Overdose Fatality Review Manual

Ohio Department of Health

RECOVERY Ohio

Table of Contents

Acknowledgments

Through the process of local reviews, communities and the state recognize that the circumstances involved in most drug overdose deaths are complex, multidimensional, and require partnerships and multi-sector collaboration at all levels. The Ohio Department of Health (ODH) and local partners from across the state worked together to create robust guidance that can be used to ensure that important key factors are being considered when establishing and facilitating local drug overdose fatality reviews in Ohio.

Governor Mike DeWine's first action as Ohio's Governor was the creation of the RecoveryOhio initiative to provide actionable recommendations to improve mental health and substance use prevention, treatment, and recovery support services. Through the collaborative work of the RecoveryOhio team and ODH, legislation was passed in 2021 to support and protect currently acting and newly established drug overdose fatality review committees in Ohio.

Introduction

Ohio has experienced a dramatic increase in unintentional drug overdose deaths during the past decade. Fatalities increased approximately 161 percent from 1,544 unintentional drug overdose deaths in 2010 to 4,028 in 2019.[1] There were 36.4 unintentional drug overdose fatalities per 100,000 people in 2019.[1] In 2007, unintentional drug poisoning became the leading cause of injury death in Ohio and the trend continued through 2019.[2]

The Centers for Disease Control and Prevention (CDC) describes the opioid epidemic in three waves: prescription opioids, heroin, and illicitly manufactured fentanyl.[3] Increased prescribing of opioids in the 1990s contributed to an increase in overdose deaths due to prescription opioids (natural and semi-synthetic opioids).[3] Heroin-involved overdose deaths were nearly five times higher in 2019 than in 2010.[4] Increases in overdoses involving synthetic opioids, specifically illicitly- manufactured fentanyl began in 2013 and fentanyl continues to be used in combination with heroin, pills, and cocaine. The rate of overdose deaths involving synthetic opioids, including fentanyl, from 2018 to 2019 increased by 16 percent in the United States.[5]

Ohio's opioid epidemic continued to evolve in 2019 as stronger drugs lead to an increase in unintentional overdose deaths. The data show a significant increase in overdose deaths involving the opioid fentanyl, the emergence of more powerful fentanyl-related drugs like carfentanil and indications that cocaine was used with fentanyl and other opiates. In 2019, Ohio had the fewest unintentional overdose deaths involving prescription opioids (natural and semi-synthetic opioids) since 2010. Fentanyl and related drugs were involved in 76.2 percent (3,070) of all unintentional drug overdose deaths in 2019 compared to 72.6 percent (2,733) in 2018, 70.7 percent (3,431) in 2017 and 58.2 percent (2,357) in 2016.[1]

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[1]*Ohio Department of Health (2019). Ohio Drug Overdose Data: General Findings. Retrieved from: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/core-violence-injury-prevention-program/media/2019+ohio+drug+overdose+report.*

[2]*Ohio Department of Health (2021). Ohio Drug Overdose Webpage. Retrieved from: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/violence-injury-prevention-program/Drug-overdose/.*

[3]*CDC (2021). Understanding the Epidemic. Retrieved from: https://www.cdc.gov/drugoverdose/epidemic/index.html.*

[4]*CDC (2021). Opioid Basics – Heroin. Retrieved from: https://www.cdc.gov/drugoverdose/opioids/heroin.html.*

[5]*CDC (2021). Opioid Basics – Fentanyl. Retrieved from: https://www.cdc.gov/drugoverdose/opioids/fentanyl.html.*

What is an Overdose Fatality Review (OFR)?

An OFR is a valuable tool for the prevention of drug overdose deaths in a community by strengthening systematic responses. The multidisciplinary team meets to share and discuss, in a focused and nonjudgmental way, comprehensive information about the circumstances leading to an unintentional overdose death and the response to that death. Review of the deaths by an OFR team allows for a more comprehensive understanding of the circumstances surrounding the deaths through the consolidation of multiple data sources such as death certificates; coroner/medical examiner scene investigations and toxicology; medical history, including controlled prescription drug usage; mental health and other treatment information; and law enforcement information. Results from the data presented and discussed at OFR meetings can be used to identify trends and patterns, recommend programmatic or policy changes and inform the work of prescribing healthcare providers, law enforcement, public health and mental health providers to reduce drug overdose deaths in the community.

There are many types of fatality reviews from which guidance for OFRs can be drawn: Child Fatality Reviews (CFR), Maternal Mortality Reviews, Domestic Violence Fatality Reviews (DVFR), Elder Abuse/ Vulnerable Adults Fatality Reviews, Disability Reviews, Citizens Review Panels, and Department of Defense/Military Reviews.[6] This manual takes guidance from CFRs and DVFRs.

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[6]*National Center for Child Death Review (2005). A Program Manual for Child Death Review. Coordinating with Other Reviews. Retrieved from: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf.*

Purpose

Understanding the spectrum of circumstances/factors of these deaths through an OFR may help prevent future deaths, particularly as the epidemic continues to evolve. Identifying current and evolving trends in a timely manner can help ensure that appropriate recommendations are made to prevent future deaths from overdose. For example, prevention strategies or policy changes that are recommended when unintentional overdose deaths are related to prescription drugs may be very different than prevention strategies and policy changes that are recommended when these deaths are related to illicitly—manufactured fentanyl.

The purpose of an OFR committee is to decrease the incidence of preventable overdose deaths by doing the following:

- Promote cooperation, collaboration, and communication between all agencies engaged in drug abuse prevention, education, or treatment efforts.
- Maintain a comprehensive database of all overdose deaths that occur in the county served by the review committee to develop an understanding of the causes and incidence of those deaths.
- Recommend and develop plans for implementing local service and program changes and changes to entities that serve local residents and might prevent overdose deaths.
- Provide the department of health with aggregate data, trends, and patterns concerning overdose deaths.

The purpose of this manual is to encourage the development of a network of OFR programs throughout Ohio, each with the flexibility to address local needs while also providing consistent data that can be aggregated and used to formulate recommendations for systems change at the state level. The manual describes strategies for developing, implementing, managing and evaluating a successful OFR program. Suggestions are offered for conducting effective reviews and making recommendations from the results of the OFR data analysis to prevent future deaths. It is meant to serve as a foundation. It should be adapted locally. Each chapter contains information about a specific aspect of the review process. The appendices include sample documents to make the process of establishing a team and conducting reviews easier. These documents should also be adapted to meet the needs of each specific community. The structure of this manual is modeled after "A Program Manual for Child Death Review"[6] and "Domestic Violence Fatality Review: A Best Practices Guide for the Development and Administration of Local Domestic Violence Fatality Review Teams."[7]

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[6]*National Center for Child Death Review (2005). A Program Manual for Child Death Review. Coordinating with Other Reviews. Retrieved from: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf.*

[7]*Pennsylvania Coalition Against Domestic Violence (2011). Domestic Violence Fatality Review A Best Practices Guide for the Development and Administration of Local Domestic Violence Fatality Review Teams.*

Objectives and Principles

OFR teams are convened to decrease the incidence of overdose fatalities by promoting collaboration between those serving individuals with substance use disorder, collecting and analyzing data, and developing recommendations to reduce the incidence of overdose deaths. OFRs are designed and used with the following objectives and principles in mind.

Objectives

- Improve communication between local and state agencies to enhance coordination efforts.
- Analyze system responses to overdoses within a community to better understand the experiences of persons with substance use disorder, identify points of contact between the decedents and local agencies, and identify improvements to policies and practices that may prevent overdose death.[8]
- Accurately identify and consistently report the circumstances surrounding unintentional overdose deaths and the systems the decedents encountered prior to an overdose.
- Analyze aggregate data to identify trends and patterns of overdose deaths, including common circumstances and risk factors preceding fatal incidents and opportunities for strengthening policies and practices that may reduce future fatalities.
- Initiate recommendations to improve overdose investigation, intervention, and prevention. Identify short- or long-term recommendations for changes in local or state statutes, regulations, policies, and procedures to prevent future overdose deaths.
- Improve delivery of services to families, providers and community members following an overdose death.
- Increase public and systems understanding of substance use disorder and overdose death.

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[8]*Websdale, N., Town, M., and Johnson, B. 1999. "Domestic Violence Fatality Reviews: From a culture of blame to a culture of safety." Juvenile and Family Court Journal, May 1999: 61-74.*

Websdale, N. 2003. "Reviewing Domestic Violence Deaths." NIJ Special Research Bulletin on Intimate Partner Homicide.

Websdale, Neil. "Community, civic engagement, and democracy: The case of domestic violence fatality review." National Civic Review 101.2 (2012): 27-33.

Principles

- By having guiding principles in place from the beginning, OFR teams can avoid having to confront potentially contested decisions and can help minimize conflicts and build trust.[9]
- **A fatality review requires multidisciplinary participation** from the community. No single professional group or agency can completely eliminate overdose deaths.
- **A review should lead to an understanding of risk factors.** In addition to a review of aggregate data, in-depth analysis of a small number of cases can provide a window into problems with system response, which may reflect the experiences of others. The circumstances of untimely deaths are likely to be repeated and detailed examination of those deaths can lead to important insights regarding risks, intervention strategies and prevention efforts.
- **Overdose deaths may be prevented through reasonable interventions.** A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths.
- **Systematic methods of inquiry** frame the work of review teams and bring consistency to the process.
- OFR teams should create a standardized data collection form and a case selection policy. This will prevent disagreements among team members over prioritization of certain deaths. Scientific principles of case selection allow teams more confidence in the validity of their results and recommendations.
- While a review of case information should be comprehensive and broad, **team members must adhere to their agencies' data sharing policies as well as state and federal law.**
- It is important for team members to be aware of the limitations of data access to avoid conflict.
- **Consistency in data collection is important** when using data to generalize findings and make prevention and policy recommendations.
- **Team members should be system experts** that can make judgements about the functioning of prevention and intervention systems. It is important that team membership is stable. However, when information needed about a case falls outside of the scope of expertise represented on the team, it is important to invite experts to the team meeting as ad hoc members to provide appropriate information.
- **Recommendations should be based on case review data** and not in support of any particular agency or made to support any particular agenda.

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[9] *American Evaluation Association (2018). Guiding Principles for Evaluators. Retrieved from: https://www.eval.org/About/Guiding-Principles.*

Establishing an OFR Team

Teams must respect the privacy and dignity of decedents, their families and friends, and the OFR review team members and the agencies they represent. Reviews examine details of the overdose victim's life and death as well as how various systems could have influenced the outcome, and team members may represent some of these systems. The multidisciplinary nature of OFRs can result in competing or adversarial agencies working together, and teams can greatly benefit from diverse agency representation. Team members also must strive to understand the mission and perspective of each agency and the constraints they may face. To hold a respectful but candid evaluation of the systems that affected decedents, teams must also consider the impact of review findings and recommendations on the affected population. Teams also must work to reconcile conflicting views on what constitutes "public good" among stakeholders. Benefits to society from system review can be conflicting and difficult to align. For example, recommendations that call for increased incarceration of drug users do not align with the need to address prison overcrowding. OFR teams can address public interest concerns by relying on well-qualified and experienced personnel who recognize the tensions inherent in system change and who advocate for sensible, measured approaches to improvement.

The first step to establishing an Overdose Fatality Review (OFR) team is to determine which agency is going to be responsible for organization and implementation. Any organization willing to commit the time and effort required to form the team and implement the OFR can take the lead. A board of county commissioners may appoint a health commissioner of a city or general health district that is entirely or partially located in the county represented by the board of county commissioners to establish a drug overdose fatality review committee. Once the lead agency has been identified, establishing an OFR team involves identifying appropriate team leadership and membership and developing team governance through a series of organizational meetings.

OFR Team Members

An OFR team is composed of a group of people from many different agencies, organizations and professions that are involved in the life and/or death of a victim of an unintentional drug overdose. This multidisciplinary team works to develop and strengthen a coordinated community response to substance use and unintentional drug overdose to prevent future deaths. The team should be diverse in perspective, expertise, ethnicity and race and should include members who directly serve persons who use drugs and members who are in a position to facilitate policy and procedural change, including those with the authority to formally approve recommendations and allocate resources, such as funding, staff and supplies to support the implementation and continuation of recommendations. The Ohio Revised Code (ORC) §307.632 (A) states that if a health commissioner establishes an OFR committee, the commissioner shall select four additional members to serve that include a county law enforcement official, a public health official, a county board of alcohol, drug addiction, and mental health official, and an authorized physician. The members of the review committee may invite additional members to serve on the OFR committee. The OFR team should be reasonable in size. It is harder to build trust among members, and members might be reluctant to share information, if there are too many people participating. If there is a long list of potential team members, one solution is to only invite persons to attend those meetings in which they can bring relevant information. Effective OFR teams have 15 to 35 members. Typical OFR team members may include:

- Local health department official.
- Local law enforcement representative.
- Medical examiner/coroner.
- Prosecutor/district attorney.
- Local human services department official.
- Substance use treatment provider.
- Medication for opioid use disorder (MOUD) provider.
- Mental health social worker.
- Pain management clinician.
- Emergency department physician.
- Primary care provider.
- Pharmacist.
- Probation and parole office.
- Emergency medical service provider.
- Drug treatment court representative.
- Patient advocate.
- Child protective services representative.
- Substance use prevention professional.
- School counselor or superintendent.
- Community leader.
- Housing authority representative.
- Harm-reduction outreach professional.
- Clergy member.

Source: Overdose Fatality Review, A Practitioner's Guide to Implementation: https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf[10]

OFR Coordination Roles and Responsibilities

A team coordinator and a team recorder should be designated. The person chosen as team coordinator/chairperson should be someone with excellent leadership skills and be respected in the community. If possible, it the chairperson should be someone familiar with the different sectors and have established relationships with partnering agencies.

The most common duties of the team coordinator are:

- Determine meeting dates.
- Send meeting notices to team members.
- Arrange meeting logistics.
- Submit records requests as needed.
- Obtain names and compile the summary sheets of unintentional overdose fatalities to be reviewed and distribute to team members two to three weeks prior to each meeting.
- Ensure that new members receive a team manual and an orientation to the OFR team prior to their first meeting.
- Ensure that all new OFR team members and ad hoc members sign a confidentiality agreement.
- Encourage sharing of information for effective case reviews.
- Chair the team meetings and facilitate resolution of agency disputes.
- Complete and submit data reports.
- Ensure that the OFR team operates according to protocols as defined by the team or law.
- Promote OFR team successes in following through with recommendations and prevention initiatives and activities.
- Facilitate contacts with the media.
- Guarantee compliance with legislation (e.g. membership metrics and submission of reports to the Ohio Department of Health (ODH).

The primary responsibilities of the recorder are:

- Assist the team coordinator with data collection prior to the OFR meeting.
- Attend each OFR meeting and complete the data collection form based on the information and records reviewed and discussed.

Because the data collection process is lengthy, it can be difficult for the team coordinator to both facilitate the review while simultaneously completing the necessary forms. Having a recorder assume this role is the most effective means of making sure all crucial information is recorded at each review.

Recruiting OFR Team Members

The team coordinator should start the process of establishing a team by first reviewing available OFR materials and assessing community readiness and need for an OFR. The assessment can strengthen the community's OFR readiness by compiling overdose fatality data and using it to understand the scope of the deaths in the community. It can also help identify partnerships and secure commitments to participate on the OFR team. The ODH Violence and Injury Prevention Section (VIPS) can provide OFR resources and contact information for existing and successful OFR teams around the state. Consulting with an existing review team in a similar jurisdiction is suggested before establishing a team. Attending an OFR meeting in another jurisdiction may also be helpful.

The team coordinator should think carefully about who to invite to be a member of the initial team. It is important to note that additional stakeholders and potential data owners may be invited to participate in the future. Fatality reviews should be conducted by community stakeholders and membership should be drawn from the community or state agencies with responsibilities for:

- The investigation of opioid overdose fatalities.
- The prevention of opioid misuse and fatalities.
- The people most at-risk and impacted by overdose fatalities.

OFR teams can benefit from ongoing recruitment of new members to address staff turnover, fill gaps in membership, or identify new trends. To prepare potential members for what to expect when participating on a review team, consider sharing the following information:

- Explain the OFR goals and review the overall structure.
- Share group rules and norms.
- Emphasize the purpose of the meetings.
- Address data sharing or confidentiality concerns.
- Summarize past and current recommendations relevant to the agency's area of work.
- Suggest ways they can participate in developing and implementing recommendations.

Drafting an email with the above information, a meeting schedule, and a clear list of partner expectations can help to recruit and communicate with new members. Refer to ***Appendix A: OFR Recruitment Letter*** for an example that can be tailored.

It is important that those invited to serve on the team are willing to be open, honest and cooperative with each other and willing to advocate for or work directly for change to prevent overdose fatalities. Thought should be given to the role each invited person plays. It is important to have members who can bring information about actions taken by their agencies related to the overdose victims or the investigations. When considering members, the team coordinator should think about:

- The expertise the individual can bring to the team (i.e. professional or lived experience).
- The assistance that the person can provide to the team to help the team accomplish goals.
- The connections between agencies and other providers that can be built through the participation of the professional on the team.

The team coordinator should contact the directors of core local agencies to serve on the team. Potential team members should be presented with the full purpose of the OFR so that they understand what their expertise can bring to the table. The highest possible level of agency staff should be invited to join the team. These people will have the authority to implement changes, if necessary, and commit their agencies to cooperative activities, projects and protocols. If a higher-level agency person cannot attend but sends a designee, it is important that the designee be a person with experience in the area of persons who use drugs and/or drug overdose. It is also important to note that having the same person attending the meeting is more beneficial than having a different designee attend each time.

Meeting Organization and Protocols

One or more organizational meetings should be held before scheduling a meeting to review cases. The team may consider having a representative from another jurisdiction that has a successful OFR attend this meeting to offer insights and assistance. The goal of this planning phase is to develop a team protocol that includes the rules and procedures that will govern the team and guide the team's review process. Organizational meetings should only be held if most of those invited are able to attend. The initial organizational meeting should include:

- Introduction of members.
- Overview of the purpose for and the history of OFRs in Ohio.
- Description of how a review team operates.
- Presentation of unintentional overdose fatality statistics for the jurisdiction.
- Discussion of the current response to overdose deaths by agencies in the community from the time a 911 call is initiated, or a person arrives at the hospital to when the person dies.
    - This is a good way to help member agencies understand their different roles and the systems that respond to an overdose death.
- Description of the current resources available in the community related to death investigation and addiction services.
- Description of other review processes that may be occurring in the community or state such as Child Fatality Review or Domestic Violence Fatality Review.
- Discussion of the benefits of OFR team involvement for participating agencies.
    - Each person attending should be provided time to ask questions, express concerns, raise issues and participate.

The organizational meeting(s) should result in a governing protocol containing the team's policies, procedures and assurances of confidentiality. The protocol should include:

- The team's statement of purpose or mission statement.
- A list of members and designated members for each participating agency.
- A description of the team structure.
- Establishment of a meeting schedule.
- Policies and/or procedures for:
    - Ensuring confidentiality and destruction of confidential documents.
        - Development of a Team Interagency Agreement and a Confidentiality Agreement which are to be signed prior to conducting an OFR.
        - Development of solutions to possible legal and institutional barriers to these agreements.
        - A system for storing, processing, indexing, retrieving and destroying information obtained in the course of reviewing a drug overdose death (e.g., information could be kept in locked offices or locked filing cabinets, destroyed at the meeting location, returned with the people who brought it to the meeting, etc.). They should also detail who has access to these files and how the team's information will be turned into aggregate data for wider distribution.

- Decision-making within the group.
- Selection and identification of cases for review.
- Reviewing cases that involve multiple jurisdictions.
- Appointing and training new members.
  - Materials to compile and distribute to team members at their first review meeting which should include basic information about:
    - OFRs.
    - Any authorizing legislation.
    - The data collection form.
    - Preliminary agreements made at the initial meeting.
  - Materials can be used to create a local OFR team manual that is provided to new members.
- Notifying team members of the cases for review and what information is needed for the review.
- Ground rules for meetings.
- Collecting necessary data and metrics.
- Considering how to include surviving family members and others who knew the victim in the review process.
- Formulating recommendations for intervention and prevention strategies, changes in existing policies and procedures or other systems change work aimed at overdose prevention.
- Implementing recommendations, including communicating recommendations to relevant agencies, institutions or groups and working with them to successfully implement recommendations.
- Procedure for resigning from the review team.
- Viewing crime scene or other gruesome photos or videos.
- Supporting the team members (e.g. offering debrief counseling).
- Media relations.

Copies of all rules, procedures, reports and recommendations that are generated during the process should be kept for reference.

OFR Review Meeting Logistics

Maintaining optimum membership, participation and investment in the process will best occur if review team members commit to:

- Meeting on a regular, scheduled basis with dates set far in advance.
    - If a jurisdiction has very few deaths, the team can decide to meet only in the event of a death, in which case, one person should be designated to call meetings as needed.
- Facilitating meeting location and ensuring meetings begin and end on time.
- Ensuring relevant agencies and groups are continuously represented.
- Encouraging attendance and involvement in the team's work.
- Emphasizing routine information exchange and updates pertinent to the reviews.
- Ensuring the tone of discussions avoids blaming and finger-pointing and instead focuses on practical improvements that can be made to prevent future overdose deaths.

Some administrative costs may be associated with OFR team meetings, such as for mailing meeting notices and requests for records, meeting space and time needed by the team coordinator to prepare for a review. Costs may also be incurred related to any subsequent recommendations or other subcommittee meetings. Normally, these costs are contributed in-kind by the participants, usually by the team coordinator's agency or organization.

OFR team members do not receive any compensation for, nor are they paid for, any expenses incurred while participating in an OFR unless compensation for, or payment for expenses incurred, is received as part of the team member's regular employment.

Meeting Preparation

There is some preliminary work that must be done prior to an OFR meeting. The OFR should be held in a confidential setting, and members of the committee should be limited to those who can provide additional data points. The team coordinator should send a confidential letter to all team members reminding them of the date, time and location of the meeting along with the name(s) of the person(s) whose cases will be reviewed. The team members should be asked to bring all pertinent information about any services or contacts they or their agency had with the person(s) to be reviewed. Case reviews are only effective if team members show up for the meetings and bring all pertinent information with them. Some team members may prefer to provide the team coordinator with the information before a review. Refer to ***Appendix C: Pre-Meeting Letter*** for an example template.

To open each meeting, the team coordinator should welcome members and review the mission, goals and objectives of the OFR. It should be ensured that confidentiality statements have been signed by all members present. Those who do not have a signed confidentiality statement on file should sign one before moving forward with the meeting. Old business should be reviewed, as there may be cases that were not completed at previous meetings that need to be re-reviewed. Time should also be made at every meeting to discuss past recommendations and prevention actions. Refer to ***Appendix E: Sample Meeting Agenda*** for examples on flow and items to include for discussion during an OFR meeting.

Confidentiality

The issue of confidentiality extends beyond how the OFR team handles the information, records and discussions that result from OFR meetings. Issues of confidentiality also include how the OFR team accesses information from outside sources. These sources have their own policies that may prevent the disclosure of confidential information. Confidentiality also relates to the method by which information about the OFR team's findings and recommendations are disseminated to stakeholders and the public. For information regarding confidentiality, please refer to the ORC §307.635-307.639.

Confidentiality Agreements

Confidentiality of the OFR team's handling of information, records and discussions can be addressed through the use of signed confidentiality agreements. All team members should sign a confidentiality agreement before participating in an OFR meeting. It can also be addressed through an Institutional Review Board (IRB). For examples, refer to ***Appendix B: Sample Confidentiality Agreement and IRB Documents.*** A confidentiality agreement should include:

1. The purpose of the review process.
2. References to any statutes that pertain to OFR, especially those that address confidentiality.
3. References to the consequences of breaking the confidentiality agreement (e.g. removal from the team or disciplinary action within the team member's agency).
4. Circumstances under which it is permitted to share team information.
5. The type of information that can be shared.

The signed confidentiality agreements should be kept on file. They can be signed once, or they can be renewed on an annual basis to remind members about their responsibilities of maintaining confidentiality. Teams may wish to include the confidentiality statement at the top of their sign-in sheets for each meeting to help ensure that all members are participating under current agreements, including ad hoc members that may be called in for one case only or on a sporadic basis. OFR teams may also require support staff to sign confidentiality agreements.

OFR policies and procedure documents should include a system for storing, processing, indexing, retrieving and destroying information obtained in the course of reviewing a drug overdose death (e.g., information could be kept in locked offices or locked filing cabinets, destroyed at the meeting location, returned with the people who brought it to the meeting). They should also detail who has access to these files and how the team's information will be turned into aggregate data for wider distribution. Security measures should be in place to prevent unauthorized access to records containing information that could reasonably identify any person.

The team cannot do an effective OFR without access to information about the unintentional overdose fatality victim and the circumstances surrounding the death. Agencies and individuals, however, may be hesitant to share information or even discuss the case if the OFR is open to the public or information collected for or from the OFR is subject to litigation. These concerns do not have to impede the OFR process if they are appropriately addressed.

Privacy Rules and Public Health Information (PHI)

The Health Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 is often cited as a reason that information cannot or will not be shared. This often stems from a misunderstanding of HIPAA and a lack of knowledge or understanding of HIPAA exemptions and permissible disclosures. A "covered entity" under HIPAA is a healthcare provider, a health plan or a healthcare clearinghouse that transmits any health information in electronic form in connection with a transaction.[11] Most covered entities will be reluctant to readily share PHI with an OFR team because of their concern that they may be violating the Privacy Rule and be subject to criminal and civil penalties. It will be up to the OFR team to identify if and how covered entities can disclose PHI to the OFR team and to ensure that if team members are covered entities or business associates that they abide by the HIPAA rules. HIPAA allows for disclosure of PHI for public health, safety and law enforcement purposes. Always consult with the lead agency's legal counsel to ensure that OFR team strategies are in compliance with the law.

Section 164.512 of the HIPAA Privacy Rule provides disclosures for public health activities that permits covered entities to disclose PHI without authorization for specific public health purposes. The Centers for Disease Control and Prevention (CDC) also published guidance on the HIPAA Privacy Rule and Public Health. For the public health exception and disclosures to apply, the OFR must be under a public health authority defined under HIPAA as, "an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency."[12]. It is also important to ensure that the OFR is a public health activity, because under HIPAA, "The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions." [12]

Understanding these exceptions, both in terms of what they do and do not permit is essential to developing a clear idea of how an OFR will be affected. To ensure that the OFR team can obtain the data needed for effective reviews and to fully understand the confidentiality of entities providing information, please refer to the ORC §307.635-307.639.

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[11] *CDC (2003). Morbidity and Mortality Weekly Report (MMWR). Selected Privacy Rule Concepts and Definitions. Retrieved from: https://www.cdc.gov/mmWr/preview/mmwrhtml/su5201a2.htm.*

[12] *U.S Department of Health & Human Services (2003). Health Information Privacy. Disclosures for Public Health Activities. Retrieved from: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-public-health-activities/index.html.*

Public Access and Sharing

The ORC §307.639 states that any information, document, or report presented to an OFR committee, all statements made by review committee members during meetings, all work products of the committee, and data submitted by the review committee to ODH, are confidential and shall be used by the review committee, its members, and ODH only in the exercise of proper functions.

An individual or public or private entity providing information, documents, or reports to an OFR committee is immune from any civil liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of providing the information, documents, or reports to the review committee. Each member of a review committee is also immune from any civil liability that might be incurred or imposed as a result of the member's participation on the OFR committee.

Once the OFR team has met, reviewed cases and made recommendations, stakeholders and the public may have an interest in the process. They may want access to the meeting minutes or other written information, or they may want to attend meetings. There are various ways that confidentiality can be maintained while meeting a request for information. Steps to determine whether any agency or individual is entitled to or restricted from accessing OFR information should be identified up front. An OFR team should turn to their state, local and agency statutes, regulations, policies, case law, court rules and memorandums of agreement. There are statutes that may give the public access to review information, and OFR teams should be sure to consult with participating agencies to be sure the OFR is not subject to these. The ORC §307.635-307.639 addresses information regarding the appropriate collection and maintenance of sensitive records. Open meeting laws make the meetings of government organizations open to the public. These laws often include a listing of exceptions for certain types of meetings, of which OFR meetings may be a part. Statutes may also restrict the access of others to OFR team information. The law may even stipulate with whom OFR team information can be shared. There are four groups that might be entitled to access:

a. Team members.
b. Other government officials or agencies.
c. Media/Press.
d. Public.

The OFR team may consider potential approaches to gaining or restricting access. For example, the team can consider if state statutes or regulations should be amended to allow certain people to have access to the team's identified information or to protect the disclosure of the team's identified information. Confidentiality agreements remind the team members to keep confidential the information that is not to be shared beyond the team. Court orders can identify the information that is available to the public and that which is not. If the information the OFR team maintains is de-identified, PHI will not be at risk of being disclosed. De-identified information and prevention approaches should be shared with the public. If people or agencies are hesitant to become involved in the OFR due to confidentiality concerns, connect them with a person or organization similar to theirs that has already been involved with OFR.

The team must also determine if meeting minutes can be subpoenaed in any litigation involving the death. State confidentiality laws need to be considered in the types of information discussed at the meeting and the information that goes into the meeting minutes. Many teams specifically choose not to record minutes.

Conducting Case Reviews

Case Selection Criteria

OFR teams use the information about the circumstances surrounding unintentional overdose deaths to determine trends and develop prevention strategies. The more cases reviewed, the better the data available for these activities. Small jurisdictions may be able to review all unintentional overdose deaths, while larger jurisdictions may have to decide on a method to determine the number of cases to review. If it is not feasible to review all cases in a jurisdiction, a representative sample of cases should be chosen. The method for choosing cases should be documented in the OFR team's policies and procedures documents. The team's decision on how often and for how long to meet will influence the number of cases that can be reviewed. Meeting schedules should be planned and structured to maximize the number of cases the team is able to review.

Jurisdiction Inclusion

The OFR team needs to decide if they will review the fatalities of residents of their jurisdiction only or all deaths, regardless of residence who die in the jurisdiction. To make this determination, there are a couple of things to consider. First, information on residents who die outside of the jurisdiction, particularly in other states, is often more difficult to obtain. Second, if a jurisdiction serves as a major hospital system for surrounding counties, many of the deaths that occur in the jurisdiction may occur as a result of unintentional overdoses that happened outside the jurisdiction, so these reviews may be of little use when deciding prevention strategies in the jurisdiction conducting the review. All OFR teams should consider developing cooperative relationships with other jurisdictions. This can be facilitated by proactively sharing information with relevant jurisdictions when requested such as when a resident dies in another jurisdiction.

Cases Under Investigation

An OFR team may not conduct a review of a death while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney agrees to allow the review. A prosecutor or district attorney should be consulted to determine if cases under civil or criminal litigation can be reviewed. The reasons for waiting until the close of all criminal legal proceedings are to ensure:

- The fatality review does not interfere with an investigation or prosecution by law enforcement.
- To allow law enforcement agencies to participate in the fatality review process while also abiding by their standard policies of not releasing information about an ongoing investigation.
- To achieve finality in the outcome of the criminal proceeding so that the review team has all relevant information about the case.

Case Information

Case information and data collection begins before the OFR meeting and is a critical activity of the case review process. At a minimum, the following types of information are needed to conduct a comprehensive review:

- Death investigation reports (e.g. scene reports, interviews, information on prior criminal activity).
- Autopsy reports.
- Medical and health information.
- Information on social services provided.
- Information from court proceedings or other legal matters resulting from the death.
- Media accounts.
- Criminal history.
- Law enforcement incident documentation from closed cases (e.g. incident reports, dispatch records, witness reports).
- Coroner/medical examiner reports.
- Court records.
- Probation and parole information.
- Statements from friends, family and employers of the victim. These may be obtained by the team coordinator.

Any individual, law enforcement agency, or other public or private entity that provided services to a person whose death is being reviewed by an OFR committee, on request of the review committee, shall submit a summary sheet of information. This information should be kept in mind:

- For a request made to a health care entity, the summary sheet shall contain only information available and reasonably drawn from the person's medical record created by the health care entity.
- For a request made to any other individual or entity, the summary sheet shall contain only information available and reasonably drawn from any record involving the person to which the individual or entity has access.
- On the request of the review committee, an individual or entity may at their discretion make any additional information, documents, or reports available to the review committee.
- On the request of the review committee, a county coroner shall make available to the review committee the coroner's full and complete record that relates to the person whose death is being reviewed.

Data Collection

Structured data collection forms and databases are essential components of the OFR process. This allows the standardization of information collected for each case and contains the information that is aggregated and used to determine trends and make recommendations for prevention of future deaths. An OFR committee shall establish a system for collecting and maintaining information necessary for the review of drug overdose or opioid-involved deaths in the county. In an effort to ensure confidentiality, each committee shall do all of the following:

- Maintain all records in a secure location.
- Develop security measures to prevent unauthorized access to records containing identifiable information.
- Develop a system for storing, processing, indexing, retrieving, and destroying information obtained in the course of reviewing a drug overdose death.

To collect comprehensive information from multiple agencies participating in the OFR, data collection must include:

- Demographic information (e.g. age, sex, race, and ethnicity).
- Year in which the death occurred.
- Geographic location of the death.
- Cause of death.
- Any factors contributing to the death.
- Any other information the committee considers relevant.

Refer to ***Appendix D: OFR Data Collection Form*** for an available comprehensive form that can be used to collect the recommended data points.

If using the OFR Data Collection Form, the team coordinator and/or the recorder should consult all public records before the meeting and fill out the form with the information gathered. Sections of the form can be distributed to the OFR team members or agencies most likely to be able to provide the information so that they can fill out the information in advance and provide the useful information to the team at the OFR meeting. If additional information is provided by team members during the OFR meeting, the recorder will capture it and add it to the form.

Data Reporting

By the first day of April each year, OFR committees shall prepare and submit to ODH a report that includes all of the following information for the previous calendar year:

- Total number of drug overdose or opioid-involved deaths in the county.
- Total number of drug overdose or opioid-involved deaths reviewed by the committee.
- Summary of demographic information for the deaths reviewed, including age, sex, race, and ethnicity.
- Summary of trends or patterns identified by the committee.
- Specification of the number of drug overdose or opioid-involved deaths that were not reviewed during the previous calendar year.
- Recommendations for actions that might prevent other deaths.
- Any other information the review board determines should be included.

The team coordinator or team member(s) with substantial knowledge of the case should present the basic facts and circumstances of the case such as basic demographics, personal history, including: medical, mental health, legal, services obtained by the victim before fatal overdose and services rendered to family and any other affected persons after the fatality. A chronological timeline of the events that led to the death is the best format for describing the circumstances of the event. In some cases, no paper records are shared among team members and all sharing is verbal. Individual team members leave with only their own records. All team members should take the lead in presenting their own agencies' information.

Once all team members have shared their case information, the team may determine that there are gaps in information or that the case needs further exploring due to complexity. If this is the case, it may be best to table the discussion until the next meeting when information not able to be shared due to team member absences or other reasons may be brought to the following meeting. To ensure that the needed information is available for the next meeting, it is important to assign a specific team member to the task of obtaining it.

If information is needed from an agency not represented on the team, a member should reach out to appropriate people with access to the pertinent information. These individuals can be invited to the meeting as an ad hoc member, or, for information that may be needed on a regular basis, such as medical records, relationships should be developed with these people. There may be laws or policies that make it difficult or impossible for the team to access some needed information. Confidentiality may address some of these issues. If there is restriction on access, the team may consider if there are any methods that can be used to gain access such as legislation or memorandum of understanding (MOU).

Topics of Discussion

Once the basic information has been reviewed, the team should discuss the case. Topics for discussion include:

Investigation:

- Was there a death scene investigation?
- Were other investigations conducted?
- What were the key findings of the investigation?
- Does the team feel that the investigation was adequate?

Background:

- What was the person's opiate and other drug use history?
- Who knew or suspected that the person had this history, including family, friends, co-workers, neighbors, the courts, etc.?
- What actions were or were not taken as a result of those contacts or awareness/suspicions of substance abuse?
- What information was available to each agency involved in the case?
- What risks and/or lethality indicators were present for the victim? Refer to ***Appendix F: Lethality Indicators*** for an inclusive list.
- What is the person's medical/behavioral history?

Agencies involved:

- Which agencies had contact with the victim?
- Which agencies had contact with the family or anyone else affected in the case?
- Did any criminal justice agency have contact with the victim?
- Detail the circumstances: 911, hotline and request for services.
- What was the extent of involvement (if any) of the parties involved with the legal system and other related community services agencies?
- What interagency communication/collaboration was initiated in response to the case?

Policies and protocols:

- What do reviews of various agency policies, protocols, trainings, records and practices reveal?
- Are written policies and procedures in place?
- Were all the current written policies and procedures followed?
- What are the "best practice" procedures? How do these compare with those developed by other communities?
- Are current policies and protocols adequate? If not, how could they be improved?

Services provided:

- What services were offered/provided/declined to the victim, family, or anyone else affected before and after the fatal overdose?
- When did services and interventions occur?
- What does the event timeline tell the team?
- What other services could have been used?
- Were services provided to responders, witnesses or community members?
- Are there additional services that should be provided to anyone?
- Who will take the lead in following up on these service provisions?
- Does the team have any suggestions to improve service delivery systems?

Other topics:

- Data on other unintentional overdose deaths; These data may show trends that will help the team in advocating for necessary changes in state policies or procedures.
- Information on local and state resources, services, programs, and policies relevant to the prevention of this type of death and/or the delivery of services.

Risk factors:

It is important to identify the risk factors involved in each death, as these become the basis upon which a team will formulate its findings. The findings are, in turn, used to generate recommendations for improved investigations, delivery of services, changes in systems, local ordinance or state legislation or community or state prevention initiatives. These system improvements and prevention programming are the ultimate goal of an OFR process that is based on the public health model. Risk factors can be grouped into the following broad categories. This is not an exhaustive list.

- Health.
- Social.
- Economic.
- Behavioral.
- Environmental.
- Systemic (agency policies and procedures).
- Product safety.
- Other.

Outcomes:

- What services are lacking in the community?
- What were the barriers to obtaining services for the victim?
- What were institutional barriers (e.g., language, cultural and social costs)?
- Were their legal barriers (statutes) to assistance or prevention?
- What were the barriers to interagency communications?
- What specific interventions could have resulted in better outcomes?
- What kind of prevention strategies flow from the interventions identified?
- Were there any other significant recommendations?
- Did the review team have all pertinent information it needed to complete the review and if not, what recommendations are there to improve investigative practices and/or available information?
- Could this death have been prevented and if so, what changes in behaviors, technologies, agency systems and/or laws could prevent another death?
- What recommendations are there for making changes?
- Who should take the lead in implementing the OFR team's recommendations?

The discussion process is not meant to determine if a person or agency made mistakes in some way or to place blame. It is to determine if all pertinent questions have been answered about the circumstances of the death and to ensure that those who may be touched by a death receive needed support services. If not, it may be appropriate for the team to recommend that further investigation is warranted or that the agency policy and protocol be examined to be sure that future overdose death investigations are as complete as possible. There may be issues involving agency response that need to be addressed. The team member representing that agency can explain the agency's protocols to the team. Team members learn more about other agency responsibilities and parameters as well as the legal purviews of the organizations that each member represents.. The team may identify gaps in policy and procedure in response to the death. If the agency does not have representation on the team, the team may have to make efforts to contact the agency regarding their recommendations. Phone calls or an invitation for an agency representative to attend the next meeting may be the best way to approach this.

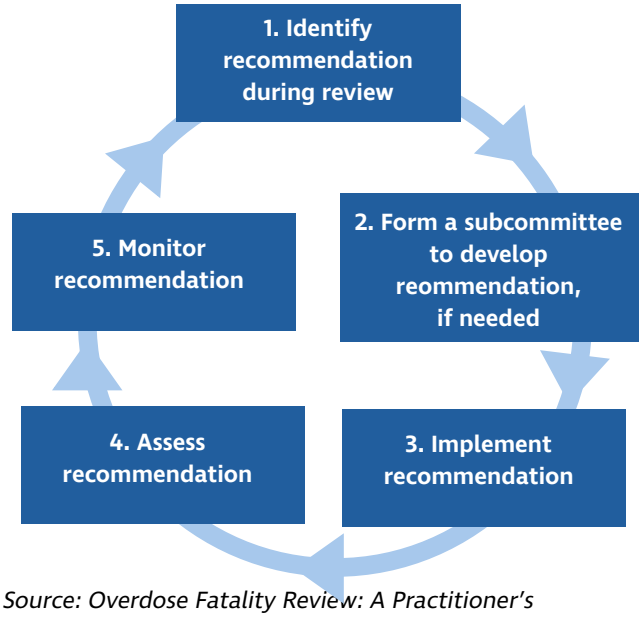
If the OFR team is making recommendations to an agency, it is important that it be handled in a diplomatic fashion. Comments should be limited to perceived gaps or barriers without too much direction on what the team thinks should be done to correct this. The team should request that the agency provide them with feedback regarding any decisions that the agency may make on the matter. This topic will be discussed further in the *Recommendations* section.

For additional information on building a successful OFR team and cultivating a comprehensive process, refer to CDC's guidance: Overdose Fatality Review: A Practitioner's Guide to Implementation.[10]

[10] *Bureau of Justice Assistance (2020). Overdose Fatality Review: A Practitioner's Guide to Implementation. Retrieved from: https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf.*

Recommendations

The OFR process is driven by data and information received from members representing multiple agencies. Sensitive and crucial information surrounding the circumstances of a drug overdose death can inform the understanding of the overdose problem and potential solutions. This section summarizes the types of recommendations that may be developed through the overdose fatality review process; provides an overview of the recommendation process, from developing to sustaining recommendations; and offers a method to track, monitor, and assess the implementation of recommendations.



Source: Overdose Fatality Review: A Practitioner's Guide to Implementation [10]

Identifying Recommendations During the OFR Review

Successful OFRs rely on active engagement by members beyond the detailed case discussions, including formation, implementation, assessment, and continuation of prevention strategies. It is important that the OFR facilitator reinforce that recommendations can be identified and implemented through the OFR's collaborative, data-driven, problem-solving process.

Problem solving occurs during a collaborative process that fosters accountability and transparency. Identified solutions usually involve a cross-agency response that reduces duplication and information silos. The process is best served if it prioritizes addressing system issues and making recommendations for improvement.

Strategies should be evidence-based and appropriate for each community. To identify recommendations that are evidence-based, it is important to review prevention literature and understand the spectrum of prevention. Refer to ***Appendix G: Spectrum of Prevention*** for additional information. Teams do not have to implement their proposed prevention strategies and activities themselves, but they should follow up to make sure that someone or an agency has assumed responsibility.

Types of Recommendations

OFR teams may generate a variety of recommendation types across the continuum of care or systems. These recommendation types are outlined in the following table.

Target Audience		Definition	Example
Systemic	Professionals, agencies, and organizations.	Addresses a gap weakness, or problem within a system or across systems.	Improve communication between inpatient I treatment providers upon discharge to an outpatient. Medication for opioid use disorder (MOUD}-formerly known as medication-assisted treatment (MAT}-provider by establishing an automated alert system.
Agency	Only one sector or partner agency.	Addresses a service gap or failure.	Give naloxone to people who have been released from incarceration. Local health department to provide training to all hotel staff members on how to administer naloxone.
Research	Academic organizations and agencies that research overdose deaths or evaluate programs or policies.	Recommendation to research a topic or issue area.	Determine the number of deaths from prescription opioids for those who had a prescription for an opioid. Establish a process for case review outcomes to inform research priorities.
OFR Quality Assurance	OFR team.	Strengthen or improve the OFR process.	Increase the length of meetings to allow for more time developing recommendations.
Population-Specific	Individuals and groups at increased risk.	Evidence-based intervention that will reduce a specific risk factor for overdose.	Increase access to buprenorphine among incarcerated populations.

Source: Overdose Fatality Review: A Practitioner's Guide to Implementation [10]

Documenting Recommendations

The OFR initial recommendations are captured in the meeting minutes and can be recorded in the 'Prevention Strategies/Recommendations' section of the OFR Data Collection Form or in the OFR data collection database chosen for use by the jurisdiction. The following list includes suggestions for recommendation—related information to collect:

- A public summary of the recommendation.
- A working summary of the recommendation.
- Date recommendation identified.
- Cases related to the recommendation.
- Data sources shared at the review meeting.
- OFR members present at the review meeting.
- Type of recommendation (e.g., agency-specific or research-related).
- Level of prevention.
- Population or issue of focus.
- Jurisdiction level responsible for implementing the recommendation.
- Agency responsible for implementing the recommendation and contact information.
- Status of the recommendation.
- Recommendation strategies (short-, medium-, and long-term).
- Recommendation implementation accomplishments.
- Notes regarding any media coverage.

Forming a Subcommittee to Develop Recommendations

Recommendations can be diverse, and some are easier to implement than others. Planning and implementing recommendations is a rewarding process that can have immediate and tangible results. Some recommendations maintain momentum, and others may slowly lose support. The process can be challenging when factors outside of the OFR team's control impact progress. Creating subcommittees to focus and implement specific recommendations can maintain momentum by building sustained internal and external support for the strategy. Subcommittees meet separately from the OFR team and report out at case review meetings on their aims and progress. Subcommittees are formed and disbanded as needed, serving temporarily or on an ongoing basis.

Subcommittees assigned to lead the development and implementation of a recommendation should follow these steps:

1. *Identify a subcommittee lead* – The OFR coordinator will designate a lead for the subcommittee. The subcommittee lead needs to be a neutral convener, to avoid possible competition among agencies for future grant opportunities or services provided, and in a leadership position that will ensure progress in implementing the recommendation.

2. *Identify and recruit key partner agencies* – The success and momentum of recommendation development rests largely on who is participating on the subcommittee. Each subcommittee will want a champion who provides energy around the focused problem or solution. Subcommittee membership may include members from the governing committee, the OFR team, and outside experts. Additional subcommittee membership requirements can be found in the ORC §307.632.

3. *Assign roles and responsibilities* – As with any workgroup, there a several roles to be filled. Some common formal and informal roles include lead, researcher, support, monitor, and champion. A description of each role is provided in the section below on subcommittee roles and responsibilities.

4. *Host meetings* – One or several meetings may need to be scheduled. Meetings will happen in person or virtually and at times and locations that work best for subcommittee members.

Subcommittee Roles and Responsibilities

It takes multiple stakeholders to effectively develop, implement, and monitor recommendations. Recommendations can also be brought to a larger cohort, such as the jurisdictions local coalition, for implementation. This section reviews the OFR coordinator's, facilitator's, and subcommittee members' roles and responsibilities regarding recommendations.

OFR Coordinator and Facilitator

The process for developing and implementing recommendations is collaborative and fluid. Success is possible only with open communication, timely information sharing, and trust building. Trust must be established in both the process and the other agencies involved. The OFR coordinator and facilitator will be tasked with the following responsibilities during the recommendation process.

OFR Coordinator

- Manages competing agendas, interagency conflicts, and unpopular or criticized recommendations.
- Ensures that the process is fair, data-driven, and likely to produce results.
- Designates the subcommittee lead, recruits participants, supports the subcommittee as needed, and checks in regularly with the subcommittee on the status of the development and implementation of recommendations.

OFR Facilitator

- Develops trust and collaboration through the entire OFR process which are crucial to successfully implementing recommendations.

Subcommittee Members

To ensure successful development and implementation of recommendations, members should fulfill five key subcommittee roles:

- **Lead** – The OFR coordinator assigns the subcommittee lead. The lead is responsible for setting the agenda, facilitating subcommittee meetings, taking notes, sending reminders, monitoring activities, and reporting to the OFR facilitator and others as identified (such as the governing committee or the OFR team).
- **Researcher** – The OFR coordinator designates a team member to present data trends such as overdose deaths, substances, hot spots, and related prevention and risk factors, as well as policy, practices, or procedures for a system or agency. This information helps inform decisions and guide the implementation of recommendations.
- **Supporter** – The OFR coordinator designates a supporter to provide minimal informal support as requested from the subcommittee. Examples of support may be connecting the subcommittee with an individual or an agency, finding meeting space, or reviewing draft materials.
- **Monitor** – Works with the subcommittee lead and OFR coordinator to systematically monitor the implementation of a recommendation, ensure that it is addressing the problem it was intended to resolve, suggest refinements, ensure the status of the recommendation is tracked in the OFR database, and periodically report results to the OFR team and/or the governing committee.
- **Champion** – Any member who provides motivation, political will, and energy around the focused problem or solution.

Implementing a Recommendation

Once the subcommittee has developed a recommendation, it needs to be implemented. It is important to do so strategically. The subcommittee lead may consider sharing recommendation materials with persons not on the subcommittee for their review and feedback. The subcommittee is responsible for developing a work plan for implementing recommendations that:

- Identifies key action steps needed to implement and monitor the recommendation.
- Assigns responsibility to members and partners.
- Determines intermediate measures of success.
- Establishes a realistic timeline for completion. An example work plan is included in ***Appendix H: Sample Recommendation Work Plan.***

Assessing and Monitoring Recommendations

Plans for assessing and monitoring recommendations need to be developed at the beginning of the initiative. Steps for regularly updating and tracking the status of recommendations include the following:

- **Status updates** – The subcommittee lead will check regularly with subcommittee members on the status of assigned tasks and implementation.
- **Reporting** – Prior to each fatality review and scheduled governing committee meetings, the subcommittee lead will provide the OFR coordinator with status updates on the implementation as well as ongoing plans to monitor and support recommendations. The subcommittee lead will likely provide a verbal progress report during OFR case review meetings.
- **Tracking** – Documenting the implementation status of a recommendation is encouraged. The OFR coordinator, in partnership with the subcommittee monitor, is responsible for systematically monitoring the status of recommendations. If the OFR coordinator is not involved throughout the recommendation implementation process, he or she will need to follow up with partners (for example, the subcommittee lead or monitor) to learn the status of the recommendation. The status of the recommendations should also be tracked within an OFR database or data collection tool selected by the jurisdiction.

Information Dissemination Plans

A dissemination plan is used to disseminate research findings or products to those who will use the information in practice. It will assist your OFR team in providing the results of successful recommendations and interventions. Information dissemination plans can range from a formal annual report to a simple infographic summarizing key datapoints that the OFR team has deemed vital for their particular community. For additional information, refer to CDC's Creating an Effective Dissemination Plan.

Annual reports should include an executive summary that includes unintentional drug overdose data, OFR findings, prevention recommendations and an overview of the OFR process; a summary of unintentional overdose mortality data, including numbers and rates; and a summary of OFR team findings for all deaths by key indicators collected in the case reporting form. The following are considerations when creating an annual report:

- Do not release case specific information that is confidential.
- Include mortality data by year and trends over 10 years if possible.
- Include a general description of the cause of death, relative to national data, key risk factors, known proven interventions to prevent the deaths, and resources available for more information.
- Include breakdowns by age, race, ethnicity, gender and substance used.
- Include key risk factors identified through the review process.
- Include actions taken as a result of the reviews locally or at the state level.
- Include recommendations for state and local leaders.
- Include recommendations for parents and caregivers.

When incorporating additional supporting documentation in an annual report, potential appendices include:

- A list of figures and tables for the total number of drug overdose or opioid-involved deaths in the county or region.
- The total number of drug overdose or opioid-involved deaths reviewed by the committee.
- A summary of demographic information for the deaths reviewed, including age, sex, race, and ethnicity.
- A summary of any trends or patterns identified by the committee.
- The number of drug overdose or opioid-involved deaths that were not reviewed during the previous calendar year.
- Recommendations for actions that might prevent other deaths.
- Other information the OFR committee determines should be included.

Annual reports may be considered public records under Section 149.43 – Availability of public records for inspection and copying of the Ohio Revised Code.

In addition to an annual report, an infographic can be used to include the vital datapoints that the OFR team has deemed important for their particular community. Information included in an annual report can be used to create infographics for data visualization. Refer to ***Appendix I: Infographic*** example.

Evaluation

As OFRs are being established, it is important to consider evaluation. Changes and improvements to the process and inviting new partners to the table can positively impact the program and give the OFR team a clear path to a successful and efficient OFR structure. During implementation of any intervention, ongoing evaluation of the overall approach and the individual activities will provide the information needed for making ongoing adjustments to the activities that are best suited to meet the objectives. It can be used to inform and modify prevention efforts.

The most common ways to approach evaluation is through the implementation or process of the OFR and the effectiveness or outcome of recommendations. Process evaluations document whether a program has been implemented as intended—and why or why not. Outcome evaluations assess progress on the sequence of outcomes the program is to address. Key questions to consider when evaluating an OFR may include:

- What does a successful OFR look like? Use the comparison of best practices and what has been successful for other OFRs throughout the state to shape your own OFR.
- What structure is needed to produce effective outcomes and actionable recommendations? This could include the use of roles in the structure, communication needs, and the appropriate access and use of data sources.
- What are the membership needs of your OFR? Are all necessary agencies involved that can contribute in providing key information on the circumstances of the overdose deaths?

Evaluation should also be a part of dissemination planning. When a product or information is sent out into the community, you should consider the following:

- How many people did you reach?
- Did it reach the audiences you intended?

Effective evaluation can lead to successful meetings, identification of trends, and the creation of impactful recommendations that can bridge gaps in prevention efforts to reduce overdose death rates in communities.

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Appendices

Appendix A: OFR Recruitment Letter

Appendix B: Sample Confidentiality Agreement and IRB Documents

Appendix C: Pre-Meeting Letter

Appendix D: OFR Data Collection Form

Appendix E: Sample Meeting Agenda

Appendix F: Lethality Indicators

Appendix G: Spectrum of Prevention

Appendix H: Sample Recommendation Workplan

Appendix I: Infographic

Appendix A: OFR Recruitment Letter

Overdose Fatality Review Practitioner's Guide
Sample Documents

Sample: OFR Recruiting Letter

[Insert agency letterhead]

[date]

[Name]

[Address]

[City, state, ZIP code]

Dear Colleague/Partner:

You are invited to participate in overdose fatality review (OFR), an innovative data-sharing process to address drug-related overdoses in our community.

OFR involves a case review process that generates information about decedents and their interactions with our services and systems. This information will be used to craft recommendations to prevent future similar deaths. This process has been effective for reviewing homicides, child fatalities, and maternal deaths and is now a nationally recognized model.

The OFR team will meet [monthly, quarterly] at the [location] from [time]. Members must commit to regular attendance, providing data about the decedent, and contributing to the discussion.

The authority to conduct case review through data sharing is detailed [information here] in [statute, MOU, regulations]. Attached is an interagency agreement and a confidentiality agreement that need to be signed prior to your participation on the OFR team.

Thank you for your consideration. Please direct any questions about the program to me. I look forward to working with you.

Sincerely,

[your name here]

This project is supported by the Bureau of Justice Assistance (BJA), Office of Justice Programs, U.S. Department of Justice, and the U.S. Centers for Disease Control and Prevention by Grant No. 2017-AR-BX-K003 awarded by BJA. The contents of this document were developed by the Institute for Intergovernmental Research and do not represent the official position or policies of the U.S. Department of Justice or the U.S. Centers for Disease Control and Prevention.

https://www.cossapresources.org/Tools/OFR

Source: Overdose Fatality Review: A Practitioner's Guide to Implementation [10]

Overdose Fatality Review

Confidentiality Agreement

All members of the _____(county/region) Overdose Fatality Review (OFR) Committee must abide by all local, state, and federal laws and regulations pertaining to the security, privacy, and confidentiality of medical records' information, also referred to as protected health information or PHI.

All information acquired or created by the OFR including all documents, reports, work products, and statements made by OFR members during meetings of the committee are kept de-identified and shall be used by the committee and its members in the exercise of the proper function of the review. No member nor any person assisting the committee shall disclose or provide access to identified information to the public nor to any third party who are not subject to this policy.

This policy shall be applicable to OFR members, any persons providing staff services to the committee, and any guests invited to attend meetings. Each such person shall sign and date a copy of this policy statement prior to participation in case review. The signed agreement shall be permanently kept on file by _____ (lead agency).

_____ _____

Name Agency

_____ _____

Signature Date

Appendix B: Nondisclosure Agreement

NONDISCLOSURE AGREEMENT
(COUNTY/REGION)
OVERDOSE FATALITY REVIEW (OFR) COMMITTEE

This Nondisclosure Agreement is entered by and between _____(party) and _____ (party) for preventing the unauthorized disclosure of Confidential Information as defined below. The parties agree to enter a confidential relationship with respect to the disclosure of certain proprietary and confidential information.

1. Definition of Confidential Information: For purposes of this Agreement, "Confidential Information" shall include all information or material that has or could have medical, legal, and other personal identifying information. During Overdose Fatality Review (OFR) Committee meetings, all written and oral communication pertaining to the individuals named as "fatalities" or "near-misses" is constituted as Confidential Information.

2. Explanation of Purpose for Disclosure: The OFR Committee will collect, consolidate, and catalog information obtained through a multi-pronged process of investigation, assessment, treatment and counseling of individuals involved in drug overdose cases in _____ (county). By collecting data and sharing information from de-identified patients, the OFR Committee can analyze and discuss the potential trends, commonalities, and antecedent issues associated with each case in order to ostensibly inform the development of more effective modalities of prevention, intervention, and education in order to combat the opiate health crisis.

3. Exclusions from Confidential Information: Receiving Party's obligations under this Agreement do not extend to information that is: (a) publicly known at the time of disclosure or subsequently becomes publicly known through no fault of the Receiving Party; (b) discovered or created by the Receiving Party before disclosure by Disclosing Party; (c) learned by the Receiving Party through legitimate means other than from the Disclosing Party or Disclosing Party's representatives; or (d) is disclosed by Receiving Party with Disclosing Party's prior written approval.

4. Obligations of Receiving Party: Receiving Party shall hold and maintain the Confidential Information in strictest confidence for the sole and exclusive benefit of the ORF Committee. Receiving Party shall carefully restrict access to Confidential Information to employees, contractors and third parties as is reasonably required and shall require those persons to sign nondisclosure restrictions at least as protective as those in this Agreement. Receiving Party shall not, without prior written approval of Disclosing Party, use for Receiving Party's own benefit, publish, copy, or otherwise disclose to others, or permit the use by others for their benefit or to the detriment of Disclosing Party, any Confidential Information. Receiving Party shall return to Disclosing Party any and all records, notes, and other written, printed, or tangible materials in its possession pertaining to Confidential Information immediately if Disclosing Party requests it in writing.

5. Time Periods. The nondisclosure provisions of this Agreement shall survive the termination of this Agreement and Receiving Party's duty to hold Confidential Information in confidence shall remain in effect until the Confidential Information no longer qualifies as protected or until Disclosing Party sends Receiving Party written notice releasing Receiving Party from this Agreement, whichever occurs first.

6. Federal Protections for Information Disclosed from Records of Client Receiving Addiction Services: Client—identifying information disclosed to the Committee by providers of addiction services is protected by the federal regulations governing the confidentiality of such information, 42 C.F.R. Part 2. Therefore, in addition to all other protections provided for under this Agreement, such information shall not be disclosed by Receiving party to any third parties, aside from the members of the Committee at a meeting of the Committee, in a manner that identifies a person as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person, unless such disclosure is expressly permitted by 42 C.F.R. Part 2.

This Agreement and each party's obligations shall be binding on the representatives, assigns and successors of such party. Each party has signed this Agreement through its authorized representative.

THEREFORE, based on the requirements of the IRB approval through _____ (agency) on _____ (date), I have set forth my signature and will abide by these statutory requirements. I will not release this information to a third party (with myself being the second party).

_____ _____

Printed Name Printed Name

_____ _____

Signature Signature

_____

Agency

_____

Address

Appendix C: Pre-Meeting Letter

[Insert agency letterhead]

[date]

Dear Colleague/Partner,

You are invited to participate in the next OFR meeting on [date and time] at the [location].

The authority to conduct case review through data sharing is detailed [information here] in [statute, MOU, regulations]. Attached are the interagency agreement your agency has signed and a copy of the confidentiality agreement that must be signed and collected at the beginning of the meeting. Copies will be made available for your signature at the meeting.

We will be reviewing the following case(s) at the review. Keep this and all information you prepare about the case confidential.

Case 1.

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

Case 2.

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

Please be prepared to share any information you have about the individual, the community, and your services as it relates to the overdose death. See the attached guide to collecting case information and agency-specific data elements to summarize the information.

If you need additional information about the decedent for identification in your records, feel free to contact me at [phone number].

Sincerely,

[your name here]

Source: Overdose Fatality Review: A Practitioner's Guide to Implementation [10]

Appendix D: OFR Data Collection Form

OVERDOSE FATALITY REVIEW DATA FORM

Date of OFR meeting

County code:

Unique ID:

Sources of data used for this OFR (check all that apply)

- ☐ Clerk of Courts
- ☐ Coroner/medical examiner
- ☐ County Auditor
- ☐ Death certificate
- ☐ EMS reports
- ☐ Medical records
- ☐ Mental health records
- ☐ Municipal court records
- ☐ News stories
- ☐ Obituaries
- ☐ Personal interviews
- ☐ Police reports
- ☐ Other Specify:

OFR meeting attendees (check all that were present/represented for this review)

- ☐ Advocacy organization
- ☐ Coroner/medical examiner
- ☐ EMS
- ☐ Health department
- ☐ Hospital
- ☐ Local community group
- ☐ Mental health
- ☐ Other healthcare provider
- ☐ Pharmacist
- ☐ Physician
- ☐ Prosecutor/district attorney
- ☐ Substance abuse provider
- ☐ Other Specify:
- ☐ Other Specify:
- ☐ Other Specify:
- ☐ Other Specify:

Official manner of death from the death certificate

☐ Accident ☐ Undetermined ☐ Pending ☐ Other

If other manner of death, please- specify:

DEMOGRAPHIC INFORMATION

Age (in years)

☐ Unknown

Date of birth

☐ Unknown date of birth

Date of death

☐ Unknown date of death

Sex

☐ Male ☐ Female ☐ Unknown

☐ Transgender M to F (check only if "yes") ☐ Transgender F to M (check only if "yes")

Race (check all that apply)

☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaska Native
☐ Unknown race

Ethnicity

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Resident address

City

County

Zip code

☐ Unknown resident address

Homeless

☐ No ☐ Yes ☐ Unknown

Did the decedent have stable housing at the time of death?

☐ No ☐ Yes ☐ Unknown

Weight (in pounds)

☐ Unknown weight

Height (in inches)

☐ Unknown height

Highest educational level completed

☐ Less than high school (HS)
☐ HS graduate or GED
☐ Some college
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate (e.g. PhD EdD) or professional degree (e.g. MD DO DDS DVM LLB JD)
☐ Unknown

DEMOGRAPHIC INFORMATION

Work status (choose the most accurate response)

- ☐ Employed full-time (FT)
- ☐ Employed part-time (PT)
- ☐ Employed (unknown FT/PT)
- ☐ Unemployed
- ☐ Homemaker
- ☐ Disabled not working
- ☐ Retired
- ☐ Student
- ☐ Drug dealer/drug trafficking
- ☐ Sex Worker
- ☐ Unknown

Receiving Worker's Compensation?

☐ No ☐ Yes ☐ Unknown

Marital Status

- ☐ Married/domestic partnership
- ☐ Single never married
- ☐ Widowed
- ☐ Divorced
- ☐ Married/domestic partnership but separated
- ☐ Single not otherwise specified
- ☐ Unknown

Relationship status

☐ Not currently in a relationship ☐ Currently in a relationship ☐ Unknown

Sexual orientation

☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Questioning ☐ Unknown

Was the decedent pregnant at the time of death?

☐ No ☐ Yes ☐ Unknown ☐ Not applicable

Did the decedent have children that were less than 18 years of age at the time of the decedent's death?

☐ No ☐ Yes ☐ Unknown

If yes, please specify the number of children under 18 years of age. ☐

If yes, were the children living with the decedent at the time of the decedent's death?

☐ No ☐ Yes all of them ☐ Not applicable ☐ Yes some of them ☐ Unknown

If yes, were the children involved with child protective services?

- ☐ No
- ☐ Yes (first encounter prior to the overdose death)
- ☐ Yes (first encounter as a result of the overdose death)
- ☐ Unknown
- ☐ Not applicable

INSURANCE/MILITARY /CRIMINAL BACKGROUND

Health insurance (check all that apply)

☐ None ☐ Medicare
☐ Private ☐ Other Specify: _____
☐ Medicaid ☐ Unknown

Military Service

☐ No ☐ Yes (current) ☐ Yes (past) ☐ Unknown

If yes, did the decedent have combat experience?

☐ No ☐ Yes ☐ Unknown ☐ Not applicable

Criminal history (check all that apply)

☐ None ☐ Drug-related ☐ Robbery/theft
☐ Arson ☐ Homicide ☐ Weapons charges
☐ Assault ☐ Intimate partner violence ☐ Other Specify: _____
☐ Child maltreatment ☐ Rape/sexual assault ☐ Unknown

Was the decedent ever incarcerated?

☐ No ☐ Yes ☐ Unknown

If yes, when was the last time the decedent was released from a jail, prison, or detention facility?

☐ Incarcerated at time of death
☐ Less than 1 month prior to death
☐ 1 month to less than 6 months prior to death
☐ 6 months to less than 12 months prior to death
☐ 12 months or more prior to death
☐ Not applicable

PHYSICAL AND MENTAL HEALTH CONDITIONS

Please check all physical and/or mental health conditions that the decedent was diagnosed with in his/her lifetime:

Physical

- ☐ None
- ☐ Arthritis
- ☐ Cancer Specify: ____
- ☐ Central nervous system disorder Specify: ____
- ☐ Chronic pain Specify: ____
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other liver disease
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Neuropathy
- ☐ Obesity
- ☐ Respiratory disease (e.g., COPD, asthma)
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other Specify: ____
- ☐ Unknown

Mental

- ☐ None
- ☐ Anxiety disorder
- ☐ Attention deficit/hyperactivity disorder (ADD/ ADHD)
- ☐ Bipolar disorder
- ☐ Depression/dysthymia
- ☐ Eating disorder
- ☐ Obsessive-compulsive disorder
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Schizophrenia
- ☐ Substance use disorder (SUD) diagnosed by a provider
- ☐ Other Specify: ____
- ☐ Unknown

Sensory

- ☐ None
- ☐ Hard of hearing/deaf
- ☐ Vision/blind
- ☐ Other Specify: ____
- ☐ Unknown

DEATH INVESTIGATION

Was the decedent taking medications for any of the disorders on the previous page?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Did the decedent start any new medications in the week before death?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Did the decedent change the dose of any medications in the week before death?

☐ No
☐ Yes
☐ Unknown but found alone
☐ N/A- not taking any medications

If yes, specify:

Did the decedent have any acute illness in the two weeks before death?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Did the decedent ever receive mental health services?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Was the decedent currently receiving mental health services?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Did the decedent have a history of self-harm (other than drugs) or suicidal thoughts/behaviors? (check all that apply)

☐ No
☐ Yes, self-harm (e.g., cutting)
☐ Yes, suicidal thoughts
☐ Yes, suicide attempt(s), but no medical treatment
☐ Yes, suicide attempt(s), with medical treatment
☐ Unknown

Was the decedent the victim of child maltreatment?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Was the decedent the victim of intimate partner violence?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

Was the decedent the victim of sexual violence?

☐ No ☐ Yes ☐ Unknown

If yes, specify:

SUBSTANCE ABUSE HISTORY

Did the decedent have a history of substance abuse?
☐ No ☐ Yes ☐ Unknown

If yes, describe circumstances:

If yes, which substances were abused? (check all that apply)

☐ Alcohol
☐ Benzodiazepines
☐ Cocaine
☐ Hallucinogens
☐ Heroin
☐ Illicit fentanyl
☐ Marijuana
☐ Methamphetamines
☐ Prescription opioids
☐ Other prescription drugs
☐ Over-the-counter drugs
☐ Other
☐ Unknown

Specify:
Specify:
Specify:

If the decedent had a history of substance abuse, did alcohol/drug intoxication contribute to other situations/injuries requiring medical care at any time prior to death?
☐ No
☐ Yes
☐ Unknown but found alone
☐ N/A – no history of substance abuse

If yes, check all that apply:
☐ Choking/asphyxiation ☐ Fire/burn ☐ Near-drowning
☐ Fall ☐ Motor vehicle crash ☐ Other Specify:

Did the decedent receive treatment for substance abuse? (check all that apply)
☐ No
☐ Yes, inpatient ☐ Date of last admission: ☐ Unknown date
☐ Yes, outpatient ☐ Date of last admission: ☐ Unknown date
☐ Yes, unknown type ☐ Date of last admission: ☐ Unknown date
☐ Yes, medically assisted therapy (e.g., methadone, Suboxone) Date of last dose: ☐ Unknown date
☐ Yes, self-help therapy (e.g., AA, NA) Date of last meeting: ☐ Unknown date
☐ On a waiting list at time of death
☐ Other Specify:
☐ Unknown

Did the decedent have a history of unintentional drug overdose?
☐ No ☐ Yes ☐ Unknown
If yes, number of times:
☐ Unknown number of times

If yes, what was the date of the most recent unintentional drug overdose prior to death? ☐ Unknown date
☐ No ☐ Yes ☐ Unknown ☐ Not applicable

If yes, was naloxone administered at the most recent overdose prior to death?
☐ No ☐ Yes ☐ Unknown ☐ Not applicable

If yes, was 911 called at the most recent overdose prior to death?
☐ No ☐ Yes ☐ Unknown ☐ Not applicable

Did the decedent have a family history of substance abuse?
☐ No ☐ Yes (parents) ☐ Yes, both parents other relative(s) ☐ Unknown

DEATH INVESTIGATION

Location of the fatal overdose (check all that apply)

- ☐ Decedent's home
- ☐ Relative's home
- ☐ Friend's home
- ☐ Other home
- ☐ Place of work
- ☐ School
- ☐ Hospital or medical facility
- ☐ Public area (e.g., roadway, sidewalk, playground)
- ☐ Natural area (e.g., park, woods)
- ☐ Drug/trap house
- ☐ Drug treatment facility
- ☐ Jail/prison/detention facility
- ☐ Bathroom
- ☐ Motor vehicle
- ☐ Commercial establishment (e.g., grocery store, restaurant, Motor retail outlet, laundromat), including parking lot
- ☐ Other Specify: _____
- ☐ Unknown

Location of death (check all that apply)

- ☐ Decedent's home
- ☐ Relative's home
- ☐ Friend's home
- ☐ Other home
- ☐ Place of work
- ☐ School
- ☐ Hospital or medical facility
- ☐ Public area (e.g., roadway, sidewalk, playground)
- ☐ Natural area (e.g., park, woods)
- ☐ Drug/trap house
- ☐ Drug treatment facility
- ☐ Jail/prison/detention facility
- ☐ Bathroom
- ☐ Motor vehicle
- ☐ Commercial establishment (e.g., grocery store, restaurant, Motor retail outlet, laundromat), including parking lot
- ☐ Other Specify: _____
- ☐ Unknown

Was the decedent recently released from an institution (within a month of death)? (check all that apply)

- ☐ No evidence of re-cent release
- ☐ Jail/prison/detention facility
- ☐ Hospital
- ☐ Psychiatric hospital
- ☐ Other psychiatric institution
- ☐ Supervised residential facility for alcohol or substance abuse (e.g., residential tax facility, sober house, group home)
- ☐ Supervised residential facility NOT for alcohol or substance abuse (e.g., halfway house, work-release home)
- ☐ Long-term residential health facility (e.g., nursing home)
- ☐ Other Specify: _____
- ☐ Unknown type of institution

DEATH INVESTIGATION

Was the decedent alone at the time of the overdose?

☐ No
☐ Yes
☐ Unknown but found alone
☐ Unknown

Type of area where overdose occurred

☐ Urban ☐ Suburban ☐ Rural ☐ Unknown

Is the area where the overdose occurred in Appalachia?

☐ No ☐ Yes ☐ Unknown

Was Poison Control called?

☐ No ☐ Yes ☐ Unknown

Was 911 called?

☐ No ☐ Yes ☐ Unknown

Was the decedent breathing when 911 was initially called?

☐ No
☐ Yes
☐ Unknown
☐ NA – 911 has not called

Was the decedent conscious when 911 was initially called?

☐ No
☐ Yes
☐ Unknown
☐ NA – 911 has not called

EMS response time

Minutes:

☐ Unknown
☐ N/A · EMS not called
☐ N/A · EMS never arrived

Did the decedent receive CPR or rescue breathing before EMS arrived?

☐ No
☐ Yes CPR (breathing and chest compressions)
☐ Yes rescue breathing only
☐ Yes chest compressions only
☐ Unknown

Was an autopsy performed?

☐ No ☐ Yes ☐ Unknown

TOXICOLOGY

Was a toxicology screen performed?

☐ No ☐ Yes single drug toxicology ☐ Yes poly drug toxicology ☐ Unknown

If yes, did the screening include a panel for fentanyl analogues?

☐ No ☐ Yes ☐ Unknown ☐ Not applicable

Toxicology Results (check all boxes that apply)

	Positive	Contributed to death
Alcohol	☐	☐
Hallucinogens (PCP, LSD)	☐	☐
Marijuana	☐	☐
Antidepressants		
Amitriptyline	☐	☐
Bupropion	☐	☐
Citalopram	☐	☐
Fluoxetine	☐	☐
Sertraline	☐	☐
Trazodone	☐	☐
Venlafaxine	☐	☐
Other Antidepressant	☐	☐

Specify "Other": ☐

Opioids	Positive	Contributed to death
Opioids, not specified	☐	☐
Buprenorphine	☐	☐
Codeine	☐	☐
Heroin	☐	☐
Hydrocodone	☐	☐
Hydromorphone	☐	☐
Meperidine	☐	☐
Methadone	☐	☐
Morphine	☐	☐
Oxycodone	☐	☐
Tramadol	☐	☐
U47700	☐	☐
Fentanyl	☐	☐
Carfentanil	☐	☐
Acryl fentanyl	☐	☐
Furanyl fentanyl	☐	☐
Other fentanyl analogue	☐	☐

Specify other fentanyl analogue: ☐

Other opioid 1	☐	☐
Other opioid 2	☐	☐

Specify "Other 1": ☐

Specify "Other 2": ☐

TOXICOLOGY

Toxicology Results (check all boxes that apply)

Sedatives. anxiolytics, muscle relaxants, anticonvulsants	Positive	Contributed to death
Benzodiazepines, not specified	☐	☐
Alprazolam	☐	☐
Clonazepam	☐	☐
Diazepam	☐	☐
Lorazepam	☐	☐
Butalbital	☐	☐
Carisoprodol	☐	☐
Cyclobenzaprine	☐	☐
Gabapentin	☐	☐
Zolpidem	☐	☐
Other sedative, etc.	☐	☐

Specify "other sedative, etc.": ☐

Stimulants

Amphetamines (e.g., Adderall)	Positive	Contributed to death
Caffeine	☐	☐
Cocaine	☐	☐
Methamphetamines	☐	☐
Pseudoephrine	☐	☐
Other stimulants (e.g, Ritalin)	☐	☐

Specify: ☐

Other drugs

	Positive	Contributed to death
Antihistamines/sleep aids	☐	☐
Specify: ☐		
Blood pressure medication	☐	☐
Cardiac medication	☐	☐
Dextromethorphan	☐	☐
Other 1	☐	☐
Other 2	☐	☐
Other 3	☐	☐

Specify "Other 1": ☐

Specify "Other 2": ☐

Specify "Other 3": ☐

PRESCRIPTION HISTORY

Did the decedent have a valid prescription within 90 days of death for any controlled substance(s) found in the toxicology screen?

- ☐ No
- ☐ Yes
- ☐ Unknown
- ☐ N/A – no controlled substances found in the toxicology screen

If yes, please list the fields below:

Drug 1: _____ Drug 4: _____

Drug 2: _____ Drug 5: _____

Drug 3: _____ Drug 6: _____

How many different prescribers/providers prescribed controlled substances to the decedent in the 90 days preceding the death?

- ☐ 0
- ☐ 1 to 2
- ☐ 3 to 4
- ☐ 5 to 10
- ☐ 11 to 20
- ☐ More than 20
- ☐ Unknown

Was there any indication that prescription drugs were NOT being taken as prescribed?

- ☐ No
- ☐ Yes
- ☐ Unknown
- ☐ N/A- not taking prescription drugs

If prescription drugs were not physician-prescribed, what was the source? (check all that apply)

- ☐ Bought on the street
- ☐ Bought from a friend/relative
- ☐ Free from a friend/relative
- ☐ Internet/dark web
- ☐ Stolen
- ☐ Other Specify: _____
- ☐ Unknown
- ☐ N/A - not taking prescription drugs

Prior to illicit drug use, was the decedent ever prescribed opioids?

- ☐ No
- ☐ Yes
- ☐ Unknown
- ☐ N/A-- decedent did not use drugs illicitly

Did the decedent have a history of prescription drug misuse?

- ☐ No
- ☐ Yes
- ☐ Unknown

Was the decedent ever prescribed naloxone along with an opioid prescription?

- ☐ No
- ☐ Yes
- ☐ Unknown
- ☐ N/A- decedent never had a prescription for opioids

Did the decedent ever access naloxone from a source independent of his/her medical provider, such as from a pharmacy without a prescription or from a Project DAWN?

- ☐ No
- ☐ Yes
- ☐ Unknown

DRUGS AT THE SCENE OF OVERDOSE

Were illicit drugs found at the scene/on the decedent's person? (check all that apply)

- ☐ No
- ☐ Yes, at the scene
- ☐ Yes, on the decedent
- ☐ Unknown

Was drug paraphernalia found at the scene/on the decedent's person? (check all that apply)

- ☐ No
- ☐ Yes, at the scene
- ☐ Yes, on the decedent
- ☐ Unknown

Were prescription drugs found at the scene/on the decedent's person? (check all that apply)

- ☐ No
- ☐ Yes, at the scene
- ☐ Yes, on the decedent
- ☐ Unknown

Were the prescription drugs found at the scene in their own properly labeled container(s)?

- ☐ No
- ☐ Yes some of them
- ☐ Yes all of them
- ☐ Unknown
- ☐ N/A- no prescription drugs found at the scene
- ☐ N/A- unknown if prescription drugs found at the scene

Where were the prescription drugs found at the scene stored? (check all that apply)

- ☐ Open area
- ☐ Open cabinet, unlocked
- ☐ Open cabinet, unlocked
- ☐ Closed cabinet, locked
- ☐ On the decedent
- ☐ Other specify: _____
- ☐ Unknown
- ☐ N/A- no prescription drugs found at the scene
- ☐ N/A- unknown prescription drugs found at the scene

Were opioid antagonists (e.g., naloxone) administered? (check all that apply)

- ☐ No
- ☐ Yes, by a bystander(s) at the scene
- ☐ Yes, by EMS at the scene
- ☐ Yes, by law enforcement at the scene
- ☐ Yes, at the hospital
- ☐ Unknown
- ☐ N/A - not-an opioid overdose

Did drug intoxication contribute to other situations/injuries leading to the death?

- ☐ No
- ☐ Yes
- ☐ Unknown

If yes, check all that apply:

- ☐ Choking/asphyxiation
- ☐ Drowning
- ☐ Fall
- ☐ Fire/burn
- ☐ Motor vehicle crash
- ☐ Other Specify: _____

FACTORS CONTRIBUTING TO DRUG USE

What factors may have contributed to drug use? (check all that apply)

- ☐ Chronic pain
- ☐ Death of a family member or friend
- ☐ Death of a spouse
- ☐ Divorce/separation
- ☐ Family problems
- ☐ Gambling problems
- ☐ Health issues
- ☐ History of physical abuse/assault
- ☐ History of rape/sexual abuse
- ☐ Job problems
- ☐ Lack of access to drug treatment
- ☐ Money problems
- ☐ Problems with the law
- ☐ Relationship problems
- ☐ Sexual orientation
- ☐ Suicide by a family member or friend
- ☐ Unintentional drug overdose death of a family member or friend
- ☐ Other Specify:
- ☐ Unknown

MEETING BARRIERS AND OUTCOMES

Barriers to an effective review (check all that apply)

- ☐ None
- ☐ Confidentiality issues prevented full exchange of critical information
- ☐ HIPAA regulations prevented access to or exchange of PHI
- ☐ Inadequate investigation
- ☐ Meeting was held too long after the death
- ☐ Meeting was held too soon after the death
- ☐ Necessary team members were not present
- ☐ No access to OARRS reports
- ☐ Records or information were needed from another locality
- ☐ Team disagreement on circumstances
- ☐ Team members did not bring adequate information to review

☐ Other factors Specify: _____

☐ Other factors Specify: _____

☐ Other factors Specify: _____

☐ Other factors Specify: _____

Meeting overview

How can information from this death review assist prescribers in preventing future overdoses/deaths?

How can information from this death review assist law enforcement in preventing future overdoses/deaths?

How can information from this death review assist public health/mental health in preventing future overdoses/deaths?

Prevention strategies/Recommendations

Media campaign/public education:

Provider education:

Public forum:

Other education:

New policies:

Revised policies:

New Services:

New law/ordinance:

Amended law/ordinance:

Enforcement of law/ordinance:

Other, specify:

Other, specify:

NARRATIVE

Use this space to detail the circumstances of the death and to describe any other relevant information not captured by the questions. Do not include identifiers in the narrative.

Narrative content:

Completed by:

Name:

Title:

Agency:

Phone:

Email:

Date entered:

Appendix E: Sample Meeting Agenda

OFR Meeting Agenda

Date, Time,

Location

1. Opening Remarks and Introduction
    a. Members' introduction
    b. Updates from previous meeting
    c. Upcoming events
    d. Data presentation
    e. Review case selection criteria
    f. Other announcements
2. Goals and Ground Rules
    a. Read goals and ground rules
    b. Ask for any additional ground rules
3. Confidentiality
    a. Read confidentiality statement
    b. Collect signed forms
4. Case Presentation
5. Member Report-Outs (reverse chronological)
6. Group Discussion
7. Case and Timeline Summarized
8. Formulate Recommendations
9. Summarize and Adjourn
    a. Members reflect on how the meeting went
    b. Collect any paperwork with confidential information
    c. Remind members of confidentiality
    d. Encourage members to take time for self-care

Next meeting: date, time, and location

Source: Overdose Fatality Review: A Practitioner's Guide to Implementation[10]

Appendix F: Lethality Indicators

Factors contributing to increased death from drug overdose/Lethality Indicators:

1. Amount of drug taken.
2. Purity of drug/mixture of drugs or other toxic products.
3. Taking higher doses than prescribed.
4. Taking more frequently than prescribed.
5. Administering drugs IV.
6. Using illegal drugs.
7. Mixing drugs with alcohol or other medication that causes respiratory suppression.
8. Having a mental disorder.
9. Having substance use disorder.
10. Medical conditions such as HIV, liver, lung or cardiac disease.
11. History of overdose.
12. Resuming opioid use after a period of abstinence.
13. Low income.
14. Homeless.
15. Using drugs alone.
16. Children.
17. Elderly.
18. Male.

Source: World Health Organization, Opioid Overdose Fact Sheet. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/opioid-overdose;

Source: BlueCrest Recovery Center, How Does a Drug Overdose Kill You. Retrieved from: https://www.bluecrestrc.com/how-do-overdoses-kill/.

Spectrum of Prevention

The Spectrum of Prevention is a model that can be used to create long-lasting, positive changes in the community. It describes six levels at which prevention activities can take place that complement the prevention efforts that already exist within a community. These are:

1. Strengthening individual knowledge and skills.
2. Promoting community education.
3. Educating providers.
4. Fostering coalitions and networks.
5. Changing organizational practices.
6. Influencing policy and legislation.

All six levels are complementary and synergistic and when used together, have a greater effect than would be possible from a single activity or initiative. It is a tool for developing a multifaceted approach to injury prevention and seeks to aid practitioners to reduce injuries and their severity by identifying the need for a systems approach. A systematic approach allows for continuity in interventions and a better understanding of the best solutions to the injury problem. It helps specify the array of activities necessary for an effective prevention campaign.

The activities at each level can support one another. Success at one level can encourage activities that lead to further change at other levels. For example, "media advocacy" is a strategic use of the media for community education (level 2) that may be directed at a change of policy (level 6). Effective policy discussions often lead to further individual and community education (levels 1 and 2) through media attention to an issue. When a policy is changed, it often changes organizations' practices (level 5) and creates the need to educate providers (level 3) on the implementation of new policy. Tool files and examples of how the Spectrum of Prevention has been used can be found on the Prevention Institute's website.[13]

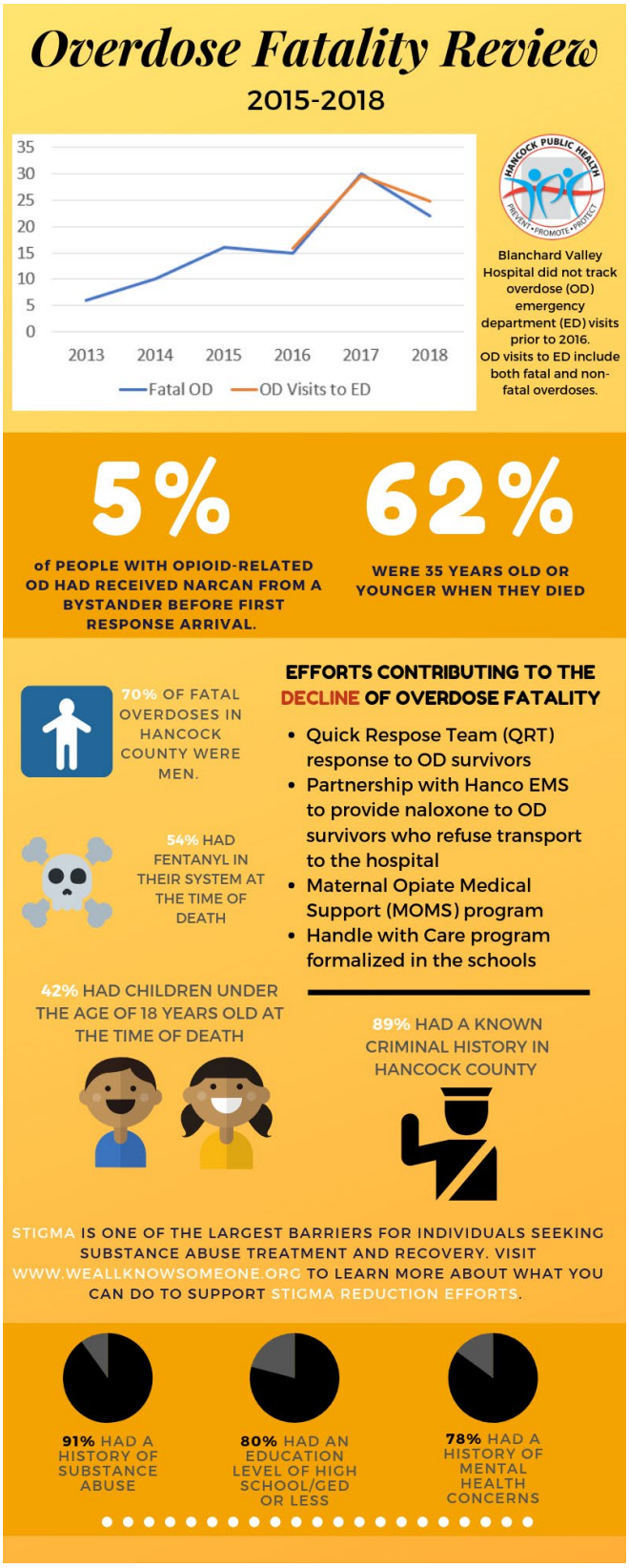
[13] *Cohen L, Swift S. The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention. Injury Prevention 1999; 5:203-207. Retrieved from: https://injuryprevention.bmj.com/content/injuryprev/5/3/203.full.pdf.*

Appendix H: Sample Recommendation Work Plan

Recommendation	Activity/Action Steps	Lead Agencies/ Supporting Agencies	Timeline

Source: Overdose Fatality Review: A Practitioner's Guide to Implementation[10]

Appendix I: Infographic



Ohio Department of Health

RECOVERY Ohio