Overdose Fatality Review in Maryland

BJA Harold Rogers PDMP National Meeting
September 2014

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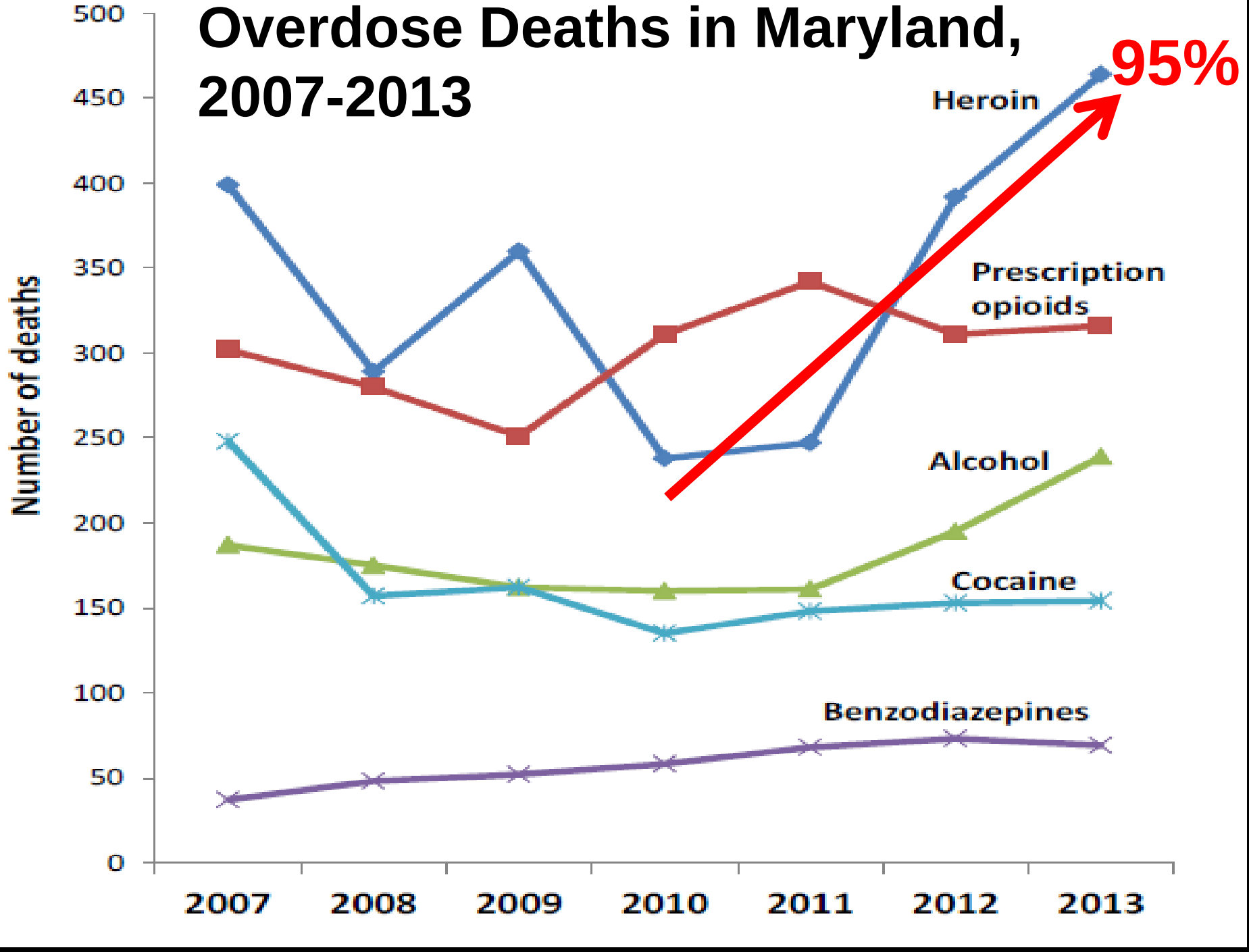
MARYLAND
DEPARTMENT OF HEALTH
& MENTAL HYGIENE


Overdose Deaths in Maryland, 2007-2013
95%
Heroin
Prescription opioids
Alcohol
Cocaine
Benzodiazepines
Number of deaths
500
450
400
350
300
250
200
150
100
50
0
2007
2008
2009
2010
2011
2012
2013

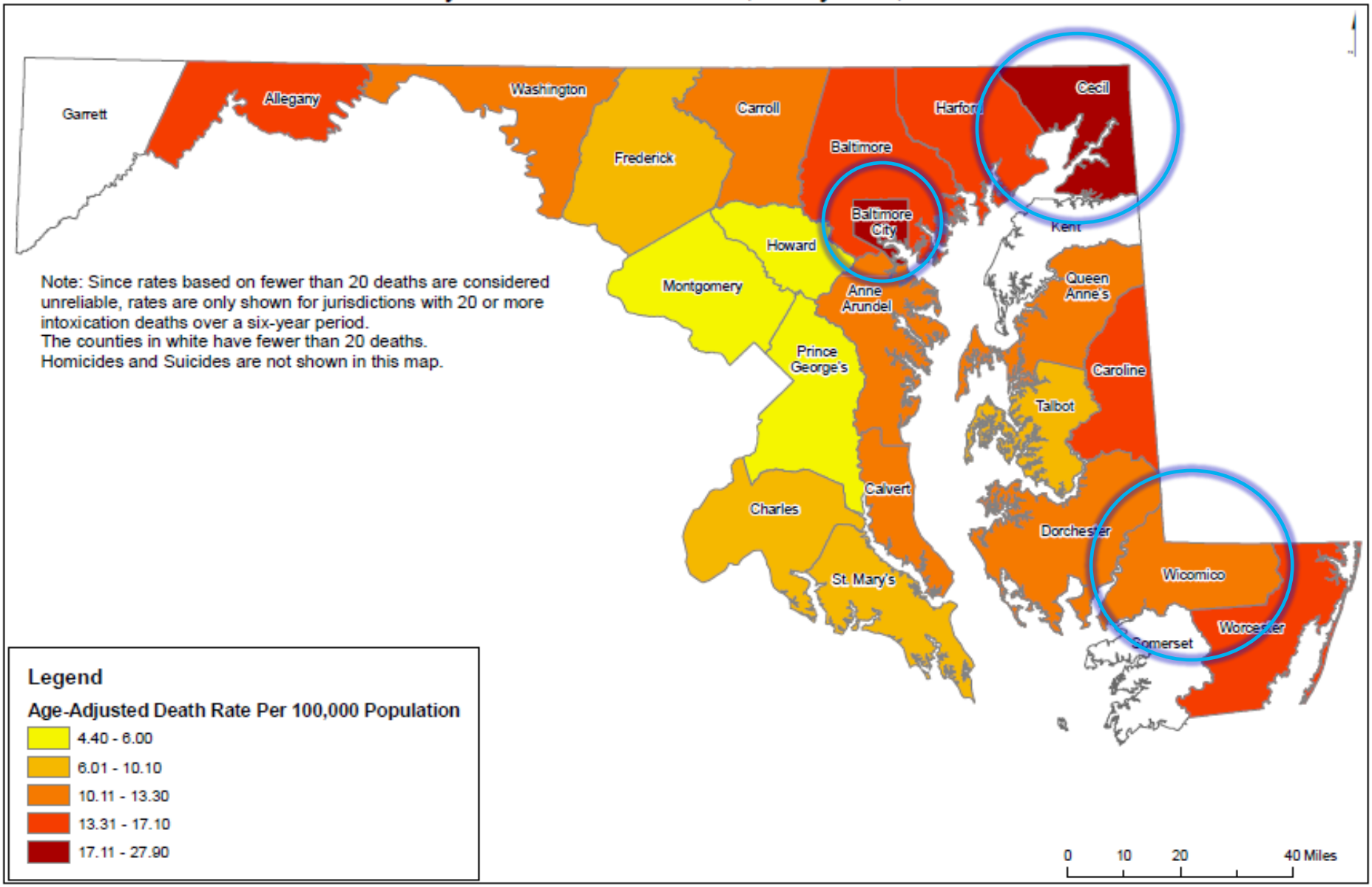
2013: State Overdose Prevention Plan

- Enhanced epidemiology
- Expand Medication Asst. Tx: methadone & bupe
- Reduce Rx abuse:
  - PDMP: within CRISP, state Health Info Exchange
  - DHMH investigative “fusion center” w/ licensing boards
  - CDS patient support following license suspensions
  - Standardize “lock-in” across Medicaid MCOs
  - Clinical education: FDA REMS
- Naloxone: 3rd party training/credentialing law
- Local: all jurisdictions required to create local overdose prevention plans

Overdose Fatality Review

- State-supported, in-depth review of OD deaths by local-level stakeholders
- Modelled on existing mortality review teams for children, fetal/infant, domestic violence, etc.
- Goals:
  - Identify OD risk factors to improve local prevention planning
  - Identify missed opportunities for prevention/intervention
  - Make recommendations to law/policies/programs to prevent ***future*** deaths
  - **Increase inter-agency communication/collaboration, trust and buy-in around OD issue**

Age-Adjusted Death Rates for Total Intoxication Deaths by Place of Residence, Maryland, 2007-2012



Source: Maryland Department of Health and Mental Hygiene
Map Created: July 2013

Local Overdose Fatality Review Teams

- Est. by local health departments: Baltimore City, Cecil County & Wicomico County pilots
- Multi-agency, multi-disciplinary:
  - LHD
  - SUD/Mental Health coord.
  - Healthcare providers
  - EMS
  - Hospital
  - Social Services
  - Law enforcement
  - Prosecutors
  - Corrections
  - Juvenile services
  - Schools
- **Confidential proceedings** & records protected from discovery/subpoena in civil litigation
- Primarily review resident deaths

Data Process

Office of Chief Medical Examiner: monthly OD death record query:

- Decedent info (name, DOB, sex, address, etc.)
- Incident info (COD & MOD, location)
- ME investigative notes (LE, witness, kin info)
- Toxicology results

Vital Statistics Admin: analyze & code OCME records for substances/classes, matches against death certificates

Behavioral Health Admin:

- Matches death records w/ SUD Tx records
- Formats all data in secure file & sends to LOFRTs
- LOFRT Data Use Manual
- LOFRT technical assistance

LOFRT: Team members must query agency systems for decedent info and bring to meetings

Recordkeeping Requirements

- Team coordinators must maintain notes from meetings
- Notes must include:
  - Demographic information
  - Substances involved in death
  - Time spent reviewing case
  - Systems with which the deceased interacted
  - Key observations from review
- List of meeting attendees
- Observation and recommendation tracking chart

LOFRTs & PDMP data

- MD PDMP law does not allow direct data disclosure to LOFRTs
- PDMP regulations changed to allow data ***re-disclosure*** to LOFRTs
- DHMH currently working w/ OCME to est. routine request & re-disclosure process
- Proposal to change PDMP law in 2015 to allow LOFRTs to request data directly

House Bill 1282, 2014

- Modelled on Child Fatality Review statute
- Est. OFR in law and gives local jurisdictions authority to create teams (voluntary)
- Gov. agencies & healthcare providers must provide decedent records at LOFRT request
- LOFRT members & people that provide info are immune from civil liability
- DHMH oversees LOFRTs and may require reports

Implementation to Date

- 2013 HRPDMP grant: funding for DHMH program coordinator
- First meetings February 2014
- Mostly monthly, 2 hour meetings
- 50 cases reviewed by 3 pilot jurisdictions
- No formal recommendations made yet, but….

Sample of Highlighted Issues

- SUD Tx program patient death reporting to DHMH: new investigative process established
- Lack of followup w/ aftercare on discharge SUD Tx
- Examine/improve OTP protocols for pregnant women
- Naloxone in recovery houses
- Improve referral to naloxone training through EMS, community outreach, housing partners
- Promote PDMP use by somatic providers and OTPs
- Develop PDMP provider alerts on dangerous drug combinations
- Access to care limited by insurance paneling
- Need better child/family services for addicted patients
- Large number of individuals w/ intimate partner violence: need for trauma-informed care
- Need to conduct outreach post EMS-treated non-fatal overdose