OPIOID FATALITY REVIEW BOARD

2021 ANNUAL REPORT

Washington, DC

MISSION OF OFRB

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

OPIOID FATALITY REVIEW BOARD MEETING CHAIR AND VICE CHAIR

Dr. Jewell Reddick
Vice-Chair, Opioid Fatality Review Board

CONTRIBUTORS

Tracie Martin
Senior Fatality Review Program Specialist

Kera Johnson
Staff Assistant

OCME FATALITY REVIEW DIVISION STAFF

Jenna Beebe-Aryee
Fatality Review Division Program Manager

Tadessa Harper-Nichols
Fatality Review Specialist

Breanna Cuchara
Fatality Review Specialist

Candace Hardin
Staff Assistant

PRESENTED TO

The Executive Office of the Mayor

The Council of the District of Columbia

The Citizens of the District of Columbia

OPIOID FATALITY REVIEW BOARD

2021 ANNUAL REPORT

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GREETINGS FROM THE
CHIEF MEDICAL EXAMINER

Francisco J. Diaz, MD
FCAP FASCP
Chief Medical Examiner
Office of the Chief
Medical Examiner
Washington, D.C.

In 2021, The opioid crisis in the District of Columbia continued as overdose deaths related to fentanyl, or a fentanyl analog, quietly disrupted the lives of our residents, most of whom resided in our most vulnerable communities.

Although overdose deaths due to the opioid crisis is a national concern, the District of Columbia has a team of multidisciplinary leaders representing both government and community-based systems that address the most difficult circumstances associated with opioid deaths. The work of the District of Columbia's Opioid Fatality Review Board (OFRB) is unmatched. The OFRB continued to meet monthly to address systemic issues and devise recommendations that challenge the way we think about substance abuse disorders, and substance abuse treatment. As naloxone changed the outcome of surviving an opioid overdose, we can continue to work to improve the outcomes of those struggling with substance abuse dependencies in the District of Columbia. The work of the OFRB is a unique opportunity to evaluate our system of care and develop sound, yet robust recommendations to improve substance abuse treatment services throughout this great city.

We present the 2021 Opioid Fatality Review Board Annual Report. We hope this report will help to inform the District's broader population of our efforts to address this crisis.

Sincerely,

Francisco J. Diaz

GREETINGS FROM THE
OFRB CHAIR

On behalf of the Opioid Fatality Review Board (OFRB), I am pleased to present the 2021 OFRB Annual Report.

Jewell J. Reddick, PharmD, Esq.
Opioid Fatality Review Board Vice-Chair

In 2021, the United States experienced a record number of drug overdose deaths. From 2020 to 2021, there was a 12.5% increase[1] in the number of drug overdose deaths in the U.S. The Centers for Disease Control and Prevention estimates over 550 people died of a drug overdose in the District of Columbia in 2021-almost 10% more than 2020. The District also experienced numerous non-fatal overdoses in 2021. Many of the drug overdose incidences, both fatal and non-fatal, in the District can be attributed to the spread of Fentanyl and its analogs. The Opioid Fatality Review Board (OFRB) continues to focus on reducing opioid deaths by conducting case reviews of fatal opioid overdoses to provide recommendations to relevant stakeholders for systemic changes to District agency policies and programs.

It has been an honor to serve as Vice-Chair of the OFRB. I continue to be inspired by the passion and resolve of the OFRB Board members to tackle the diverse and difficult challenges of the opioid crisis. I look forward to continuing the important work of this Board as we develop innovative recommendations to reverse the increase in opioid deaths in the District of Columbia.

Sincerely,

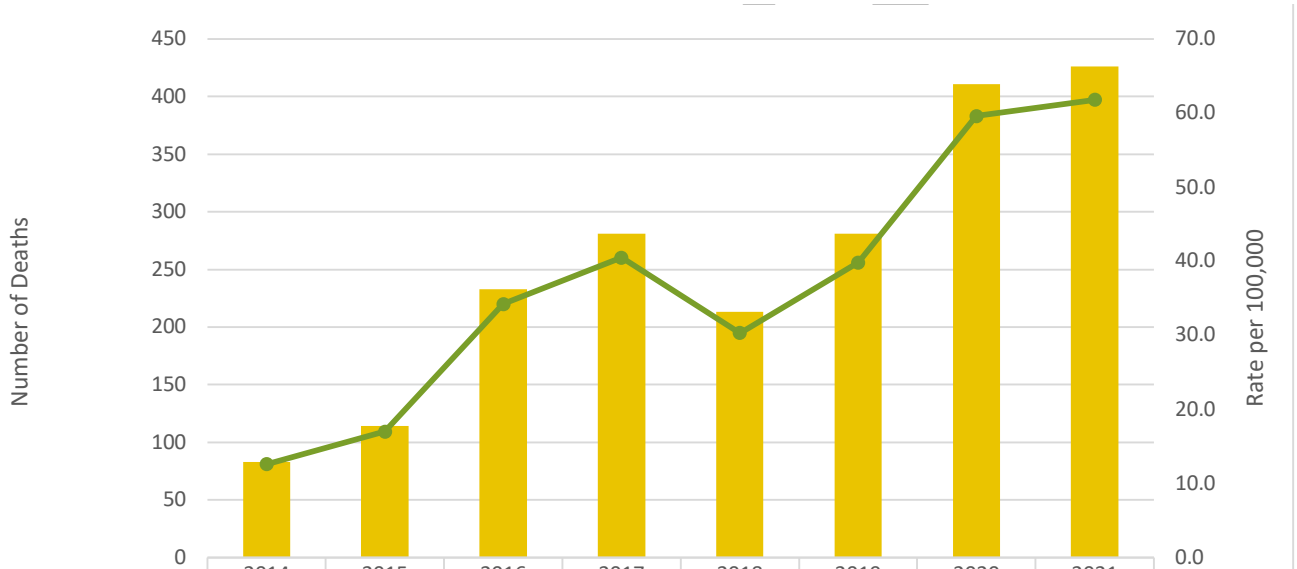
Jewell J. Reddick

1 https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

AN OVERVIEW OF THE OPIOID CRISIS IN THE DISTRICT

Data from Mayor Bowser's Strategic Plan**, *LIVE.LONG.DC.* and the DC Office of the Chief Medical Examiner (OCME) highlights that OCME investigated a total of 426 overdose deaths in 2021.

FIGURE 1 NUMBER AND RATE OF OCME CASES BY YEAR, 2014-2021*



	2014	2015	2016	2017	2018	2019	2020	2021
Deaths	83	114	233	281	213	281	411	426
Mortality Rate	12.6	17.0	34.2	40.5	30.3	39.8	59.60	61.78

*Due to the pending population size for 2021, 2020 data was used to calculate mortality rate: https://www.census.gov/quickfacts/fact/table/DC#

In 2021, there were 426 opioid overdose deaths, with the average number of fatal overdoses per month being 34.

In 2021, 95% of cases contained fentanyl or fentanyl analog

In 2021, 57 prescription opioids contributed to drug overdoses. These prescription drugs included codeine, oxycodone, hydrocodone, buprenorphine, and methadone.

** Live.Long. DC Website-https://ocme.dc.gov/publication/epidemiology-and-surveillance-reports

OVERALL DEMOGRAPHICS

Gender

- 73% of the decedents were males
- 27% of the decedents were females

Age

- 3 of the decedents were less than 16 years old
- 6 of the decedents were between the ages of 16-19 years old
- 28 of the decedents were between the ages of 20-29
- 66 of the decedents were between the ages of 30-39
- 45 of the decedents were between the ages of 40-49
- 118 of the decedents were between the ages of 50-59
- 135 of the decedents were between the ages of 60-69
- 24 of the decedents were between the ages of 70-79

Race/Ethnicity

- 366 of the decedents were African American
- 46 of the decedents were White
- 10 of the decedents were Hispanic
- 1 of the decedents were other

Jurisdiction of Residence

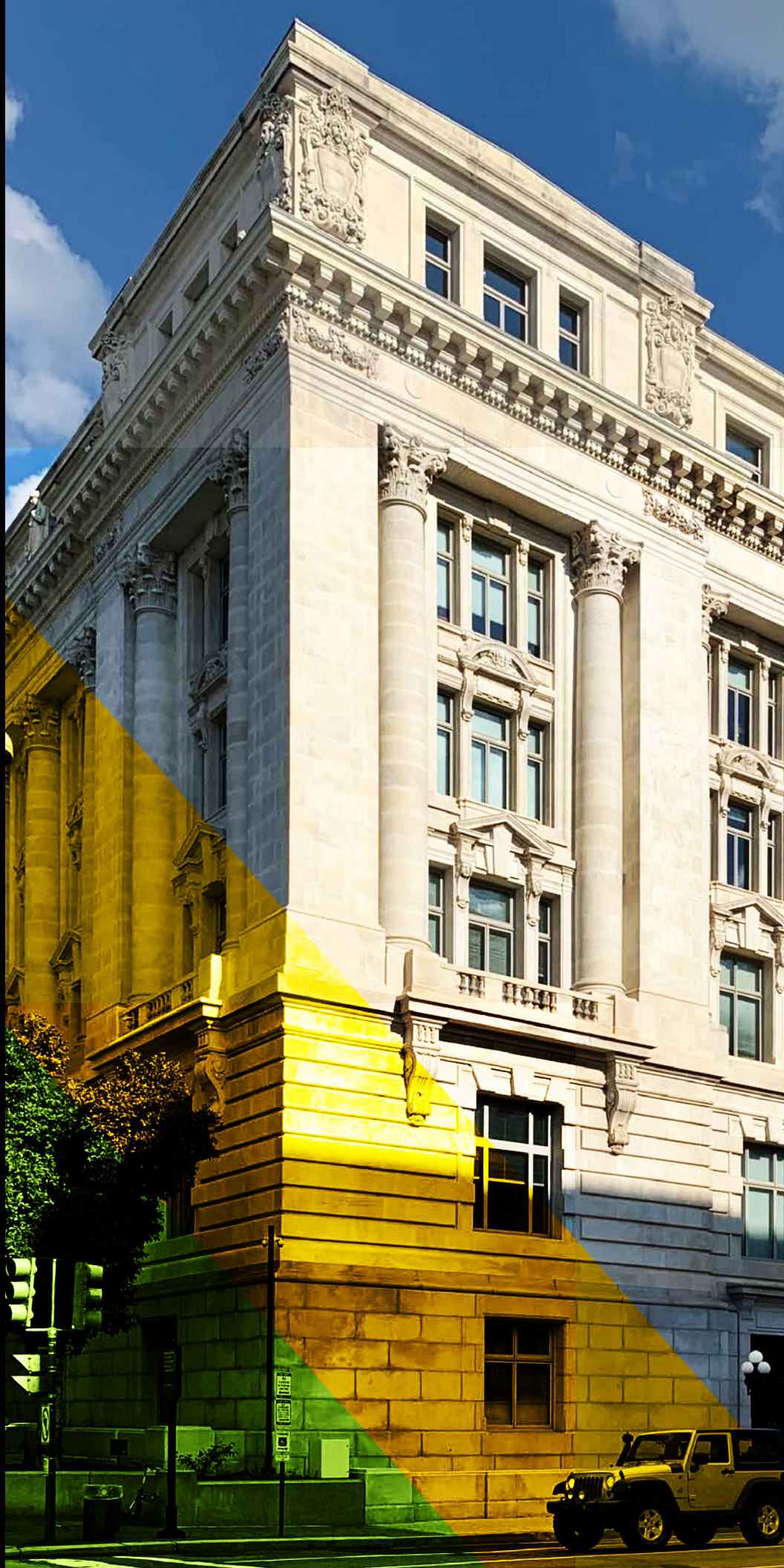
Most decedents (222) were residents within the District of Columbia (DC). Within DC, opioid related fatal overdoses were most prevalent in wards 5,6,7 & 8.

AUTHORITY

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

The OFRB currently falls under Goal 1 of LIVE. LONG. DC – The District's Strategic Plan to reduce opioid use, misuse, and related deaths. 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.

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 the District.



EXECUTIVE SUMMARY

The District of Columbia's Opioid Fatality Review Board (OFRB) is proud to present its 3rd Annual Report. The OFRB was established in 2019 and explored the root cause of overdose deaths in the District and made recommendations to prevent these deaths by implementing system-level changes that would positively affect the community.

METHODOLOGY

The OFRB 2021 Annual Report covers data from decedents whose cause of death was due to an opioid overdose in 2021.

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

BOARD COMPOSITION

In 2021, members and meeting participants were comprised of the following District Government agencies, community-based service providers, and District residents 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

2021 ACCOMPLISHMENTS AND HIGHLIGHTS

OFRB DISCUSSIONS AND FINDINGS

The OFRB utilizes a multi-disciplinary approach when reviewing cases where the cause of death was due to an opioid overdose. During 2021 case review meetings, the following topics were discussed:

- The Effectiveness of Medication Assisted Treatment for Opioid Use Disorder
- Co-occurring Disorders - Mental Health Disorders and Substance Use Disorder
- Effective Harm Reduction Strategies Used to Prevent Opioid Overdose
- The Relationship between Housing Status and Substance Use Disorder

The Effectiveness of Medication Assisted Treatment for Opioid Use Disorder

When left untreated, substance use disorders (SUDs) have profound effects on health outcomes. Understanding what these substances do in and to the brain and body is crucial to understanding why medication-assisted treatment (MAT) is effective.[2] Prevalence amongst two of the most problematic SUDs, opioid use disorders (OUDs) and alcohol use disorders (AUDs), has increased dramatically in the last 10 years. This increase created a significant impact on individual health status, associated health care, and socioeconomic programs. As a result, patients with SUDs have higher rates of comorbid conditions that lead to further complications and accelerate the progression of these conditions.[3] Data from the National Survey on Drug Use and Health suggests that there is a burden placed on the quality of care and costs associated with delivery systems and communities.[3]

MAT is designed to address and treat substance use disorders by using medications, in combination with counseling and behavioral therapies.[2,4] The primary use is for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medication reverses the negative effects of the substance used to provide normal functioning and relieve cravings. These benefits help patients stay committed to their treatment.

Research shows that MAT's focus is sustaining recovery for individuals struggling with addiction and preventing overdose.[5] The program does this by delivering a "whole-patient" approach, to support its ultimate goal of full recovery, with tailored treatment that provides a sustainable self-directed life.[3] In doing so, MAT has been deemed effective at treating SUDs and improving comorbid health conditions.[3,4]

Common medications used in treatment for opioid addition include Methadone, Buprenorphine, and Naltrexone, which are all FDA-approved.[3] Buprenorphine, representing the latest advancement in MAT, and unlike Methadone, is the first medication used to treat OUD that is permitted to be prescribed or dispensed in physician offices. This led to a significant increase in access to treatment.[6]

Health and human services agencies and community-based providers are identified as service-providers for SUDs, emphasizing MAT. DC Health lists addiction treatment locations identifying those who provide MAT, Substance Use Disorder Treatment (SUD), and Syringe Service Programs (SSP). Of the 14 locations listed, 9 provide MAT: Andromeda, Bread for the City, Community of Hope, Family & Medical Counseling Services, HIPS, Howard University Hospital, Mary's Center, Unity Health Care, and Whitman-Walker Health.[7]

The Department of Behavioral Health (DBH) provides a network of community-based providers certified to provide SUD treatment services.[8] Additionally, DBH provides prevention, recovery services, and integrated care for those also struggling with mental illness. An assessment and referral center via DBH is provided through the agency website for enrollment to services.[9] Same day assessment and referral are available for individuals seeking treatment for SUDs.

The Department of Health and Human Services (HHS) provides a search option to find treatment programs.[10] Patients can filter facilities based on location, treatment type, payment options, and MAT programs.

Additional resources/programs found that offer MAT in DC:

- PIDARC (Partners in Drug Abuse Rehabilitation Counseling)
- Another Way Methadone & Suboxone Clinic
- UPO (Uniting People with Opportunities)
- Good Hope Institute
- DOC Central Detention Facility Methadone Program
- Department of Veterans Affairs Community Clinic
- BHG (Behavioral Health Group)

Co-Occurring Disorders – The Relationship Between Mental Health Disorders and Substance Abuse

Substance use disorder (SUD)—defined as the repeated misuse of alcohol and/or drugs- often occur simultaneously in individuals with mental health disorders.[11] Their coexistence is often referred to as a co-occurring disorder. According to SAMSHA's 2020 National Survey on Drug Use and Health, approximately 17 million adults in the United States had a co-occurring disorder.[3] When substance use and mental disorders co-occur, they can differ in severity and change over time. Those who have a combination of disorders, in comparison to individuals that have a single disorder, tend to experience more severe medical challenges.[3] Furthermore, they may require longer periods of treatment. With symptoms ranging from moderate to severe, addiction is found to be the most severe form of SUDs.

Common co-occurring disorders include anxiety disorder, depressive disorders, attention-deficit hyperactivity disorder (ADHD), schizophrenia, bipolar disorder, and personality disorders.[11] According to the National Institute of Mental Health, "while SUDs and other mental disorders commonly co-occur, that does not mean that one caused the other."

Common risk factors can contribute to both SUDs and other mental disorders.

- The passing of genes that have been changed due to environmental factors such as stress or trauma

Mental disorders can contribute to substance use and SUDs.

- Substance use as a form of self-medication that can lead to worsening of symptoms, brain changes, and addiction

Substance use and SUDs can contribute to the development of other mental disorders.

- Substance use as a trigger to brain changes and level of functioning resulting in development of mental disorder[11]

Treatment guidelines for co-occurring disorders recommend that treatment for both disorders are received at the same time.[11] In doing so, accurate diagnosis and targeted treatment plans can be provided without the challenge of overlapping symptoms. Integrated treatment for co-occurring disorders incorporates behavioral therapies and medications. Cognitive behavioral therapy, dialectical behavioral therapy, assertive community treatment, therapeutic communities, and contingency management are some common examples of effective behavioral therapies for adults with co-occurring disorders.[11] An integrated treatment plan is important because of its effectiveness at producing the best health outcomes and its impact on long-term success.[12]

The Department of Behavioral Health (DBH) supports integrated care with screening, diagnosis, and treatment for co-occurring disorders. DBH lists community-based SUD providers (27 in total – listing provider name, address, phone numbers, and hours) on their website and access to the assessment and referral center. Same day assessment and referral are available for individuals' seeking treatment.[13]

A 2005 resource directory was found that lists agencies in the district that provide services specifically for individuals with co-occurring substance use and mental health disorders. All information, population, location, phone number, fees, type of programs, and services, is provided.[14]

Effective Harm Reduction Strategies Used to Prevent Opioid Overdose

Harm reduction is a public health approach designed to reduce the negative social and/or physical impacts of behavior associated with substance use.[15] Harm reduction programs act as a bridge for prevention, treatment, and recovery services. Strategies are created and put in place to act as a barrier to lessen the negative impacts of substance use. Interventions are designed to focus on safer use, managed use, abstinence, and meeting people who use drugs, "where they are".[15] This evidence-based model allows for the promotion of health, regardless of whether an individual uses drugs, which in turn lessens the stigma associated with substance use and overdose.[15] Due to the opioid epidemic, harm reduction services and interventions are an increasing necessity.

Fentanyl, a synthetic opioid that is 50 times as potent as heroin, is one of the leading causes of overdose deaths.[16] Many people intentionally use fentanyl because of its potency while others consume it without proper knowledge.[16] Specific strategies have been created to minimize the risk of an overdose such as using fentanyl test strips. Fentanyl test strips were piloted in 2017 as a response to the increase of fentanyl in the drug supply.[17] This is used to identity the presence of fentanyl in unregulated drugs which include injectable drugs, powders, and pills. Due to its access, availability, and simplicity, the test strips have been found to be highly successful in creating safer drug use practices. This will ultimately aid in the reduction of overdoses. The National Harm Reduction Coalition (NHRC), an advocate bringing harm reduction strategies to scale, lists practices and recommendations for people who choose to use drugs.[16]

Test strips allow people who use drugs to be more informed about the drugs they are buying and consuming. Additionally, this creates increased general awareness and understanding of fentanyl among people who use drugs.[17] Knowing that fentanyl is present is the first step to minimizing one's risk of an overdose as it gives users an opportunity to utilize harm reduction strategies.[17]

The lead agencies working on facilitating the use of fentanyl testing strips is NIH, FDA, CDC, and SAMHSA.[18] SAMSHA does a great job at outlining specific harm reduction activities and intended outcomes.[15]

The CDC reported that the COVID 19 pandemic exacerbated the spread of high potent synthetic opioids such as fentanyl.[19] The CDC also reported that, "we have crossed the tragic milestone of a predicted 100,000 overdose deaths in 12 months from May 2020 to April 2021; this represents nearly 29 percent increase compared to the same window of time last year."[15] DBH is now in the process of developing guidance for the use of test strips and have added test strip usage as a strategy to consider in their opioid strategic plan.[20] ***LIVE.LONG.DC.*** is the detailed report addressing the goals and approaches of ending DC's opioid epidemic.[21] Right now, the only harm reduction programs being offered is the naloxone and syringe services program (needle exchange).[22]

The Relationship between Housing Status and Substance Use Disorder

There is a relationship between housing status and substance use disorder due to the impact one has on the other. Stable housing plays a vital role in one's recovery from SUDs and without access to housing, recovery from SUDs can be negatively impacted.[23] The stress from not having housing can trigger substance misuse and relapse. In turn, homeless individuals who have SUDs are less likely to address their substance use because of the lack of a safe and stable environment.[23] Having access to housing when dealing with a SUD is extremely important.

Meeting the housing needs of people with substance use disorders can be challenging. There are multiple barriers that people with SUDs face when it comes to housing.[26] One is finding affordable housing assistance. Applying and waiting for affordable housing is already a strenuous process due to the long waiting lists and scarcity of resources.[26] When you add low-income and SUDs, people tend to face even more barriers to accessing housing.[26] Studies have shown that not only is providing housing needed, but that the availability and accessibility of these programs must be increased as well.[26]

The "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act of 2018 (the SUPPORT Act)" comprises of dozens of individual bills that direct additional federal resources toward prevention and treatment.[24] Since the passing of the SUPPORT Act, states and localities have been able to address the relationship between housing and substance use disorder through the establishment of the pilot program. The pilot program, used to help individuals in recovery from a substance-use disorder become stably house is known as the Recovery Housing Program. The Recovery Housing Program allows states and the District of Columbia to provide stable, transitional house for individuals in recovery from a substance-use disorder. It was authorized under the SUPPORT Act and funded, giving the District of Columbia a total of $2,284,604 for its implementation.[25]

DC Department of Housing and Community Development (DHCD) created an action plan outlining its use of said funds.[25] DHCD also partnered with the DBH, DHCF, and ICH to administer the recovery housing program funds.[25] These funds will fund the construction of low-income affordable housing for persons living with SUDs. More information discussing the plan, use of funds, and anticipated outcomes are detailed in the action plan.[25]

The Department of Behavioral Health Services and Activities 2021 Highlights

Naloxone Distribution

In fiscal year 2021, the Department of Behavioral Health (DBH) doubled down on the distribution of life saving naloxone. During, fiscal year 2021, 56,810 naloxone kits were distributed compared to 31,917 kits in fiscal year 20—a 78 percent increase. Naloxone is now widely available at no cost, with no ID or prescription required.

- There are now 43 locations in all eight wards to pick up naloxone. You can also text for delivery by mail or in person.
- Seven faith-based institutions and four peer-operated centers serve as distribution sites.
- Outreach teams deploy to areas with a reported spike in overdoses to distribute naloxone and treatment information.
- The DBH mobile van weekly travels to targeted communities to meet individuals where they live.

Treatment Strategies

Harm reduction strategies have one goal—keep people alive with the possibility of treatment and recovery. Through the District's combined efforts, we are making it easier to get treatment through multiple entry points that include certified community-based providers; medication-assisted treatment centers; the emergency departments of six community hospitals, eight community health clinics, and a roving DBH mobile van.

A substance use disorder treatment unit for women at the DC Jail opened last August. So that transportation is not a barrier, District residents can get free roundtrip rides to opioid treatment and recovery support.

DBH is on course to establish the new DC Stabilization and Sobering Center (DCSSC) to support individuals under the influence of alcohol or drugs who require stabilization services and supports, but do not need to be transported to a hospital emergency department. The DCSSC will provide culturally appropriate care in a therapeutic environment. As DBH developed new strategies to encourage treatment, we believe the DCSSC will be a low barrier, stepping-stone to ongoing treatment and sustained recovery. The DBH continues to build partnerships and public awareness to combat stigma and encourage treatment.

Twenty-three faith-based organizations continued activities that expanded outreach, opioid education, and naloxone training throughout the District and eight new grants were awarded in this year.

Our robust public awareness campaign to promote naloxone and treatment includes posters in 150 retail locations; 75 electronic ads at Metro stations; ads at gas stations, and a mobile truck ad that visited areas with high overdose rates.

Sustaining and Enhancing Behavioral Health Services During the Pandemic

The DBH remained focused on maintaining continuity of services and supports, enhancing and expanding services to meet the needs of all District residents, and providing clear direction based on DC Health guidance to providers for quality service delivery in the new environment.

The DBH conducted the following activities:

- Secured federal funding to support the mental health of providers who deliver vital public health services while coping with their own COVID-19 related trauma and loss.
- Met virtually each week with providers and partners to identify and solve challenges facing the provider network and provided guidance on the DBH website
- Worked with the Department of Health Care Finance to secure a 20 percent rate increase for substance use disorder services in our Medicaid State Plan. In FY 21, to maintain this critical service, we provided a

total of $2 million to the four contracted residential substance use disorder providers who were not eligible for the enhanced rate but documented lost revenue due to restricted capacity following COVID guidelines

- Contracted with a certified community provider, MBI, to provide 24-hour onsite behavioral health supports at the DHS operated isolation and quarantine sites. The goal of the quarantine sites were to prevent individuals from getting COVID who were most at risk for hospitalization or death due to underlying chronic medical conditions. Nearly 75 percent of the people living in the four quarantine hotels have known behavioral health challenges and are linked to DBH providers. MBI works closely with these providers to coordinate care and to track their progress on a permanent housing plan.

Through the hard work of DBH staff and providers who maintain services both in person and telehealth services, nearly 37,650 people received mental health and substance use disorder services in FY 21, a small increase from FY 20.

We are providing devices and Internet access to about 4,100 individuals so they will have access to telehealth services. We also are setting up 10 telehealth stations in community locations.

DBH Intensive Care Coordination teams as well as State Opioid Response Care Coordination grantees will be responsible for reconnecting and staying connected with individuals who may have been incarcerated or dropped in and out of care. We know these individuals are more at risk for psychiatric crisis or hospitalization, homelessness, and chronic physical health care needs. Care coordinators will pay particular attention to individuals who cycle in and out of medication-assisted treatment programs.

DBH, the Metropolitan Police Department, DC Fire & Emergency Medical Services and the Office of Unified Communications launched the Behavioral Health Call Diversion pilot on June 1, 2021, to transfer certain behavioral health related calls to the 911 system to DBH rather than an automatic law enforcement response. To be clear, our MPD partners have a crucial role to play in assuring the safety of the individual, the community, and the responders when necessary.

When a 911 call is transferred to DBH, a behavioral health specialist on the Access Helpline works to resolve the crisis through supportive counseling, coaching, and problem-solving. If an in-person response is required, the Community Response Team (CRT) is deployed. The pilot program, which began with a limited number of hours, demonstrated that mental-health related calls to the 911 system could be safely transferred and timely, appropriate clinical care provided.

The Department of Human Services Response to COVID-19

During the height of the Covid-19 pandemic, the Department of Human Services (DHS) developed the Pandemic Emergency Program for Medically Vulnerable Individuals (PEP-V). The PEP-V program allowed private accommodation for individuals experiencing homelessness who were at high risk of developing severe complications and/or death if they contracted COVID-19. The primary goal of PEP-V was to reduce the exposure of COVID-19 to the elderly and medically vulnerable individuals residing in congregate shelters where risk of infection was high due to the inability to isolate.

In conjunction to the development of PEP-V, DHS developed Isolation and Quarantine (ISAQ) sites for District residents to quarantine or self-isolate while awaiting COVID-19 test results, and residents who tested positive for COVID-19, or displayed symptoms associated with COVID-19 and required evaluation by medical staff at an ISAQ site.

Additionally, DHS, in collaboration with the Department of Mental Health and Hygiene (DMHH) addressed the proliferation of encampments by targeting four of the largest encampments in the District. These encampments were also identified as a result of public health and safety concerns. During the pilot program, DHS added additional outreach staff to conduct encampment specific intensive engagement activities supported by direct housing resources funded through local funds for up to 12 months. While housed, individuals were transferred to an appropriate housing resource. These included Permanent Supportive Housing (PSH), Targeted Affordable Housing (TAH), and Rapid Rehousing for Individuals (RRH-I).

Access to the Pandemic Emergency Program for Medically Vulnerable Individuals (PEP-V) or Bridge Housing programs were made available to unhoused individuals. The majority of individuals who engaged with these programs received housing placements. The DHS continues to support these individuals as they transition to other housing resources. Additional information is available by visiting the following website: https://dhs.dc.gov/page/responsetocovid19.

CASE SELECTION FOR OFRB REVIEW

A comprehensive search is conducted by the DC Department of Health's Vital Records Division to identify all opioid involved deaths that occurred in the District of Columbia. This information is identified and shared with the Fatality Review Division at the DC Office of the Chief Medical Examiner.

Cases identified for a full case review are selected based on the decedent's level of involvement with District government agencies. This is done for a magnified systems-level view of the role and impact of District agencies in the outcomes of decedent's lives who are diagnosed with substance use disorder.

Office of the Chief Medical Examiner (OCME)
Toxicology reports, death investigation reports, autopsy reports, scene investigations

MPD
Any relevant police reports, investigations, arrest history, PD 120

DC Department of Human Services
Records related to TANF, Disability Assistance, emergency housing, and childcare

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
- Mental health-related diagnostic service assessment:
  - Treatment/encounter notes
  - Psychological evaluation
  - Other document producing a formal diagnosis (medication history, treatment plan, and discharge summary)
  - Counseling
  - 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

OAG
Related police reports, arrest history

CSOSA
Records regarding parole, probation, supervised release, civil orders of protection, deferred sentencing agreements

DOC
Arrest/ Incarceration history, medical/treatment services

District of Columbia Superior Court Drug Intervention Program
Records related to court cases, treatment, and intervention services

Pretrial Services Agency
Arrests records, Criminal court case reports

DEA
Related law enforcement records, drug-related/ criminal investigations

OFRB 2021
STATISTICAL CASE REVIEW

The Opioid Fatality Review Board (OFRB) completed a summary of statistics based on 228 total cases of decedents who died of an opioid overdose in the District of Columbia in 2019. This information was gathered from DC Health Vital Statistics- Death Certificate, the Office of the Chief Medical Examiner (OCME), Department of Healthcare Finance (DHCF), Department of Behavioral Health (DBH), Mayor's Office of Veteran's Affairs (MOVA), Department of Human Services (DHS), and the Department of Corrections (DOC).

In this statistical review, 75% of the decedents were male and 84% were Black between the ages of 50-69 years of age, who were home at the time of the fatal event. Approximately, 79% were DC residents that lived in Ward 5 (22%) or Ward 8 (31%). In the review of toxicology reports, Fentanyl was detected in 90% of the cases, with 20 instances of Acetyl Fentanyl present. This information, along with the toxicology reports, highlighted the fatal effects of Fentanyl to the user population.

Records indicate 67% of the decedents had no prior overdose events. In some cases, decedents were using heroin for years without any documented overdose. It was not known if Narcan had been used prior to a decedent's fatal overdose or if it was present at the scene(s). Additionally, OCME records indicate 73% of the decedents had no evidence of treatment in the past. It should be noted that this does not indicate that a decedent ever sought treatment in the past.

Records covering agency involvement indicate more than half of the decedents were known to the Department of Corrections (51%), Department of Behavioral Health (55%), and the Department of Healthcare Finance (76%). It is hoped that this demonstrated cross-over agency involvement can further assist District agencies with developing more targeted programs to at-risk populations - utilizing an understanding of drug trends and how to decrease preventable deaths.

FIGURE 2

2019 OFRB Decedent Gender

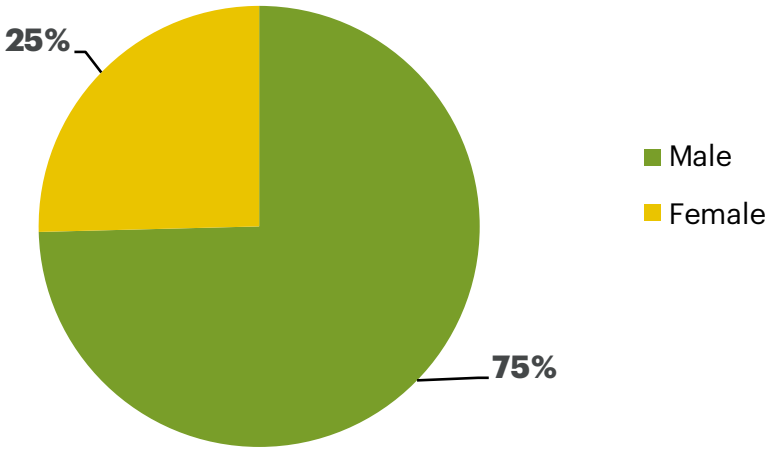
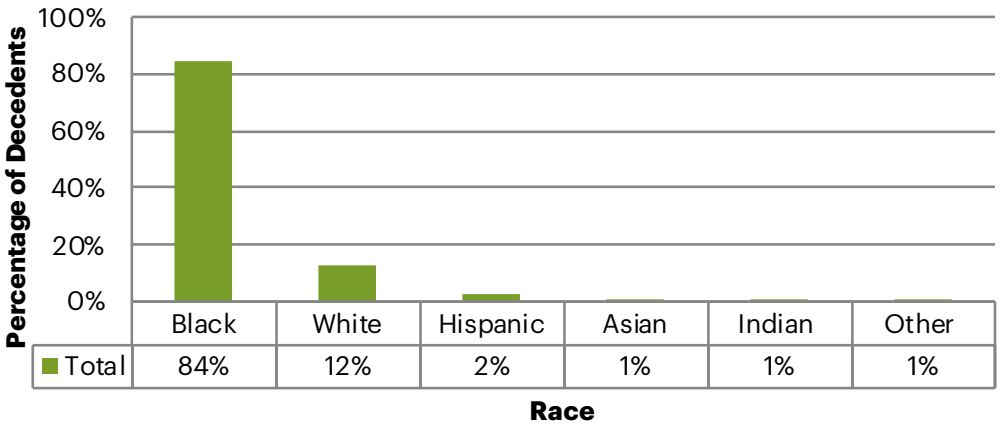


FIGURE 3

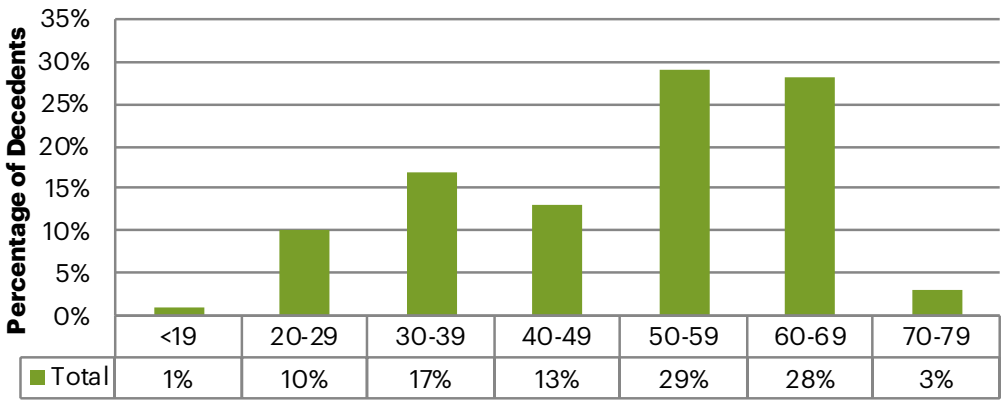
2019 OFRB Decedent Race



Of the 228 decedents reviewed, 75% (N=170) were male and 25% (N=58) were female. The decedent race information as identified on the Death Certificate indicated that 84% (N=192) of the decedents were Black and 12% (N=28) were White and two percent (N=5) were Hispanic. One percent were Asian (N=1), Indian (N=1), and Other (N=1) respectively.

FIGURE 4

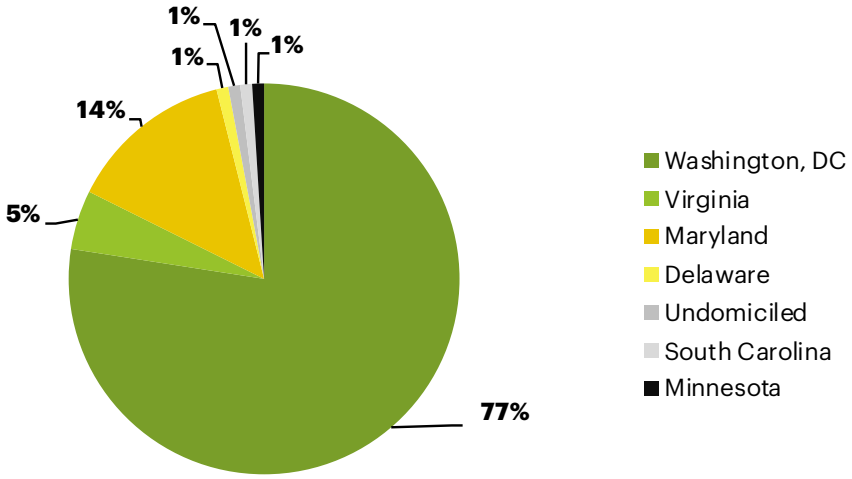
2019 OFRB Decedent Age



Twenty-nine percent of decedents were between the ages of 50-59 (n=65), 28% were between the ages of 60-69 (n= 64), 17% were between the ages of 30-39 (n=39), 13% were between the ages of 40-49 (n=29), 10% were between the ages of 20-29 (n=23), three percent were between the ages of 70-79 (n=6), and one percent were less than 19-years-old (n=2).

FIGURE 5

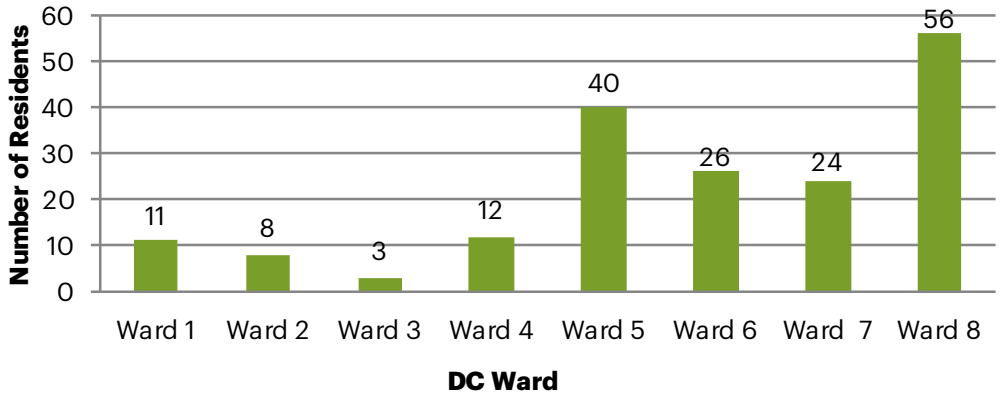
2019 OFRB Decedent State of Residence



Most decedents (79%) resided in Washington, DC (n=179), 14% of the decedents resided in Maryland (n=31) and five percent resided in Virginia (n=12). One percent of decedents were undomiciled (n=3), one percent of the decedents resided in South Carolina (n=1), one percent resided in Minnesota (n=1), and one percent resided in Delaware (n=1) respectively.

FIGURE 6

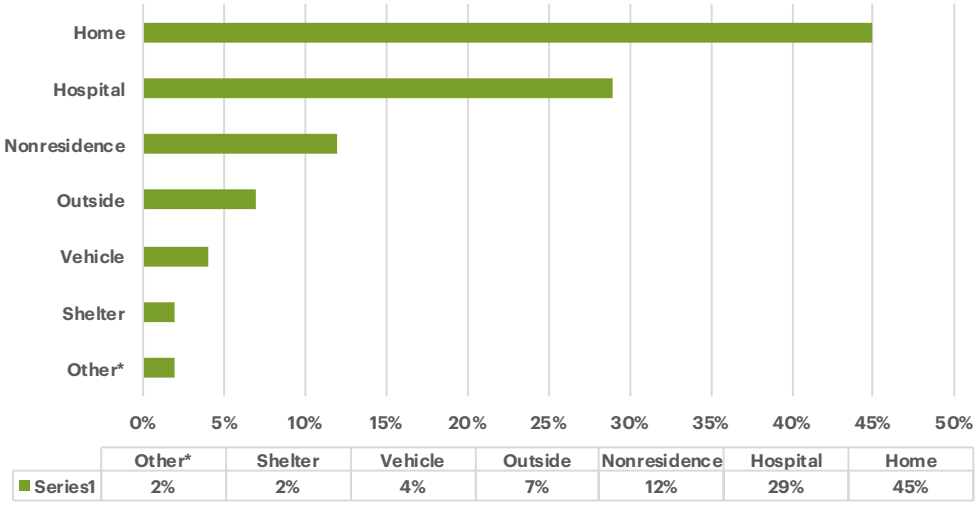
2019 OFRB Decedent Ward of Residence



Most decedents (31%) resided in Ward 8 (n=56), 22% of decedents resided in Ward 5 (n=40), 15% resided in Ward 6 (n=26), 13% resided in Ward 7 (n=24), six percent resided in Ward 1 (n=11), six percent resided in Ward 4 (n=12), four percent resided in Ward 2 (n=8), and two percent of decedents resided in Ward 3 (n=3). The ward of residence was not always the same as the injury location.

FIGURE 7

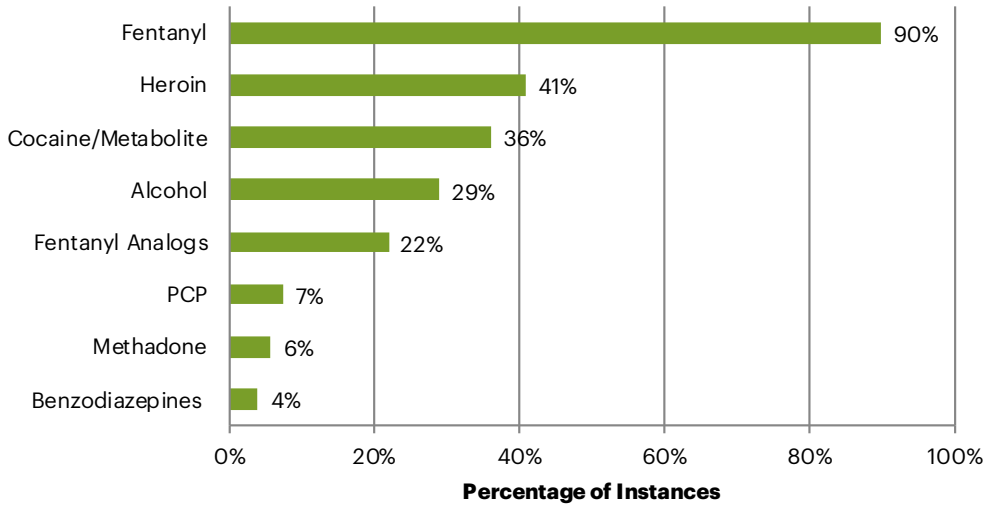
2019 OFRB Injury Locations



Forty-five percent (n=103), died at home, while 29% (n=67) of the decedents died at the hospital, 12% died in a non-residential building[27] (n=26), 7% died outside[28] (n=15), 4% of decedents died in a vehicle (n=9), 2% (n=4) died at a shelter or other location[29] (n=4).

FIGURE 8

2019 OFRB Toxicology Results



Fentanyl was present in 90% of the cases in this statistical sample (n=205). Heroin was present in 41% of the cases (n=93). Thirty-six percent of decedents had Cocaine/Metabolite present (n=82) in their system and 29% had alcohol present (n=66). Twenty-two percent of decedents had the presence of a fentanyl analog (n=50), 17% had PCP present (n=17), six percent had Methadone (n=13), and four percent (n=9) had benzodiazepines present.

fentanyl Analogs	n
Acetyl fentanyl	20
para-Fluoroisobutyryl fentanyl	8
Valeryl fentanyl	1

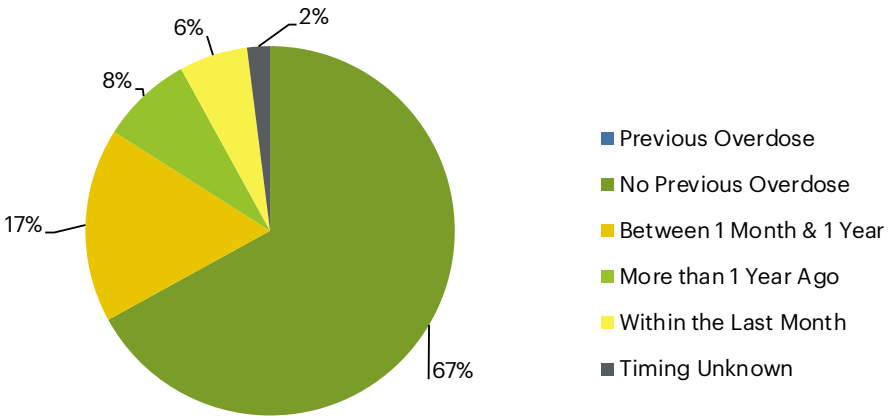
2019 OFRB FENTANYL ANALOGS

Research indicates that fentanyl analogs are chemical compounds that are similarly structured to fentanyl. Small changes are made to the chemical structure to evade law enforcement.[30] Of the 50 cases with a fentanyl analog present in the cause of death, Acetyl fentanyl was identified in 40"% (n=20) of cases, para-Fluoroisobutyryl fentanyl was present 16% (n=8) of cases and Valeryl fentanyl was present in four percent (n=2) of cases.

Sixty-seven percent (n=152) of the decedents review had no previous overdose, 17% (n=39) experienced an overdose within a month to a year prior to their death, eight percent had an overdose more than a year ago (n=19), six percent had an overdose within the last month (n=13), and two percent had an overdose recorded, but the timing was unknown (n=5). Specific information pertaining to the total number of overdoses a person experienced in the past was not available.

FIGURE 9

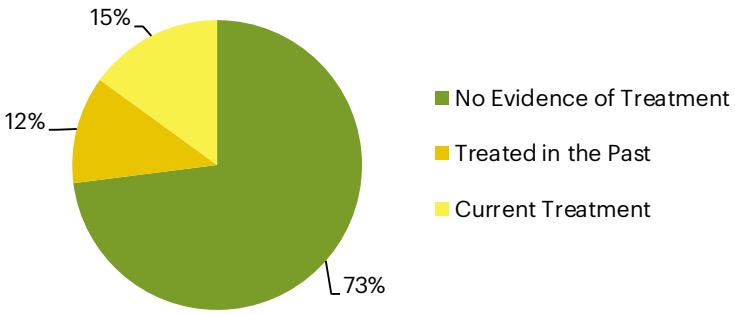
2019 OFRB Previous Overdoses



Seventy-three percent of the decedents (n=166) reviewed did not have a documented history of treatment, 15% were currently seeking treatment prior to their death (n=34), and 12% of the decedents had sought treatment in the past (n=28).

FIGURE 10

2019 OFRB History of Substance Use Treatment



Systems Involvement

FIGURE 11

2019 OFRB Military Statuses

Of the 228 decedents reviewed, 84% (n= 192) had no military involvement while 11% were in the U.S. Armed Forces (n=25) and five percent (n=11) of the decedent's veteran status was unknown.

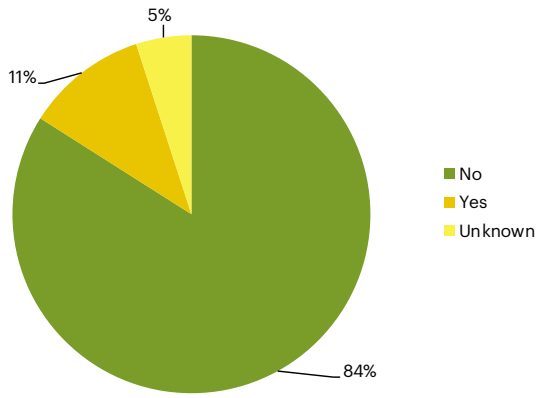
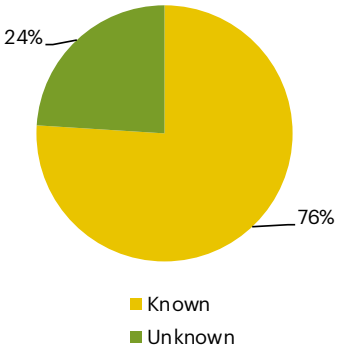


FIGURE 12

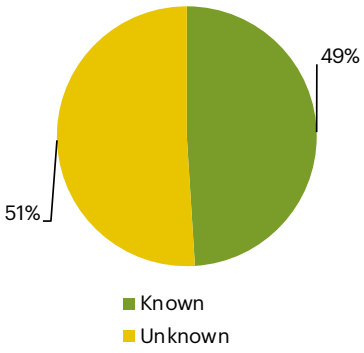
2019 OFRB Decedents known to the Department of Health Care Finance



Seventy-six percent of the decedent's were known to Department of Health Care Finance (DHCF) (n=174) while 24% were not known (n= 54).

FIGURE 13

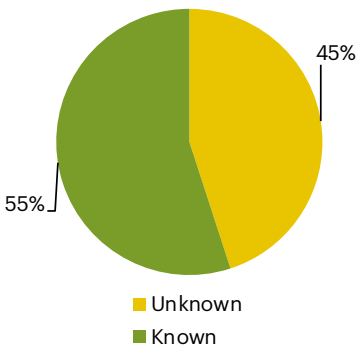
2019 OFRB Decedents known to the Department of Corrections



Forty-nine percent of the decedents were known to the Department of Corrections (DOC)(n=111) and 51% were not known (n=117)

FIGURE 14

2019 OFRB Decedents known to the Department of Behavioral Health

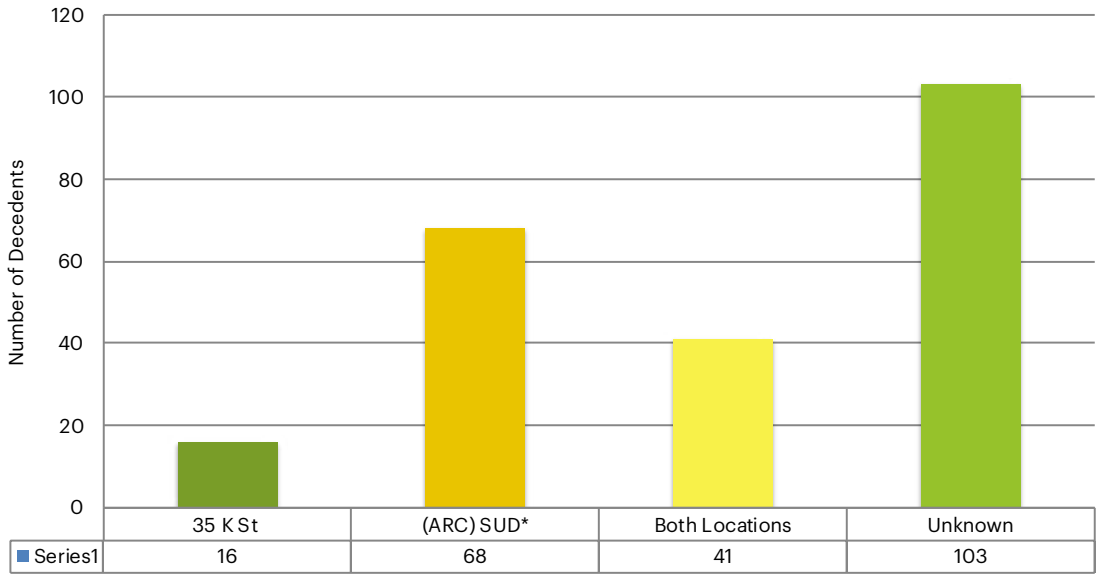


Fifty-five percent of the decedents were known to DBH (n=125) and 45% were unknown to the Department of Behavioral Health (DBH) (n=103).

FIGURE 15

2019 OFRB Decedents known to specific Department of Behavioral Health Locations

Fifty-five percent of the decedents were known to DBH (n=125) and 45% were unknown to the Department of Behavioral Health (DBH) (n=103).[31]



DATA FROM OFRB CASE REVIEWS

The OFRB reviewed six (6) full case reviews and two (2) cluster reviews. Table 2.0 provides details of the findings:

TABLE 2.0: 2021 CASE REVIEWS

#	Decedent Demographics/ Ward of Residence	Cause of Death	Associated Risk Factors
1	51-year-old/AA/Female/ Ward 7	Fentanyl, Methadone, and Xylazine Toxicity	• History of substance abuse • Mental health diagnoses • Co-morbidities • Housing insecurity • Use of multiple prescription medications
2	62-year-old/AA/Male/ Ward 8	Combined toxic effects of acetyl fentanyl, fentanyl, and heroin	• History of substance abuse • Adverse childhood experiences • Homelessness • Violence • Use of multiple prescription medications • History of incarceration
3	55-year-old/AA/Female/ Ward 6	Combined drug (diazepam and fentanyl) intoxication	• Co-morbidities • Adverse childhood experiences • Housing insecurity • History of polysubstance use • Mental health diagnoses • Suicide attempts • History of Incarceration
4	63-year-old/AA/Female/ Ward 8	Acute encephalopathy due to opiate intoxication	• Co-morbidities • Mental Health Diagnoses • History of polysubstance use • Use of multiple prescription medications
5	30-year-old/AA/Female/ and Ward 6	Acute toxicity due to the combined effects of cocaine, despropionyl fentanyl, and phencyclidine	• History of Incarceration • Mental Health Diagnoses • Adverse childhood experiences • Housing insecurity • Financial instability • Substance use disorder
6	36-year-old/AA/Male/ Ward 2	Acute intoxication by the combined effects of diphenhydramine, ethanol, eutylone, and fentanyl; Other significant conditions: Hypertensive and atherosclerotic cardiovascular disease	• Chronic homelessness • Adverse childhood experiences • Financial instability • Substance use disorder • Mental health diagnoses • History of incarceration

CLUSTER #1

#	Decedent Demographics/ Ward of Residence	Cause of Death	Associated Risk Factors
1	46-year-old/W/Female/ Ward 2	Amitriptyline, Cocaine, Fentanyl Phencyclidine and Valeryl Fentanyl Intoxication	• Mental health diagnoses • Co-morbidities • Chronic pain
2	51-year-old/AA/Female/ Ward 8	Alcohol, Despropionyl fentanyl, Fentanyl and Heroin Toxicity	• Financial insecurity • Co-morbidities • Alcohol use disorder • Housing insecurity
3	62-year-old/AA/Male/ Ward 7	Acute intoxication by the combined effects of Codeine, Ethanol, Fentanyl and Heroin	• Substance Use Disorder • Co-morbidities
4	64-year-old/AA/Male/ Ward 5	Heroin toxicity	• Substance Use Disorder • Co-morbidities
5	28-year-old/W/Male/ Ward 6	Combined toxic effects of Cocaine, Fentanyl and Heroin	• Mental health diagnoses • Substance Abuse Disorder • Polysubstance use
6	56-year-old/AA/Male/ Ward 4	Combined drug cocaine,cocaethylene, ethanol, fentanyl and heroin intoxication	• Polysubstance use • Co-morbidities
7	29-year-old/AA/Male/ Ward 8	Acute Fentanyl Intoxication	• Mental health diagnosis • Polysubstance abuse • Comorbidities • Incarceration • Housing and financial instability

CLUSTER #2

#	Decedent Demographics/ Ward of Residence	Cause of Death	Associated Risk Factors
1	33-year-old/W/Male/ Ward 4	Acute Intoxication By the Combined Effects of Ethanol and Fentanyl	• Polysubstance abuse • Comorbidities • No health insurance
2	44-year-old/AA/Male/ Ward 3 (JULY)	Acute Intoxication by the Combined Effects of Cocaethylene, Cocaine, Ethanol and Fentanyl	• Polysubstance abuse • Comorbidities • Incarceration
3	62-year-old/AA/Male/ Ward 8	Combined toxic effects of buprenorphine and fentanyl	• Mental health diagnosis • Polysubstance abuse • Comorbidities
4	63-year-old/AA/Female/ Ward 5	Combined toxic effects of cocaine, cocaethylene, and fentanyl	• Polysubstance abuse • Comorbidities
5	61-year-old/AA/Male/ Ward 8	Acute Fentanyl Intoxication	• Polysubstance abuse • Comorbidities • Incarceration • Housing and financial instability

RECOMMENDATIONS

The Board voted to approve the following recommendations:

1. In order to improve care coordination for clients who become disconnected from treatment, the DBH and DC Health should engage providers and develop protocols/practices to improve linkages with community response teams and certified peer recovery specialists.

2. DC FEMS in partnership with the DC hospital association should improve data collection and documentation practices by revisiting patients transported to the hospital categorized as "Jane/John Doe" by linking a patient's incident # and medical record # in safety pad in order to refer them to appropriate services.

3. When a patient is suspected of a drug overdose on admission, all DC Hospitals should obtain and preserve blood and urine samples. DFS shall develop a mechanism for receiving and testing these samples. A monthly surveillance report will be disseminated to all DC Hospitals and other official stakeholders.

4. The OCME should obtain admission blood samples and perform toxicology testing for all cases where there is a potential drug overdose and the individual dies within a hospital setting.

5. The DBH should refine their disenrollment policy and ensure that a comprehensive approach is in place to engage consumers in opioid treatment programs. The policy should include intensive outreach efforts (ie. home visit) to clients who are referred, refuse or become dis-enrolled.

6. The DBH should revisit a capture/recapture program model to address individuals who become dis-enrolled with mental health and MAT services, especially when they present to any District government agency/program.

7. The DBH should provide training to community service providers and conduct a social media campaign to address co-occurring disorders related to mental health (trauma/stigmas) and opioid or other substance use disorders. The campaign should target stigmas and other deterrents to treatment.

8. DBH should include the messaging, "Do not use alone" as a part of their communications campaign.

9 DC Health should coordinate a program to place public health machines/vending machines in at-risk areas to expand access to naloxone, fentanyl test strips, and needles. The Department of Human Services (DHS), the Department of Behavioral Health (DBH), HIPS, and Family Medical (FMCS) should be included in the discussions when determining contents of the machines at shelters in an effort to further raise community awareness of the machines and how to utilize the contents.

10 The Department of Behavioral Health (DBH), in partnership with other District government agencies, should explore additional strategies to expand their reach and connect individuals to peer specialist's and SUD/Mental Health resources available throughout the District through sites such as myrecoverydc.org. This information should be linked and available via all government agency websites.

11 DBH in collaboration with DC health should develop a messaging system to immediately inform the community when there is a spike in overdoses/ toxic supply.

Agency responses to these recommendations will be published independently from this report.

ENDNOTES

1. ©Number of drug overdose deaths in the U.S.: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
2. Medication-Assisted Treatment (MAT). *Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/medication-assisted-treatment
3. Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. *Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf
4. Information about Medication-Assisted Treatment (MAT). *U.S. Food & Drug Administration.* https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat
5. Medication Assisted Treatment (MAT): Find MAT Treatment Near Me. *American Addiction Centers.* https://americanaddictioncenters.org/addiction-medications
6. Medication-Assisted Treatment for Opioid-Use Disorder. *Mayo Clinic.* https://www.mayoclinicproceedings.org/article/S0025-6196(19)30393-3/fulltext
7. DC Area Addiction Treatment Locations. *DC Health.* https://dchealth.dc.gov/page/dc-area-addiction-treatment-locations
8. Substance Use Disorder Services. *Department of Behavioral Health.* https://dbh.dc.gov/page/substance-use-disorder-services
9. Treatment Services: Substance Use Disorder Assessment and Referral Sites. *Department of Behavioral Health.* https://dbh.dc.gov/service/treatment-services
10. Searching for Treatment Options. *FindTreatment.gov.* https://findtreatment.gov/results/
11. Substance Use and Co-Occurring Mental Disorders. *National Institute of Mental Health.* https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health
12. Substance Use Disorder Treatment for People With Co-Occurring Disorders. *Substance Abuse and Mental Health Services Administration.* https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
13. Substance Use Disorder Services. *Department of Behavioral Health.* https://dbh.dc.gov/page/substance-use-disorder-services
14. Treatment Services For Co-Occurring Disorders. *Department of Human Services.* https://www.mwcog.org/file.aspx-?D=2tsZYIncFZkSnf8HgTGZ%2Fa7t60PnHqXGaTc0QciclCg%3D&A=sgbvj5U5XYVVoEd08PSAS129Uszle3%2BHMNVKunH3l28%3D
15. Harm Reduction. *Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/find-help/harm-reduction
16. Fentanyl. *National Harm Reduction Coalition.* https://harmreduction.org/issues/fentanyl/

17. Fentanyl Test Strip Pilot. *National Harm Reduction Coalition.* https://harmreduction.org/issues/fentanyl/fentanyl-test-strip-pilot/

18. Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips. *Centers for Disease Control and Prevention.* https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html

19. Fentanyl. *Centers for Disease Control and Prevention.* https://www.cdc.gov/opioids/basics/fentanyl.html

20. Uniform Application Block Grant. *Center for Substance Abuse Prevention Division of State Programs.* https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/FFY%202019%20Revised%20MHBG%20SABG%20Block%20Grant.pdf

21. Updated LIVE.LONG.DC. 2.0, the District's Strategic Plan to Combat the District's Opioid Epidemic. *Executive Office of the Mayor.* https://mayor.dc.gov/release/dbh-releases-updated-livelongdc-20-district's-strategic-plan-combat-district's-opioid

22. Opioid Crisis. *Executive Office of the Mayor.* https://livelong.dc.gov/node/1368541#harmreduction

23. Meeting the Housing Needs of People With Substance Use Disorders. *Center on Budget and Policy Priorities.* https://www.cbpp.org/sites/default/files/atoms/files/5-1-19hous.pdf

24. Recovery Housing Program. *U.S. Department of Housing and Urban Development.* https://www.hud.gov/program_offices/comm_planning/rhp

25. District of Columbia Recovery Housing Program Action Plan. *Executive Office of the Mayor.* https://dhcd.dc.gov/sites/default/files/dc/sites/dhcd/publication/attachments/Draft%20FY%2022%20RHP%20Action%20Plan%20with%20Cover.pdf

26. Access to Housing Subsidies, Housing Status, Drug Use and HIV Risk Among Low-Income U.S. Urban Residents. *Substance Abuse Treatment, Prevention, and Policy.* https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-6-31

27. Note: The **non-residence** location means that the decedent did not die at their residence, but a friend's place, restaurant, etc.

28. Note: If the decedent died **outside**, locations such as an alleyway, homeless encampment, bus stop, etc., are included in this category.

29. Note: The **other*** category included a decedent dying at a transition home (n=1), group home (n=1), restaurant (n=1), and at the department of corrections jail cell (n=1).

30. Vardanyan RS, Hruby VJ. Fentanyl-related compounds and derivatives: current status and future prospects for pharmaceutical applications. Future Med Chem. 2014 Mar;6(4):385-412. doi: 10.4155/fmc.13.215. PMID: 24635521; PMCID: PMC4137794.

31. Note: At the time of data collection, 19 decedents were documented to be known by the SUD location, but it was not known if the decedents were known to 35 K St as well. This information was not available. **35 K St:** An urgent, same day clinic for mental health services. **ARC (SUD):** a referral and assessment center for substance use disorders

ACKNOWLEDGMENT

The Office of the Chief Medical Examiner expresses its genuine gratitude for the work of the members of the Opioid Fatality Review Board. Their tireless efforts will aid the District of Columbia in preventing opioid related deaths, 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 volunteerism and work speaks truth to power, and we thank you for your service.


BODEGA
Häagen-Dazs
STARBUCKS COFFEE

OPIOID FATALITY REVIEW BOARD

2021 ANNUAL REPORT

Washington, DC

Office of the ChiefMedical Examiner
Fatality Review Division
401 E St SW
Washington, DC 20024
(202) 698-9000
https://ocme.dc.gov/