Data to Action through Public Health and Public Safety Partnerships: OFR-PHAST

COSSUP Webinar
August 2023

OFR-PHAST

A data-driven response for community change

OFR Overdose Fatality Review

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Value of Multi-sector Teams

- Facilitate a deeper understanding of the potential opportunities for prevention and intervention that may have prevented an overdose death
- See patterns of needs and opportunities, not only within specific agencies, but across systems
- Local jurisdictions develop program and policy recommendations to collaborate between agencies at the local level and improve community conditions to prevent future overdose deaths
- Share responsibility and accountability to implement recommendations

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GUIDING PRINCIPLES

- A common goal of reducing overdose deaths
- Recognition that substance use disorders are chronic and treatable diseases
- Drug overdose deaths are preventable
- Responsible use of multi-sector data to inform response strategies
- Continuous improvement

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SOS PROCESS

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Multidisciplinary Teams Use of Data for Action

Analysis and review of aggregate data to understand the local overdose landscape, provide context for cases and aid in case selection for OFRs, identify gaps overdose prevention services and make recommendations.

A series of confidential individual death reviews by a multidisciplinary team to identify system gaps and innovative community-specific overdose prevention and intervention strategies

Strategize and present recommendations to governing committee that supports and provides resources to ensure implementation and creates a framework for accountability

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PARTNERSHIP

- ✓Visible and vocal champions
- ✓Diverse partnership engagement
- ✓Provide quality services
- ✓Consistent participation
- ✓Good stewards of data

Multi-sector Partners

- Public health
- Behavioral health
- Treatment and recovery services
- Harm reduction
- Child and Family Services
- Healthcare
- Law enforcement
- Criminal justice
- Fire and EMS
- Housing services
- Medical examiner/coroner

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Important Partnership Elements

1. Having a neutral agency to lead coordination
2. Recruiting the right people to the table
3. A strong facilitator to bridge between the agencies
4. Building trust between partners and balancing power
5. Taking action and accountability
6. Showing value in partnership

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OFR-PHAST Lead Agency

An OFR-PHAST lead agency can be the local health department, human services department, prevention coalition, or other local agency and is seen as a neutral agency; typically, this agency is already involved as a leader in responding to the overdose epidemic.

The OFR-PHAST lead agency oversees the OFR-PHAST teams by providing administrative support to fulfill three key leadership roles:

- **Facilitator**
- **Coordinator**
- **Data Analyst**

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OFR-PHAST Staff Team Roles

Program Coordinator

- Primary point of contact for team
- Manage administrative and day to day activities of team
- Obtain case information from team members and do additional research when appropriate
- Review data and reports from team members
- Draft meeting agendas in collaboration with facilitator
- Document activities and track progress between meetings

Facilitator

- Facilitate meetings
- Recruit team members
- Build and maintain relationships with team members
- Orient new team members
- Draft meeting agendas in collaboration with facilitator

Data Analyst

- Analyze case specific and aggregate data
- Create and present data reports for teams and governing committee
- Lead discussions on data interpretation
- Needs, limitations, and gaps
- Enter case information and recommendations into database

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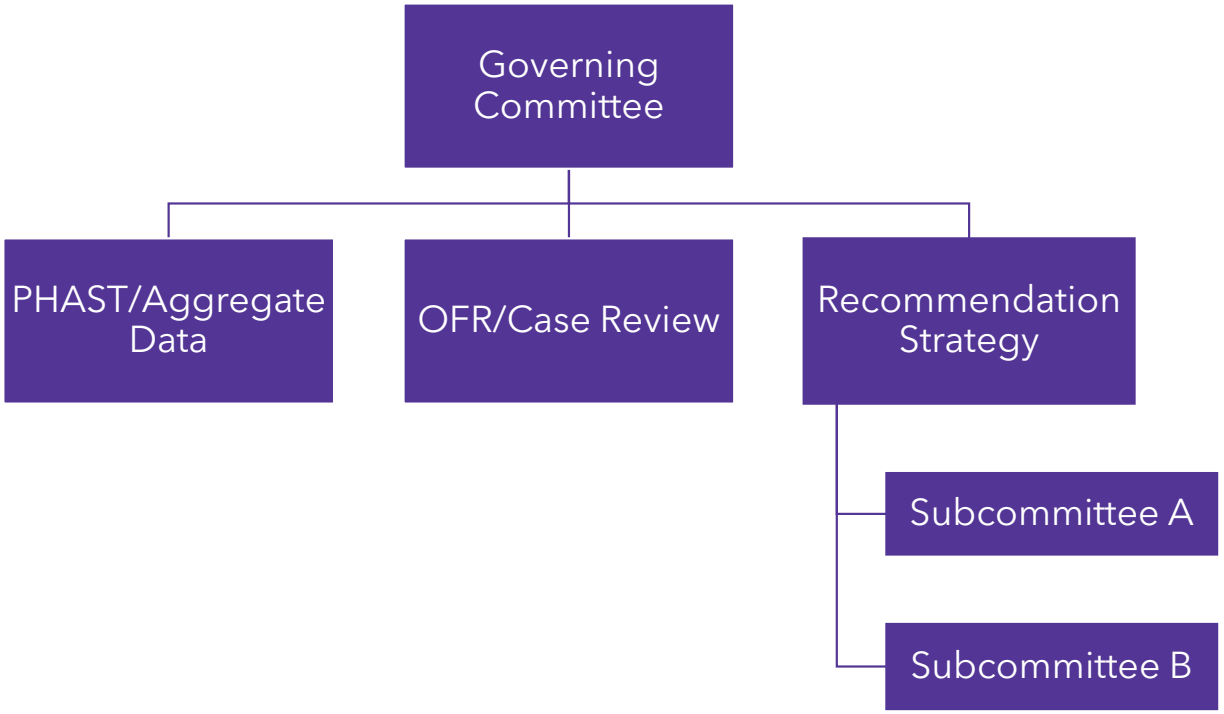
OFR-PHAST Structure



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PHAST- Aggregate Data

Analysis and review of aggregate data to understand the local overdose landscape, provide context for cases and aid in case selection for OFRs, identify gaps in overdose prevention services and make recommendations.

Examples:

- Geographical neighborhoods with high rates of overdose deaths
- Recent spike in nonfatal overdoses
- Populations with recent increases in deaths
- Substances involved in most recent overdose deaths
- Populations with known system interactions

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OFR – Case specific data

OFRs involve a series of confidential individual death reviews by a multidisciplinary team to identify system gaps and innovative community-specific overdose prevention and intervention strategies

Examples:

- Individual demographics
- Death-scene investigation
- History of life circumstances and immediate stressors before overdose
- Mental health history
- Information from family members
- Interactions with police; criminal legal system
- Medical examiner information
- Community context

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Recommendation Strategy Committee

The bulk of the work of an OFR happens outside of the aggregate and case review meetings.

Identify community specific facilitators and barriers for proposed interventions, prioritize, and develop work plans, prep for governing committee proposal/ask.

These recommendations are presented to a governing committee that supports and provides resources to ensure implementation and creates a framework for accountability.

Subcommittee membership may include members of the governing committee, OFR or PHAST team, outside experts, or those with lived and living experience.

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Governing Committee

Governing committee is composed of senior-level (decision makers) representatives of city, county, and state agencies and community partner organizations from community, health care and public safety

Committee to provide leadership and support for implementing recommendations identified through the OFR process

May be an already existing local drug prevention task force or may be formed solely to support the OFR initiative

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Example

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PHAST—Aggregate Data

Analysis and review of aggregate data to understand overdose trends, select cases to review, and provide context for case findings and recommendations.

- Recent research have highlighted the increase in overdose deaths among individuals recently released from corrections
- There has been an increase in fentanyl related overdoses
- Recent spike in nonfatal overdoses (e.g., Overdose Mapping Application Program (ODMAP) naloxone administrations)
- Northside neighborhood continues to have fatal and nonfatal overdoses almost twice the city's average
- Males overdose date is greater than females

OFR Agenda

1. Opening Remarks and Introduction
2. Goals and Ground Rules
3. Confidentiality
4. Case Presentation
5. Member Report-Outs (reverse chronological)
6. Group Discussion
7. Case and Timeline Summarized
8. Formulate Recommendations
9. Summarize and Adjourn

Opening Remarks and Introduction

Members' introduction and ice breaker

- Names, titles and their agencies' names and roles in preventing overdose fatalities
- Favorite dad joke

Updates from previous meeting

- Share updates on delegated action items or recommendations from previous meetings.
- Aggregate data (sheriff's office) showing an uptick in overdoses in neighborhoods in the 46038 area. Emergency medical service (EMS) aggregated data confirms same spike. County health department received grant dollars to distribute NaloxBoxes and will be working with sheriff/EMS to distribute in high-risk areas.
- Local nonprofit provided free training to all probation officers. Probation has modified screening services with clients; now using screening, brief intervention, and referral to treatment (SBIRT).

Upcoming events

- Naloxone training at city library on Saturday mornings throughout July from 9 a.m. to 12 Noon

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Opening Remarks and Introduction

Data presentation

- Present aggregate date (e.g., sheriff, EMS, coroner and drug-seizure data)
  - Annually, review the prior year's fatal and nonfatal overdoses
  - At each meeting, present year-to-date aggregate data and data since the last meeting

Review case selection criteria

- Recent research publication highlighted the increased risk of overdose post-release from prison
- High-risk population—recent release from prison

Other announcements

- Posting position for a harm-reduction specialist

Goals and Ground Rules

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- Be on time—at the beginning of the meeting and coming back from breaks.
- Raise your hand if you have something to say. Only one person speaks at a time.
- Listen actively to what other people are saying.
- Be respectful—no mocking or attacking other people's ideas.
- See all members as equal. Avoid favoring members with leadership titles.
- Maintain and protect confidentiality.
- Use appropriate and sensitive language when discussing the case.
- Use person-first language, such as "a person who uses drugs" versus "an addict."
- Avoid judging the decedent's decisions. Try to understand the decedent's experience through his or her eyes.
- Consider all factors that contributed to the decedent's substance use and overdose.

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Confidentiality

Collects members reviewed and signed confidentiality forms and answers any related questions.

Reminds team members that the meeting is closed, and that the information shared in the meeting shall not be discussed outside the meeting, as outlined in the agreements they have signed.

Case Presentation

Presents the case summary developed by the coordinator:

- Name, aliases
- Demographics (age, race, sex)
- Incident location, date, and time
- Obituary summary information
- Pertinent news coverage information
- Relevant social media posts

Decedent: 35-year-old male

DOD: 2/1/22

Cause of death: multi-drug toxicity, fentanyl

Residing at his mom's home (she had no criminal history)

[Read Obituary]

Member Report-Outs

Reverse chronological

Calls on each member to share what he or she knows about the decedent, his or her social connections, and the overdose incident

- Starting with the medical examiner and first-responder agencies to developing an incident timeline

Medical Examiner

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- Decedent staying with mother
- Recently released from prison (two weeks ago)
- Decedent had been drinking the night of his death
- Tetrahydrocannabinol (THC) and an unidentified substance found in the home
- Acute mixed drugs toxicity—Alcohol, THC, and Fentanyl
- Decedent found sleeping in bed and nonresponsive
- Mother called 911
- Two children under the age of five were on the scene, not decedent's children
- No primary care provider
- Mother very upset, was very excited about the son finally home after incarceration

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Public Safety

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EMS

- Narcan was administered twice by EMS
- No Narcan was administered prior to arriving
- Mother was surprised to find the son was using more than alcohol
- Mother did not begin cardiopulmonary resuscitation (CPR) because she didn't think it would help
- Prior EMS dispatch to home for a fall from balcony one year prior (person was intoxicated)

Police

- Prior visits to the mother's home for noise disturbance (mother's boyfriend)
- Mother had no prior criminal charges
- Unknown substance at the scene—mother stated she didn't know where the son got it
- Assumed he was drinking and smoking marijuana

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Corrections

- Decedent released from prison two weeks prior to his death
- Had been in prison for eight years due to drug charges (drug charges stemmed from having smuggled heroin into the county jail)
- Graduated from an Earned Release Program (ERP) which was a year long–cognitive behavior therapy curriculum
- On parole and had four contacts with agent since discharge from institution
- Release plan did not include linkage to care to treatment

Juvenile Justice System Data

Decedent went to jail at age 18 and had 20 subsequent jail stays—none were drug-related until recently

Juvenile data on decedent

- Over two years, had 15 incidents during that time (which is a high number) with county services
- Runaway, theft, burglary, drug-related
- Went to treatment at Woodloch School, a secure juvenile correctional facility for youth (three-month program), state corrections

Other Data Sources

- No child protective services data
- No Prescription Drug Monitoring Program (PDMP) data
- No recent emergency department (ED) visits

Next-of-Kin Interview with Sister

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- Decedent has one full sister.
- Graduated from high school with truancy issues.
- Dad in Illinois not really a part of his life.
- Mom remarried to decedent's stepdad.
  - Two kids (half siblings of decedent).
    - One of these individuals (half-brother) died in 2017 of an overdose at age 24.
  - Decedent and his sister felt they were treated poorly by stepdad when compared to the kids' mom and stepdad had together.
    - Decedent experienced verbal, emotional, and physical abuse in childhood by stepdad.
    - Stepdad participated in anger management.
- Mom divorced stepdad a few years ago and was dating a new guy who seemed to treat her right and was kinder to decedent and his sister, but not very involved.
- Decedent was excited to be out of prison, wanted to start a new business repairing bikes.
- Was trying to reconnect with old friends prior to prison; was having a hard time transitioning back to life outside of prison.

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Case Discussion

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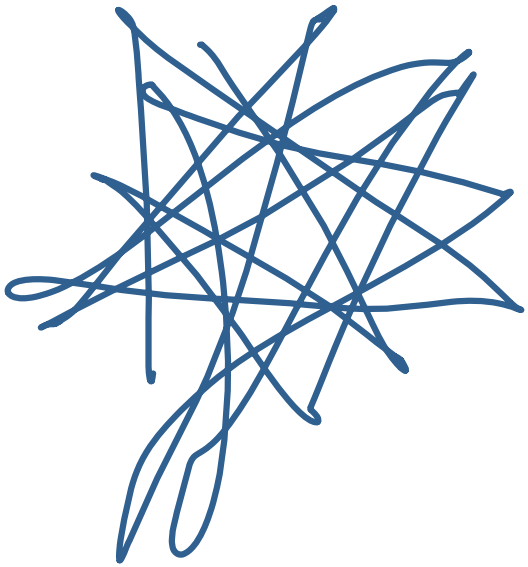

Actively guides the group discussion by encouraging members to ask questions. The group discussion will clarify the timeline of significant life events and identify missed opportunities for prevention and intervention.

*This would happen while the discussion is happening.

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Case and Timeline Summarized

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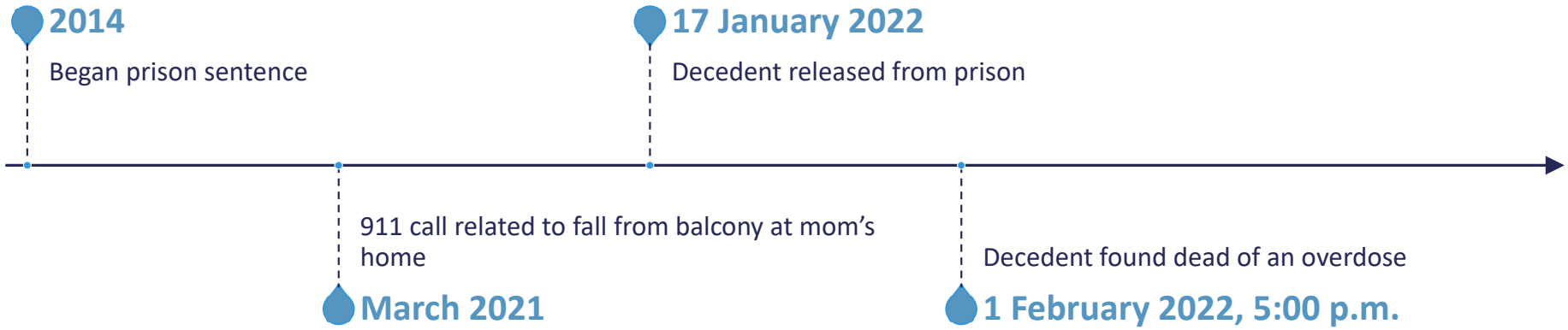
Summarizes significant case information and draws a timeline of key activities, ideally on a whiteboard.



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Complete History Timeline

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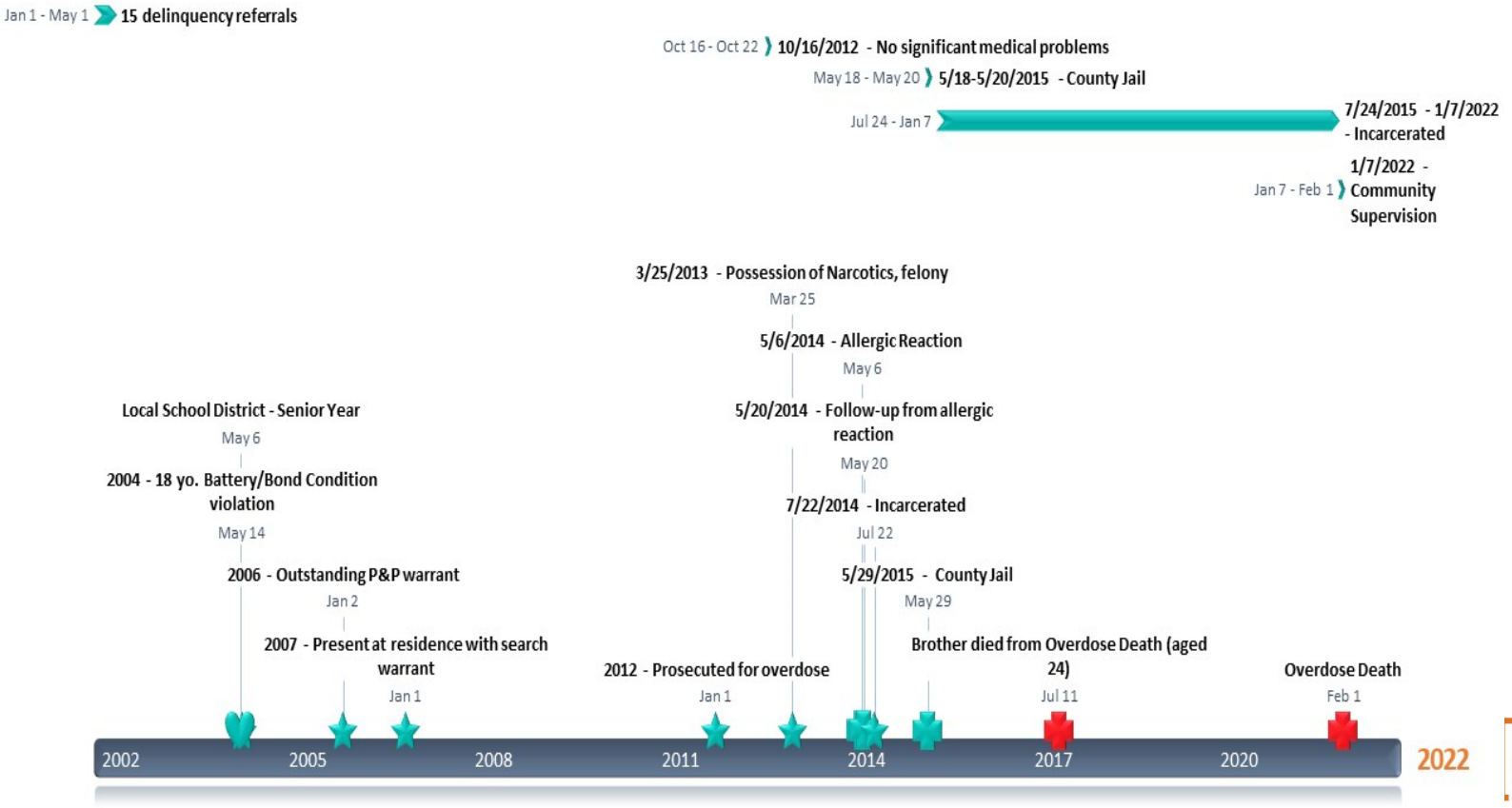

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Missed Opportunities and Recommendation Ideas

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- No Narcan on site
- CPR not administered
- Education on signs of overdose-agonal breathing was thought to be snoring
- Education about what substance-use individuals need upon prison release-harm reduction
- No linkage to treatment in release plan
- Resources upon release (24–48 hrs.)
- Interventions upon release from incarceration
- Reintegration services
- Peer-recovery connection upon release-relationships built prior to release from institutions
- Youth who are transitioning to adult systems
- Education on the potency of drugs and what can be done from a harm-reduction perspective
- Half brother and decedent funerals were at the same funeral home–consider services for family
- "Bridging the Gap" 12-step recovery model for reaching into incarcerated individuals prior to discharge
- Child Protective Services (CPS) not called for kids who were at the death scene

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Summarize Recommendations for Action

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- Treatment and linkage to care following incarceration
- Services for individuals transitioning from the youth systems to the adult systems (all new providers, services, and expectations) on how to connect to treatment and supports
- Reintegration services upon release from incarceration
  - Government phone that does not contain old contacts
  - *Very* vulnerable time for individuals with substance-use issues
- Release planner in the jails/prisons to assess the needs of those being released from institutions
- Provide naloxone upon release and training for families on signs of an overdose
- Better understand what is done for children at scene of an overdose

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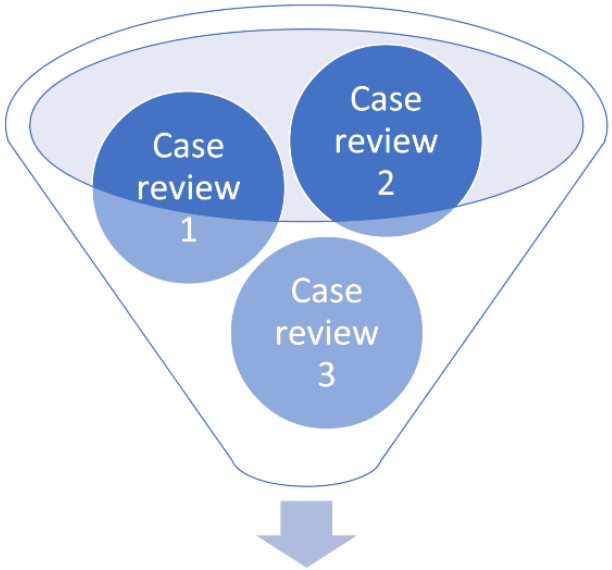
Case Review ⟶ Recommendations ⟶ Action



Example: Two more cases were reviewed at the meeting. None of the three cases had release plans included nor naloxone or family training on risk of using substances post-release.

Recommendation: How often do people get a release plan that includes reintegration services or naloxone and training? ***(Tasked to the PHAST team)***

Recommendations to Action

Recommendations workgroup will meet in two weeks to review existing local standard operating procedures (SOPs) for release from prison and jail and best practice to refine identified recommendations and develop an action plan for implementation.

The data analyst will bring information about the number of release plans that included reintegration plans and/or naloxone training.

Once an action plan has been formulated, the aggregate data, case findings, and recommendations will be presented to the governing committee.

Summarize and Adjourn

Members reflected on how the meeting went.

Recommendation to include additional aggregate data on individuals released from prison and jail with a substance use disorder (SUD).

Case information and recommends will be updated in the OFR Data System.

Hand in all paperwork with confidential information.

Reminded members of confidentiality.

It is a beautiful day out—consider taking a walk or doing something to process/decompress from this meeting before jumping back into emails and other meetings.

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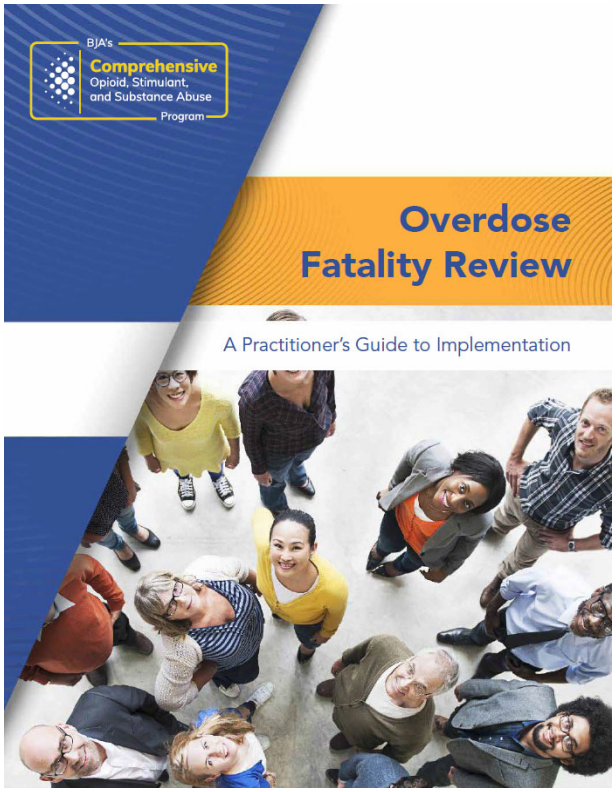

The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

QUESTIONS?