STATE DRUG OVERDOSE REVIEW
FATALITY REVIEW TEAM

November 28, 2017

Fatality Review Teams

- The purpose of fatality review teams is to collect and review data on the causes of deaths (focus population), and to recommend changes in policies and programs that will help decrease deaths in the focused population.
- Traditional focused populations: children, domestic violence and maternal mortality.

Preventability

- A death is considered to be preventable if the community or an individual could have done something that would have changed the circumstances leading to the death.
- A death is preventable if reasonable medical, educational, social, legal or psychological intervention could have prevented the death from occurring. The community, family and individual's actions (or inactions) are considered when making this determination.

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

Team Members (21)

- ❖ Attorney General
- ❖ Department of Health Services
- ❖ Arizona Health Care Cost Containment System
- ❖ Department of Economic Security
- ❖ Governor's Office of Youth, Faith and Family
- ❖ Administrative Office of the Courts
- ❖ State Department of Corrections
- ❖ Arizona Council of Human Services Providers
- ❖ Department of Public Safety
- Medical Examiner - Forensic Pathologist
- Medical Examiner – Metropolitan Forensic Pathologist
- Tribal Government Representative
- Public Member
- Professional Emergency Management System Association Representative
- Health Care Professional – Statewide Association Nurses Representative
- Health Care Professional – Statewide Association Physicians Representative
- Association of County Health Officers Representative
- Association Representing Hospitals Representative
- Health Care Professional Who Specializes in the Prevention, Diagnosis and Treatment of Substance Use Disorders
- County Sheriff or Designee Who Represents a County with a Population of Less than Five Hundred Thousand Persons
- County Sheriff or Designee Who Represents a County with a Population of More than Five Hundred Thousand Persons

Charges

- Develop a drug overdose fatality data collection system
- Conduct an annual analysis on the incidence and causes of drug overdose fatalities in this state in the preceding fiscal year
- Encourage and assist in the development of local drug overdose fatality review teams
- Develop standards and protocols for local drug overdose fatality review teams and provided training and technical assistance to these teams.
- Develop protocols for drug overdose investigation including protocols for law enforcement agencies, prosecutors, medical examiners, health care facilities and social service agencies.

Cont.

- Study the adequacy of statutes, ordinances, rules, training and services to determine what changes are needed to decrease the incidence of preventable drug overdose fatalities and as appropriate take steps to implement these changes.
- Educate the public regarding the incidence and causes of drug overdose fatalities as well as the public's role in preventing these deaths.
- Designate a member of the review team to serve as chairperson.

Statute Overview

- All information and records acquired by the team or local team are confidential and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding except that information, documents and records that are otherwise available from other sources are not immune from subpoena, discovery or introduction into evidence through those sources solely because they were presented to or reviewed by a team

Overview cont.

- Members of the team, persons attending team meetings and persons who present information to the team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of the meeting. This subsection does not prevent a person from testifying to information that is obtained independent of the team or that is public information.

Overview cont.

- A member of the team may contact, interview or obtain information by request or subpoena from a family member of a deceased person who overdosed on drugs
- Meeting of the team are closed to the public if the tame is reviewing information on an individual who overdosed on drugs- otherwise the meetings are open.

Public Service Orientation

- As an appointed public servant, you will have to fulfill certain obligations.
- As a matter of statute, all individuals appointed to a committee, board, or commission must sign a loyalty oath for each appointment, office, or position held and complete public service orientation (Standards of Conduct).
- A copy of the signed loyalty oath and training certificate are due January 1, 2018.

Models of Review

States with Drug OD Review

- Delaware enacted legislation to establish a statewide Drug Overdose Fatality Review Commission. Legislation was signed in April 2016 and it appears that the Commission is still being formed.
- Maryland enacted a law in 2014 that authorizes local overdose fatality review teams at the county level. Proposed legislation initially called for a statewide review team, but the final legislation only included county-level teams.
- Pennsylvania passed a law in 2012 that created an interdisciplinary team that reviews methadone deaths only.
- West Virginia has a statewide Fatality and Mortality Review Team "created to oversee and coordinate the examination, review and assessment of" a number of types of deaths, including "The deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses."

Rhode Island

- Only a state team
- Contract with Boston Medical Center
- The state team is provided an abstract of the information transcribed from the records
- Information on trend data
- Quarterly report with recommendation

Maryland Structure

- Local Overdose Fatality Review teams conduct confidential reviews of resident drug and alcohol overdose deaths to identify opportunities to improve member agency and system-level operations in a way that will prevent future similar deaths.
- The Department of Health's role is to provide oversight, data, and guidance to the local program teams

Maryland Findings

- 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

Yavapai County

- Overdose Fatality Review Board est 8/2016
- Review selected, unintentional OD cases
- If possible, the family is interviewed
- Make recommendations
- Modeled after local child fatality review

Yavapai's Report

- 80 drug-related deaths in the county in 2016, and of those, many died from what the medical examiner calls "mixed drug intoxication."
- Reviewed: 3 overdose fatalities in Prescott; 2 in Prescott Valley; 2 in Cottonwood; 1 in Mayer; and 1 in Black Canyon City.
- The group noted several common factors in the nine deaths examined:
  - 8 of 9 had reported mental illness
  - 7 of 9 had received outpatient substance abuse treatment
  - 5 of 9 had received inpatient substance abuse treatment
  - 5 of 9 were on probation or parole at the time of death
  - 7 of 9 were homeless at the time of death
  - 6 of 9 had used alcohol and marijuana at an early age

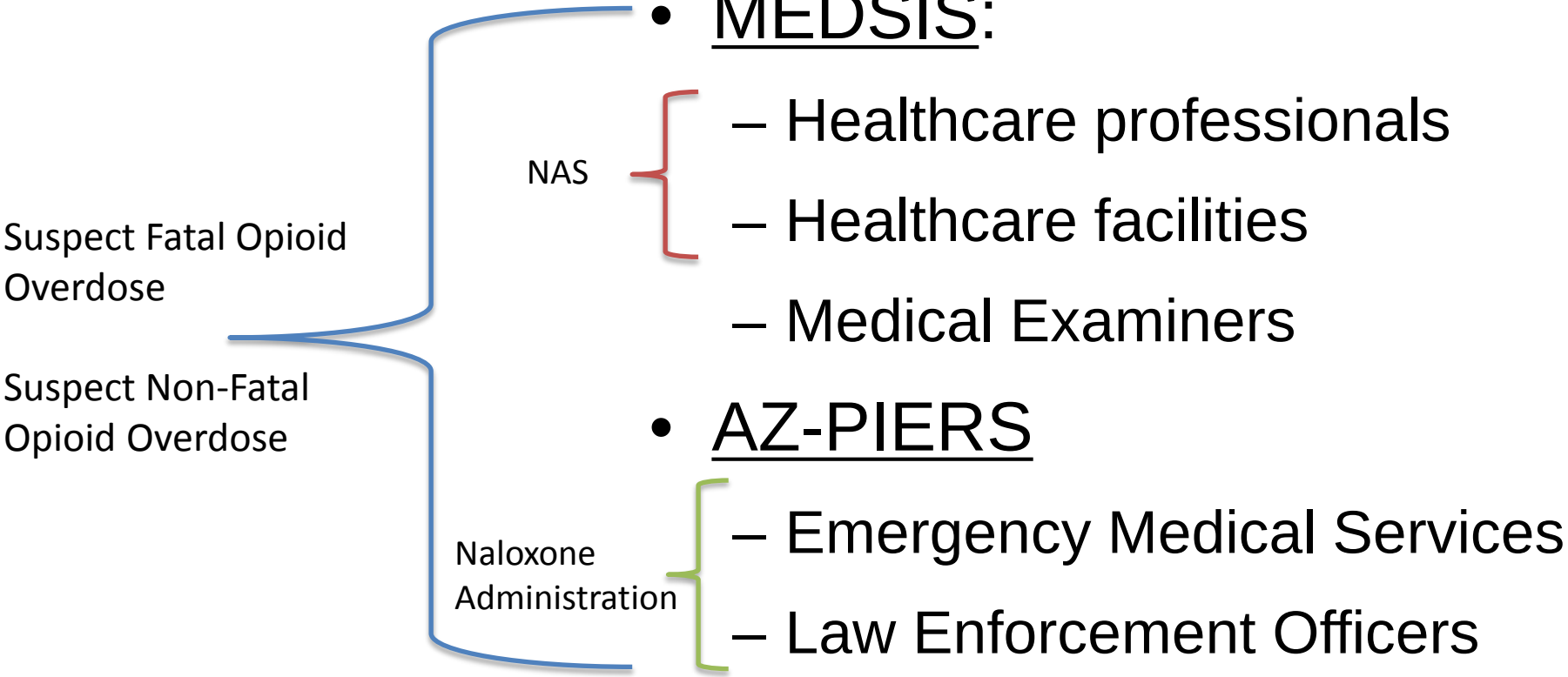
Current Data Trends

Opioid Emergency
&
Opioid Overdose Reporting

Enhanced Surveillance

- Authorized by Arizona Revised Statutes (A.R.S.) 36-782
- Reportable under enhanced surveillance:
    - Suspected opioid overdoses
    - Suspected opioid-related deaths
    - Neonatal Abstinence Syndrome
    - Naloxone administered
    - Naloxone dispensed

Required Reporters



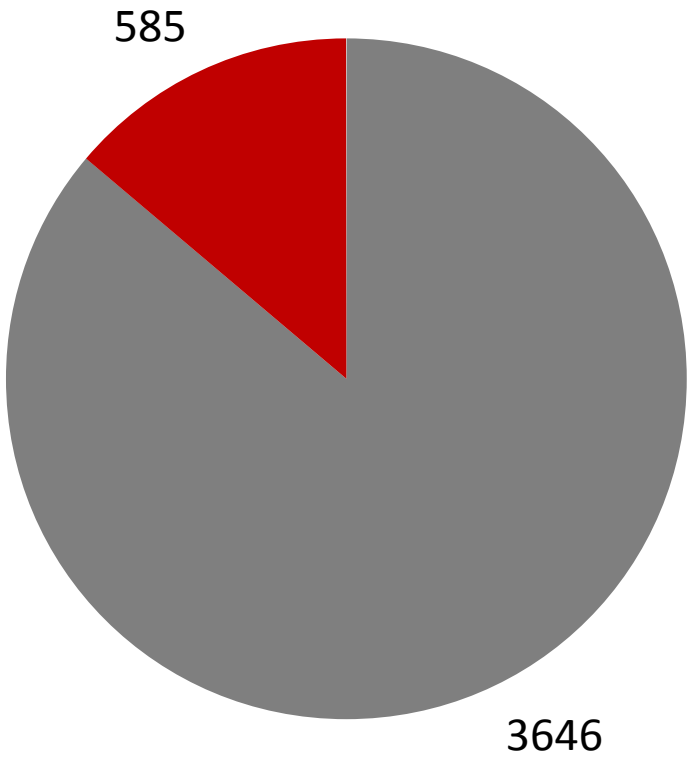
- MEDSIS:
  - Healthcare professionals
  - Healthcare facilities
  - Medical Examiners
- AZ-PIERS
  - Emergency Medical Services
  - Law Enforcement Officers
- CSPDMP
  - Pharmacies

Emergency Rulemaking

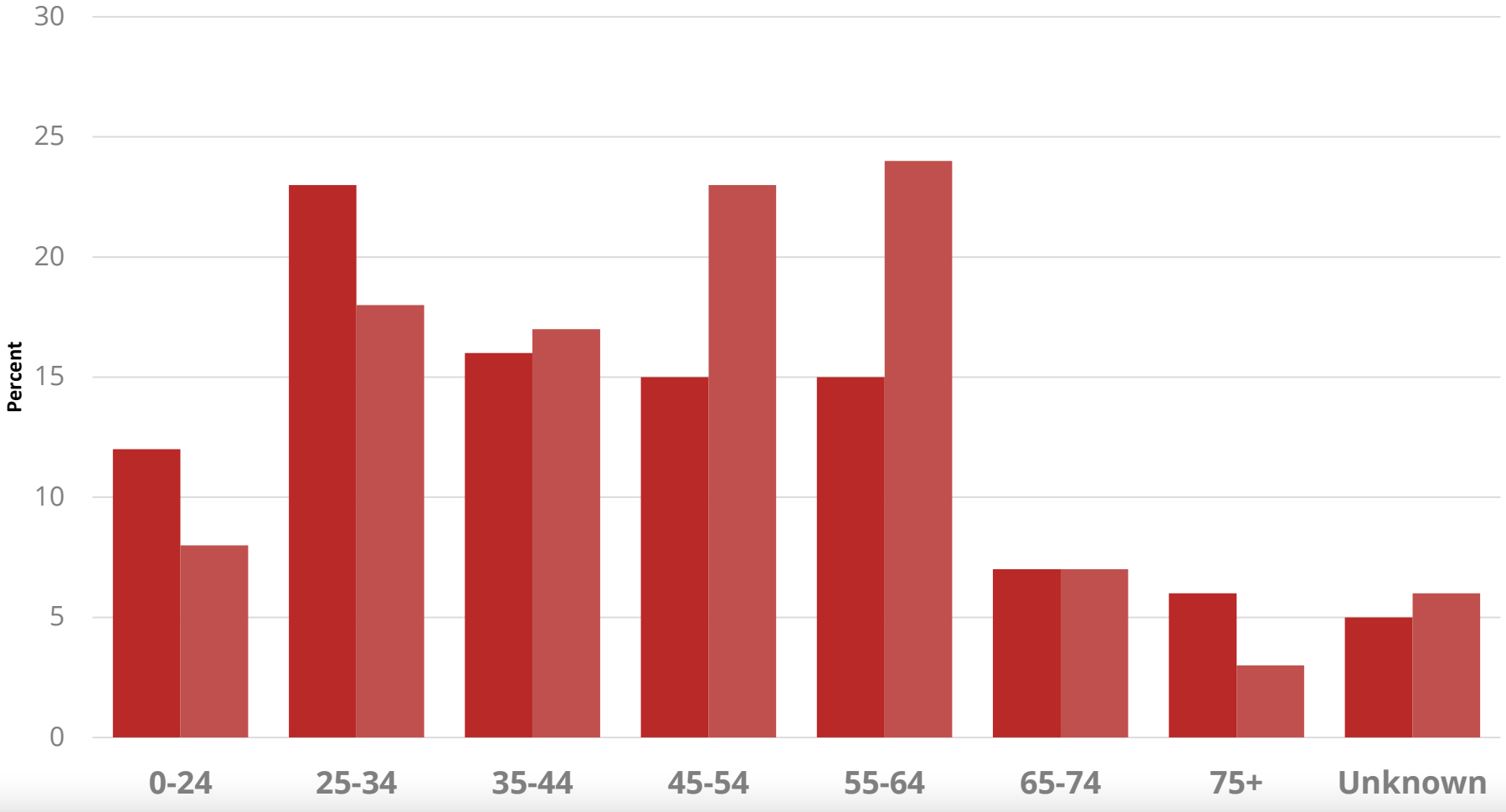
- Emergency Rule Making:
  - Amended the rules in 9 A.A.C. 4 (Non-Communicable Disease Reporting) to include a new Article for Opioid Poisoning-Related Reporting
  - Added clinical laboratory reporting of positive urine drug tests to MEDSIS
  - Same reporting as enhanced surveillance but extended reporting time frame from **24 hours to 5 business days**

What Does The Data Show?

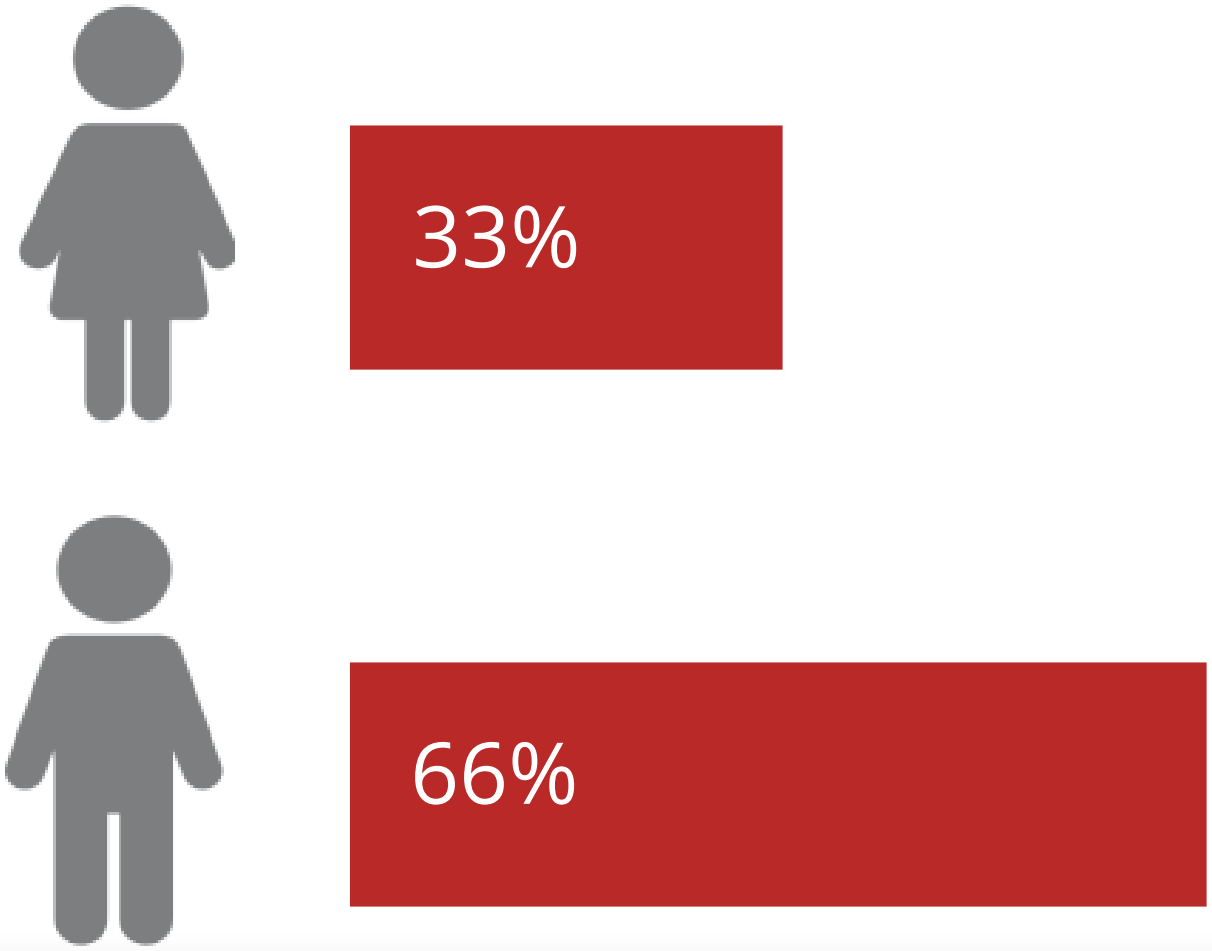
14% of the suspect opioid overdoses were fatal



The majority of fatal opioid overdoses reported during the enhanced surveillance period were in the 45 – 64 age group.

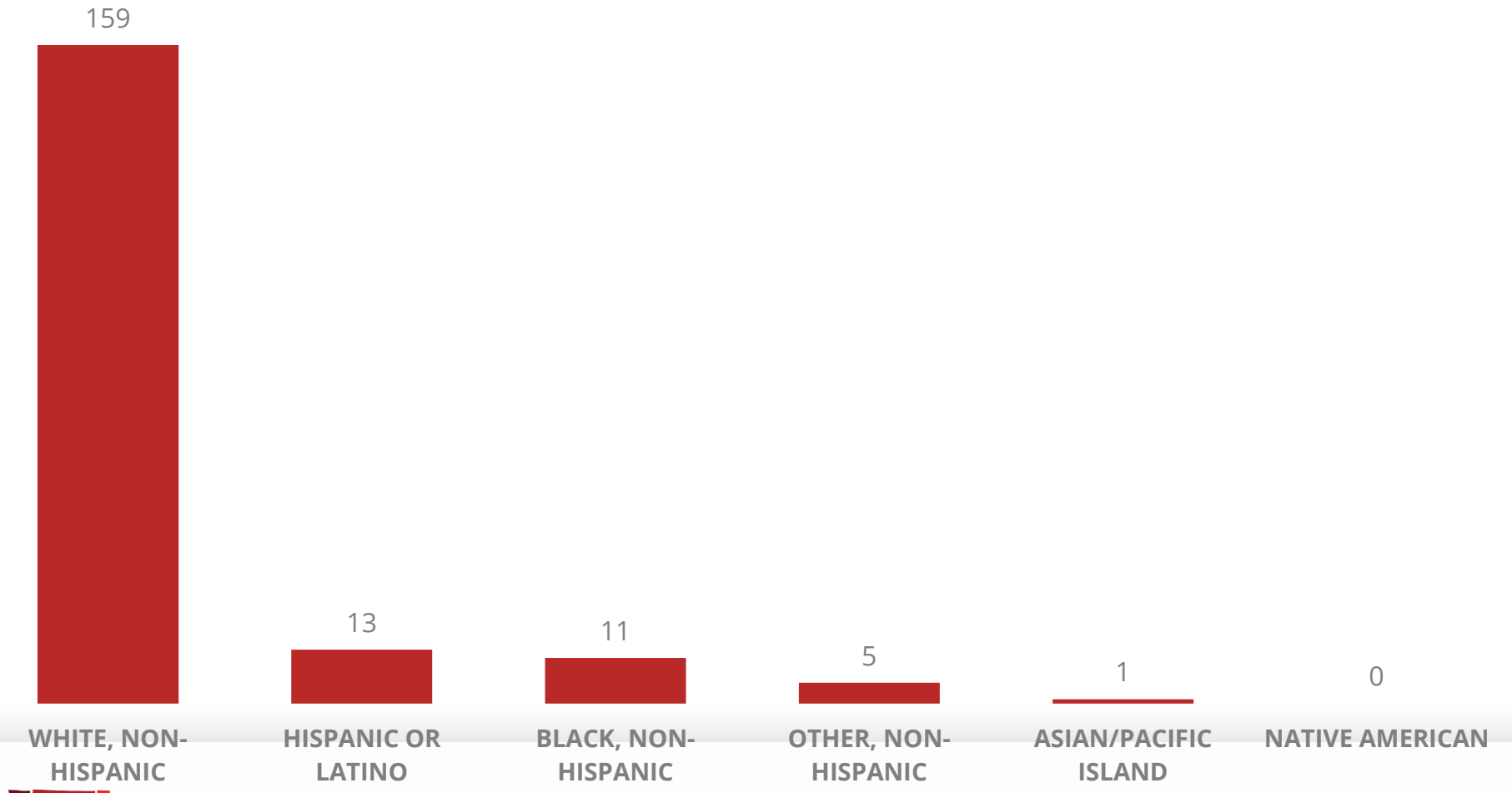


The majority of fatal opioid overdoses reported during the enhanced surveillance period were male.

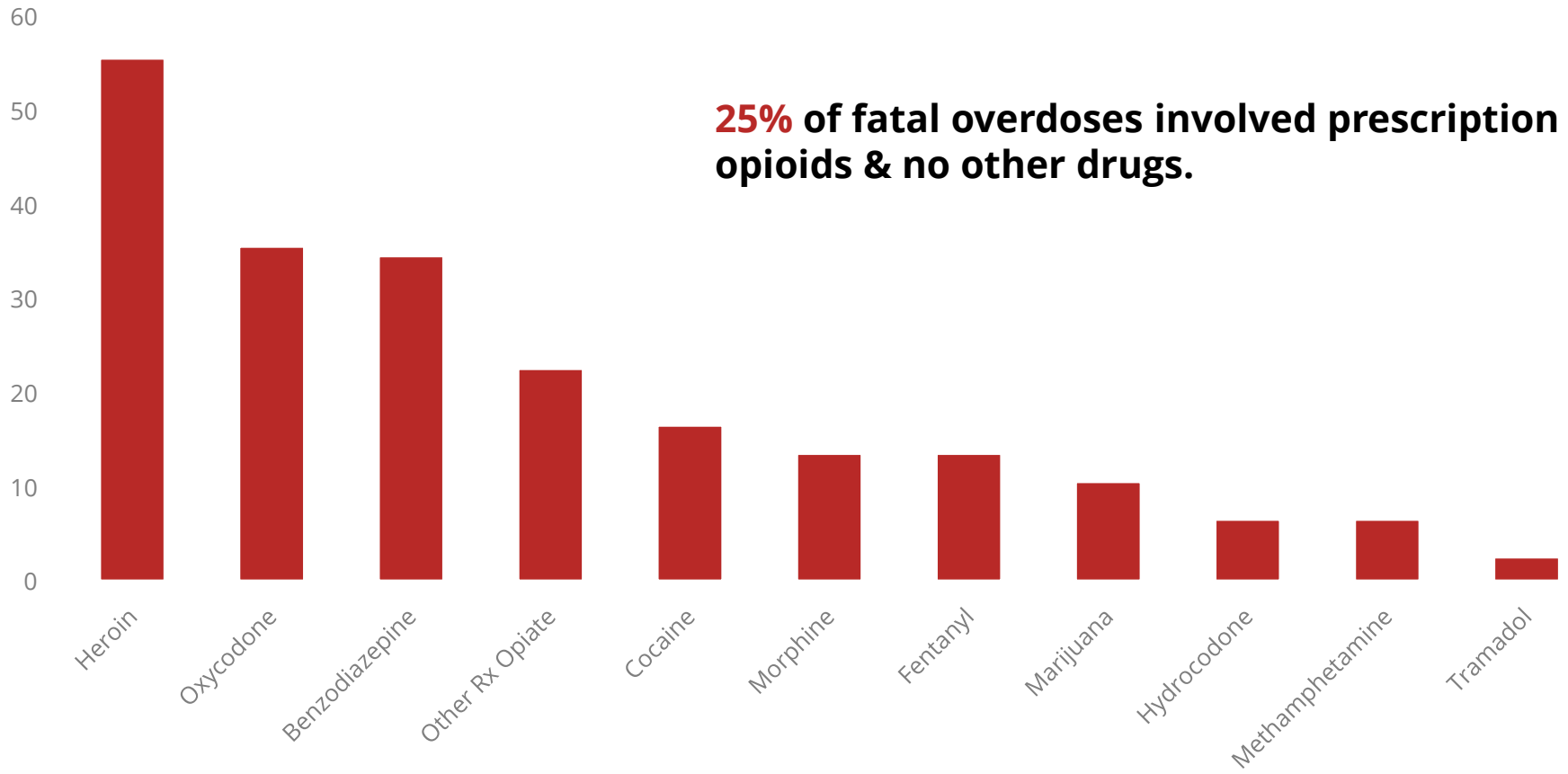


The majority of possible opioid overdoses reported during the enhanced surveillance period were white, non-Hispanic.

364 (63%) of cases did not have information about race/ethnicity available.



55% of individuals with a possible opioid overdose used at least one prescription opioid



25% of fatal overdoses involved prescription opioids & no other drugs.

Opioid Overdoses & Deaths

- **Of those hospitalized with an opioid –related cause in 2016, 12% resulted in a fatal overdose during the most recent overdose.**
- **38% of those with prescription for opioids in the two months prior to their overdose had a fatal overdose**
- **In cases where intent is known, 29% were suicides**
- **92% of fatal cases had a pre-existing condition (e.g. chronic pain, mental health diagnosis)**

ADHS Efforts

- June 5th Emergency Declaration
- Established enhanced surveillance
- Updating prescribing guidelines
- Rules for reporting and licensed facilities
- Naloxone program for law enforcement
- Laboratory testing process
- Improve access to treatment
- ED discharge

Opioid Action Plan: Opioid Overdose Epidemic Response Report

OPIOID EPIDEMIC RECOMMENDATIONS

Goals	Recommendations
Reduce Opioid Deaths	Enact legislation that impacts opioid deaths by reducing illicit acquisition and diversion of opioids, promoting safe prescribing and dispensing, decreasing the risk of opioid use disorder, and improving access to treatment
Improve Prescribing and Dispensing Practices	Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues
	Establish a task force to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Programs (CSPMP)
Reduce Illicit Acquisition and Diversion of Opioids	Meet with leaders of law enforcement and first responder agencies to expand Angel Initiative and other OUD diversion programs and assist the DEA with filling vacancies in the DEA Tactical Diversion Squad

OPIOID EPIDEMIC RECOMMENDATIONS

Goals	Recommendations
Improve Access to Treatment	Require all undergraduate and graduate medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum
	Create a call-in line resource to provide consultation to prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder
	Establish through executive order a work group to identify, utilize, and build upon Arizona's existing peer recovery support services
	Convene an Insurance Parity Task Force to research and provide recommendations regarding parity and standardization across the state
	Engage the federal government outlining necessary federal changes to assist Arizona with our response to the opioid epidemic
	Increase access to naloxone and Vivitrol for individuals leaving state and county correctional institutions and increase access to MAT therapy for individuals with opioid-use disorder while incarcerated

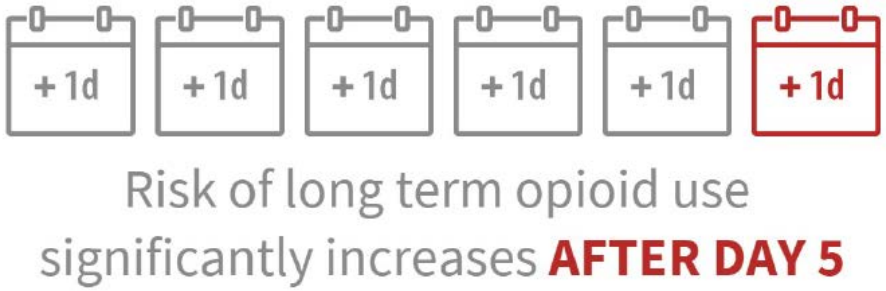
OPIOID EPIDEMIC RECOMMENDATIONS

Goals	Recommendations
Prevent Opioid Use Disorder/ Increase Patient Awareness	Utilize Public Service Announcements to educate patients, providers and the public regarding opioid use and naloxone
	Create a youth prevention task force to identify and implement evidence based, emerging and best practice substance abuse prevention/early identification curriculum, expand after-school opportunities, and identify resource needs.

OPIOID EPIDEMIC RECOMMENDATIONS

Recommendation: Enact legislation

- ✓ **Impose a 5 day limit on all first fills for opioid naïve patients for all payers**



- ➢ According to the Centers for Disease Control and Prevention (CDC), for a prescription for acute pain, **three days or less** is often enough, and more than seven days is rarely needed.

- ✓ **Require a limit (and tapering down) of doses to less than 90 MME**

- ➢ A dose of 50 MME or more per day **doubles** the risk of opioid overdose death, compared to 20 MME or less per day. At 90 MME or more, the risk increases **10 times**. Even at low doses, taking an opioid for more than 3 months increases the risk of addiction by **15 times**.

https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s_cid=mm6626a4_w

OPIOID EPIDEMIC RECOMMENDATIONS

Recommendation: Enact legislation

- ✓ **Require e-prescribing for Schedule II controlled substance medications**
  - Only **8.5%** of prescribers are currently enabled to e-prescribe controlled substances in Arizona
- ✓ **Eliminate dispensing of controlled substances by prescribers**
- ✓ **Require pharmacists to check the CSPMP prior to dispensing**
- ✓ **Change exemption on checking the CSPMP to match the 5 day fill limit; exempt for prescriptions of 5 days or less**
- ✓ **Regulate pain management clinics to prohibit "pill mill" activities**

IMPROVE THE CSPMP

25% of prescribers that wrote a prescription for opioids checked the Controlled Substances Prescription Monitoring Program (CSPMP).

DECREASE CSPMP EXEMPTIONS

41% of overdoses with a prescription for opioids had 10 or more prescribers in the past year.

IMPLEMENT A LAST LINE OF DEFENSE

Despite a black box warning, 43% of overdoses with a prescription had a combination of opioids and benzodiazepines prescribed. Pharmacists are not required to check the CSPMP prior to dispensing.

OPIOID EPIDEMIC RECOMMENDATIONS

Recommendation: Enact legislation

- ✓ **Enact a good Samaritan law to allow bystanders to call 911 for a potential opioid overdose**
- ✓ Require at least 3 hours of opioid-related CME for all professions that prescribe/dispense opioids
- ✓ Require different labeling and packing for opioids (“red caps”)
- ✓ Establish authority for hospice providers to properly dispose of opioids to prevent diversion
- ✓ Establish an all payers claim database
- ✓ Change law enforcement authority to ensure clear enforcement capabilities
- ✓ Establish enforcement mechanisms for pill mills and illegal opioid dispensing
- ✓ Eliminate or decrease the amount of time a prior authorization can take
- ✓ Require licensed behavioral health residential facilities and recovery homes to develop policies & procedures that allow individuals on MAT to continue to receive care in their facilities

OPIOID EPIDEMIC RECOMMENDATIONS

Recommendation: **Engage the federal government** to discuss the necessary federal changes to assist Arizona with our response to the opioid epidemic

- ✓ Remove the IMD exclusion to allow facilities to receive reimbursement for substance abuse treatment
- ✓ Allow Medicaid to pay for substance abuse treatment in correctional facilities
- ✓ Amend the Controlled Substances Act to require all DEA registrants to take a course in proper pain treatment and opioid prescribing
- ✓ Remove the pain satisfaction score completely from the CMS HCHAP score
- ✓ Require CMS and accreditation organizations to re-examine pain management conditions and standards

OPIOID EPIDEMIC RECOMMENDATIONS

Recommendation: **Engage the federal government** to discuss the necessary federal changes to assist Arizona with our response to the opioid epidemic.

- ✓ Require accreditation organizations of schools to ensure standards are implemented on MAT, SBIRT, naloxone, pain management
- ✓ Provide funding and resources to border states to assist law enforcement in preventing illegal supply and distribution of opioids
- ✓ Remove CFR 42 Part 2 reporting restrictions, and require facilities to meet HIPAA requirements
- ✓ Require federal entities to input data into states' prescription drug monitoring programs
- ✓ Require federal entities to submit required reporting to state and local public health authorities
- ✓ Require federal health care facilities to maintain state licensure

OPIOID EPIDEMIC RECOMMENDATIONS

Recommendation: Convene an **Insurance Parity** Task Force to identify recommendations to ensure prevention of opioid use disorder, adequate access to care for **substance abuse** and **chronic pain management** and decreased barriers to care are available across all Arizona health insurance plans.

- ✓ Identify opportunities to incentivize providers for screening & educating patients on substance abuse and opioid use disorder
- ✓ Incentivize plans to pay for Medication Assisted Treatment (MAT)
- ✓ Identify standard substance abuse treatment requirements for children under 18
- ✓ Develop & implement value-based incentives for implementation of pain management strategies
- ✓ Incentivize use of interdisciplinary pain management programs
- ✓ Prohibit fail-first protocols and prior authorization requirements

Next Steps

- Discussion on what model makes the most sense
- Frequency of meetings
- Required Quorum
- Designated delegates

THANK YOU