

OPIOID FATALITY REVIEW BOARD



2020 ANNUAL REPORT





MISSION OF OFRB

To assist the District of Columbia's efforts in preventing opioid overdose deaths and inform prevention and intervention efforts. Our retrospective reviews will improve the District Government's response to the opioid crisis.

OPIOID FATALITY REVIEW BOARD 2020 MEETING CHAIRS

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OPIOID FATALITY REVIEW BOARD

2020 ANNUAL REPORT

THIS REPORT IS PRESENTED TO:

The Mayor of the District of Columbia
The Council of the District of Columbia
The Residents of the District of Columbia

DECEMBER 2021

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GREETINGS FROM THE OPIOID FATALITY REVIEW BOARD CHAIR

As we address the unique challenges of the COVID-19 pandemic, the District of Columbia's Opioid Fatality Review Board (OFRB) continues to focus on reducing opioid-related deaths among District residents.

In 2020, opioid overdose deaths increased in the District of Columbia and throughout the nation. The OFRB will focus on reducing these deaths by conducting case reviews of opioid overdoses, informing stakeholders, and recommending evidence-based policies, practices, and implementing programs. Through case reviews of fatal opioid overdoses, the OFRB is responsible for recommending systematic changes to improve the social determinants of health among District residents.

The OFRB proudly presents the second annual report highlighting the significant 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 of Columbia.

In 2020, the District of Columbia experienced 411 opioid overdose deaths compared to 281 fatal opioid overdoses in 2019. We have also had countless non-fatal overdoses, indicating the need for systematic change. The report emphasizes the importance of understanding the affliction of addiction and the impact it has on the individual, families, and communities.

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



Sincerely,

Chikarlo R. Leak

Chikarlo R. Leak , MPH, PhD

Opioid Fatality Review Board Chair

OFRB 2020

THE OPIOID CRISIS IN THE DISTRICT

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

IN 2020

411

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

94%

94% of cases contained fentanyl or a fentanyl analog.

63

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

OVERALL DEMOGRAPHICS

GENDER

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

AGE

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

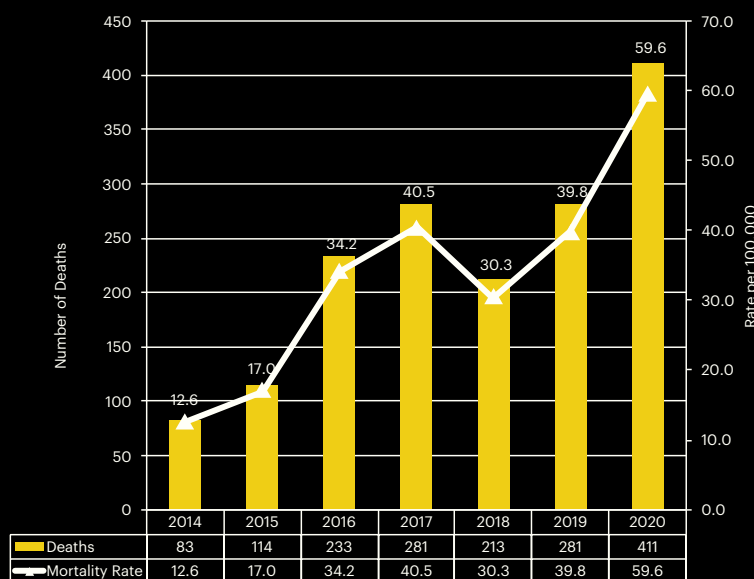
RACE/ETHNICITY

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

JURISDICTION OF RESIDENCE

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

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



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



OFRB 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 – DC's Strategic Plan to reduce opioid use, misuse, and related deaths. The purposes of the strategic plan are to level-set and develop strategic goals through the utilization of a multi-disciplinary approach to reduce opioid fatalities in DC.

GOAL

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.





OFRB AUTHORITY

The District of Columbia's Opioid Fatality Review Board (OFRB) is proud to present its 2nd 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.

Due to the COVID-19 pandemic, the OFRB held nine (9) official meetings in 2020. The majority of OFRB meetings took place virtually via WebEx

The OFRB 2020 Annual Report covers data from the eight cases reviewed in 2019. These cases represent accidental deaths that occurred in 2019 resulting from opioid abuse.

Virtual Family Assistance Center (VFAC)

During the onset of the COVID-19 Pandemic, in addition to the normal duties of the fatality review division staff, the Fatality Review Division Manager and Fatality Review Program Specialists were detailed to support the development and implementation of the Virtual Family Assistance Center (VFAC) alongside the leadership of the Department of Behavioral Health (DBH), Department of Human Services, (DHS), DC Public Schools (DCPS) - School-Based Mental Health, and the Mayor's Office of Community Relations (MOCRS). Staff from each area were the first Navigators to engage with COVID-19 decedent next of kin and their families to provide them with support and resources.

During the public health emergency declaration, the fatality review division continued to coordinate and plan meetings, offering members and participants a platform for engagement. Informal meetings were held, offering participants an opportunity to present real-time information about the services or programs they were providing to support District residents during these challenging times.

Additionally, during the public health emergency declaration, the Fatality Review Division Manager and Fatality Review Program Specialists developed and implemented a virtual fatality review platform utilizing Web-Ex software. All meetings complied with the Open Meetings Act and have proven to provide opportunities for increased and consistent participation of members during meetings, thus allowing the OFRB to resume regular business. 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.





OFRB ACCOMPLISHMENTS AND HIGHLIGHTS

A LOOK INTO 2020 OFRB OBJECTIVES

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

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

Functions of the OFRB

The OFRB is tasked with the following functions:

1. EXAMINATION

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

2. IDENTIFICATION

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

3. REVIEW AND EVALUATION

Reviewing and evaluating services provided by public and

private systems relevant to drug treatment and prevention specific to an opioid death or as part of a systemic evaluation of service providers.

4. ADVISING

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

5. CONFIDENTIALITY

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

OFRB Composition

In 2020, 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 Forensic Sciences
Department of Health Care Finance
Three (3) Community Service Providers
Department of Behavioral Health
Department of Health
Three (3) District resident members
Department of Human Services
Fire and Emergency Medical Services Department
Mayor's Office of Veterans Affairs
Metropolitan Police Department
A DC Hospital Representative
Department of Corrections





OFRB DISCUSSIONS AND CASE REVIEWS

The OFRB utilizes a multi-disciplinary approach when reviewing cases where the cause of death was due to an opioid overdose.

**"All Opioid
Overdose Deaths
are Preventable"**

The OFRB develops recommendations to reduce the number of opioid overdose deaths in the District of Columbia by implementing evidence-based strategies and leveraging government and community-based partnerships. The OFRB uses multi-pronged strategies which focus on making recommendations based on goals that primarily focus on prevention, harm reduction, treatment, and recovery. This is executed by identifying the causes and circumstances surrounding a fatal overdose.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are risks and protective factors that may increase or decrease someone's likelihood of developing a behavioral health condition like an addiction.⁴ Following this guideline while reviewing cases, risk factors such as socioeconomic status, system involvement, education, and more are identified and analyzed. Identifying system involvement assists the OFRB in reviewing and evaluating the services provided and where intervention could have prevented the death.

The OFRB is scheduled to review the previous year's cases once a month. Due to the COVID-19 pandemic, nine meetings were held. The OFRB reviewed a total of

eight cases. Most decedents were between the ages of 50 and 70, with two decedents as young as 25. The cases were similar in which most had some system involvement, a history of a mental health disorder, and/or substance abuse with a previous overdose(s) in the past. The CDC has provided strategies such as safe syringe practices, outreach programs, and more to prevent the spread of disease among IV drug users.⁵ By following the strategies implemented by the CDC nationwide, the OFRB developed recommendations for the District of Columbia in 2020. Recommendations include providing overdose kits when arriving at an overdose scene, providing community education, and implementing an awareness campaign on naloxone access and use. The OFRB also suggested making Naloxone more accessible, especially in the overdose hotspots.

The OFRB's adopted recommendations are forwarded to District Government agencies for their response. The agencies involved provide responses and solutions to the OFRB. By making suggestions and focusing on multiple factors that surround addiction, the OFRB can move closer to decreasing opioid use, deaths and create a safer environment to use.

4 Risk and Protective Factors. (2019, July 18). Retrieved August 25, 2021, from [www.samhsa.gov](https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf): <https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf>

5 Strategies for Disease Prevention in Persons Who Inject Drugs | CDC. (2018, July 19). Retrieved August 25, 2021, from [CDC](https://www.cdc.gov/pwid/disease-prevention.html): <https://www.cdc.gov/pwid/disease-prevention.html>



OFRB DISCUSSIONS AND FINDINGS

OFRB members discussed strategies to reduce the negative effects of the pandemic in the District of Columbia. Discussions included ways to support those affected by substance use disorder and prevent overdose deaths by sharing changes to services provided in the community and finding novel ways to collaborate.

Additionally, OFRB members discussed various harm reduction strategies, such as ensuring that overdose kits and Narcan are widely available and accessible among the community.

OFRB members emphasized the importance of evidence-based practice for utilizing medication-assisted treatment or opioid maintenance therapy that includes methadone, suboxone, and buprenorphine for the treatment of opioid use disorder.

FINDINGS

- ▶ **FAMILY HISTORY**
In most of the cases reviewed, the decedents had a history of adverse childhood experiences (ACEs).
- ▶ **CO-OCCURRING DISORDERS**
Many of the decedents had a documented mental health diagnosis. Although decedents sought treatment their participation lacked engagement in services.
- ▶ **EARLY INITIATION**
Many of the decedents began consuming controlled substances at a young age.
- ▶ **RECOVERY SUPPORT**
Many of the decedents were enrolled in treatment for a substance use disorder diagnosis but were either non-compliant with treatment or became disengaged from services.
- ▶ **EMERGENCY DEPARTMENT**
More than half of the decedents were previously discharged from emergency medical services after receiving treatment for a non-fatal overdose.
- ▶ **HISTORY OF INCARCERATIO**
In many of the cases reviewed, the decedents were previously in-carcerated and had a history of substance use disorder but did not re-engage with treatment or recovery services immediately upon release.

RISK AND PROTECTIVE FACTORS

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are variable risk and protective factors that contribute to substance use disorder.

Risk factors are characteristics at the biological, psychological, family, community, or cultural level. These factors are associated with a likelihood of negative outcomes.

Protective factors are characteristics with a lower possibility of negative outcomes. These factors can reduce a risk factor's impact.

All humans have biological and psychological characteristics that make them more susceptible to or resilient in the face of potential behavioral health issues like addiction.

According to the SAMHSA, these factors are correlated and cumulative. People with some risk factors have a higher chance of experiencing more risk factors and are less likely to have protective factors. Both can influence the development – or reduced development – of behavioral health issues. These correlations prove the importance of early intervention and interventions that target multiple, not single, factors.⁶

⁶ SAMHSA. 2019. Risk and Protective Factors - SAMHSA. [online] Available at: <<https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf>> [Accessed 3 August 2021].

These risk and protective factors can exist in multiple contexts such as:

▶ IN RELATIONSHIPS

- **Risk factors:** parents or family members who use drugs/alcohol or suffer from a mental illness, child abuse, and maltreatment, etc.
- **Protective factor:** parental involvement.

▶ IN COMMUNITIES

- **Risk factors:** poverty and/or violence
- **Protective factors:** availability of faith-based resources and/or after school activities

▶ IN SOCIETY

- **Risk factors:** racism, lack of economic opportunity, and norms and laws favorable to substance use.
- **Protective Factors:** hate crime laws and/or policies limiting the availability of alcohol/drugs.



OFRB CASE SUMMARY REVIEW FORM

In 2020, the OFRB adopted the *Opioid Fatality Review Board Case Summary Review Form*.

The form was developed from the CDC Maternal Mortality Review Committee Decisions Form (MMRIA) with content and risk factors for overdose deaths from the CDC Overdose Prevention guidelines.

The OFRB uses the form to enrich the review process and as a surveillance method to more effectively coordinate and abstract data.





OFRB PRESENTATIONS

DEPARTMENT OF HUMAN SERVICES (DHS) PRESENTATION/ HOMELESS SERVICES

PRESENTER: Madeleine Solan, *DHS Member*

PURPOSE

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

HOMELESS SERVICE SYSTEM OVERVIEW

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

Addressing Opioid Fatalities within Homeless Services

CURRENT STATE

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

FUTURE STATE

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



DC Walk 4 ReCover

Presenter: Rhonda L Johnson, *District Resident Member*

PURPOSE

The annual DC Walk 4 Recovery was held on July 25, 2020, at the National Mall, 12pm-5pm

The goal of the 2020 annual DC Walk 4 ReCover was to “Create innovative recovery solutions from the private and public sectors.” The annual walk takes place in Washington DC between the National Mall, the African American Cultural Museum, and the Washington Monument.

In previous years, the organization’s mission was to bring awareness, education, hope, and innovative solutions regarding co-occurring disorders and the opioid crisis. In 2018 and 2019, the goal of the DC Walk 4 ReCover was to begin the process for a National Co-Occurring Disorder week recognition for the District of Columbia to lead the way for education, hope, and solutions as it relates to Co-Occurring Disorders.

SAFER CONSUMPTION SITES

Safer Consumption Sites (SCS), also known as Supervised Injection Facilities (SIFs) are legally authorized facilities where people can use previously obtained drugs in a sterile and supervised environment. Their goal is to reduce morbidity and mortality by providing a safe environment for drug use. Staff members are trained to intervene and prevent potential overdoses and train clients in safer use. SCSs are also designed to decrease improper syringe disposal, public injection drug use, and reduce

transmission of disease and/or infection. Facilities provide detox management, and primary care services.

These facilities also provide counseling and referrals to health and social services, such as drug treatment. Currently, there are no SCSs in the United States. Multiple states/cities such as Maryland, Maine, California, Vermont, Massachusetts, and Colorado, have introduced legislation or proposed the idea of establishing Safer Consumption Sites. Presently, there are over 100 SCSs being operated throughout the world such as the Netherlands, France, Luxembourg, Germany, Switzerland, the United Kingdom, Canada, and Denmark.

Currently operated SCSs in Switzerland have found drug overdose deaths dropped by 64% and HIV infections by 84%.² Establishing SCSs in communities where public drug use is an issue can potentially decrease the number of overdoses and provide necessary resources for users.



CASE SELECTION FOR OFRB REVIEW

Based on a comprehensive search conducted by the DC Department of Health’s Vital Records Division, all opioid-involved deaths that occurred in the District of Columbia are identified and shared with the Fatality Review Unit 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.

DISTRICT GOVERNMENT AGENCIES

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 investigations
MPD – Any relevant police reports, investigations, arrest history, PD 120
DC Department of Human Services – any 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
<p>DC Department of Behavioral Health</p> <ul style="list-style-type: none"> • Substance Use Disorder service history- to include detox, residential, outpatient, prevention, recovery, and treatment records • Emergency psychiatric service history records • Community-based service provider history • Homeless services provisions to include crisis assessment and interventions • 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
<p>DC Department of Health Care Finance – insurance information, claims data</p> <ul style="list-style-type: none"> • Service Date • Billing Provider Name • Claim Type Description • Billing Provider Type • Claim Coverage Type • Diagnosis
Mayor’s Office of Veterans Affairs (MOVA)- Medical records, any treatment services, counseling, or community support records
OAG- Any related police reports, arrest history
CSOSA- Any 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- 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

DATA FROM OFRB CASE REVIEWS

The OFRB reviewed the following eight cases in 2020:

#	Decedent Demographics/ Ward of Residence	Cause of Death	Associated Risk Factors
1	64-year-old/ AA/ Female/Ward 7	Despropionyl Fentanyl and Fentanyl Toxicity	<ul style="list-style-type: none"> History of substance abuse Mental health diagnosis Comorbidities
2	36-year-old/ AA/ Female/NR (GA)	Combined toxic effects of amitriptyline, cyclobenzaprine, bupropion, diphenhydramine, metoprolol, oxycodone, promethazine	<ul style="list-style-type: none"> Morbid Obesity Comorbidities Chronic pain Use of multiple prescription medications
3	60-year-old/ AA/ Male/NR(VA)	Cocaethylene Cocaine Ethanol and Fentanyl Intoxication	<ul style="list-style-type: none"> History of substance abuse Open-air drug market
4	58-year-old/AA/ Female Ward 8	Cocaine, Despropionyl Fentanyl, and Fentanyl Toxicity	<ul style="list-style-type: none"> Adverse childhood experiences Parental substance abuse Comorbidities Mental health diagnosis
5	53-year-old/AA/ Female/NR(VA)	Combined toxic effects of cocaine, fentanyl, heroin, and para-fluoroisobutyryl fentanyl	<ul style="list-style-type: none"> Polysubstance abuse Homelessness Comorbidities Violence
6	25-year-old/AA/ Male/ Ward 8	Combined toxic effects of opiates and phencyclidine	<ul style="list-style-type: none"> Adverse childhood experiences Polysubstance abuse Mental Health diagnosis
7	61-year-old/AA/ Female/Ward 7	Combined toxic effects of alprazolam and fentanyl	<ul style="list-style-type: none"> Adverse childhood experiences Comorbidities Mental Health diagnosis
8	64-year-old/AA/ Male/Ward 5	Despropionyl fentanyl Heroin and Methadone Toxicity	<ul style="list-style-type: none"> History of Incarceration Housing Insecurity Financial Insecurity Polysubstance abuse Mental Health Diagnosis

KEY FINDINGS FROM CASE REVIEWS INCLUDED:

- **86%** of the cases reviewed had a history of a previous non-fatal overdose events
- **63%** of the cases reviewed were known to the Department of Behavioral Health
- **63%** of the cases reviewed were known to the Department of Healthcare Finance
- **38%** of the cases reviewed were non-DC residents who experienced a fatal overdose in the District of Columbia
- **50%** of the cases reviewed had a documented mental health diagnosis
- **52%** of the cases were seen at an Emergency Department in the three months before their overdose
- **38%** had previously been detained with the Department of Correction



OFRB **RECOMMENDATIONS FOR OVERDOSE DEATH PREVENTION**

In 2020, the OFRB adopted eleven recommendations and disseminated them to the relevant District Government Agencies.

THE RECOMMENDATIONS AIM TO:

(1) to reduce the number of preventable opioid overdose deaths and promote improvement of both public and private systems serving District residents with substance use disorders

(2) 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.

RECOMMENDATION #1

Office of the Chief Medical Examiner (OCME)

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

The questions shall include:

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

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

2. DBH, in collaboration with DC Health and the DHCF, should engage in a community-based consultation process

to make recommendations for better care coordination for clients receiving services and those who need to be re-engaged in the system.

Agency Response

The Office of the Chief Medical Examiner agrees with this recommendation

Best Practice

FEMS

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

MPD

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

Once these steps are completed and the interview concludes, Macdonald and her team (2017) suggest the officer/detective summarize what the bystander reported and ensure their contact information is documented

before parting. Lastly, Macdonald and her colleagues (2017) found that interviewers who are provided with a bullet point checklist of desirable behaviors were more easily able to implement them into their interview process.

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

OCME MDI/FI

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

OCME Records Unit/ IT Unit

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

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

Personal Property, and (5) Evidence Collected at Scene.

OCME Data Fusion Center/ SUDORS Abstractors

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

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

Specific Actions Planned Towards Implementation:

Action Items:

1. A bulleted checklist of the six questions will be disseminated to each MDI/FI.
2. If a death notification report comes from FEMS or the MPD specifically, after the initial death information is gathered on the phone call, if there is suspicion of an overdose, the MDI/FI will ask the reporting entity if bystanders were present. If bystanders were present, for quality assurance purposes, the reporting entity will confirm if the six questions were asked to the bystander(s) and tell the MDI/FI where the responses were recorded.
3. Once on the scene, the MDI/FI will process the scene according to standard protocol and then interview

bystanders. If the bystanders were already interviewed by the FEMS/first responding officer/detective about the six questions, the MDI/FI will ask any follow-up or probing questions about the six questions for further clarification.

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

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

OCME Records Unit/ IT Unit

Action Item

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

OCME Data Fusion Center/ SUDORS Abstractors

Action Item

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

Expected Outcomes:

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

Measurable Indicators/Milestones:

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

RECOMMENDATION #2

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

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 health information exchange 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 health information exchange 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. Health information exchanges 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 health information exchange. 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

Specific Actions Planned Towards Implementation are :

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

Specific actions taken to date towards implementation are 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 for clients receiving services and those who need to be re-engaged in the system.

Best Practices

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. It can be used to facilitate the care coordination and

consumer support process. 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 executing concrete recovery goals; delivers a 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 on August 25 with providers.
- DHCF will get feedback at the MCAC Health System Re-Design Subcommittee on August 5, 2020, about potential care management models 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 to understand their peer care management model.
- DBH met with governmental partners on August 7, 2020, to discuss a community engagement plan.
- DBH held a meeting on August 4 with DHCF to discuss a plan to engage providers.

Expected Outcomes

1. Adopt a plan for improving care management that reflects input from clients, 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.

RECOMMENDATION #4

The Department of Behavioral Health (DBH), in collaboration with the Department of Health (DC Health), Metropolitan Police Department (MPD), and DC Fire and Emergency Medical Services (DC FEMS), should develop a workgroup to discuss the tracking and communication among all government and community-based service providers that administer Naloxone/Narcan in an effort to identify ways to standardize data. This should include tracking of instances of dosage, administration, and reversals.

The Department of Health (DC Health) declined recommendation #4

Resolution

The OFRB voted to redirect this recommendation to the Department of Behavioral Health (DBH) in collaboration with DC Health. This recommendation has been transmitted to the DBH for a response and implementation.



RECOMMENDATION #5

DC Fire and Emergency Medical Services (FEMS) and the Metropolitan Police Department (MPD) should distribute overdose kits to the community upon a call or request for service. There should be community outreach/education stating that there are no penalties for calling MPD for assistance regarding an overdose (e.g., Leave Behind Program).

Agency Response

DC Fire and Emergency Medical Services (FEMS) agrees with this recommendation.

Best Practices

Currently the Fire and EMS Department distributes Narcan Kits to family members or friends of persons who have overdosed on opioid products. To date the depart has distributed roughly 3000 kits across the City. Upon the issuance of the Narcan Kits FEMS members educated the recipient on the proper use of the kits.

Expected Outcomes

To reduce the number of opioid related fatalities within the District of Columbia.

RECOMMENDATION# 6

The Department of Health (DC Health) should include the Department of Parks and Recreation (DPR), Advisory Neighborhood Commissions (ANCs), all DC pharmacies, and resource service officers under their Naloxone standing order so that Naloxone can be widely distributed to the community.

The Department of Health declined recommendation #6

Resolution

The OFRB voted to redirect this recommendation to the Department of Behavioral Health (DBH) in collaboration with DC Health. This recommendation has been transmitted to the DBH for a response and implementation.

RECOMMENDATION# 7

The Department of Behavioral Health (DBH), in collaboration with the Department of Health (DC Health), should initiate a community education and awareness campaign around Naloxone access and use. The campaign should emphasize the Good Samaritan law. Agencies should consider implementing the campaign utilizing a non-conventional approach.

The Department of Health declined recommendation # 7

Resolution

The OFRC voted to redirect this recommendation to the

Department of Behavioral Health (DBH) in collaboration with DC Health. This recommendation has been transmitted to the DBH for a response and implementation.

RECOMMENDATION #8

The Department of Behavioral Health should ensure that the Community Response Team conducts outreach to known hot spots, in collaboration with treatment providers, for the purpose of engaging individuals in treatment.

Agency Response

The Department of Behavioral Health agrees with this recommendation with modification

Modification/Alternative Recommendation

The DBH Assessment and Referral Center (ARC) will lead the operation of the new DBH mobile unit, with initial support from the Community Response Team (CRT), to provide community-based assessments and referrals in areas of high need or a history of high substance use disorder (SUD) and high overdose rates as indicated by ODMAP data available through DC Health and past outreach experience. The unit will also partner with somatic service providers to expand access across the District of Columbia.

Best Practices

In October of 2021, the Journal of Substance Abuse Treatment will publish an article highlighting the benefits of community-based assessment and referrals to care and ongoing treatment. While the mobile unit is not seeking to provide ongoing care for SUD, the administrative team is discussing procedures should consumers seek continuing service. The administrative team will use a diverse array of

data points to demonstrate the progress of the mobile unit and track the need for changes in scope and services to better align with community needs through a continuous quality improvement process.

Specific Actions Planned

The mobile unit advisory team has four goals that drive the implementation of services of the mobile unit:

GOAL 1

Provide continuous community outreach and acute grief support in a time of crisis.

Launch date: January 11, 2021

Community response and crisis services are active and serving the community. To date, the mobile unit has been in the community nearly 60 times while providing 330 naloxone kits to communities hardest hit by the opioid crisis in the District of Columbia. These services are augmented with the expansion of a registered nurse that provides a somatic focus when engaging with consumers and residents while broadening the skillset of CRT staff. Since supporting the mobile unit, the nurse has successfully performed an overdose reversal.

GOAL 2

Provide community-based assessments and referrals outside of a "brick and mortar" setting using DBH staff.

Launch date: June 2, 2021

Full implementation of assessments and referrals is complete, and the service is taking place on the DBH mobile unit. The service is supported by a licensed clinician, nurse, outreach staff from CRT, and administrative support. The ARC uses a unique approach by incorporating telehealth services on the mobile unit through the assessment and referral process. Given the limited space on the mobile unit, this innovative approach allows for more outreach staff on the unit and a continuing focus on developing high-value relationships with community members most in need of supports to access recovery.

GOAL 3

Collaborate with Chapter 63-certified SUD providers to host community-based assessments and referrals to increase access to treatment and recovery support services.

Launch date: October 4, 2021

The mobile unit administrative team is working internally to develop a DC Register notice that will advertise the availability of the DBH mobile unit for use by our provider network in collaboration with DBH staff. The unit will be driven by DBH staff to locations of high SUD service need in the District of Columbia and staffed by DBH-certified providers and DBH clinical staff that will connect with clients and link them to treatment. Once notice is posted, DBH will form a selection team to review provider applications for completeness and adherence to published requirements. We will expect to complete the selection process by late August, then begin scheduling and addressing the technical needs of providers.

GOAL 4

Provide ancillary SUD services that address community needs while fostering relationships in the community through DBH and partnerships with providers.

Launch date: TBD (Spell this out)

DBH is working to partner with community organizations with mobile units to provide access to ancillary SUD services, including STI screenings and an array of somatic health services. The launch of these services will take place after the implementation of Goal 3. DBH is also developing methods internally to expand access to SUD services further.

The mobile unit administrative team meets weekly to ensure the implementation of the mobile unit is moving forward in a timely manner. DBH has allocated nearly \$800k in State Opioid Response (SOR) funding to support the implementation and operations of the mobile unit. These funds support staff, clinical supplies, and other essential needs.

To boost awareness of the mobile unit, the DBH SOR Team is partnering with Total Family Care Coalition to host naloxone events and informational sessions in District of Columbia Housing Authority properties across the city. The properties are in areas with high overdose rates, as indicated by ODMAP data available from DC Health. Through these events, we are creating a sense of comfort and familiarity with DBH Mobile Unit staff and the physical space of the unit.



Specific Actions Taken To Date Towards Implementation

The mobile unit administrative team meets weekly to ensure the implementation of the mobile unit is moving forward in a timely manner. We have allocated nearly \$800k in State Opioid Response (SOR) funding to support the implementation and operations of the mobile unit. These funds support staff, clinical supplies, and other essential needs.

To boost awareness of the mobile unit, the DBH SOR Team is partnering with the Total Family Care Coalition to host naloxone events and informational sessions in District of Columbia Housing Authority properties across the city. The properties are in areas with high overdose rates, as indicated by ODMAP data available from DC Health. Through these events, we are creating a sense of comfort and familiarity with DBH Mobile Unit staff and the physical space of the unit.

Expected Outcomes

Enhance DBH and DBH-providers' capacity to access communities most impacted by the opioid epidemic in the District of Columbia while expanding access to ancillary SUD services. Measurable indicators/milestones related to implementation that can be reported regularly

Indicator/milestones: Implementation status of Goals 3 and 4. **Date:** June 2022

Goal 3: Collaborate with Chapter 63-certified SUD providers to host community-based assessments and referrals to increase access to treatment and recovery support services.

Goal 4: Provide ancillary SUD services that address community needs while fostering relationships in the community through DBH and partnerships with providers. **Date:** June 2022

Measurable Indicators/Milestones Related To Implementation That Can Be Reported On A Regular Basis

Indicator/milestones: Implementation status of Goals 3 and 4

Goal 3: Collaborate with Chapter 63-certified SUD providers to host community-based assessments and referrals to increase access to treatment and recovery support services.

Goal 4: Provide ancillary SUD services that address community needs while fostering relationships in the community through DBH and partnerships with providers.

Indicator/milestones: Number of assessments and referrals. **Date:** Ongoing

Indicator/milestones: Number of naloxone units distributed. **Date:** Ongoing

RECOMMENDATION #9

Within the next six (6) months, the Department of Behavioral Health (DBH), in collaboration with the Department of Health (DC Health), should revisit the idea of safe consumption sites within the District of Columbia.

The Department of Health declined recommendation #9

Resolution

The OFRB voted to redirect this recommendation to the Department of Behavioral Health (DBH) in collaboration with DC Health. This recommendation has been transmitted to the DBH for a response and implementation.

RECOMMENDATION #10

The Department of Human Services (DHS) should collaborate with the Department of Behavioral Health (DBH) and the Department of Health (DC Health) to provide Substance Use Disorder (SUD) outreach to individuals who accept or refuse Fire and Emergency Medical Services (DC FEMS) transport or medical treatment after a suspected overdose that occurs at a DHS Shelter and consider additional opportunities to connect shelter residents with MAT when appropriate.

Agency Response

The Department of Human Services agrees with this recommendation.

Best Practices

- Ensure the availability of Narcan at all DHS administered shelters for staff to distribute to clients and for staff to administer to clients in cases of overdose.
- Require Narcan training for shelter staff and security staff at all shelter sites and among DHS outreach teams.
- Establish protocols for shelter case managers to follow up with individuals who have experienced overdose to ensure that those individuals are connected to MAT and other supportive services.
- Coordinate with Unity Health Care, the primary health care provider for shelter residents, to facilitate access to MAT.
- Leverage the DC Health Opioid Peer Responder program to facilitate connections to treatment and resources after an overdose.

Specific Actions Planned Towards Implementation

- [Within 1 year] Require all DHS contractors to take the DC Health Narcan training and modify monitoring procedures to ensure compliance with the requirement.
- [Within 6 months] Establish a case manager protocol for required actions after an overdose occurs in a shelter, including calling the DC Health Peer Opioid Program and referring the client to Unity Health Care to receive additional counseling on MAT and other treatment options.
- [Within 6 months] Have all shelter and outreach teams officially covered by a DC Health Standing Order so that all teams can directly order Narcan to distribute to clients directly from DC Health.
- [Within 6 months] Update DHS Policy to modify reporting requirements to have all providers report directly to DC Health on the number of Narcan kits distributed and Narcan kits administered.
- [Within 1 Year] Improve our understanding of the number of overdoses that happen in shelters or around the vicinity of shelters by using the FY-21 Suspected Drug Overdose Location data.
- DHS has updated our standing order with DC Health to include all of our low-barrier shelters and outreach teams.
- The DHS is meeting with shelter providers every month to provide additional training and TA around accessing and distributing Narcan as well as providing connections to substance use treatment and MAT.
- The DHS is assessing shelter case management services to determine what the current protocols are to follow up after an overdose in a shelter.
- The DHS is in close contact with DC Health and the DC Department of Behavioral Health. The DHS' standing order is with DC Health, and we are therefore subject to DC Health standard operating procedures and policies – including facilitating access to treatment. The DHS and DBH have an existing MOU, where DBH provides funding for the DHS' SORE Team – the SORE Team is an outreach team that specifically provides outreach to individuals in need of substance use treatment and services.

Expected Outcomes

- Increased distribution of Narcan in shelters as well as in the community.
- Increased referrals to substance use/MAT treatment.
- Fewer opioid-related fatalities among shelter residents.
- Measurable indicators/milestones related to implementation that can be reported regularly
- Increase the number of Narcan kits distributed among shelter residents or unhoused individuals by 50%. Date: 6/30/22
- Increase the number of shelter and outreach staff who have completed the DC Health Opioid Overdose Prevention & Naloxone Education by 50%. Date: 6/30/22
- Begin tracking the number of referrals to the DC Health Rapid Peer Responders and DBH treatment and services. Date: 1/5/22

RECOMMENDATION #11

Within the next twelve (12) months, the Department of Health (DC Health) should include follow-up resources for services during Naloxone training.

The Department of Health declined recommendation #11

Resolution

The OFRB voted to redirect this recommendation to the Department of Behavioral Health (DBH) in collaboration with DC Health. This recommendation has been transmitted to the DBH for a response and implementation.





OFRB APPENDIX

RESOURCES

SAMSHA Fact Sheet

<https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf>

Opioid Fatality Review Board Case Summary Review Form

Centers for Disease Control and Prevention. (2019). MMRIA Committee Decisions Form [pdf]. Retrieved from https://reviewtoaction.org/sites/default/files/2021-06/CommitteeDecisionsForm-mmria-form-v21-fillable1_0.pdf

Washington DC's Strategic Plan to Reduce Opioid Use

Live.Long.DC is Washington DC's strategic plan to reduce opioid use, misuse and related deaths.

<https://livelong.dc.gov/>

NEED HELP?

To access treatment, call DBH's Access Helpline at 1(888)7WE-HELP or 1-888-793-4357

If you need help with your opioid addiction, call the 24/7 Access HelpLine at 1(888) 793-4357 or visit the ARC Monday through Friday, 7 am to 6 pm, at 77 P Street, NE, Washington, DC, 20002

DEFINITIONS

Alprazolam: a benzodiazepine used to treat anxiety and panic disorders and anxiety caused by depression.

Amitriptyline: a tricyclic antidepressant used to treat depression.

Analog: drugs that are structurally similar to a controlled substance listed in federal or state drug schedules.

Cyclobenzaprine: a muscle relaxant.

Bupropion: an antidepressant used to treat major depressive disorder

Diphenhydramine: an antihistamine used to reduce hives, skin rash, itching or other allergy symptoms.

Cocaethylene: metabolite of cocaine; formed in the body due to the co-administration of cocaine and ethanol.

Cocaine: a stimulant drug sometimes sold in the powdered, hydrochloride salt form or as crack cocaine (rock form).

Comorbidity: the presence of one or more health conditions a person is having with a primary illness (i.e. a patient with diabetes and hypertension).

Despropionyl Fentanyl: a metabolite of fentanyl.

Ethanol: alcohol.

Fentanyl: a synthetic opioid that is like morphine but is 50-100 times more potent; used to treat severe pain.

Heroin: an opioid drug made from morphine. It exhibits euphoric and pain-relieving properties.

Metabolite: the product that remains after a drug is broken down by the body.

Methadone: an opioid used as a replacement for heroin and other opioids as a part of treatment for substance abuse. It can reduce withdrawal symptoms of heroin.

Metoprolol: a beta-blocker that affects the heart and circulation (blood flow); used to treat chest pain and high blood pressure.

Oxycodone: an opioid pain medication used to treat moderate to severe pain.

Opiates: also known as opioids; drug derived from Opium or from chemicals designed to mimic it.

Para-fluoroisobutyryl fentanyl: a designer drug made from Fentanyl (an analog).

Phencyclidine: a synthetic compound made from piperidine; considered a dissociative hallucinogenic drug.

Polysubstance Abuse: consuming or abusing more than one drug at once.

Promethazine: an antihistamine used to treat allergy symptoms.



OFRB ACKNOWLEDGEMENTS

THANK YOU

The Office of the Chief Medical Examiner expresses its sincere appreciation for the work of the members and participants 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.



OPIOID FATALITY REVIEW BOARD

2020 ANNUAL REPORT



Office of the Chief Medical Examiner

Fatality Review Division

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