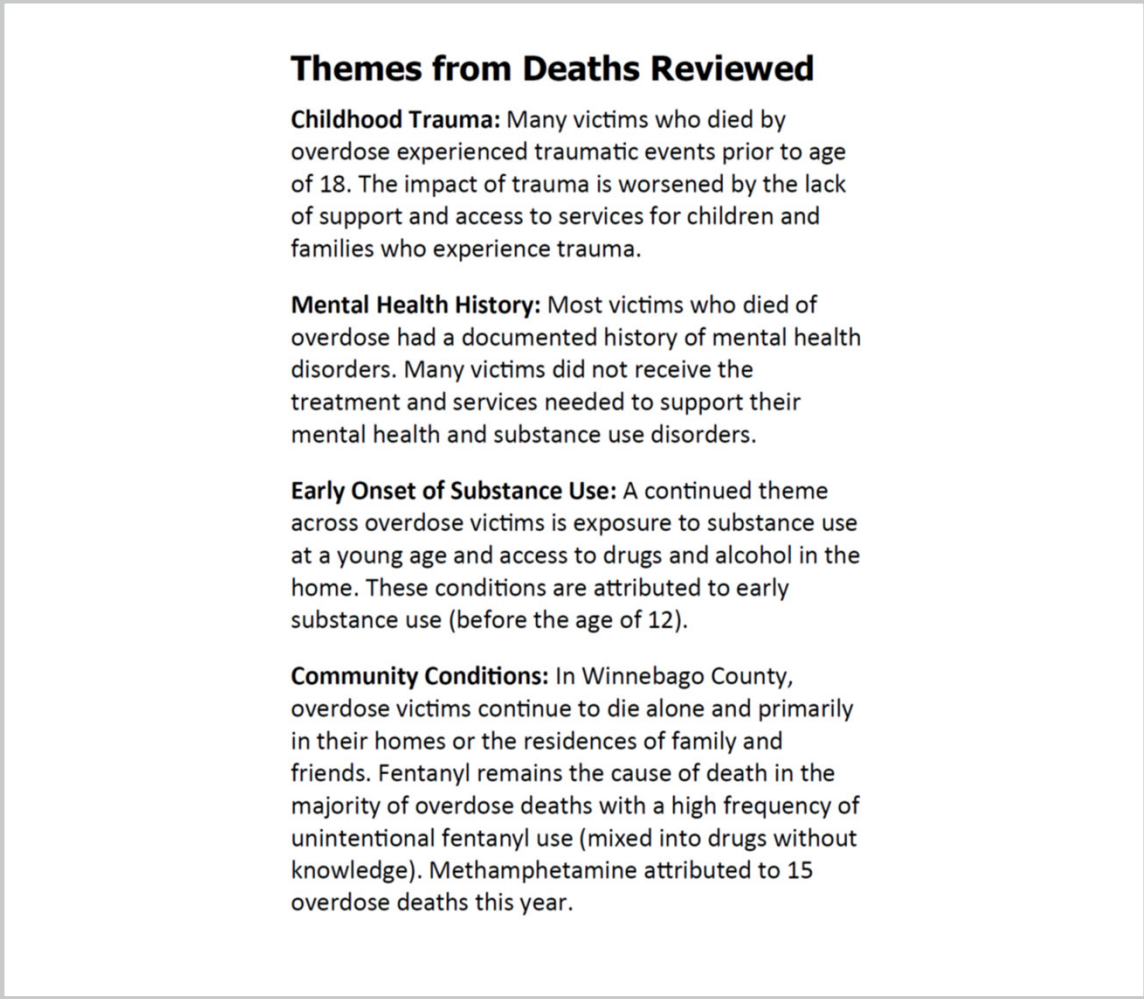
[OD-Stat-Annual-Report-2021-FINAL.pdf (phila.gov)]



Example: OFR Findings

Winnebago County, WI

https://www.co.winnebago.wi.us/sites/default/files/uploaded-files/2021-2022_winnebago_ofr_annual_report_final.pdf



Themes from Deaths Reviewed

Childhood Trauma: Many victims who died by overdose experienced traumatic events prior to age of 18. The impact of trauma is worsened by the lack of support and access to services for children and families who experience trauma.

Mental Health History: Most victims who died of overdose had a documented history of mental health disorders. Many victims did not receive the treatment and services needed to support their mental health and substance use disorders.

Early Onset of Substance Use: A continued theme across overdose victims is exposure to substance use at a young age and access to drugs and alcohol in the home. These conditions are attributed to early substance use (before the age of 12).

Community Conditions: In Winnebago County, overdose victims continue to die alone and primarily in their homes or the residences of family and friends. Fentanyl remains the cause of death in the majority of overdose deaths with a high frequency of unintentional fentanyl use (mixed into drugs without knowledge). Methamphetamine attributed to 15 overdose deaths this year.

Example: OFR Findings

Salem County, NJ

[Overdose Fatality Review Salem County, New Jersey Annual Report 2020-2021 (salemcountynj.gov)]

Identified Patterns/Trends

Supports and Relationships

88% of cases had social supports. 75% of the deaths occurred in their home and an additional 13% of the deaths occurred at friend or relative's home. Sharing information and resources with families and friends may be an opportunity to reach individuals with Opioid Use Disorder.

Recognizing Individuals Seeking Assistance

54% had a history of Mental Health treatment and 67% had more than four Emergency Department visits or Emergency Medical Services responses. These interactions demonstrate that these individuals were seeking assistance for a medical reason, even if not directly related to a substance use disorder. These interactions with healthcare providers may be opportunities to discuss opioid use.

Interactions with the Judicial System

25% of the cases had a history of incarceration. There is a need to support efforts to establish relationships with those working in the justice system to help individuals with substance use disorder to quickly gain access to treatment and recovery services, community resources, and case management.

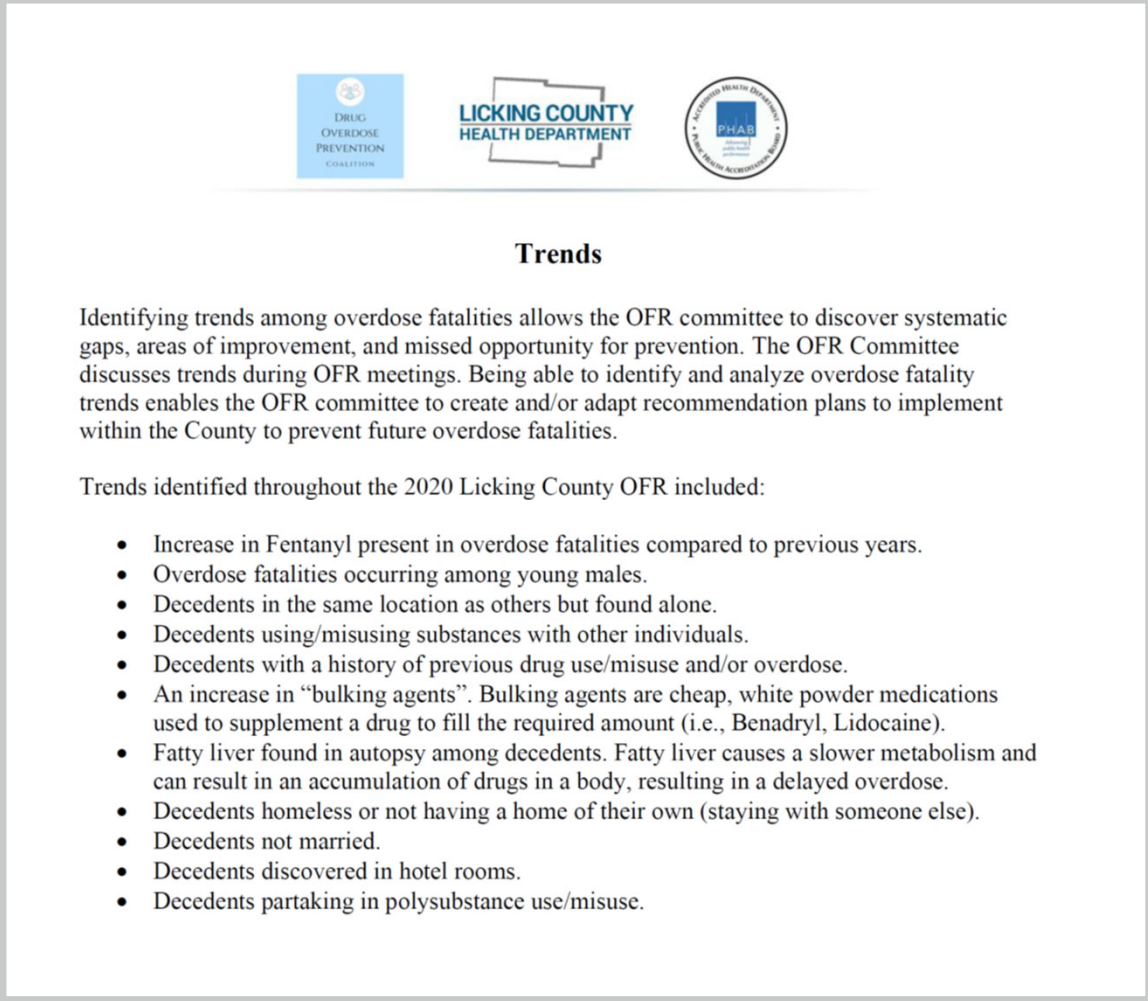
Hard To Reach Age Group

42% of the cases reviewed were between the age of 25 to 35 years old. Programs, supports and outreach efforts are often geared toward students or the elderly. The workgroup may work to identify outreach strategies and materials to reach this specific age group.

Example: OFR Findings

Licking County, OH

[Licking-County-2020-OFR-Report.pdf (lickingcohealth.org)]



Trends

Identifying trends among overdose fatalities allows the OFR committee to discover systematic gaps, areas of improvement, and missed opportunity for prevention. The OFR Committee discusses trends during OFR meetings. Being able to identify and analyze overdose fatality trends enables the OFR committee to create and/or adapt recommendation plans to implement within the County to prevent future overdose fatalities.

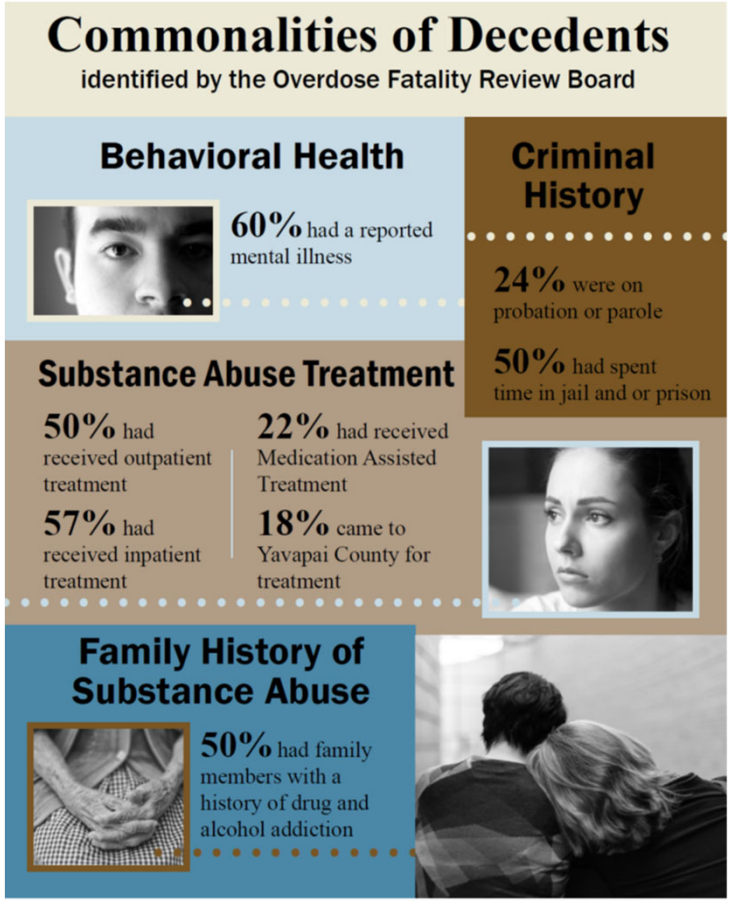
Trends identified throughout the 2020 Licking County OFR included:

- Increase in Fentanyl present in overdose fatalities compared to previous years.
- Overdose fatalities occurring among young males.
- Decedents in the same location as others but found alone.
- Decedents using/misusing substances with other individuals.
- Decedents with a history of previous drug use/misuse and/or overdose.
- An increase in "bulking agents". Bulking agents are cheap, white powder medications used to supplement a drug to fill the required amount (i.e., Benadryl, Lidocaine).
- Fatty liver found in autopsy among decedents. Fatty liver causes a slower metabolism and can result in an accumulation of drugs in a body, resulting in a delayed overdose.
- Decedents homeless or not having a home of their own (staying with someone else).
- Decedents not married.
- Decedents discovered in hotel rooms.
- Decedents partaking in polysubstance use/misuse.

Example: OFR Findings

Yavapai County, AZ

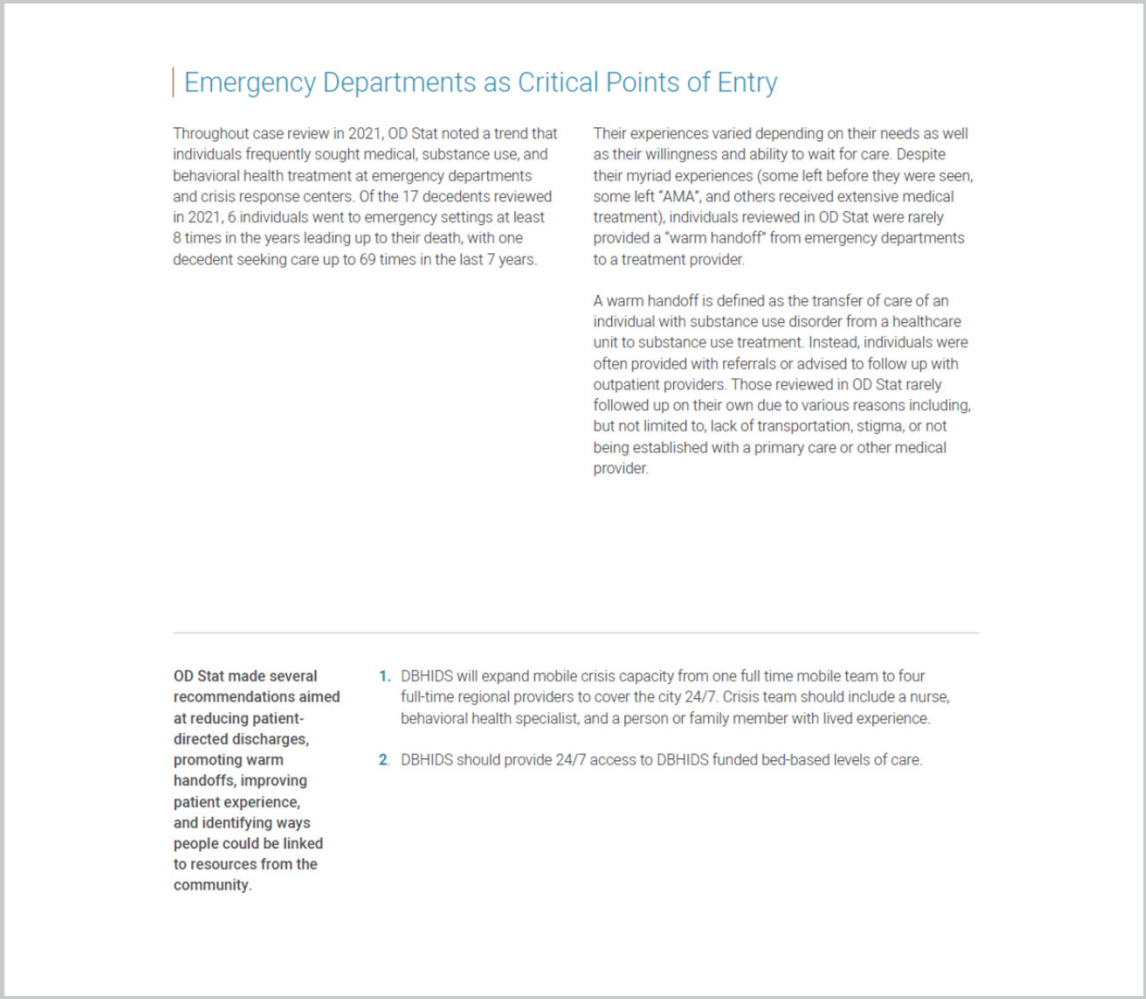
[ofrb annual report-Spring 2022_WEB.pdf (matforce.org)]



Example: OFR Findings and Recommendations

Philadelphia, PA

[OD-Stat-Annual-Report-2021-FINAL.pdf (phila.gov)]



Emergency Departments as Critical Points of Entry

Throughout case review in 2021, OD Stat noted a trend that individuals frequently sought medical, substance use, and behavioral health treatment at emergency departments and crisis response centers. Of the 17 decedents reviewed in 2021, 6 individuals went to emergency settings at least 8 times in the years leading up to their death, with one decedent seeking care up to 69 times in the last 7 years.

Their experiences varied depending on their needs as well as their willingness and ability to wait for care. Despite their myriad experiences (some left before they were seen, some left "AMA", and others received extensive medical treatment), individuals reviewed in OD Stat were rarely provided a "warm handoff" from emergency departments to a treatment provider.

A warm handoff is defined as the transfer of care of an individual with substance use disorder from a healthcare unit to substance use treatment. Instead, individuals were often provided with referrals or advised to follow up with outpatient providers. Those reviewed in OD Stat rarely followed up on their own due to various reasons including, but not limited to, lack of transportation, stigma, or not being established with a primary care or other medical provider.

OD Stat made several recommendations aimed at reducing patient-directed discharges, promoting warm handoffs, improving patient experience, and identifying ways people could be linked to resources from the community.

1. DBHIDS will expand mobile crisis capacity from one full time mobile team to four full-time regional providers to cover the city 24/7. Crisis team should include a nurse, behavioral health specialist, and a person or family member with lived experience.
2. DBHIDS should provide 24/7 access to DBHIDS funded bed-based levels of care.

Example: Recommendations

Washington, DC

[OFRB 2020 Annual Report-FINAL WEB.pdf (dc.gov)]

RECOMMENDATION #1

Office of the Chief Medical Examiner (OCME)

The Office of the Chief Medical Examiner (OCME), in collaboration with the Metropolitan Police Department (MPD) and Fire and Emergency Medical Services (FEMS), should incorporate mandatory questions into their interactions at the scene with family members and/or other individuals present. The responses to the questions should be documented in a retrievable data system.

The questions shall include:

1. To your knowledge, has the decedent had any other overdoses in the past?
2. Did you have access to Narcan/Naloxone? If so, do you know how and when to administer the drug?
3. Who provided the Narcan/Naloxone to you?
4. Did you receive training on how to administer the drug? If so, when and by whom?
5. Did you notice anything unusual about the decedent's actions or behavior leading up to their death?
6. To your knowledge, was the decedent engaged in any substance use disorder treatment programs? If so, was treatment helpful?

1. In collaboration with the DC FEMS and MPD, DC Health should collect Narcan dispensation and administration data through an HIE that can alert providers when a patient has had a Narcan reversal. Providers should be educated on this new practice and be encouraged to address client needs once notified.

2. DBH, in collaboration with DC Health and the DHCF, should engage in a community-based consultation process to make recommendations for better care coordination for clients receiving services and those who need to be re-engaged in the system.

Agency Response

The Office of the Chief Medical Examiner agrees with this recommendation

Best Practice

FEMS

According to Cabrillo College's Patient Interview/ Assessment and General Event Flow, once 911 has been called and a patient is found unconscious, bystander interviews should be conducted by medics after the standard lifesaving procedures are taken (refer to page 2). While the patient is being prepared for transport to the emergency department or while medics are waiting for the first responding officer (if the patient is pronounced dead on the scene), the bystander interview questions asked by medics should inquire about the patient's medical history, especially question 1 and question 5; but all six questions if possible.

MPD

According to Macdonald and her colleagues (2017), there are various steps the first responding officer and the lead detective can take when interviewing bystanders at the scene to create a positive, relaxing environment (refer to pages 79-80). Some of those steps include: (1) professionally greeting the interviewee (i.e., the bystander); (2) establishing the bystander's preferred name; (3) asking the bystander to call the interviewer by their first name; (4) identifying other workers in the room/ nearby and explaining their roles; (5) building adequate rapport; and finally, (6) explaining the purpose and outline structure of the interview process before starting.

Once these steps are completed and the interview concludes, Macdonald and her team (2017) suggest the officer/detective summarize what the bystander reported and ensure their contact information is documented before parting. Lastly, Macdonald and her colleagues (2017) found that interviewers who are provided with a bullet point checklist of desirable behaviors were more easily able to implement them into their interview process.

Reference: *Macdonald S, Snook B, Milne R., (2017) Witness interview training: A field evaluation. Journal of Police and Criminal Psychology 32(1):77-84. doi: http://dx.doi.org.mutex.gmu.edu/10.1007/s11896-016-9197-6.*

OCME MDI/FI

According to DC Code § 5-1406, all deaths that fall under the jurisdiction of OCME are to be reported as soon as possible to the MDI/FI (Medicolegal Death Investigator/ Forensic Investigator). The National Institute of Justice's Death Investigation: A Guide for the Scene Investigator indicates the standardized practices that all death investigations should entail, including the witness interview process and the gathering of medical and social histories (refer to pages 24-25 and 39-45).

OCME Records Unit/ IT Unit

In February 2020, the Records Unit, with the help of the IT Unit, added two new checkboxes on the CMS (Case Management System): (1) the Suspected Overdose Checkbox on the Death Certificate Tab and (2) the Narcan Observed Checkbox on the Intake Info/Medical History Tab. The medical examiners select the Suspected Overdose variable after reviewing the death investigation reports, supplemental reports, and completing an autopsy, though the toxicology report is pending.

The Narcan Observed variable is selected by the MDI/ FI on all cases of suspected overdoses where Narcan was observed on the scene (e.g., packaging) or when a bystander/officer/medic indicated the decedent was given Narcan. The recent addition of these two new checkboxes allow OCME to detect and report overdoses in a more timely manner, rather than waiting solely for toxicology results, which can take up to 90 days. Further, though no recent changes have been made to the Intake Info/Scene Investigation Tab, the five current text boxes on the tab capture scene information written by the MDI/FI: (1) Detailed Circumstances of Death for Scene Investigation; (2) Scene Description; (3) Body Position; (4) Personal Property, and (5) Evidence Collected at Scene.

OCME Data Fusion Center/ SUDORS Abstractors

Housed in the Administrative Unit of OCME is the Data Fusion Center/SUDORS Abstractors. SUDORS (State Unintentional Drug Overdose Reporting System) Abstractors capture all drug overdose deaths of unintentional or undetermined intent by reviewing the case files (e.g., death certificate, toxicology reports, investigative notes, PD-120s, FEMS reports, etc.) of all decedents who died from accidental drug overdoses. SUDORS Abstractors then abstract cases by adding key data elements into the Centers for Disease Control and Prevention's NVDRS (National Violent Death Reporting System) and synthesize each case into a short narrative.

When SUDORS Abstractors code and synthesize each case, they ensure both NVDRS's vision and LIVE. LONG. DC.'s mission is actualized. NVDRS's vision is: "To assist in the prevention of violent deaths in the U.S. through the facilitation of systematically and routinely collected, accurate, timely, and comprehensive data for prevention program development" (refer to page 4 of the NVDRS Web Coding Manual version 5.3). LIVE. LONG. DC.'s mission involves a: "Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths" (refer to page 5 of the Strategic Plan).

Specific Actions Planned Towards Implementation:

Action Items:

1. A bulleted checklist of the six questions will be disseminated to each MDI/FI.

2. If a death notification report comes from FEMS or the MPD specifically, after the initial death information is gathered on the phone call, if there is suspicion of an overdose, the MDI/FI will ask the reporting entity if bystanders were present. If bystanders were present, for quality assurance purposes, the reporting entity will confirm if the six questions were asked to the bystander(s) and tell the MDI/FI where the responses were recorded.

3. Once on the scene, the MDI/FI will process the scene according to standard protocol and then interview bystanders. If the bystanders were already interviewed by the FEMS/first responding officer/detective about the six questions, the MDI/FI will ask any follow-up or probing questions about the six questions for further clarification.

4. The MDI/FI will record the responses to the six questions in their scene investigations notes, specifically in the new tab created on CMS (refer to OCME Record Unit/ IT Unit Action item below).

5. Of note, questions one and six can be asked to family and friends not present at the scene. However, if family and friends lived with the decedent but were not at the scene in the immediate time leading up to the death (e.g., left home to go to work a few hours prior), questions 1-6 can still be asked and placed in a Supplemental Report, not the new text box created on the CMS (refer to OCME Record Unit/ IT Unit Action item below).

OCME Records Unit/ IT Unit

Action Item

1. On the Intake Info/Scene Investigation Tab, there will be an additional sixth text box that is specifically made to capture the responses of the six questions by the MDI/ FI. The sixth text box should be entitled "Suspected Overdose/Witness Interview Responses." In the text box, there should be each separate bystander(s) responses to the six questions if there is more than one bystander.

OCME Data Fusion Center/ SUDORS Abstractors

Action Item

OCME Opioid FI will perform quality assurance with the help of the SUDORS Abstractors by pulling a sample of FEMS reports/PD-120s and comparing narratives to OCME MDI/FI scene investigation reports. See Figure 1 Below.

Expected Outcomes:

An expected outcome of this recommendation's implementation is that the information will be gathered in a standardized way. Over time, a compilation of the information will inform various agencies, practitioners, and policy workers on how best to reduce overdoses and assist in ensuring the mission of LIVE. LONG. DC. comes to fruition.

Measurable Indicators/Milestones:

About 25% of the sampled reports that will be examined will contain adequate responses to the six questions across all three agencies after four months.

Example: Recommendations

Muskegon County, MI

[Muskegon-OFR-Findings-7-9.png (800×2000) (michiganofr.org)]

Example: Recommendations

Winnebago County, WI

https://www.co.winnebago.wi.us/sites/default/files/uploaded-files/2021-2022_winnebago_ofr_annual_report_final.pdf

Overdose deaths have increased for the second consecutive year. Our family, friends, and neighbors are dying from this horrible disease. The work of OFR continues to focus on preventing overdose deaths, but progress and positive impact is also being made in other ways. To illustrate the ripple effect, several of our partners have shared their reasons for participating in OFR and the impact that we are making.

"Being part of the Winnebago OFR team has been very enlightening. I have been in this business for 18 years and I continue to learn so much from the other partners involved. This is a very heavy topic, but we strive to work together as a team and community to help make a difference, and for that I am grateful for those that continue to struggle." - Jolie VerVoort, Apricity

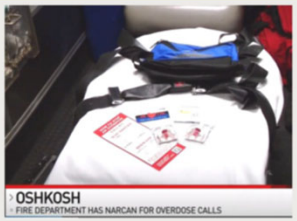
"The OFR Team has opened lines of communication between community groups that previously have not talked, taken down silos, and has created actionable plans to assist those dealing with

Example: Successes

Winnebago County, WI

https://www.co.winnebago.wi.us/sites/default/files/uploaded-files/2021-2022_winnebago_ofr_annual_report_final.pdf

HIGHLIGHTS OF OFR PARTNER SUCCESSES



Handle with Care: A partnership between Oshkosh Police Department, Oshkosh Area School District, Valley Christian School, and Lourdes Academy, connects students who have experienced trauma with needed assessments and supports. Within the first 18 months, 250 referrals were made. This work received the Oshkosh Area School District Spirit of Education award for its collaboration and success.

Oshkosh Fire Department (OFD) Leave Behind Narcan Kits: OFD initiated a program to distribute "Leave Behind Narcan Kits" to those at high risk of overdose. Between February and June 2022, OFD distributed 20 Narcan kits while out on calls in the community.

Fentanyl Test Strip Distribution: Winnebago County Health Department, in partnership with Vivent Health, began distributing fentanyl test strips out of their Oshkosh office location. Test strips allow people to identify if fentanyl is present in substances prior to use. Fentanyl is the cause of most overdoses and overdose deaths in Winnebago County. Fentanyl test strips are available at no cost at the health department. For details, call 920-232-3000.

University of Wisconsin Oshkosh (UWO)'s Addiction Training and Naloxone Boxes: OFR partners from UWO Police Department, Unity Recovery Services, and Winnebago County District Attorney presented an overdose prevention training for over 100 UWO staff and students. This training, along with installing Naloxone Boxes, have helped to prevent overdose deaths on campus.

Dissemination Strategies

- Internal review and discussion
- Press event and coverage
- Social media
- Target mailing/distribution
- Outreach and presentations
- Post on website

OFR Members and Governing Committee

- Presentations
- Internal review and discussions
- 1:1 meetings

Example: Mobilize Community Action

Yavapai County, AZ

[ofrb annual report-Spring 2022_WEB.pdf (matforce.org)]

Community Resources

Statewide Resources

- **1-888-688-4222 | Opioid Assistance and Referral Line**
  Local medical experts offer patients, providers, and family members opioid information, resources and referral 24/7. Translation services available.
- **1-800-662-HELP (4357) | SAMHSA's National Helpline**
  Free, confidential treatment referral and information service available 24/7 (in English and Spanish).
- **NaloxoneAZ.com**
  See where the opioid overdose reversal drug naloxone is available near you.
- **DumpTheDrugsAZ.org**
  Find a location to dispose of unused, unwanted, or expired medication.
- **FindTreatment.gov**
  Find treatment resources available in your area.
- **TalkNowAZ.com**
  Get tips on talking with youth about substance use.
- **TheNewMeth.com**
  Learn about

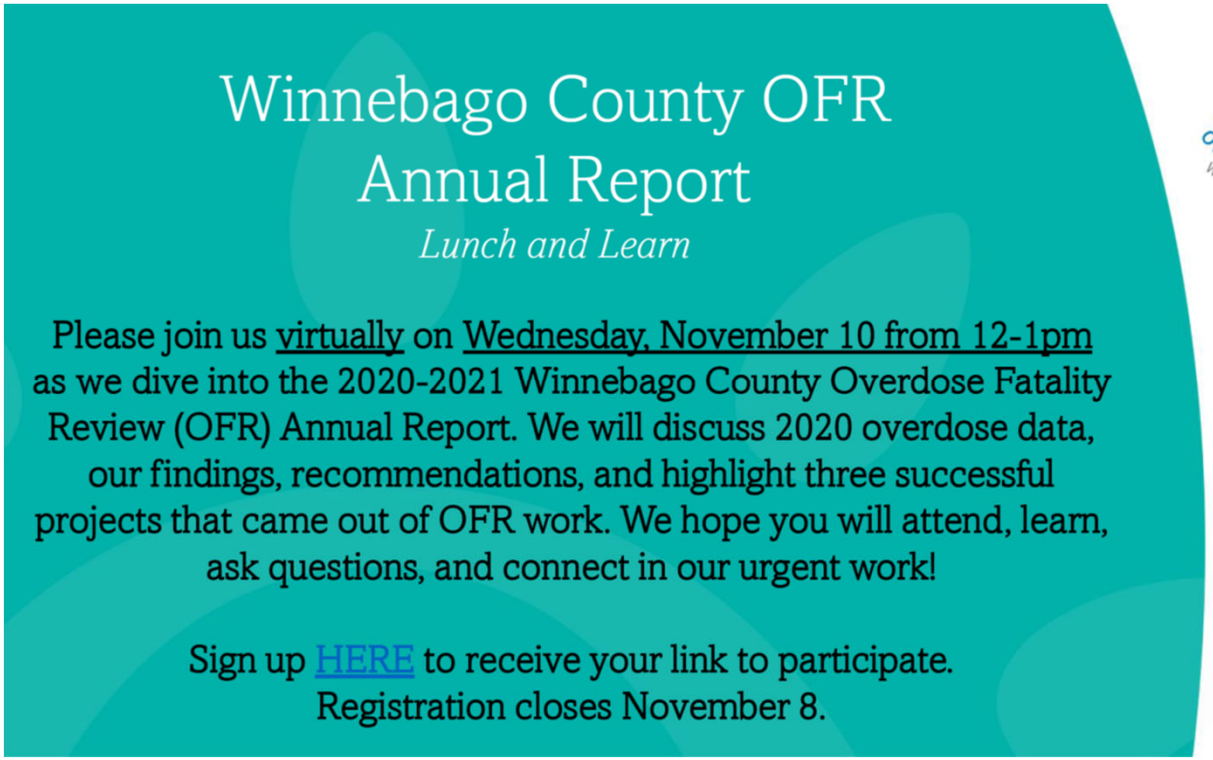
In Crisis?
Call 24/7

1 (877) 756-4090
Northern Arizona Crisis Line

Youth Resources

- Text *HELLO* to **741741** to text anonymously with a trained crisis counselor for free, 24/7
- **Teen Lifeline** | *Available 24/7*
  1-800-248-TEEN (8336)
  Arizona support line for teens operated by teens.
- **Suicide Prevention Lifeline** | *Available 24/7*
  1-800-273-8255
  Helps individuals in suicidal crisis with support.
- **Trevor Project Lifeline** | *Available 24/7*
  1-866-488-7386
  Confidential suicide hotline for LGBT youth.

Example: Outreach and Presentation



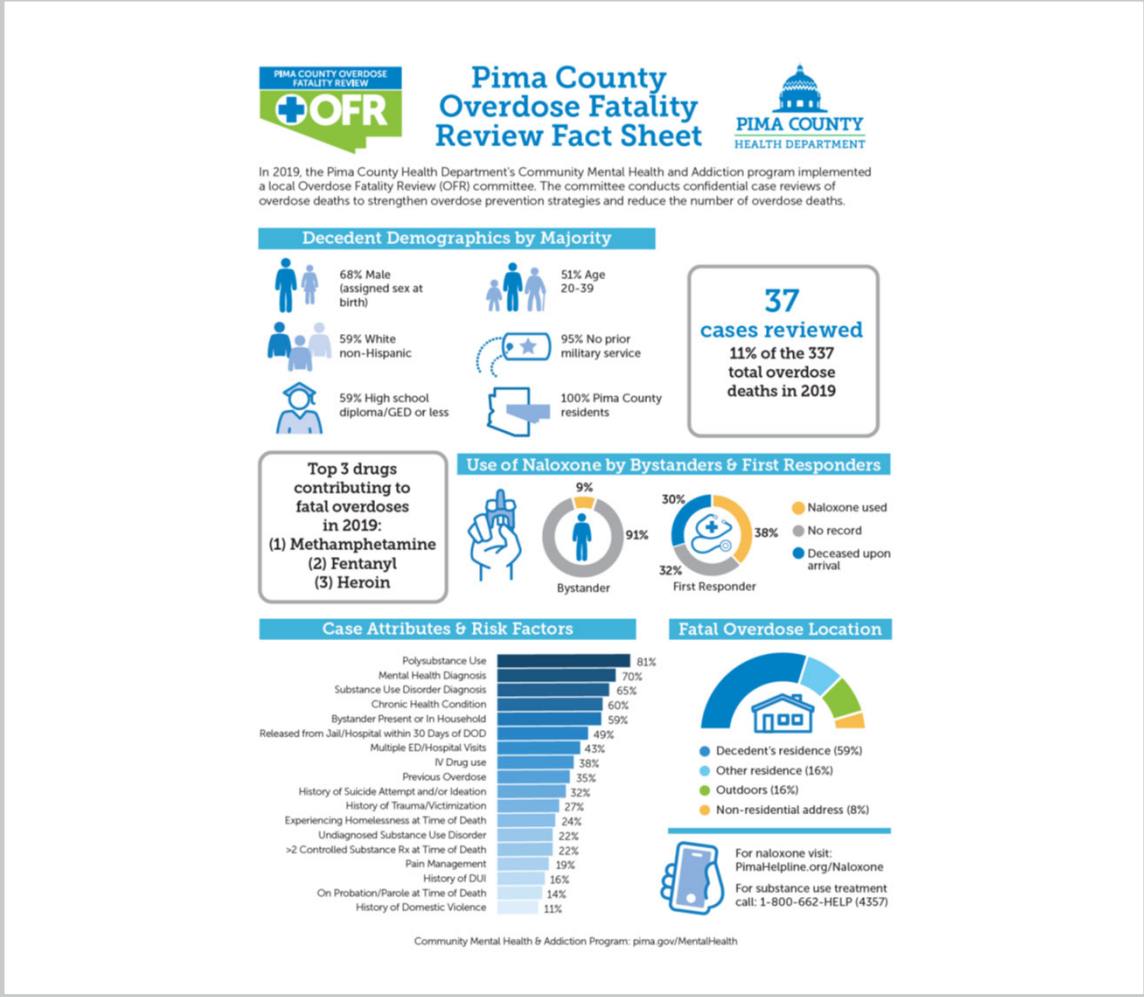
Example: Media

- Lackawanna County, PA
- September 7, 2021, Press Conference
  - Fentanyl Is Everywhere
  - Not Just Heroin
  - Pure Fentanyl Being Disguised as Pills
  - Need for Fentanyl Testing Strip Criminalization
- DA, Mayor, Chief of Police, Local Media
- News and Newspaper Coverage
- *Catching Up With COSSAP* – October 2021

Example: Fact Sheets

Pima County, AZ

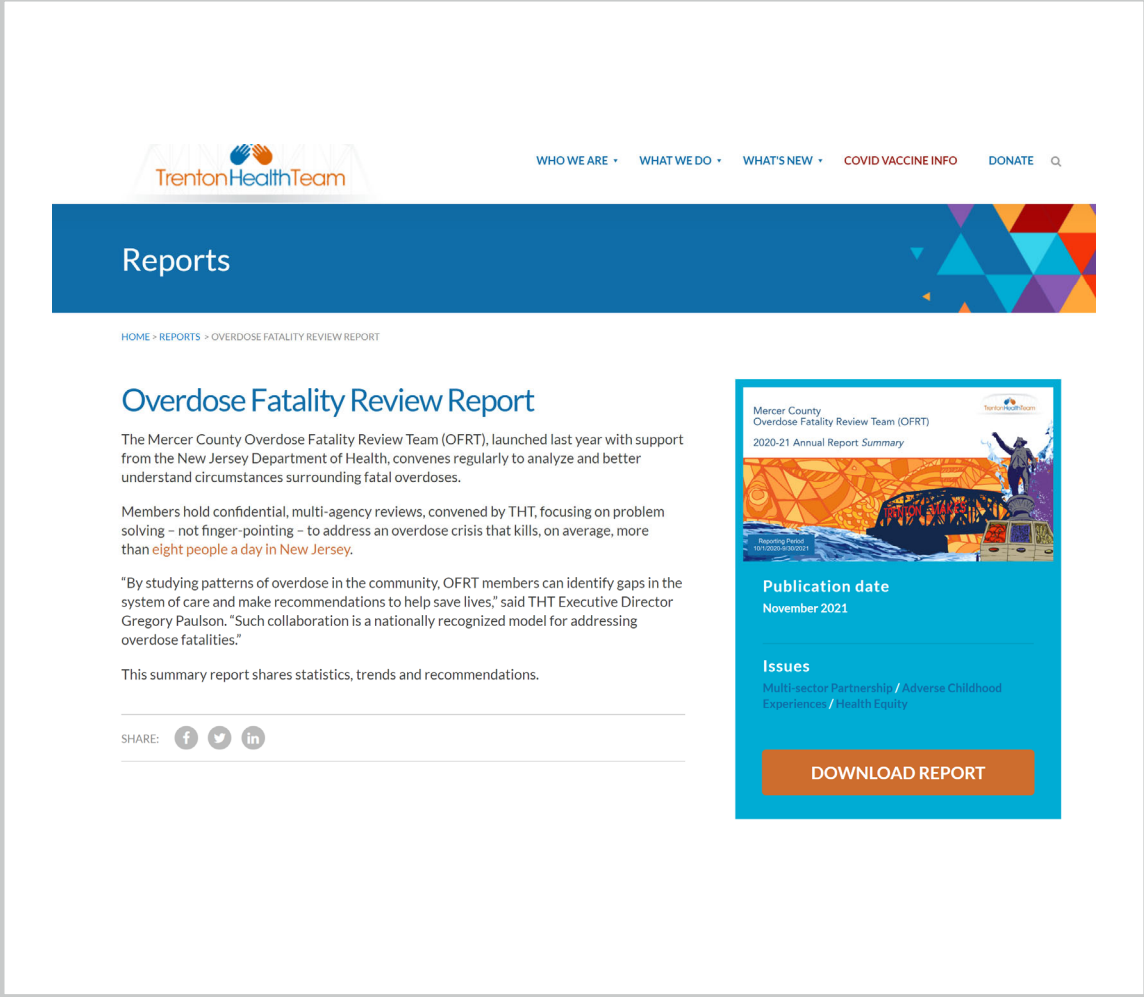
[17951 - Logo and Infographic Template for OFR Team Report RTP (pima.gov)]



Example: Post on Website

Mercer County, NJ

[Overdose Fatality Review Report - Trenton Health Team]

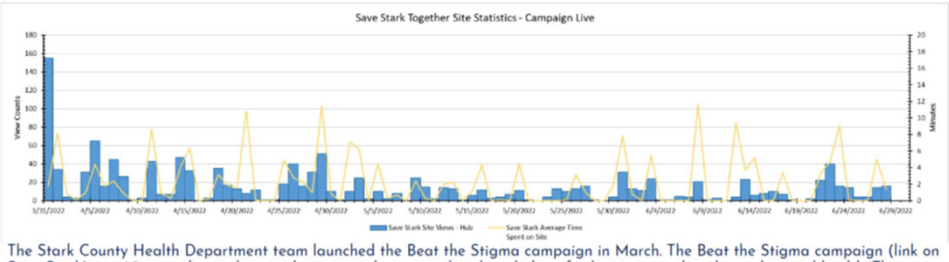


Mobilize Community Action

Stark County, OH

[Overdose Fatality Review (OFR) Stark County 2021: Annual Report_Sized (revize.com)]

Figure 10: Landing Page Metrics as of 06/29/2022



The Stark County Health Department team launched the Beat the Stigma campaign in March. The Beat the Stigma campaign (link on Save Stark) is a 60 second quiz that residents can take to test their knowledge of substance use disorder and mental health. The team also created the Save Stark landing page in conjunction with the launch of the campaign. The page is filled with local resources, locator maps, and helpful links. The page has had over 1,300+ visits which is an average of 14 visitors per day since the site launched on March 31, 2022. Those visiting spend an average of 3 minutes searching the site for treatment, recovery, harm reduction or prevention resources.

The campaign efforts have included Beat the Stigma language and a link to the Save Stark page on 45 SARTA buses, a mailer to 17,000+ homes in some of the highest incident areas, social media posts, and a poster campaign to local providers. Collectively social media (paid and organic) has reached approximately 24,000+ individuals on Facebook alone. The Save Stark page has also reached national attention from Esri, creator of the landing page technology, and was featured at the 2022 Esri Health and Human Services National Conference. There are links to the presentation, the success story, and the landing page below.

Save Stark Success Story by Esri

Communicating to Audiences with the Use of GIS Presentation

Save Stark Landing Page

This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Office of Health Improvement and Wellness Violence and Injury Prevention Section and as a sub-award of a grant issued by the Centers for Disease Control and Prevention under the Overdose Data to Action grant, grant award number grant 1 NU17CE924989-01-00, and CFDA number 93.136

OFR Data System

Data storage,
access, and reports

- Case information
- Next-of-kin interview
- Community context
- Recommendation monitoring

OFR Data System

- County Profile
- Recommendation Monitoring
- Next-of-kin Interview
- 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
- Case Information, continued
  - 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

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

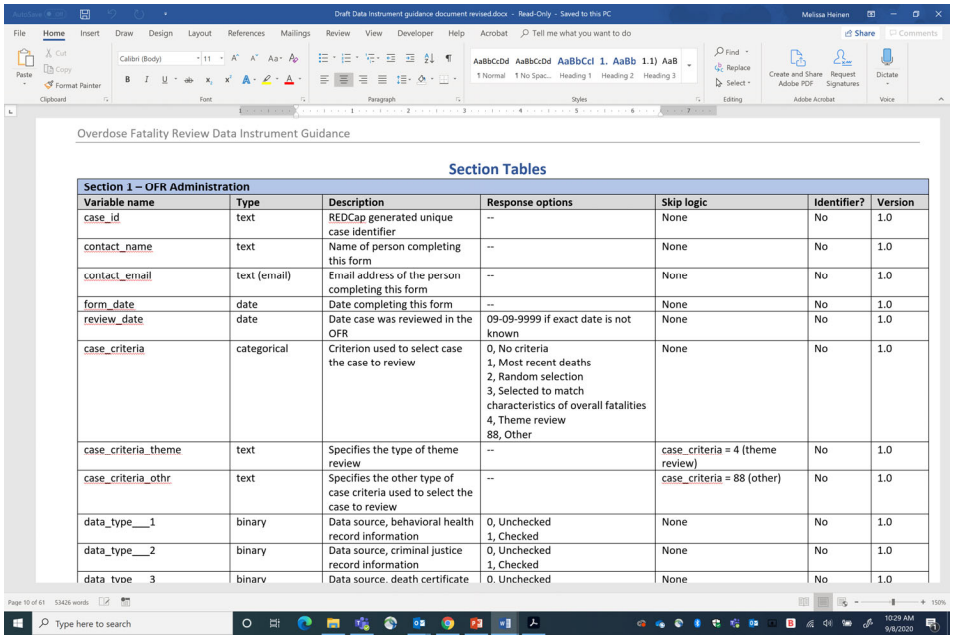
Variable: contact_name

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



Overdose Fatality Review Data Instrument Guidance

Section Tables

Section 1 – OFR Administration						
Variable name	**Type**	**Description**	**Response options**	**Skip logic**	**Identifier?**	**Version**
case_id	text	REDCap generated unique case identifier	--	None	No	1.0
contact_name	text	Name of person completing this form	--	None	No	1.0
contact_email	text (email)	Email address of the person completing this form	--	None	No	1.0
form_date	date	Date completing this form	--	None	No	1.0
review_date	date	Date case was reviewed in the OFR	09-09-9999 if exact date is not known	None	No	1.0
case_criteria	categorical	Criterion used to select case the case to review	0, No criteria 1, Most recent deaths 2, Random selection 3, Selected to match characteristics of overall fatalities 4, Theme review 88, Other	None	No	1.0
case_criteria_theme	text	Specifies the type of theme review	--	case_criteria = 4 (theme review)	No	1.0
case_criteria_othr	text	Specifies the other type of case criteria used to select the case to review	--	case_criteria = 88 (other)	No	1.0
data_type___1	binary	Data source, behavioral health record information	0, Unchecked 1, Checked	None	No	1.0
data_type___2	binary	Data source, criminal justice record information	0, Unchecked 1, Checked	None	No	1.0
data_type___3	binary	Data source, death certificate	0, Unchecked	None	No	1.0

Data Reports and Analysis

- Export data to analyze in various data analysis software
- Build and run canned reports

PRACTICE - OFR Case Information PID 22

Data Exports, Reports, and Stats

VIDEO: How to use Data Exports, Reports, and Stats

+ Create New Report | My Reports & Exports | Other Export Options | View Report: Criminal justice involvement

Number of results returned: 3
Total number of records queried: 12
Report execution time: 0.1 seconds

Stats & Charts | Export Data | Print Page | Edit Report

Live filters: [Sex of decedent]

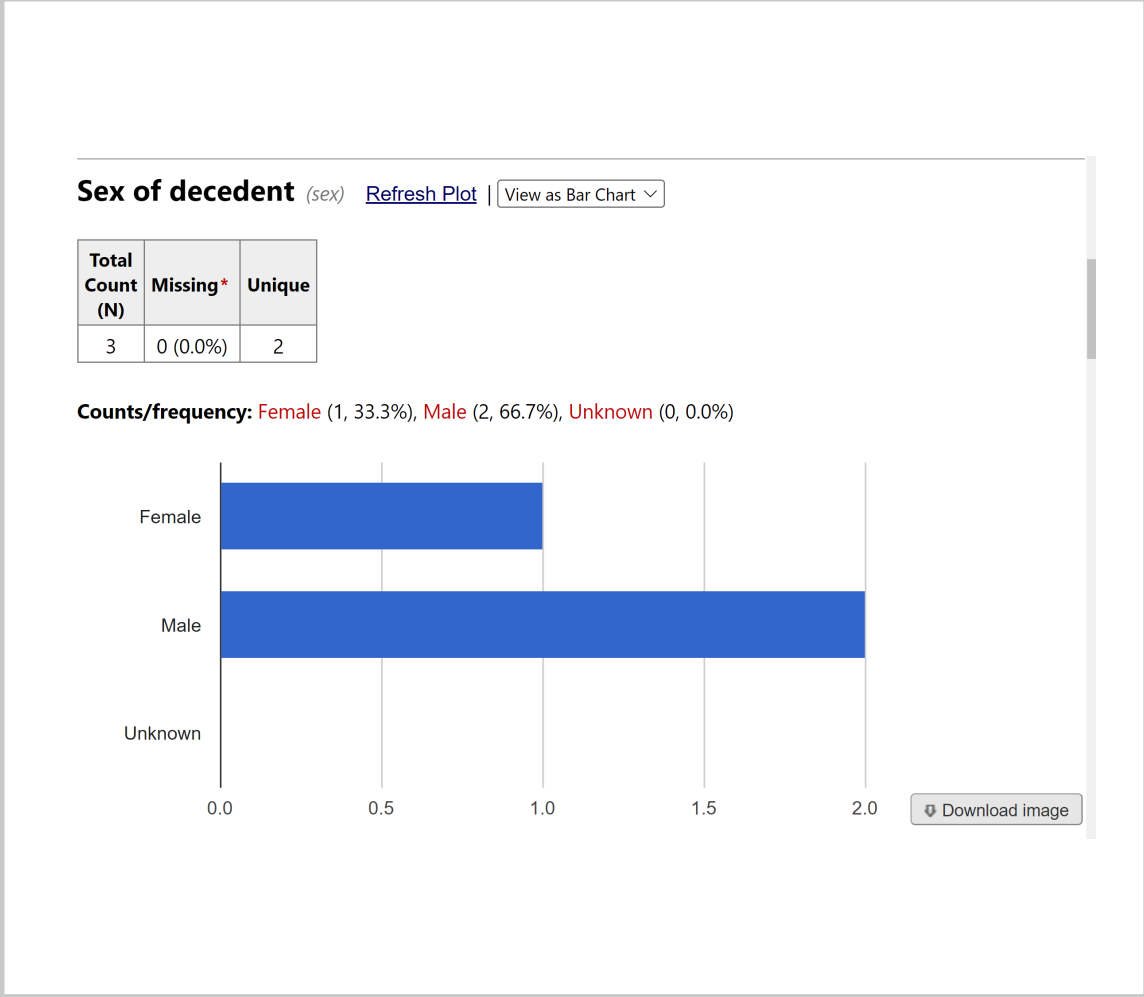
Criminal justice involvement

Search

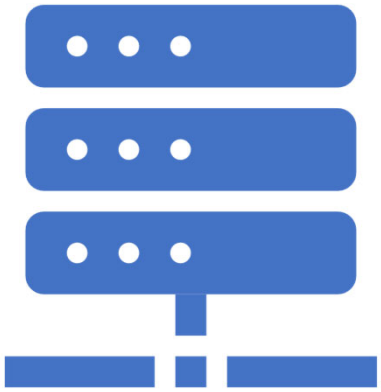
Case-unique identifier (REDCap generated) case_id	Age in years age_years	Date of death death_date	Sex of decedent sex	Location of overdose incident overdose_location	Date of the most recent known nonfatal drug overdose od_recent_date	Date of most recent known arrest arrest_recent_date	At the time of the overdose incident, was the decedent under community supervision? supervision_od	At the time of the overdose incident, was the decedent incarcerated? incarceration_od	Date of entry for most recent known post-adjudication program and/or specialty court spec_court_date	Date of most recent known pre-arrest/pre-charge diversion pre_arrest_date
1			Female (1)							
12-1 DOD: 11-19-2020	58	11-19-2020	Male (2)	Decedent's residence (1)		09-26-2020				
12-2 DOD: 04-27-2021	33	04-27-2021	Male (2)	Hotel or motel (5)		07-26-2011		No (0)		

Data Reports and Analysis

- Display data and download image



Access OFR Data System



- Local on-site REDCap Server
- State REDCap OFR Data Access Group
- IIR REDCap OFR Data Access Group
- Data access groups are a feature of REDCap that allows for multiple centers to enter data into the same database (or tool) but only have access to their own data and not see other centers' data

Use the OFR Data System

- Register online to use the OFR Data System
- Participate in monthly OFR Data User Group

Become an OFR Data System User

OFR Data System Registration (smartsheet.com)