Overdose Fatality Review
in
Indiana

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Indiana Child Fatality Review
Indiana State Department of Health

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Overdose Fatality Review

- Modeled after other mortality review teams (child fatality review, fetal-infant mortality review, etc.)
- Multi-agency/multi-disciplinary team assembled to conduct **confidential** case reviews of overdose deaths
- The goal is to prevent **future** deaths by:
  - Identifying missed opportunities for prevention and gaps in system
  - Building working relationships between local stakeholders on overdose prevention
  - Recommending policies, programs, laws, etc. to prevent overdose deaths
  - Informing local overdose prevention strategy
- Team members bring info from respective agencies about decedents to inform review

Recommended Team Members

- County coroner
- Local pharmacy
- Local department of social services
- Prosecuting attorney representative
- Representative from school systems
- Department of Child Services (DCS) representative
- A state, county, or municipal law enforcement officer
- Pathologist
- Local medical provider/family physician
- Director of behavioral health services in the county
- An emergency medical services provider
- Adult Protective Services
- County health officer
- Hospital representative

Recommended Team Members

- A health care professional who specializes in prevention, diagnosis and treatment of substance use disorders
- Representative of a local jail or detention center
- Representative from parole, probation and community corrections
- Representative of juvenile services
- Department of Natural Resources (DNR) representative
- A member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the county health officer
- Any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer

Overdose Fatality Review

- **Pilot Program January-June 2018**
  - Prescription Drug Overdose Supplemental Grant funded qualitative research on the process/effectiveness of overdose fatality review
  - Child Fatality Review (CFR) Program is working with local CFR teams to incorporate overdose review
  - ISDH collaborating with IU Fairbanks School of Public Health to conduct the research component
  - Participating counties – Tippecanoe, Montgomery, Knox and Vanderburgh
  - Interest from other counties
- **Evaluation on process improvements and recommendations for policy and program development**

During the Review …

- Discuss the investigation and death response
- Discuss the delivery of services
- Identify risk factors
- Recommend system improvements
- Identify and catalyze community action
- Share current local data

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Draft Manual/Auditing Tool

- Guidance document
  - Modeled Maryland lessons & format
  - Description of case criteria
  - Finalized outcome will result from pilot team input
- Data collection form
  - Collaboration with epi & opioid/drug outreach teams for data points
  - Sustainability challenges
    - End-user friendly
    - Data repository

Team Formation

- Identified high-functioning local CFR teams
- Proposal letters to leadership/in-person introductions to process
  - Shared draft manual
  - Recommended team membership
- Preliminary meetings with team membership to approve process
- Identification of pilot case load
  - Timeframe
  - Retrospective, with the intent of going prospective
- Involvement of media

Discussion Points: Team Establishment

- Case definition, time
- Mental Health records access
- Hospital records access

  Legal requests submitted for approval
- INSPECT data
  - ➢Who accesses?
  - ➢How far back should we go?

Discussion Points: Team Establishment

- Coroner involvement
  - Willingness varies
    - "not my job, per statute"
    - "I'll subpoena the records as part of my investigation
  - Investigation practice varies

Challenges

- Original emphasis on opioid deaths
- Legislation
- Medical records/mental health records – HIPAA

  Does public health crisis/epidemic suspend HIPAA?
- How/when to notify members of cases on review docket

Challenges

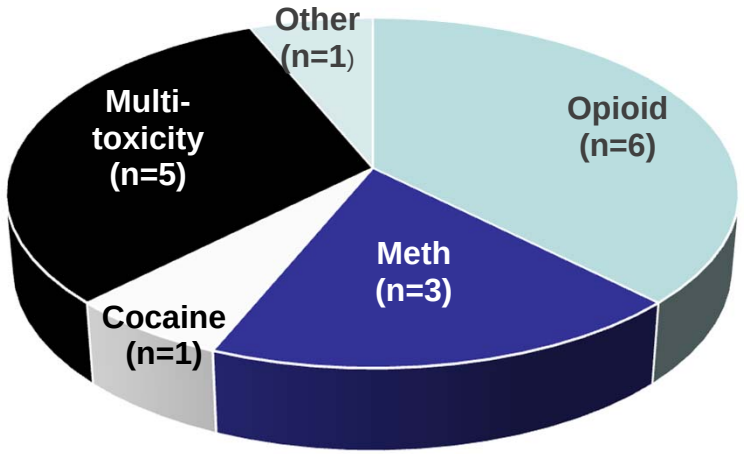
- Variation of team-member roles, per county (i.e. coroner)
- Failure to include DCS, health department
- Failure to include LCC's
- Disagreement about anonymizing cases
- "All we have to do is change the names on the slides ..."

Results to Date

20 reviewed cases

- Average age – 41.3 years
- 9 cases had documented mental health history
- 12 cases had documented history of incarceration
- 3 cases had history of suicide attempt
- One case was a high school teacher with a master's degree
- One drowning death, two suicides

Toxicology Results



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Discussion Points: Case Review

- Post-vention services for survivors, especially children
- Punitive mindset vs disease/recovery mindset
- Support for those recently released from jail/prison
- Access to VA records
- Naloxone administration – transport policies
- Completion of death certificates accurately versus what is hidden from public

Discussion Points: Case Review

- Prevention versus Intervention
- Post-op prescribing practices
- Include family members, per FIMR model?
- Offered access to inpatient population for "pre-fatality" insights
- Assignation of MoD by coroner – accident versus suicide
- Coroner did not realize they were not getting all medical case information from practice of request

Preliminary Outcomes

- Responder fatigue – collaboration with DMHA, ICJI
- Addiction/Recovery stigma
- Finalization of guidance document/tool kit
  Will be adding anti-stigma guidance for meeting facilitators
- Prosecution of fraudulent reports of stolen prescriptions
- Recognition of ACES
- Coroner confiscating prescribed meds at terminal scene
  Training funeral homes to provide resource/knowledge about dropbox locations

Preliminary Outcomes

- Training of local pharmacists/hospital prescribers

  Challenges of pharmacists who do not want to fill scripts, but face blowback
- Funding search for lock boxes
- Plans to track naloxone administrations to see how many patients ultimately die
- Beginning stages of collecting resource list for teams/first responders

What Next?

- Dedicated OFR Coordinator
- Funding training event for OFR teams
- Identify appropriate team leadership
- Training teams in thorough case review
- Utilization of CRS with personalized data fields
- Development of CAT teams from LCC's

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