Overdose Fatality Review Teams (OFRTs) in New Jersey:

An Overdose Prevention Initiative, Strengthening Public Health & Law Enforcement Partnership in Ocean County and Monmouth County

Heroin Response Strategy

Investing in partnerships to build safe and healthy communities

The mission of the HRS is to reduce fatal and non-fatal opioid overdoses by developing and sharing information about heroin and other opioids across agencies and disciplines and by offering evidence-based intervention strategies.

The Public Health and Public Safety Network

The Public Health and Public Safety Network (PHPSN) includes one Drug Intelligence Officer (DIO) and one Public Health Analyst (PHA) in each HRS State. This network fosters cross-disciplinary collaboration and enhances interstate and intrastate information sharing.

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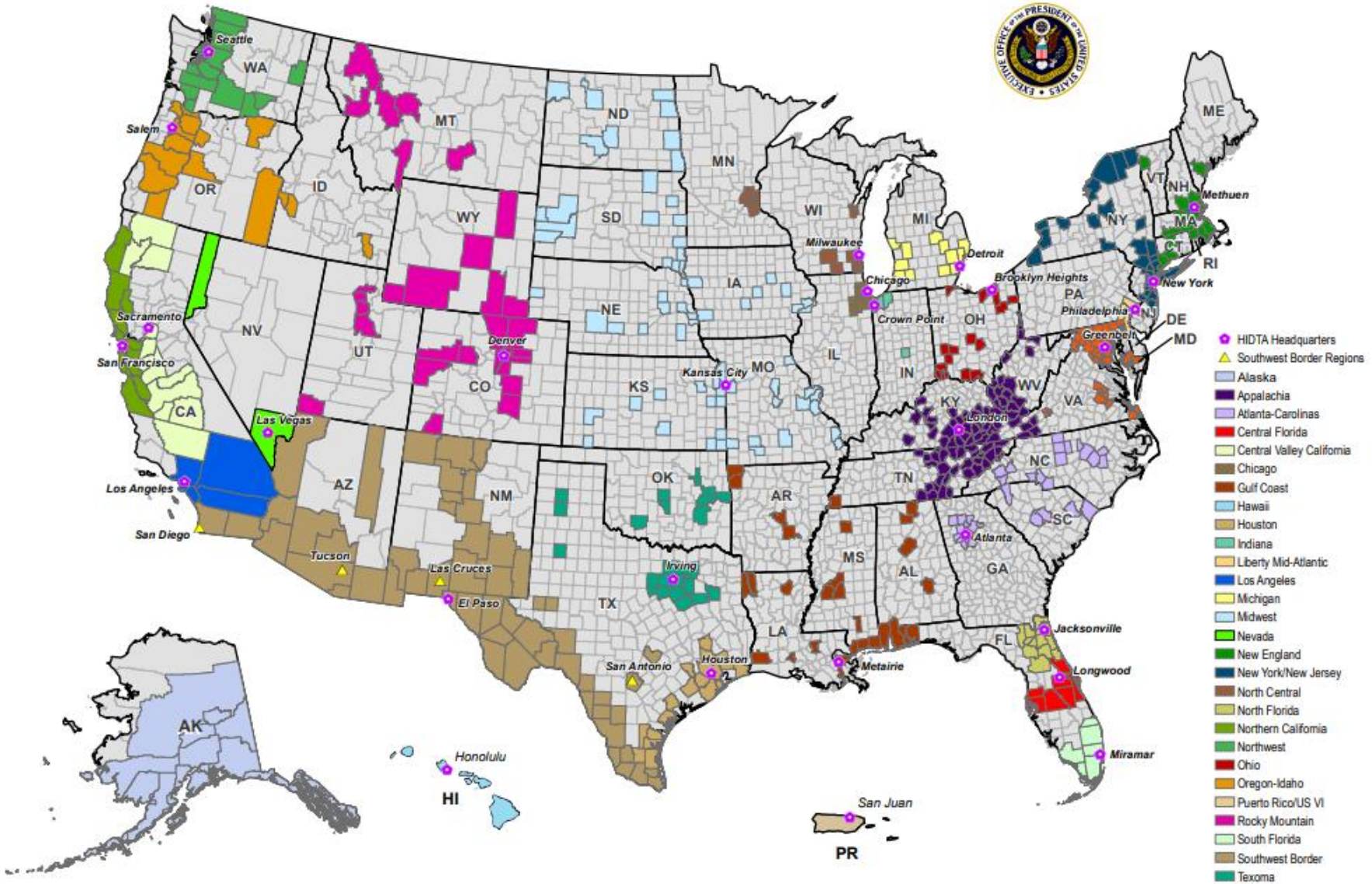
High Intensity Drug Trafficking Areas Program Counties

as of May 2018



Source: Office of National Drug Control Policy, High Intensity Drug Trafficking Areas Program (HIDTA), May 2018.

Overdose Fatality Review Team (OFRT)

- An initiative established by the Drug Enforcement Administration (DEA), NY/NJ High Intensity Drug Trafficking Areas (HIDTA) and the NJ Department of Health, Office of Local Public Health (OLPH).
- Multi-agency/multi-disciplinary team assembled at jurisdiction level to conduct ***confidential*** reviews of multiple individual overdose death cases.
  - **Allows public health authorities to receive information and expert consultation from a wide array of stakeholders while *preserving the confidentiality of protected information, including personal health information (PHI)***

- **2 Operational Teams in NJ**
  Monmouth County
  Ocean County

Goals

❖ **TO PREVENT FUTURE DEATHS BY**

-Identifying missed opportunities for prevention and gaps in system

-Building working relationships between local stakeholders on Overdose prevention

-Recommending policies, programs, laws, etc. to prevent Overdose deaths

-Informing local overdose & opioid misuse prevention strategy

→ ***Modeled on existing mortality review teams for children, fetal/infant, domestic violence & fatality review team in Maryland***

Ocean County Overdose Fatality Review Pilot Program

Daniel E. Regenye, Public Health Coordinator/Health Officer
Kimberly L. Reilly, Chief of Administrative Services

- The main **mission** of the Ocean County Overdose Fatality Review Pilot Program is, through the review of overdose fatalities, to identify gaps in public systems and social services that if strengthened, could prevent future deaths from drug overdose

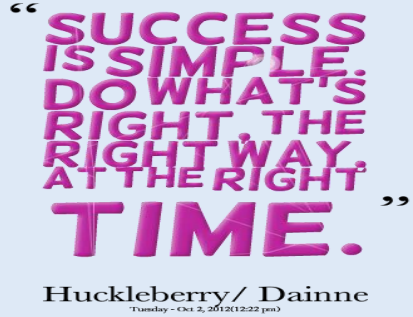
- The **goal** is to reduce overdose fatalities through targeted prevention, treatment and recovery strategies and programs

Objectives:

- Identify missed opportunities for prevention and gaps in system
- Build working relationships between local stakeholders on overdose prevention
- Recommend policies, programs, laws, etc. to prevent OD deaths
- Inform local overdose & opioid misuse prevention strategy

Main Considerations in Development

- How do we maintain compliance to HIPAA and the confidentiality rights of the decedent in this process?
- How do we get agencies to participate and create a "safe" place for information sharing?
- How do we create community buy in for this project?



Timeline

- December 2016 — First Meeting/Introduction
- January 2017 — Begin hosting **monthly** executive meetings
- February-March 2017 — Meetings with key partners to discuss project
- April 2017 — Kick Off Event for Ocean County
- September 2017 — Board of Health Resolution Passed
- November 2017 — Affiliation and confidentiality agreements mailed
- January 2018 — First decedent review meeting

Ocean County Health Department Kicks Off Overdose Fatality Review Taskforce

Health Commissioner Cathleen Bennett joined the Ocean County Health Department on April 24 to kick off the county's Overdose Fatality Review Taskforce meeting. Aligning with the goal of population health, which focuses on prevention and wellness, the taskforce's overall mission is to intervene before a drug problem begins and prevent future deaths and non-fatal repeat overdoses. This can be done by identifying missed opportunities and gaps, building relationships with stakeholders, recommending policies, programs and legislation and informing local overdose and opioid misuse strategies.

Assistant Commissioner Christopher Rinn, Commissioner Bennett, Ocean County Health Officer Daniel Regenye and Shereen Semple, director of the Department's Office of Local Public Health.

"In 2015, there were nearly 1,600 drug-related deaths in New Jersey, which is three times greater than the number of people killed in car accidents in the same year," said Commissioner Bennett.

Ocean and Monmouth counties have been particularly hard hit by the epidemic. Recognizing how urgent this challenge is to New Jersey, earlier this year, Governor Chris Christie declared that the abuse of and addiction to opioid drugs is a public health crisis. Under his leadership, the Department is focused on identifying barriers, reducing obstacles and developing and executing a comprehensive strategy to combat opioid addiction.

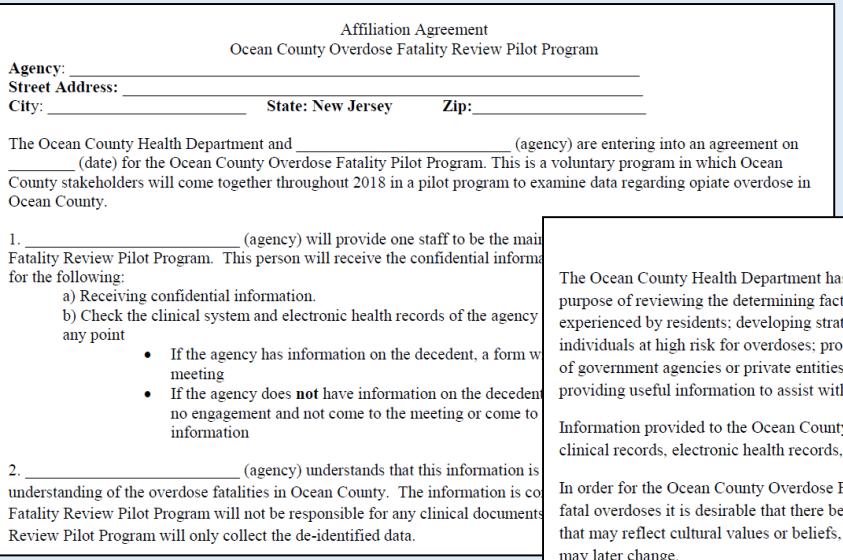
To ensure all residents are connected to care, Governor Christie launched a "Help is Within Reach" public awareness campaign and a 24/7 helpline at 1-844-ReachNJ for instant drug addiction-related help. As part of the Governor's comprehensive plan to stem New Jersey's opioid public health crisis, the Department issued a Certificate of Need (CN) call earlier this year for 864 new adult inpatient acute psychiatric beds.

Ocean County Health Department

Public Health
Prevent. Promote. Protect.

Affiliation Process

- Community stakeholders entered into an annual affiliation agreement and confidentiality agreement with the Ocean County Health Department
- Additional confidentiality agreements are signed at each meeting
- 42 contacts from 29 agencies are represented



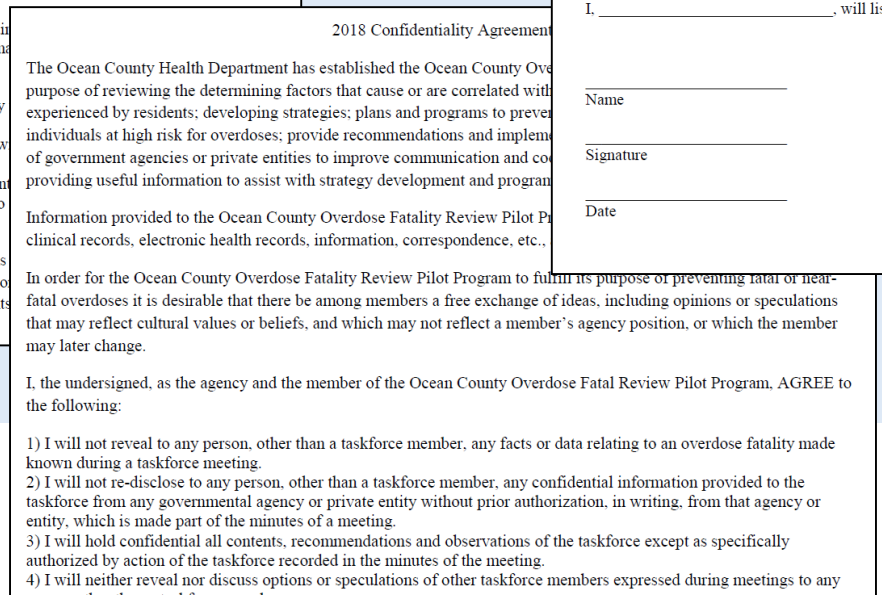
Affiliation Agreement
Ocean County Overdose Fatality Review Pilot Program

Agency: _____
Street Address: _____
City: _____ **State: New Jersey** **Zip:**_____

The Ocean County Health Department and _____ (agency) are entering into an agreement on _____ (date) for the Ocean County Overdose Fatality Pilot Program. This is a voluntary program in which Ocean County stakeholders will come together throughout 2018 in a pilot program to examine data regarding opiate overdose in Ocean County.

1. _____ (agency) will provide one staff to be the mai
Fatality Review Pilot Program. This person will receive the confidential informa
for the following:
a) Receiving confidential information.
b) Check the clinical system and electronic health records of the agency
any point
- If the agency has information on the decedent, a form w
meeting
- If the agency does **not** have information on the decedent
no engagement and not come to the meeting or come to
information

2. _____ (agency) understands that this information is
understanding of the overdose fatalities in Ocean County. The information is co
Fatality Review Pilot Program will not be responsible for any clinical document
Review Pilot Program will only collect the de-identified data.



2018 Confidentiality Agreement

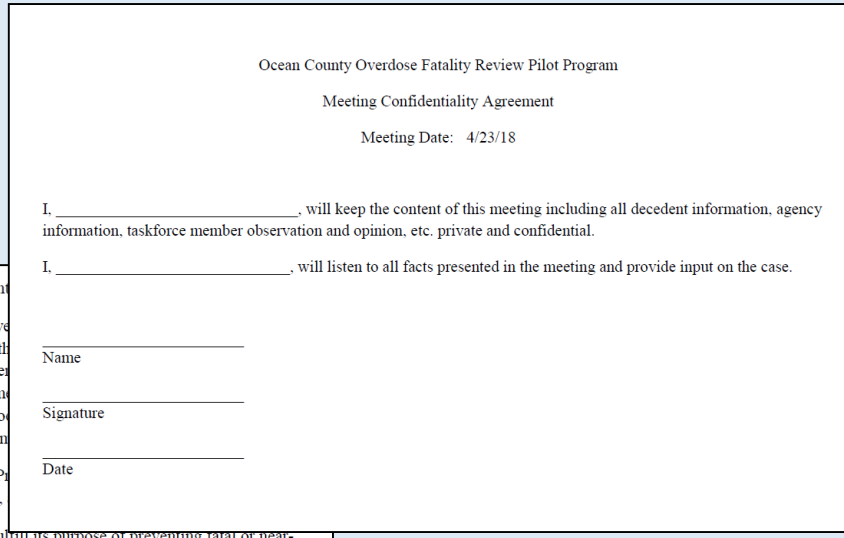
The Ocean County Health Department has established the Ocean County Ove
purpose of reviewing the determining factors that cause or are correlated with
experienced by residents; developing strategies; plans and programs to prever
individuals at high risk for overdoses; provide recommendations and implem
of government agencies or private entities to improve communication and co
providing useful information to assist with strategy development and program

Information provided to the Ocean County Overdose Fatality Review Pilot Pr
clinical records, electronic health records, information, correspondence, etc.,

In order for the Ocean County Overdose Fatality Review Pilot Program to fulfill its purpose of preventing fatal or near-fatal overdoses it is desirable that there be among members a free exchange of ideas, including opinions or speculations that may reflect cultural values or beliefs, and which may not reflect a member's agency position, or which the member may later change.

I, the undersigned, as the agency and the member of the Ocean County Overdose Fatal Review Pilot Program, AGREE to the following:

1) I will not reveal to any person, other than a taskforce member, any facts or data relating to an overdose fatality made known during a taskforce meeting.
2) I will not re-disclose to any person, other than a taskforce member, any confidential information provided to the taskforce from any governmental agency or private entity without prior authorization, in writing, from that agency or entity, which is made part of the minutes of a meeting.
3) I will hold confidential all contents, recommendations and observations of the taskforce except as specifically authorized by action of the taskforce recorded in the minutes of the meeting.
4) I will neither reveal nor discuss options or speculations of other taskforce members expressed during meetings to any



Ocean County Overdose Fatality Review Pilot Program

Meeting Confidentiality Agreement

Meeting Date: 4/23/18

I, _____, will keep the content of this meeting including all decedent information, agency information, taskforce member observation and opinion, etc. private and confidential.

I, _____, will listen to all facts presented in the meeting and provide input on the case.

_____
Name

_____
Signature

_____
Date

Ocean County Health Department

Public Health
Prevent. Promote. Protect.

Monthly Case Review Process

- The affiliated contact will receive a monthly a phone call with the decedent information
  - No fax or e-mail
  - Confirm speaking to affiliated contact
  - Information then protected as per their agency's confidentiality policy
- An internal review of agency records will be done by the affiliated contact
  - If contact was made, either a data document will be filled out and brought to the meeting or a verbal narrative will be provided at the meeting
- **Only** OC-OFRPP members who have signed a Confidentiality Agreement may participate in meetings
- Data documents provide a profile of the individual, nothing that can identify the decedent!

Data Collection: Capturing the narrative

- Each case is discussed at the decedent review
- The Prosecutor's Office and Medical Examiner provide the first narrative report (crime scene information and autopsy report)
- Everyone is encouraged to ask questions, look for trends
  - Social Autopsy: objective is to identify common themes amongst the "stories" of the deceased residents
- OCHD facilitator and epidemiologist take de-identified notes throughout the meeting
    - All information shared is confidential to the taskforce
    - Nothing is recorded
- Large post it notes are used to capture key information to provide a visual of information (de-identified)
- A data collection document was developed pulling from Maryland's model
  - This is optional for the affiliated contact
  - Respect the affiliated contacts time
  - Try to make the process seamless and easy

Obstacle 1:

- The data document provide some information but does not give the "whole" picture
  - Gaps in information
  - Unanswered questions
  - Decedent presents differently based on dates of engagement

Lesson Learned 1:

The information that we don't have tells a story too!

Why are there gaps in treatment or contact with county agencies? Were services not available or not offered? Or was there recovery? If recovery, was there relapse?

Is there issues with how information is captured? Do we need better record sharing?

Obstacle 2 :

- Some agencies can't participate in a decedent review
- We are unable to get data from when the decedent was in school

Lesson Learned 2:

Try to meet the agency where they are at, if they can't do a decedent review are they able to participate another way? Can they be a key expert in their respective area? Would the be agreeable to a focus group?
Ultimately, there needs to be more information sharing!

Output

- A Quarterly Report is done and provided to the executive committee and the affiliated contacts – not for public consumption
- BI-ANNUAL reports will be done with more formalized data to be shared
- The outcome document identifies:
  - Overdose death trends
  - System barriers and gaps
  - Trends, systemic issues and barriers that contribute to overdose death
  - Ways to either develop and/or supports community prevention/early intervention programs
  - Assess treatment options and availability for residents
  - Enhance recovery supports