

Opioid Fatality Review Board

2019 ANNUAL REPORT



Mission



To assist the District's efforts in preventing opioid overdose deaths and inform prevention and intervention efforts by reviewing opioid deaths in the District and making recommendations to improve the activities and response of government agencies, private organizations, individuals, and the community.

Opioid Fatality Review Board Meeting Chair and Vice Chair

Chikarlo R. Leak, DrPH, MPH, Supervisory Epidemiologist, Office of the Chief Medical Examiner, Chair, Opioid Fatality Review Board

Morgan M. Medlock, MD, MDiv, MPH, Howard University Department of Psychiatry, Vice-Chair, Opioid Fatality Review Board

Office of the Chief Medical Examiner Opioid Fatality Review Board Staff

Jenna Beebe-Aryee, MSW, Fatality Review Program Manager

Tadessa Harper-Nichols, RN, Fatality Review Program Specialist

Candace Hardin, BSW, Staff Assistant

Table Of Contents

Greetings from the Opioid Fatality Review Board Chair and Vice-Chair	6
The Opioid Crisis in the District	8
Establishment of the Opioid Fatality Review Board	11
▶ Implementation Timeline	12
▶ Board Composition	13
▶ Purpose	13
▶ Functions	14
▶ Duties	14
Case Review Process	15
▶ Records - Sources of Data for Analyzing Overdose Deaths	16
2019 Board Discussion Topics	19
▶ Social Determinants of Health	20
▶ Risk Factors for Opioid Misuse and Overdose	20
▶ Naloxone Access and Availability	21
▶ Overdose Detection Mapping Application Program (ODMAP)	21
Accomplishments and Highlights	22
A Look into 2020 OFRB Objectives	24
A Preview of Adopted Recommendations	26
Acknowledgments	38



Greetings from the Opioid Fatality Review Board Chair & Vice-Chair



CHIKARLO R. LEAK,

*DrPH, MPH Chair, Opioid
Fatality Review Board*

The District of Columbia's Opioid Fatality Review Board (OFRB) continues to make progress in our endeavors to reduce the burden of the opioid epidemic through the comprehensive review of opioid overdoses, informing stakeholders, and recommending evidence-based policy and programs. The nation and the District continue to grapple with the opioid epidemic and strive to reduce opioid use, misuse and related deaths. Through case reviews of fatal opioid overdoses, the board is charged with recommending systematic changes that improve the social determinants of health.

The OFRB is happy to present the inaugural annual report highlighting the pertinent activities and efforts of a committed group of members as we strive to reverse the tide of opioid use, misuse and deaths in the District.

In 2019, the District of Columbia experienced 281 fatal opioid overdoses and countless nonfatal overdoses. This report emphasizes the affliction of addiction and devastation of an overdose on individuals, families, and communities. The OFRB findings identify real opportunities for the District to educate the public and to prevent further tragedies through harm reduction, early intervention, and a robust continuum of treatment of care.

I am honored to serve as the Board Chair and inspired by the dynamic and dedicated Board members. The continued work of this Board proves that by working together, we can improve the lives of District residents and make a difference in our community and nation.

Healthy Regards,

Chikarlo R. Leak



MORGAN M. MEDLOCK,

*MD, MDiv, MPH, Howard
University Department
of Psychiatry, Vice-Chair,
Opioid Fatality Review Board*

In 2019, the Opioid Fatality Review Board was established as part of a larger strategy to reduce opioid overdose deaths in the District of Columbia. At the time, none of us could have predicted that just eight months after formation, our Board would be challenged to think about solutions for the opioid crisis, while also addressing a viral pandemic and a plethora of racism-related tragedies. With awareness of the central role of social context to the overall well-being of DC residents and communities, we have focused our recommendations on integrating systems of care, utilizing technology effectively to track overdose rates, and strengthening communities to become effective recovery networks.

It is my hope that the Board's recommendations will move the District of Columbia forward in addressing concurrent crises that impact urban, minority communities. It has been a pleasure to serve this past year as Vice-Chair, and I look forward to the further work of this Board in developing evidence-based interventions for DC residents and their families.

Morgan M. Medlock

The Opioid Crisis in the District

Data from Mayor Bowser's Strategic Plan¹, LIVE. LONG. DC and the DC Office of the Chief Medical Examiner (OCME) highlights that OCME investigated a total of 1,096 opioid-related fatal overdoses from January 1, 2014 to September 17, 2019.

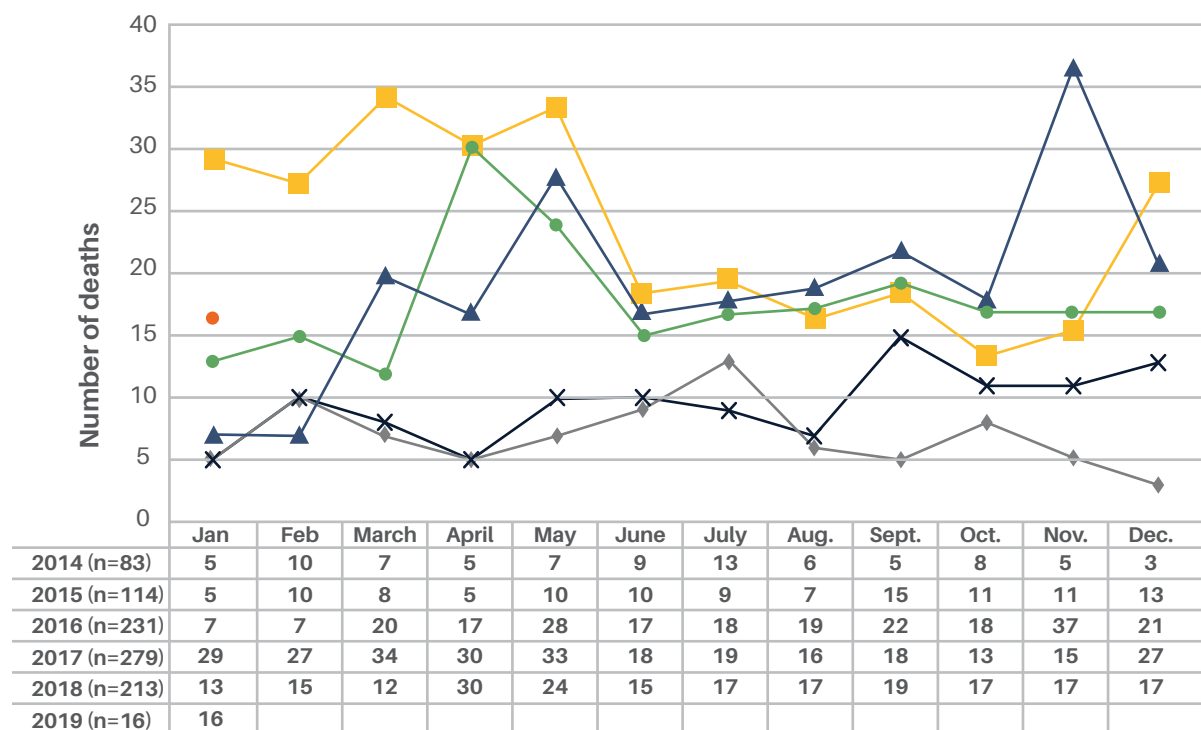


Overall Demographics

- ▶ 73% of the decedents were male
- ▶ 78% of the decedents were between the ages of 40-69 years
- ▶ 82% of the decedents were African American
- ▶ The majority of decedents were residents of the District of Columbia (DC). Within DC, opioid-related fatal overdoses were most prevalent in Wards 7 and 8.
- ▶ Approximately 80% of all overdoses (due to opioid drug use) occurred among adults between the ages of 40-69 years old, and such deaths were most prevalent among people ages 50-59 years.
- ▶ Eighty-nine percent of DC opioid users are over 40 years old and 58% are more than 50 years old.
- ▶ Twenty-two percent of DC opioid users have been using heroin (the most commonly used opioid in DC) for more than 40 years. 59% have used heroin for more than 25 years, and 88% have used it for more than 10 years.
- ▶ Data from the Department of Forensic Sciences (DFS) DC Controlled Substances Report also confirms that heroin is the most commonly used opioid in DC.

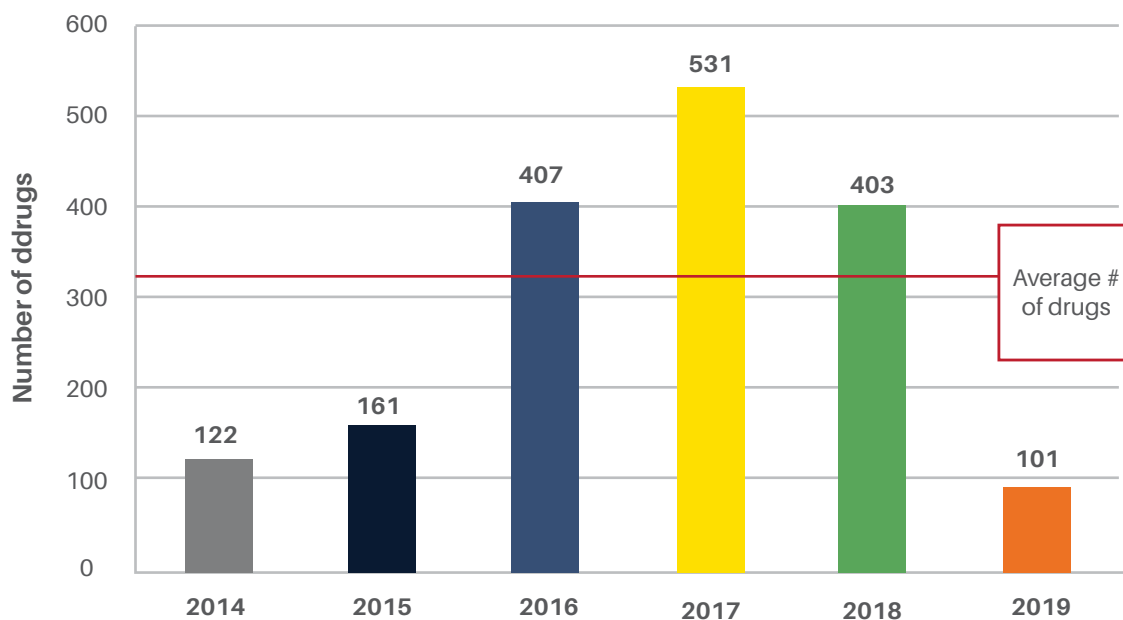
Opioid-related Fatal Overdoses: January 1, 2014 to January 31, 2019

Fig. 1(b): Number of Drug Overdoses due to Opioid Use by Month and Year (N=936)



Since 2019, the number of fatal opioid overdoses per month continued to decline from 2017 as per Fig.1(b).² In 2017, there was an average of 23 opioid-related fatal overdoses per month. However, the number of opioid-related overdoses per month decreased to average 17 per month in 2018. The total number of opioid overdoses in 2018 was slightly less than 2016 levels.

Fig. 2(a): Total Number of Opioid Drugs Contributing to Drug Overdoses by Year (All Opioids)



*Average excludes 2019 date

As depicted in Figure 2(a), there has been a steady increase in the total number of opioids found in fatal overdoses between 2014 and 2017. The majority of opioid overdoses were due to multiple drug toxicity, ranging from 1 to 7 opioids per death. There was a total of 122 opioids found in the 83 deaths in 2014, 161 opioids in the 114 deaths in 2015, 407 opioids in the 231 deaths in 2016 and 531 opioids in the 279 deaths in 2017. There were 403 opioids identified in the 213 decedents in 2018.

² Leak, C., 2019. Snapshot of The Opioid Epidemic In The District, Fatal Vs. Non-Fatal Overdose Data.

Establishment of the Opioid Fatality Review Board (OFRB)



Authority

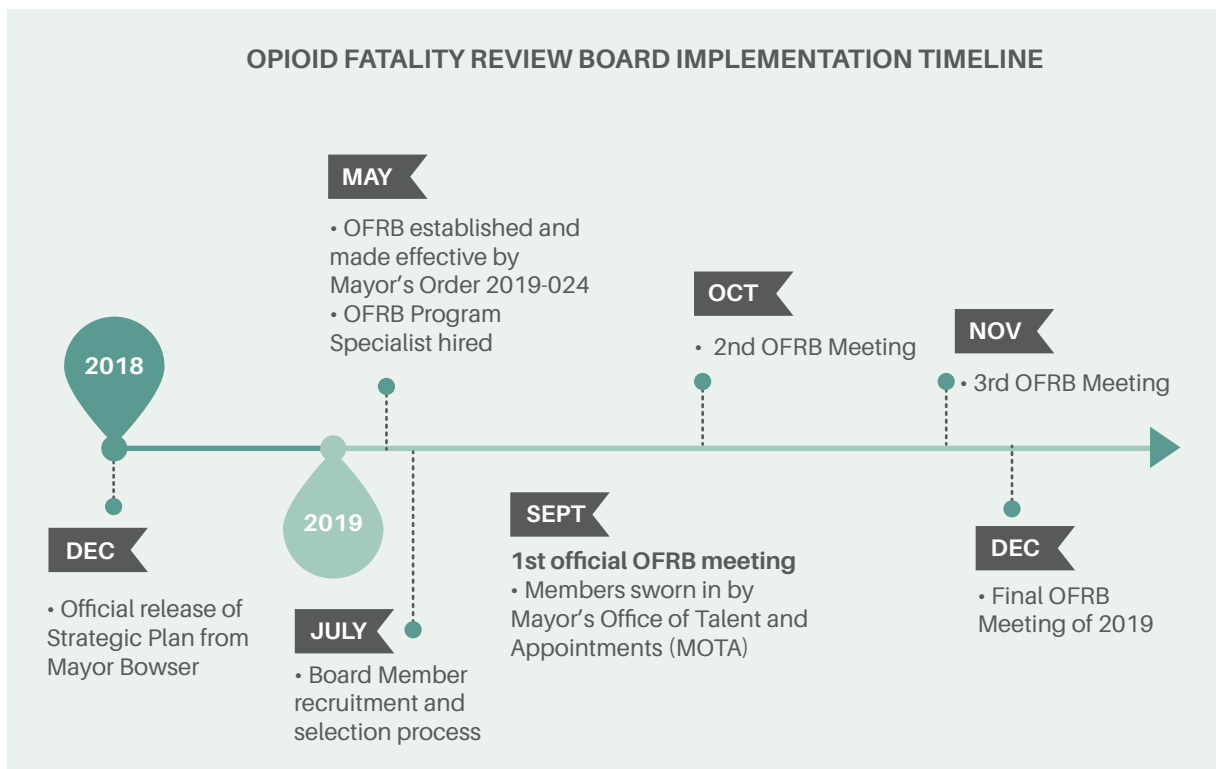
The Opioid Fatality Review Board (OFRB) was established by Mayor's Order 2019-024³ on May 2, 2019.

The OFRB falls under Goal 1, Strategy 1.1 of LIVE LONG. DC – DC's Strategic Plan⁴ to reduce opioid use, misuse and related deaths. The purpose of the strategic plan is to level-set and develop strategic goals through the utilization of a multi-disciplinary approach to reduce opioid fatalities in DC.

Goal 1: Reduce legislative and regulatory barriers to create a comprehensive surveillance and response that supports sustainable solutions to emerging trends in substance use disorders, opioid-related overdoses, and opioid-related fatalities.

Strategy 1.1: Establish an Opioid Fatality Review Board to review all opioid-related deaths that occur in Washington, DC.

2019 OFRB Implementation Timeline



Board Composition

The first official OFRB meeting was held on September 30, 2019 at the DC Office of the Chief Medical Examiner. The OFRB held four (4) meetings in 2019 and conducted one (1) full case review.

The OFRB convenes on the second Tuesday of each month and holds a quarterly recommendations subcommittee meeting to formally adopt recommendations proposed during official meetings.

In 2019, members and meeting participants were comprised of the following: District government agencies, community-based service providers and District resident members who have been affected by a drug overdose death of an immediate family member or have been direct recipients of drug treatment services in the District.

Office of the Chief Medical Examiner

Department of Human Services

Department of Forensic Sciences

**Fire and Emergency Medical Services
Department**

Department of Health Care Finance

Mayor's Office of Veterans Affairs

Three (3) Community Service Providers

Metropolitan Police Department

Department of Behavioral Health

A DC Hospital Representative

Department of Health

Department of Corrections

Three (3) District resident members

Purpose and Functions of the Opioid Fatality Review Board

The purpose of the OFRB is to assist the District's efforts to prevent opioid overdose deaths and report prevention and intervention efforts by reviewing opioid deaths in the District, and making recommendations to improve the activities and responses of government agencies, private organizations, individuals, and the community.

The OFRB is tasked with the following functions:

- ▶ Examining the incidence of deaths of District residents over the age of eighteen (18) years who died as a result of a confirmed opioid (illicit and prescription) overdose.
- ▶ Identifying the causes and circumstances contributing to an opioid overdose death, including: socioeconomic risk factors, education, behavioral health, and public and private system contact including criminal justice and treatment.
- ▶ Reviewing and evaluating the 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.
- ▶ Advising the Mayor on the findings and recommendations to reduce the number of preventable opioid overdose deaths and promote improvement of both public and private systems serving District residents who have substance use disorders.
- ▶ Issuing findings and recommendations for systemic changes to promote improved and integrated public and private systems, programs, policies and laws to address substance use disorders for District residents in an effort to prevent future overdose deaths;
- ▶ Recommending components for opioid overdose prevention and education programs;
- ▶ Recommending training to improve the identification and investigation of opioid overdose fatalities;
- ▶ Engaging in educational forums and producing educational material on opioid overdose prevention and intervention;
- ▶ Advising on approaches to promote improvement of both public and private systems serving District residents with substance use issues; and
- ▶ Issuing an Annual Report that includes: findings and recommendations to public and private entities that address gaps, barriers, or improvements to existing systems in an effort to prevent future opioid overdoses and opioid overdose deaths; steps taken by public and private entities to implement recommendations of the Board; and statistical analyses of data relevant to opioid overdose and substance use.

The duties of the OFRB as set forth in the Mayor's Order are:

- ▶ Developing review criteria to include statistical, individual, cluster, and multidisciplinary case review processes;

The Case Review Process



The OFRB conducts a systematic, multi-agency, multi-disciplinary review of opioid overdose deaths within the District, taking a non-judgmental approach. The case review process is retrospective and begins after data has been reconciled by various organizations (hospitals, government agencies, community service providers). The analysis of each case includes an overview of past events and circumstances by reviewing records and other pertinent documents from public and private agencies.

The full case review process models a systems framework. All systems that the decedent interfaced with are analyzed to determine how that system contributed to the decedent's outcome; then recommendations are made by the committee to strengthen those systems. The main objective of the review is to identify whether opportunities exist to alter outcomes (strong, possible, none). If such opportunities exist, then board members enumerate them and make specific recommendations.

The OFRB uses a methodological approach to examine the interaction of the complex systems of District residents.

Full case review summaries include the follow data points:

- ▶ Demographic information on decedent such as race, ethnicity, educational attainment
- ▶ Hospital or medical center where decedent sought medical care, Emergency Department visits, ongoing specialty care
- ▶ Substance Use Disorder treatment
- ▶ Mental Health treatment
- ▶ Location and circumstances leading to the death
- ▶ Periods of incarceration
- ▶ Use of public benefits (i.e. SNAP and Medicaid)

In instances where a decedent had limited interaction with government systems and community-service providers, a statistical case review is conducted. This process was adopted from the District's Child Fatality Review Committee (CFRC).

Decedent records are requested from the following District government agencies:

- ▶ **Office of the Chief Medical Examiner (OCME)** - toxicology reports, death investigation reports, autopsy reports, scene investigation
- ▶ **Metropolitan Police Department** - any relevant police reports, investigations, arrest history, PD 120
- ▶ **DC Department of Human Services** - any records related to TANF, SNAP, EBT, emergency housing, childcare, medical assistance, counseling services
- ▶ **DC Department of Health** - vital records, Prescription Drug Monitoring Program (PDMP), naloxone distribution
- ▶ **DC Fire/EMS** - medical/transport records, naloxone administrations
- ▶ **Department of Forensic Sciences (DFS)** - data on substances tested or found at the scene
- ▶ **DC Department of Behavioral Health**
 - Substance Use Disorder service history - to include detox, residential, outpatient, prevention, recovery and treatment records
 - Any mental health-related diagnostic service assessment, treatment/encounter notes, psychological evaluation or other document producing a formal diagnosis, medication history, treatment plan and discharge summary, counseling or community support records
 - Emergency psychiatric service history records
 - Community-based service provider history
 - Homeless services provisions to include crisis assessment and interventions
- ▶ **DC Department of Health Care Finance**
 - Insurance information
 - Claims data
 - Service Date
 - Claim Type Description
 - Claim Coverage Type
 - Billing Provider Name
 - Billing Provider Type
 - Diagnosis

- ▶ **Mayor's Office of Veterans Affairs (MOVA)** - medical records, any treatment services, counseling or community support records
- ▶ **Office of the Attorney General** - any related police reports, arrest history
- ▶ **CSOSA** - any records regarding parole, probation, supervised release, civil orders of protection, deferred sentencing agreements
- ▶ **Department Of Corrections** - arrest/incarceration history, medical/treatment services
- ▶ **District of Columbia Superior Court Drug Intervention Program** - any records related to court cases, treatment and intervention services
- ▶ **Pretrial Services Agency** - any arrests records, criminal court case reports; DEA - any related law enforcement records, drug related/criminal investigations

There are five key questions that OFRBs reference for each death reviewed:

1. Were there opportunities for intervention?
2. Was the death preventable?
3. What were the factors that contributed to the death?
4. What are the recommendations and actions that address those contributing factors?
5. What is the anticipated impact of those actions if implemented?

2019 Board Discussions



Social Determinants of Health

The Board members discussed the opportunity to address the social determinants of health (SDOH) of the population affected by the opioid crisis. This discussion took place among District agency representatives, substance use disorder treatment providers, community-based service providers and District resident members. The SDOH include access to medical treatment, social support, safety, socio-economic conditions, food deserts, access to quality education, transportation and job opportunities.

SDOH are defined by the Centers for Disease Control and Prevention (CDC) as the conditions in which people live, learn, work, and play that affecting a wide range of health risks and outcomes.⁵

Risk Factors for Opioid Misuse and Overdose⁶

The Fatality Review staff presented information to the Board and discussed the known risk factors for opioid misuse and overdose as well as strategies to identify and mitigate an individual's risk of developing an opioid use disorder. These risk factors include the following:

- ✓ Personal history of substance abuse
- ✓ Unemployment
- ✓ Young/middle age
- ✓ Family history of substance abuse
- ✓ History of criminal activity or legal problems including DUIs
- ✓ Regular contact with high-risk people or high-risk environments
- ✓ History of severe depression or anxiety
- ✓ Risk-taking behavior
- ✓ Heavy tobacco use
- ✓ Problems with past employers, family members and friends (mental disorder)
- ✓ Prior drug or alcohol rehabilitation
- ✓ Stressful circumstances
- ✓ Poverty
- ✓ Trauma

⁵ Social Determinants of Health- <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

⁶ Risk Factors for Opioid Overdose- <https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372>

Overdose Detection Mapping Application Program (ODMAP)⁷

Information on the forthcoming implementation of ODMAP spearheaded by the District of Columbia Department of Health (DC Health) was presented to the Board.

ODMAP is a tool that has the capacity to collect surveillance data on both suspected fatal and non-fatal overdoses, in real time, across the District, to coordinate a cohesive and collaborative response. The surveillance data is provided to community service providers, first responders via the District of Columbia Fire and Emergency Medical Services Department and other relevant agencies in an effort to support public safety and public health effort.

Narcan Access and Availability within the District⁸

The OFRB discussed the availability and access to Narcan by the community through collaborative efforts such as an increase in education and awareness training, and distribution of materials across all wards using a collaborative approach.

District residents have the ability to access Narcan within the all District wards:

- ▶ For free by prescription from a physician for pick up at select District pharmacies
- ▶ Through availability at more than thirty (30) sites across all wards within the District
- ▶ By calling 1-888-7WE-HELP 24/7 to find out where residents can receive free naloxone kits⁹
- ▶ Free Narcan administration training is available through the District of Columbia Department of Health

⁷ OD Map- <http://www.odmap.org/>

⁸ Narcan Training - <https://dchealth.dc.gov/opioids>

⁹ Narcan Access- <https://dchealth.dc.gov/node/1450461>



September 2019 - December 2019 Accomplishments and Highlights

In 2019, the Board accomplished the following:

1

Members were identified and officially sworn-in by MOTA

2

Members received orientation from the fatality review staff

3

Members produced draft Rules and Procedures

4

Quorum and meeting frequency were established

5

OFRB Mayor's Order was reviewed

6

Robert's Rules of Order was incorporated

7

First sample case review began in November 2019

A Look into 2020 OFRB Objectives





- ▶ Development of a robust framework for the identification of findings and recommendations
- ▶ Development of the OFRB Case Review Form adapted from the CDC¹⁰ Maternal Mortality Review Committee Decisions Form MMRIA
- ▶ Meeting of Quarterly recommendation sub-committee 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 add an additional Opioid Fatality Review Program Specialist. The specialist will support the planning and coordination of case reviews as required by the OFRB.

10 Source: <https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form>

A Preview of 2020 Adopted Recommendations



Recommendation #1

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 in 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 the treatment helpful?

Agency Response:

The Office of the Chief Medical Examiner agrees with this recommendation.

Best Practice

DC Fire and Emergency Medical Services (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 include the patient's medical history, especially question 1 and question 5, but all 6 questions if able.

Metropolitan Police Department (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, relaxed 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 his/her 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 give a summary of 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.
- 1. 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>.

Office of the Chief Medical Examiner Investigations and Forensic Investigators (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 2 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 Suspected Overdose variable is selected by the medical

examiners after reviewing the death investigation reports and supplemental reports, and completing an autopsy, even 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 2 new checkboxes allows OCME to detect and report overdoses in a timelier 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 5 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, DCFEMS 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 then synthesizing each case into a short narrative. When SUDORS Abstractors code and synthesize each case, they ensure that both NVDRS's vision and LIVE. LONG. DC.'s mission be 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 6 questions will be disseminated to each MDI/FI.
2. If a death notification report comes from DCFEMS or 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 6 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 FEMS/first responding officer/detective about the 6 questions, the MDI/FI will ask any follow-up or probing questions based on the 6 questions for further clarification.
5. The MDI/FI will record the responses to the 6 questions in their scene investigations notes, specifically in the new tab created on CMS (refer to OCME Record Unit/ IT Unit Action item below).
6. Of note, questions 1 and 6 can be asked to family and friends not present at the scene. However, if family and friends were living with the decedent, but they were not at the scene during the immediate time leading up to the death (e.g., left the 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 CMS (refer to OCME Record Unit/ IT Unit Action item below).

OCME Records Unit/ IT Unit

Action Item

- ▶ 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 6 questions by the MDI/FI. The sixth text box should be entitled "Suspected Overdose/Witness Interview Responses." In the text box, there should be separate bystander(s) responses to the 6 questions, if there are more than one bystander.

OCME Data Fusion Center/ SUDORS Abstractors

Action Item

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

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 apprise a variety of agencies, practitioners, and policy workers on how to best reduce overdoses and assist in ensuring that 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 6 questions across all 3 agencies after four months.

Recommendation #2

DC Health, in collaboration with DCFEMS and MPD, should collect Narcan dispensation and administration data through a 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.

Agency Response:

DC Health responded "No, with explanation and alternative recommendation."

DC Health agrees with the spirit of the recommendation but does not accept it as currently proposed. CRISP DC is the District's Designated HIE and is overseen by Department of Health Care Finance (DHCF), not DC Health. Enhancements to the HIE and recruitment of new participating providers or provider types will fall under their purview and expertise. CRISP DC has existing connections to DCFEMS, and Narcan dispensing by DCFEMS is currently available to the HIE under an existing approved use case. Connections to Department of Behavioral Health (DBH), IMD providers, and most DBH certified providers are already in place or close to completion.

Secondly, provider education about new alerts related to Narcan use, and subsequent follow-up care for individuals, is best overseen by DBH as the relevant subject matter expert. Finally, a

strategy to collect Narcan dispensation and administration data should include identification of all relevant data sources, which may not be limited to DCFEMS and MPD, and a plan to address data-sharing/privacy concerns.

DC Health does have a technical assistance role to play in the implementation of this recommendation and progress towards its intent. DC Health currently receives DCFEMS data and shares data with MPD and DBH. While data-sharing between DCFEMS data and CRISP DC would be best addressed directly through DHCF, DC Health can provide technical assistance regarding potential data sources and suitable data elements to share that could help frame our strategic response (in collaboration with DBH).

In addition to DCFEMS data related to Narcan, the District has a retail pharmacy dispensing program as well as community partner dispensing. The current recommendation does not account for these potential data sources, which are relevant for a centralized repository. Participation of these program providers in CRISP DC would be best assessed by DHCF, though DC Health can provide technical assistance on the data elements to be shared, in collaboration with DBH who also works closely with these providers.

Best Practices

- ▶ The tracking of Narcan dispensation and administration access is one critical component of an opioid overdose prevention and response strategy. Monitoring this data can keep both clinical and public health management informed of individuals and the population, respectively. The sharing of the data with appropriate parties and with attention to both confidentiality and the strengths and limitations of the data sources can improve this management.
- ▶ HIEs offer a secure and easy (single sign-on) way to exchange data across participating clinical providers to facilitate continuity of care across different care settings. Provider notifications and subsequent action can result in improved follow-up of patients and better outcomes. This relies on patients being known/assigned to providers who participate in the HIE. Participating providers are typically clinical providers, not community-based providers or peers.
- ▶ Privacy and data-sharing standards around protected health information and public health surveillance data are well-documented.

Specific Actions Planned Towards Implementation:

1. Review DCFEMS data elements and identify actionable MPD data elements for CRISP DC and potential data analyses - FEMS, MPD, DHCF, DBH, DC Health.
2. Review approved use case and other considerations with CRISP DC Clinical Committee.
3. Link MPD data elements to CRISP DC (if appropriate and actionable).
4. Create care alert for providers regarding Narcan administration (if appropriate) - CRISP DC/DHCF.
5. Develop toolkit for providers (if CRISP DC alerts are activated) - DBH.
6. Assess data currently and potentially available from other sources of Narcan dispensation and administration such as retail pharmacies and community providers - DBH, DHCF, DC Health.
7. Assess feasibility of integration with CRISP DC - DHCF, pharmacies, community providers.
8. Review use case and other considerations (and obtain approval if new use case) with CRISP DC Clinical Committee.
9. Link to CRISP DC (if appropriate and actionable) - DHCF, pharmacies, community providers.

Specific actions taken to date towards implementation

1. DCFEMS shares data with DC Health.
2. DCFEMS shares data with CRISP.
3. DBH has participation agreement and access to CRISP; most DBH certified providers, and all IMDs have access to the DCFEMS data in CRISP.
4. DHCF launched Consent Management project with CRISP to implement eConsent for SUD.

5. DC Health shares de-identified data with MPD.
6. DC Health shares data with DBH until DBH-FEMS data-sharing is implemented.
7. ODMAP is developed and accounts are activated for relevant users.

Expected outcomes

The primary expected outcome is follow-up of a person who experienced a Narcan reversal by the person's provider.

Measurable indicators/milestones

- ▶ Identification of actionable data elements for CRISP DC
- ▶ Linkage of data sources to CRISP DC (if appropriate, requires approval of use case)
- ▶ Provider toolkit developed (if CRISP DC alerts are activated)

Recommendation #3

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

Agency response:

DBH agrees with this recommendation.

Best Practice

DBH and its partners are committed to improving care coordination and transition planning in the substance use disorder (SUD) system of care. DBH recently drafted a bulletin explaining DBH's expectations for all providers to provide quality care coordination for clients, ensuring that their needs beyond the current treatment episode are addressed while in care.

The following is the framework that will guide the development of a care management model:

- ▶ Individuals with “lived experience” will serve as Care Coordinators.
- ▶ Addiction is a chronic, relapsing disease; therefore, services will be available 24/7 from the individual’s peer partner.
- ▶ Care will be individualized.
- ▶ The service system will incorporate value-based principles.
- ▶ Care will be culturally and linguistically competent.

Models/tools that have been explored for consideration are:

- ▶ Recovery Monitoring and Support (RMS), an evidence-based model developed by Chestnut Health Systems that is implemented with individuals after discharge from an acute episode of treatment, regardless of whether or not the treatment was completed, can be used to facilitate the care coordination and consumer support process. The staff support clients with: (1) monitoring of substance use and use triggers; (2) recovery support designed to increase recovery capital; and, when needed, (3) early re-intervention and linkage back to treatment
- ▶ Recovery Capital (REC-CAP), an evidence-based assessment and recovery planning instrument developed by Dr. David Best. It assesses an individual’s recovery strengths, barriers, and unmet service needs; supports trained navigators to guide individuals in the execution of concrete recovery goals; and delivers longitudinal measurement of recovery capital gains over quarterly intervals
- ▶ Recovery-Oriented System of Care (ROSC), a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems
- ▶ Pay for performance models

Specific Actions Planned Towards Implementation:

Multiple initiatives are underway to address elements of care coordination: SUD Capacity Grant, SOR 2 care management, 1115 Waiver Transition Planning Benefit, and key performance indicators for medically monitored withdrawal management and residential SUD step downs. Staff leading these initiatives will develop a coordinated plan with clients and providers to address care coordination to improve outcomes for clients.

- ▶ DBH will release a care coordination bulletin by August 31, 2019.
- ▶ DBH and partners will hold virtual meetings by August 31, 2020, with clients and providers on ways to improve outcomes for clients by implementing care management activities or incentives for providers for improved care (e.g., pay for performance). The first meeting is August 25, 2020 with providers.
- ▶ DHCF will receive feedback at the MCAC Health System Re-Design Subcommittee on August 5, 2020 about potential models of care management to specifically target individuals with OUD as an enhancement to DC's SOR grant.

DBH will meet with staff at So Others Might Eat by August 14, 2020 to learn about the Together4Health AmeriHealth project that provides care management under a value-based model.

- ▶ DBH held internal meetings in June and July 2020 to discuss proposed funding for care coordination included in the SOR 2 grant and the 1115 Waiver Transition Planning Benefit.
- ▶ DBH met with Dr. Moghimi, Medical Director, Behavioral Health, AmeriHealth, on June 25 and 26, 2020 to understand their peer care management model.
- ▶ DBH met with governmental partners on August 7, 2020 to discuss a plan to engage the community.
- ▶ DBH held a meeting on August 4, 2020 with DHCF to discuss a plan to engage providers.

Expected Outcomes:

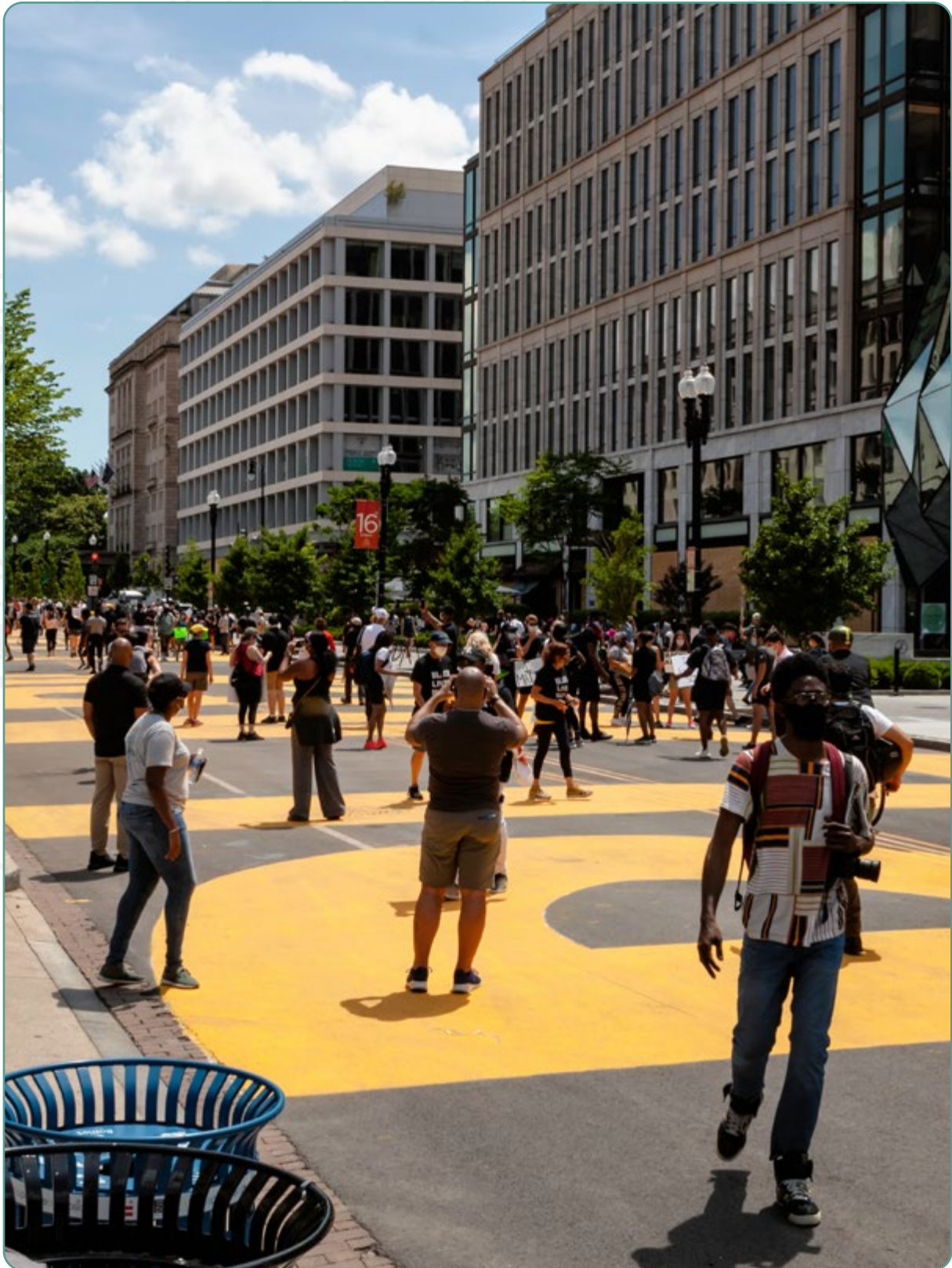
1. Adopt a plan for improving care management that reflects input from client, providers, and governmental partners.
2. Once the plan is implemented, improved client outcomes will be seen in the following domains:
 - a. Employment
 - b. Housing
 - c. Engagement in mental health care as needed
 - d. Engagement in medical care as needed
 - e. Engagement in long-term recovery activities
 - f. Benefits attainment
 - i. Medicaid
 - ii. SSI/SSDI
 - iii. Food Stamps
3. Relapse reduction
4. Reduction in re-admissions to higher levels of care - Measurable Indicators/
Milestones: Meeting held with governmental partners, providers and consumers



Acknowledgment

The Office of the Chief Medical Examiner expresses its sincere appreciation for the work of the members of the Opioid Fatality Review Board. Their tireless volunteerism will help the District of Columbia to combat the opioid crisis, while improving outcomes for all residents.

We recognize that with this group of dedicated individuals, the work of the OFRB will not be in vain. Your work speaks truth to power, and we thank you for your service.





The Honorable Muriel Bowser, Mayor
District of Columbia Government

Roger A. Mitchell Jr., MD, Chief Medical Examiner
Office of the Chief Medical Examiner

**DISTRICT OF COLUMBIA GOVERNMENT
OPIOID FATALITY REVIEW BOARD
D.C. OFFICE OF THE CHIEF MEDICAL EXAMINER**

📍 **401 E STREET, SW
WASHINGTON, DC 20024**

☎ **(202) 698-9000**

🌐 **WWW.OCME.DC.GOV**

✉ **OCME@DC.GOV**