Overdose Fatality Review in Indiana

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Indiana Child Fatality Review
Indiana State Department of Health
Overdose Fatality Review

• Modeled after other mortality review teams (child fatality review, fetal-infant mortality review, etc.)

• Multi-agency/multi-disciplinary team assembled to conduct confidential case reviews of overdose deaths

• The goal is to prevent future deaths by:
  ➢ Identifying missed opportunities for prevention and gaps in system
  ➢ Building working relationships between local stakeholders on overdose prevention
  ➢ Recommending policies, programs, laws, etc. to prevent overdose deaths
  ➢ Informing local overdose prevention strategy

• Team members bring info from respective agencies about decedents to inform review
Recommended Team Members

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

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

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

• Evaluation on process improvements and recommendations for policy and program development
During the Review …

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

• Guidance document
  ➢ Modeled Maryland lessons & format
  ➢ Description of case criteria
  ➢ Finalized outcome will result from pilot team input

• Data collection form
  ➢ Collaboration with epi & opioid/drug outreach teams for data points
  ➢ Sustainability challenges
    o End-user friendly
    o Data repository
Team Formation

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

• Case definition, time
• Mental Health records access
• Hospital records access
  Legal requests submitted for approval
• INSPECT data
  ➢ Who accesses?
  ➢ How far back should we go?
Discussion Points: Team Establishment

• Coroner involvement
  ➢ Willingness varies
    o “not my job, per statute”
    o “I’ll subpoena the records as part of my investigation”
  ➢ Investigation practice varies
Challenges

• Original emphasis on opioid deaths
• Legislation
• Medical records/mental health records – HIPAA
  Does public health crisis/epidemic suspend HIPAA?
• How/when to notify members of cases on review docket
Challenges

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

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

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

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

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

• Training of local pharmacists/hospital prescribers
  Challenges of pharmacists who do not want to fill scripts, but face blowback

• Funding search for lock boxes

• Plans to track naloxone administrations to see how many patients ultimately die

• Beginning stages of collecting resource list for teams/first responders
What Next?

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