RODA – Overdose Fatality Review Preliminary Recommendations

Year 2 OFR: September 2020 – August 2021

Purpose

The mission of the Overdose Fatality Review (OFR) team is to improve countywide surveillance of overdose mortality. This enhanced surveillance will inform prevention efforts to address new cases of drug addiction, overdose, and death. This multidisciplinary team reviews selected overdose deaths to fill gaps in knowledge of local overdose mortality trends and to increase coordination and collaboration among partner agencies. OFR teams has proven to be a valuable tool in other states and counties for informing strategic planning, policy change, and other program improvements at the local and state level.

Confidentiality

All team proceedings are strictly confidential. Except as necessary to carry out the team's purpose and duties, members of the OFR and guests may not disclose what transpired at the meeting. These meetings are not recorded, and notes transcribed during meetings only reflect a general overview of key themes discussed. Confidentiality agreements are required of all team members and support staff that access confidential information to complete investigations and/or analysis of information in performing overdose death reviews. It is not only important for the integrity of the team to protect proceedings at team meetings, but also for respect of the privacy of the deceased and family members. All data provided to the team must adhere to protection standards of its original source and cannot be re-disclosed as a record of the fatality review team. While a majority of OFR members and guests do not have access to confidential information, a signed confidentiality form is required before participating in the OFR meetings.

Meeting Structure

- Meeting takes place during the last Wednesday of every month from 1-3p.m.
- RUHS-Public Health, Sheriff-Coroner's Department, Emergency Medical Services, and RUHS-Behavioral Health present pertinent information on decedents.
- Updates from Epidemiology Department regarding overdose trends are provided at each meeting.
- The OFR members are provided de-identified summaries and timelines on each decedent as preparation for each meeting.
- The OFR team has access to an action plan that assists the team in staying on track of implementing recommendations.

Agencies Present

- Riverside University Health System
    a. Public Health
        i. Epidemiology and Program Evaluation
        ii. Public Health Nursing
        iii. Injury Prevention Services
    b. Behavioral Health
        i. Substance Abuse Prevention & Treatment Programs
        ii. Research
        iii. Prevention and Early Intervention
- Riverside County Sheriff-Coroner Department
- Riverside Emergency Management Services Agency
- University of California-Riverside
- Inland Empire Harm Reduction Coalition
- Inland Empire Health Plan (IEHP) - Clinical Pharmacy Programs
- Riverside County Probation Department
- Riverside County Department of Housing & Workforce Solutions
- Riverside County Office of Education
- County of Riverside Office of the District Attorney

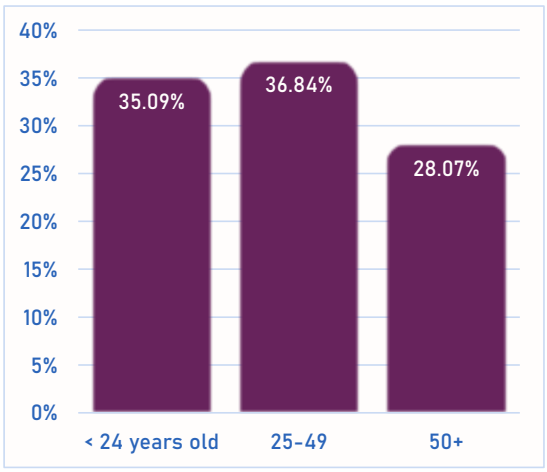
Case Review

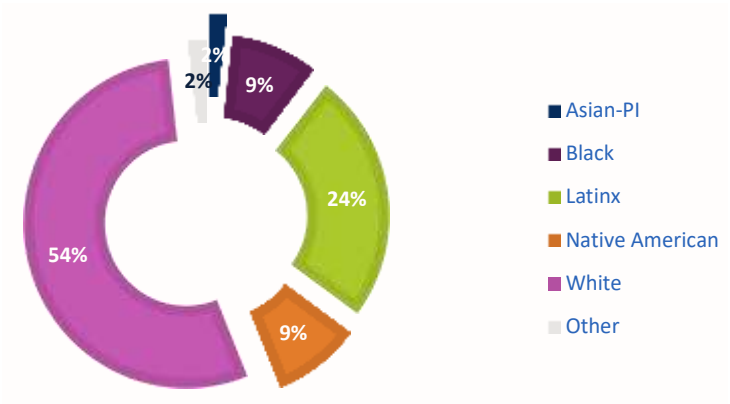
57 total cases reviewed (February 2020 to November 2021)

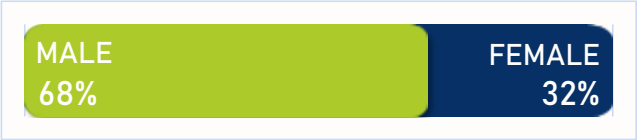
- September: Three (3) overdose deaths involving phencyclidine (PCP).
- October: Four (4) overdose deaths involving benzodiazepines.
- November: Four (4) overdose deaths among individuals who identify as Native American.
- December: Four (4) overdose deaths among the youth population (ages <24 years).
- January: Four (4) overdose deaths involving decedents age 65 and older.
- February: Four (4) overdose deaths involving methamphetamine use.
- March: Focused on reviewing recommendations and discussed ways to improve OFR meetings and data collection on decedents.
- April: Four (4) overdose deaths involving fentanyl and methamphetamine.
- May: Four (4) overdose deaths involving individuals in the LGBTQ+ community.
- June: Four (4) suicide deaths by overdose.
- July: Three (3) overdose deaths among women of childbearing age (ages 22-43).
- August: Four (4) overdose deaths where there were multiple overdoses reported.

Monthly themes are chosen based on a review of the enhanced surveillance data indicating areas of particular concern.

Demographic breakdown of reviewed cases in Years 1 and 2







Recommendations

Partnerships

1. Reach out to other organizations for culturally appropriate harm reduction messaging for methamphetamine use among the non-Hispanic white gay population.
2. Explore possibility of working with neighboring counties for EMS and Probation information on decedents who lived out of County. Sheriff Department can pull entire record, in or out of county but many other agencies cannot.
3. Explore the possibility to follow up with the reporting parties and provide resources to them – mental health support, harm reduction, and grief support.
4. Partner with local colleges and universities to address substance use disorders.
5. Reach out to local tribes/bands regarding their support services. Connect and ask local tribes how Public Health and Behavioral Health could provide support.

Education and Training

1. Aim to reduce the stigma of drug and alcohol dependency among business and non-profit leaders.
2. Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) with primary care physicians – currently used in emergency departments and community health clinics.

3. Harm reduction education to include the dangers of touching and sniffing, not just ingesting fentanyl.
4. Mental health screening should be given for domestic abuse perpetrators and survivors.
5. Provide education to providers to educate their patients on the complications of mixing medications.
6. Educate and provide Naloxone to motel staff.
7. Make fentanyl drug kits available to the community. Promote and inform the community and other agencies about Inland Empire Harm Reduction and their harm reduction resources, including fentanyl testing strips.
8. Provide and ensure individuals recently released from jail or prison receive harm reduction education and resources. Provide more relapse education.
9. Provide the community and those recently incarcerated on the dangers of mixing alcohol and drugs.
10. Develop and provide front line staff with empathy, motivational interviewing, ACE's, and trauma informed training.
11. Many cases reviewed highlighted trends of adverse childhood experiences (ACES). Agencies and providers should receive training and educational materials on ACEs and their connection to substance use, as well as practices for screening for ACEs.
12. Provide mental health resources and follow up for individuals who have experienced sexual trauma.

OFR Structure

1. Include domestic violence program staff. Most programs are court mandated and are offered through private entities, but Behavioral Health does have anger management programs that can be included.
2. Work on overdose legislation to protect OFR – use existing partnerships with state level agencies.
3. Contact those individuals who wrote coroner's report if clarification on report is needed.
4. Include medical providers in OFR.
5. Expand OFR invitation to include agencies that specialize in youth programs. Possibly Child Protective Services or Operation Safehouse.
6. Include DPSS to provide information on kids/family court, but aim to include as many DPSS program representatives as possible.

Harm Reduction

1. Continue to provide naloxone education and distribute naloxone to the community.
2. Distribute/provide naloxone to different agencies and their clients.
3. Promote and distribute naloxone to families who know of someone that has overdosed.

4. Offer naloxone to families and individuals who are waiting to get treatment.
5. Promote the "never use alone" hotline, especially within pharmacies.
6. Work with providers to advocate for alternatives for pain management- promote pain management clinics with physicians.
7. Involve family in the recovery process, including family education, therapy, stigma reduction.

Resources

1. Provide family support after an overdose. "Grief support team" to provide overdose prevention education, naloxone distribution, safe coping skills, and other resources immediately after an overdose death in the household. Include substance use screening for risk of substance use to individuals who witnessed an overdose.
2. Work on system to notify primary care physicians of overdoses that occurred with their patients.
3. Ensure there is post-injury medication and care follow up. Provide those that are prescribed medication overdose education.

Recommendations currently being addressed

1. Explore partnership with Substance Use Navigator's (SUNS) or Public Health Nurses to follow up with individuals who overdosed. Provide individuals with mental health support, harm reduction strategies, and case management services.
    a. Initial meeting between PHN and EMS took place in July 2021.
    b. Currently exploring ways to incorporate PHN in FirstWatch account and how alerts can be tailored to what information PHN would need (name, number, medical history, etc.). Also, confirming what policies or documents are needed for data sharing.
2. Research and promote/start a campaign for patient self-advocacy. Provide individuals with the tools and skills necessary to feel confident and comfortable communicating their healthcare needs.
    a. Working with IEOCC – Safe Prescribing Workgroup.
    b. Exploring other ways to include UCR and IEHR.
3. Provide education for individuals who break the 72-hour 5150 hold. Education and counseling should also be given to the families/ friends who pick up their loved ones from inpatient mental health treatment centers.
    a. Behavioral Health - Prevention and Early Intervention and the Suicide Prevention committee working on care transitions from hospital to home.

Recommendations Previously Implemented

1. Provide EMS with easy to access resources for overdose contacts.
    a. Public Health created QR codes specific to EMS regions and needs.
    b. QR Codes also featured in EMS app.
2. Ensure supporting agencies receive naloxone training.
    a. Public Health contracted with Inland Empire Harm Reduction to provide harm reduction and naloxone trainings to partner agency staff and the community.
3. Send out de-identified decedent report and timeline to entire OFR team prior to the meeting.
    a. Decedent packet includes de-identified coroner report summary and decedent timeline with major life events.
4. Include school personnel on OFR team.
    a. Riverside County Office of Education is represented at each OFR meeting.