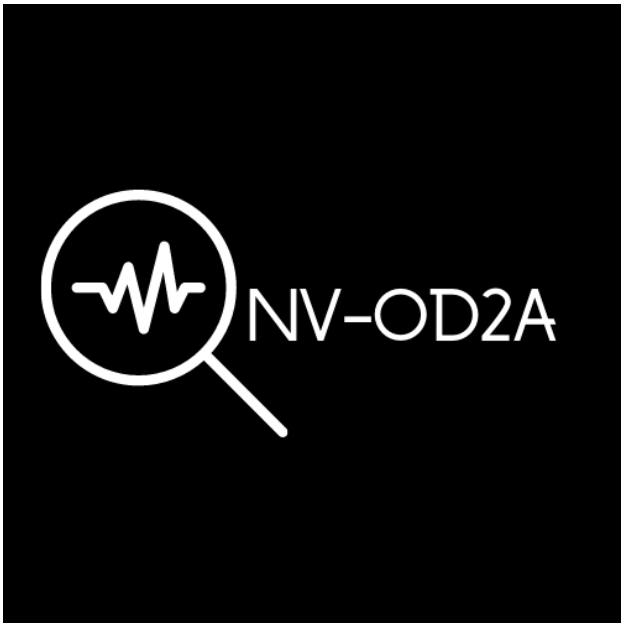

OVERDOSE FATALITY REVIEW PILOT

Nevada Overdose Data to Action

ABSTRACT

Summary of Overdose Fatality Review Pilot project. Report includes review of existing fatality review in Nevada, summary of pilot project findings and recommendations for implementation for Overdose Fatality Review in Nevada

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Background

The Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A) program supports state, territorial, county, and city health departments in obtaining more comprehensive and timelier data on overdose morbidity and mortality. The Collaborative Agreement program is meant to enhance opioid overdose surveillance, reporting, and dissemination efforts to better inform prevention and early intervention strategies. OD2A is Nevada's main source of CDC funding for fatal and non-fatal overdose surveillance. OD2A is working to improve the quality of data collected and reported by the state to help inform prevention and intervention activities in the state. The OD2A Program is administered by the Division of Public and Behavioral Health and has partnered with the University of Nevada, Reno School of Public Health.

The CDC's OD2A program provides nine comprehensive strategies for jurisdictions to work within in the fight against rising overdose deaths. These strategies range from the collection of non-fatal and fatal data, Prescription Drug Monitoring Program Data reporting, linkage to care, to empowering people to make safer choices.

CDC Overdose Data to Action Program Components and Strategies

Track	Strategy	Priority
Surveillance	1	Overdose Surveillance: Morbidity
	2	Overdose Surveillance: Fatality
	3	Innovative Overdose Surveillance
Prevention	4	Prescription Drug Monitoring Program
	5	Integration of State and Local Efforts
	6	Linkages to Care
	7	Health System Support
	8	Public Safety Coordination
	9	Empowering Individuals to Make Safer Choices

Figure 1

In its third grant year, the OD2A program worked to conduct a pilot overdose fatality review committee under the strategies related to the integration of state and local efforts.

An Overdose Fatality Review (OFR) exemplifies the spirit and intent to "Data to Action" by providing state program and policy leaders important qualitative information to our fatality data that can help to inform prevention and intervention programming.

The objective of this OFR Pilot Project was to conduct an overdose fatality review, and to provide recommendations and guidance to the State of Nevada in developing an Overdose Fatality Review.

Current Nevada Overdose Landscape

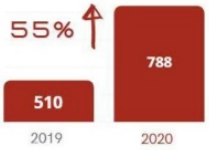


Figure 2

From 2019 to 2020, there was a 55% increase in drug overdose deaths of unintentional/undetermined intent among Nevada residents (2019: 510 vs. 2020: 788). Recently, during the first half of 2021, the rate of drug overdose deaths increased by 20% compared to the first half of 2020. Overdoses have increased throughout COVID-19, for several reasons. Changes in the drug supply, abrupt cessation of SUD treatment services during lockdown, and change in habits due to isolation of people who use drugs, leading to use alone.

Nevada's current mortality data tells us that from 2019 to 2020, there was a significant increase in the percentage of deaths among younger populations, most notably less than 25 years of age (7.5% to 13.4%). There is also a disproportionate impact on communities of color. There was a 120% increase in the percentage of deaths among Hispanic persons. Deaths have been driven by an increase in overdose deaths attributed to synthetic opioids, such as illicitly manufactured fentanyl. From 2019 to 2020, there was a 227% increase in overdose deaths involving illicitly manufactured fentanyl.

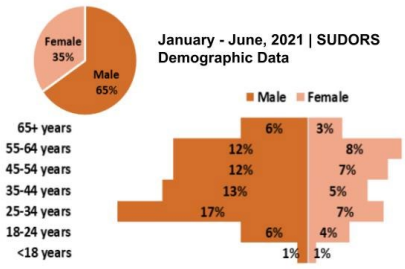


Figure 3

The state has also seen a rise in polysubstance use. More recently, from January to June 2021, 28% of overdose deaths among Nevada residents involving an opioid and stimulant. Three in every four overdoses occurred in the decedent's home, 58% of overdoses had a bystander present at the time of overdose, 38% had a mental health diagnosis, 13% had a prior overdose, 12% had their drug use witnessed, 10% ever received treatment for substance use disorder, 9% were homeless, and 8% were recently released from prison/jail, treatment, or hospital, within a month prior to death. 77% of decedents had at least one potential opportunity for linkage to care prior to death or implementation of a life-saving action at the time of overdose or missed opportunity for linkage to care. A potential opportunity for life-saving action or missed opportunity for linkage to care includes recent release from an institution within past month (prison/jail, treatment, hospital), previous nonfatal overdose, mental health diagnosis, ever treated for substance use disorder, bystander present when fatal overdose occurred, and fatal drug use witnessed.

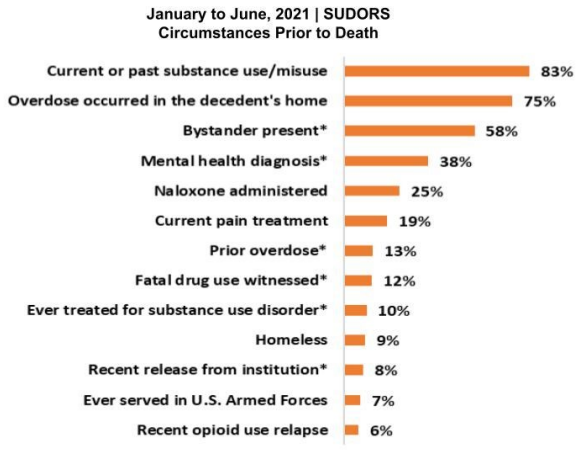
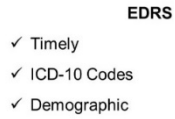


Figure 4

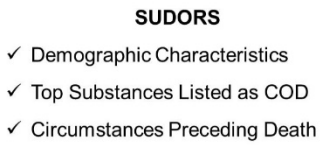
Existing Overdose Fatality Reporting

Nevada OD2A supports the collection and reporting of Nevada's Mortality data. Mortality data is collected through the Coroner/Medical Examiner (C/ME) Offices in Washoe County and Clark County, Nevada. Deaths suspected to be caused by drug overdose are investigated by a medical examiner or coroner. They determine the manner of death (accidental/unintentional, suicide, etc.) by investigating the circumstances around the death, and this is reported on the death certificate, which is typically available two to three months after the date of death. The State Unintentional Drug Overdose Reporting System (SUDORS) uses death certificates and C/ME reports (including post-mortem toxicology testing results) to capture detailed information on toxicology, death scene investigations,

route of drug administration, and other risk factors that may be associated with a fatal overdose. Information from death certificates and C/ME reports are abstracted by trained abstractors located in the Clark County Office of the C/ME and Washoe County Regional ME office into the online CDC platform. Data is made available typically twice a year.



Currently, Nevada utilizes two primary systems to gain insights into fatality data. Nevada Department of Health and Human Services (DHHS) uses death certificate information from the Nevada Electronic Death Registry System (EDRS) to report on overdose mortality in the state. This source relies on ICD-10 codes. The OD2A program reports on EDRS or data in its monthly surveillance reports. On average, the cause and manner of death are available two to three months after the death investigation.

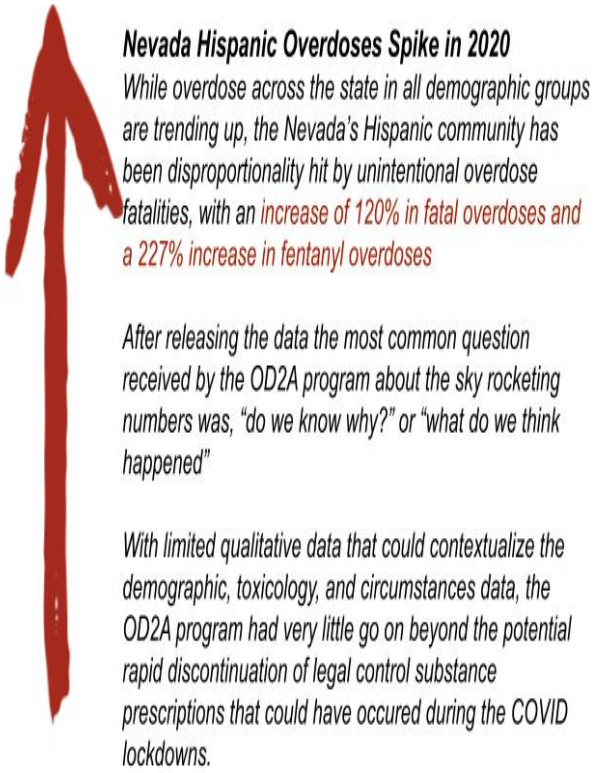


The second system reports confirmed unintentional overdoses. This data is reported twice a year through the State Unintentional Drug Overdose Reporting System (SUDORS). SUDORS uses death certificates and coroner/medical examiner reports (including post-mortem toxicology testing results) to capture detailed information on toxicology, death scene investigations, route of drug administration, and other risk factors that may be associated with a fatal overdose. SUDORS was established in Nevada in 2017 with opioid-related deaths of unintentional/undetermined intent only. In 2019, it was expanded to cover drug-related overdose deaths of unintentional/undetermined intent. It takes time to abstract data from death records and this results in reporting delays. Additionally, data completeness is dependent on information documented at the time of death, which results in large amounts of missing data. SUDORS data is reported twice a year. The first half of the year (January to July) is reported before January of the following year and the second half of the year is reported by August.

Existing Data Limitations

The OD2A program acknowledges that there are no perfect data collection sources or mechanisms and that a meaningful surveillance system is one that can pull data from various sources or systems to help paint the clear picture of the overdose risk landscape.

Nevada's EDRS data give the state timely information about the suspected overdose instances. However, data is not confirmatory. Additionally, another limitation is select ICD-10 codes group multiple opioids together, making it difficult to separate specific opioids that may have been attributed to deaths. In addition, complete toxicology and information about the circumstances preceding death are unavailable.



While Nevada gets information about some of the circumstances prior to death, the current fatality surveillance does not get a lot of information about how decedents are interacting with services or systems prior to their fatal overdose. A regularly scheduled overdose fatality review, in which a multidisciplinary team is reviewing instances of fatal overdoses to identify missed opportunities for intervention or prevention can help provide that contextualizing information, which can help inform prevention programming and policy changes.

Overdose Fatality Review

The purpose of an overdose fatality review (OFR) is to effectively identify system gaps and innovative community specific overdose prevention and intervention strategies. OFRs include a series of confidential decedents documents are reviewed to examine a decedent's life cycle in terms of drug use history, comorbidity, major health effects, social-emotional trauma, encounters with law enforcement and the criminal justice system, treatment history and other factors, including local conditions, to facilitate deeper understanding of the missed opportunities for prevention and intervention that may have prevented an overdose death (Heinen & O'Brien, 2020).

Fatality Review in Nevada

In Nevada, fatality reviews are enabled in state statute. While statute is not required to convene professionals from various sectors, enabling language in state statute allows for state agency administrative support, funding, and most importantly- data and records sharing, something that is an absolute necessity to conduct a meaningful overdose fatality review. This section of the report looks at the existing fatality review committees that are currently enabled by state statute.

Child Death Fatality Review - (NRS 432B.407)

The Child Death Review (CDR) was established in the early 1990s. The CDR is administered by the Nevada DHHS- Division of Child and Family Services. In 2003, a law was passed that levied a fee on death certificates to support the state's CDR work. Nevada has both state and local CDR teams. There are six local teams, and one state team, the Executive Committee to Review the Death of Children. The Nevada CDR program works to promote prevention, education, and case analysis to help change policy and programs in order to prevent child death. Data collected across the various jurisdictions is standardized, which allows for the state to produce one annual CDR report (*Spotlight – Nevada – The National Center for Fatality Review and Prevention*, 2020).

Child Death Review and Overdose

In 2020 the state's CDR program coordinator reached out to the OD2A program and asked for information related to data collection, naloxone distribution, and fentanyl testing as a result of findings from a recent local overdose fatality review, in which the local team found that overdoses in the under 18 population were increasing.

Domestic Violence Fatality Review - (NRS 217.475)

The Domestic Violence Fatality Review Committee is housed in the Nevada Attorney General's Office. The 10-member multidisciplinary team compiles information to review deaths related to domestic violence (Phebus, 2014). The Committee produces an annual report.

Intimate Partner Violence and Opioid Substance Use

A 2019 study published in *Injury Epidemiology* found that intimate partner violence is frequent among people who use opioids. The study reports that opioid use is elevated in intimate partner violence as compared to the general population (Stone & Rothman, 2019).

Maternal Mortality Review Committee - (NRS 442.751)

The 2019 Nevada Legislative Session established the Nevada Maternal Mortality Review Committee. The committee was effective January 1, 2020, with the goal of eliminating preventable maternal deaths and reducing maternal morbidity (Nevada Maternal Mortality Review Committee, n.d.). Beginning April 1st, 2021, the committee will submit a report to the LCB by December 31st of even numbered years. The report will also include recommendations for how to prevent maternal deaths.

Maternal Deaths and Overdose

In December of 2020, The Nevada DHHS Office of Analytics released Maternal Mortality Nevada from December 2018-2020. Drug overdose deaths were identified using underlying and contributing ICD-10 cause-of-death codes, unintentional, suicide,

homicide, and undetermined. This report shows that 80% of drug overdose deaths had non transport accidents as the underlying death cause. Additionally, this report finds that 100% of the drug overdose deaths were unintentional (Zhang, 2020).

Suicide Fatality Review - (NRS 439.5102)

Established in 2013, the Statewide Committee to Review Suicide Fatalities (CRSF) was created with in the Office of Suicide Prevention (OSP). In 2016 the committee's first report was released and it highlighted areas to improve coordination and communication to help prevent suicide. From this report the OSP developed a statewide Action Plan to guide activities. The CRSF holds biannual fatality reviews.

Unintentional overdose and suicide.

There is a mounting body of evidence that supports the intersection of suicide and overdose and their prevention and intervention strategies. A review of 250,000 national emergency department visits by adults for opiate overdose show that only 54% of the overdoses were classified as "unintentional": 26.5% were deemed intentional, and 20.0% were "undetermined." Together, these data and other ED data suggest that the true proportion of suicides among opioid-overdose deaths is somewhere between 20% and 30%, but it could be even higher. A recently released evaluation of veterans found a significant interaction between both the initiation and termination of an opioid treatment plan and overdose and suicide (Oqendo & Volkow, 2018), (Olivia et al., 2020).

Pilot Project Overview

OD2A funds were used to contract with Social Entrepreneurs Inc (SEI) to support and document recommendations from the overdose fatality review exercise. The OD2A program manager, grants and project analyst, and opioid epidemiologist met with Office of Suicide Prevention staff to discuss opportunities to conduct an OFR pilot. OD2A staff presented to the Committee to Review Suicide Fatalities to obtain support for the pilot from the committee members. The OD2A program attended two committee meetings.

The OD2A program gave two presentations to the committee. During the June 2021 meeting the OD2A committee proposed piloting an overdose fatality review under the CRSF, using data to show the intersection of suicide and overdose. During this meeting, committee members raised concerns about the challenges determining intentional vs. unintentional intent for overdose. The coroner medical examiners committee members believed that this could be a barrier in determining which cases the committee would review. The committee requested OD2A staff work with OSP staff to review the most recent data available to determine how many suicides were caused by overdose.

In January of 2022 the OD2A program presented before the CSRF. The requested data was provided and can be found in figure 1[ER2]. In addition to providing the committee with the requested data, and in response to the concerns regarding determination on intent, the OD2A program provided a study released in 2019 that found that 44% reported using opioids with passive intent to die by suicide[1]. Additionally, the OD2A program provided a suggested case definition to use when selecting cases. The committee members engaged in a robust conversation about determining intent. At the end of the discussion the committee decided they would be interested in looking at cases where overdose was the cause of death, but the intent was undetermined.

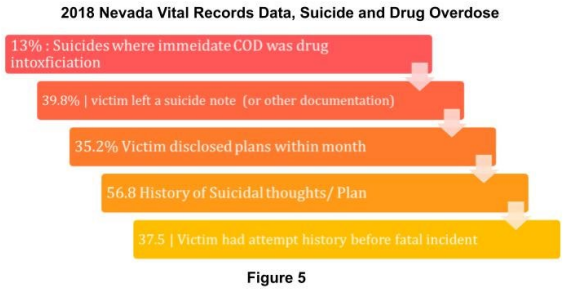


Figure 5

Once the committee agreed they would look at fatal overdoses of undetermined intent, OD2A staff met with OSP staff to begin pulling cases for review. The case documentation provided to the committee primarily included documents from the Coroner/ Medical Examiner Investigation. While NRS allows for CFRS to pull decedent's records from other state agencies, limited documentation was provided to the OSP prior to the meeting.

[1] Pergolizzi, J, Breve, F, et al. 09/18/2021. *Suicide by Opioid: Exploring the Intentionally of the Act.* DOI: 10.7759/cureus

The OFR was held as part of the CRSF's annual review in Las Vegas on June 13th, 2022 at the Clark County Coroner's Office. The Committee reviewed four cases over fatal overdose, of undetermined intent.

OFR Pilot Summary

The Overdose Data to Action Program worked with the Office of Suicide Prevention to propose a pilot overdose fatality review. The Committee to Review Suicide Fatalities met twice to consider holding the pilot review. Member of the committee of the raised concerns over the CRSF holding an overdose fatality review because of some of the challenges related to determining the intent of death. The committee was able to reach consensus related to pulling cases that were left as "undetermined."

The Overdose Fatality Review Pilot occurred as a second day meeting for the CRSF meeting in June. Per NRS, the fatality review happens in both an open and closed session. The notes for the closed session are not included in this report but have been archived with in the Nevada OD2A Program's files and provided to the OSP for their records.

Meeting Participants:

- **Dr. Laura Knight, Coroner** Chief Medical Examiner, Washoe County Regional Medical Examiner's Office
- **Allison Zednicek,** CEO, Desert Parkway, Interim CEO for Reno Behavioral Hospital
- **Lesley Dickson, MD,** Nevada Psychiatric Association
- **Fran Maldonado,** Tribal Liaison, Division of Child and Family Services
- **Jamie Elizabeth Ross,** Executive Director, PACT Coalition for Safe and Drug-Free Communities
- **Terry Kerns,** Substance Abuse Law Enforcement Coordinator, Nevada Attorney General's Office

- **Sheila L. Leslie, MA,** Retired, Washoe County Social Services, Consultant, Sagepine Strategies
- **Misty Vaughan Allen,** Nevada Statewide Suicide Prevention Coordinator, Division of Public and Behavioral Health (DPBH), Bureau of Child Family and Community Wellness (BCFCW), Office of Suicide Prevention (OSP)
- **Richard Egan,** Training and Outreach Facilitator, DPBH-BCFCW-OSP
- **Nick Christie,** Administrative Assistant, DPBH-BCFCW-OSP
- **Kathryn Hooper,** City of Henderson
- **Miranda Branson,** Nevada Overdose Data to Action

CRSF Overdose Fatality Review Pilot - Missed Opportunities

The following issues were identified during the case review.

- **Post Discharge Support**
    - **Safety Planning with Family/ Social Support (s)** Based on the cases reviewed, there appeared to be a problem with developing safety plans with familial support system for people who are over the age of 18. The highest risk for suicide is 24 hours to 30 days period after an attempt. Patients should be sent home with a safety plan which includes reduction to access to lethal means, and this plan should be communicated to the patient's support system. One of the challenges discussed during the closed session were potential issues related to HIPPA.
        - **Overdose Reversal, Co Prescription, or at Discharge** In 2015 Nevada expanded access to the Overdose reversal drug, Naloxone (Narcan). Naloxone can now be provided for free from a community based organization, or co-prescribed and covered by insurance at a pharmacy. Based on the cases reviewed there are still opportunities for naloxone to be provided, whether it is provided to a patient upon Emergency Department Discharge or co-prescribed with an opioid prescription.

- **Coordination of care**
    - **Behavioral Health Medical Care Disconnection(s)**. Based on the cases reviewed there appeared to be a disconnect between medical care providers and mental health care providers, in these cases it was specific to the sharing of information related to screening results and risk assessments. An example of improved communication in this situation could be a social worker sharing the responses to a Columbia Suicide Severity Rating Scale Assessment with psychiatrist/ Family if permission is given.

- **Medication Reconciliation**
    - **PDMP Check.** While state law requires controlled substance prescribers check the PDMP at various clinical intervals, there were some missed opportunities for potential intervention to lethal means that may be been able to be circumvented had a PDMP check been conducted.
    - **Records from individual prescribers.** Controlled substance prescriptions are required to be registered in the state's PDMP at dispensing. However, there is no such registry or requirement for non-controlled substances. Based on the case review there may be a need to provide medication management or reconciliation for patients that are dealing with complex medical and behavioral health issues in which many providers are rendering care and writing prescriptions.

- **Interventions and Supports for Vulnerable Youth**
    - **School-based resources and Drug Endangered Children's Program.** Students, parents, and faculty throughout Nevada have access to SafeVoice, an anonymous reporting system used to report threats to the safety or well-being of students. SafeVoice was established by the Nevada Department of Education under SB 212 in 2017 to protect student wellness, prevent violence and save lives.

In partnership with the Nevada Department of Public Safety, the SafeVoice program provides students a safe place to submit tips concerning their own safety or that of others. A fully trained professional team of experts responds in an appropriate manner 24/7/365. Tips always remain anonymous.

Handle With Care (HWC) is part of the Drug Endangered Children initiative mandated under Senate Bill 80. Handle with Care was established trough Senate Bill 80 in 2012 to better help children exposed to trauma so they can learn. Effective January 1,2020 all counties across the state are required to implement the program. The program requires law enforcement to alert school personnel when a child is exposed to a traumatic event during a first responder call. The intent is to notify schools when a student has experienced trauma in case extra support is warranted. School personnel are asked to keep a caring eye on the student or provide appropriate trauma-sensitive interventions immediately, if needed. Handle With Care requires, the following,

1. Police to send notification to schools.

2. Schools to receive notifications and prepare trauma-sensitive support.

3. Teachers provide trauma sensitive environments.

4. School counselors, social workers, mental healthcare providers to partner with schools for on-site assistance and off-site services.

- ***Education and support to family for child who was transitioning.*** *Based on the cases reviewed there may be a need to provide education or training to family support systems for younger people who are experiencing gender transition treatment.*

CRSF Overdose Fatality Review Pilot - Program Recommendations

- **Provide more opportunities for youth prevention.**
    - *The State of Nevada supports youth substance abuse prevention programming through various federal and state funded grant programs. Drug Free Community Prevention Collations support school and community-based prevention opportunities. Finding opportunities to expand the opportunities for community-based prevention could help to strength youth protective factors.*
- **Provide more peer support in the discharge process**
    - *Ensuring that Peer Support Services are embedded as part of the Emergency Room discharge planning process can help to increase social supports and improve patient outcomes (Bassuk, 2016). Nevada DHHS supports overdose response peer support services through the SAMSHA State Opioid Response Grant. Peer services were also made Medicaid Reimbursable in the 2021 Nevada Legislative Session. Expanding established peer response model to include intentional overdose attempts, or suicide attempts, could help to ensure improved outcomes for those individuals.*
- **Naloxone outreach to hotels/clubs**
    - Currently, *ODMAPs collects geo-located data on fatal and nonfatal suspected overdoses. While ODMAP doesn't specifically collect overdose intent data (intentional or unintentional), it can be combined with data retrieved from the State's EMS system, Image Trend. Data from these systems, could be used to see where suicides and overdoses are happening in hotel rooms to try to get buy in from hotels to keep Naloxone on site. Some local stakeholders, including casinos, have questions about the Good Samaritan Law and the implications it may have.*
- **Lifespan Review,**
    - *Gathering information about past traumas, risk factors, like ACES may help state program and policy leaders to better understand where the systems are failing as well as deepen the psychological understanding of the*

individual that is dying by intentional or unintentional overdose. While the state attempts to paint the picture of a decedents life through an overdose fatality review, a deeper more nuanced review may be needed. Nevada's Syphilis's Case Review uses familial and key informant interviews to help contextualize syphilis case review. The state may want to examine how principles from the Syphilis case review model may be used in overdose or suicide review. The committee listed the following to be considered as part of a lifespan review.

- *Use NRS/ability to request documents legally*
- *Interview key people*
- *Start with family and investigator that was on the scene*
- *Need to get legal advice on whether we can proceed with that for cases that are undetermined*
- *Look deeper into connection of care*
- *Look into early childhood trauma*
- *Obtain more qualitative data*

Policy Recommendations

- **Discharge patients with three-day supply of buprenorphine.**
    - *Initiating buprenorphine treatment in the Emergency Room when someone presents for a suspected nonfatal overdose has been shown to improve patient outcomes and treatment regimen compliance. At present, the Nevada Hospital Association is working with a number of hospitals in Nevada to pilot a Buprenorphine initiation program. There may be legislative or regulatory steps needed to be taken to allow for this practice.*

Additional Questions

- **Hospital morbidity and mortality conference review**
    - *One question for potential follow-up was related to hospitals' policy and practices related to morbidity and mortality conferencing after a patient death. A Morbidity and Mortality Conference is an educational series that occurs largely in health care facilities which have training and residency programs. These are potential opportunities for learning from medical errors, complications, and unanticipated outcomes (Kavet & Howell). The committee would like to know if* ***mortality conferences*** *are standard practices in Nevada hospitals after a patient dies. If not, the committee would like to explore opportunities to have these implemented in Nevada*.

OFR Process Development Recommendations

The OD2A Program Recommends the State of Nevada Department of Health and Human Services support an overdose fatality review to improve the state's ability to use data to inform overdose prevention and intervention programming and policy. The OD2A program recommends the follow specific recommendations:

- **Examine Leveraging Existing Committees**

  There are at least four fatality review committees enabled in Nevada State Statue. Each of these fatality review committees have either found overdose to be an issue or concern in the last year, or data supports strong ties in mortality in the target populations. The state should explore using these existing fatality review committees to pull and review cases related to intentional and unintentional overdose and make recommendations. Embedding overdose fatality review into an existing fatality review committee will help maximize state resources. Additionally, many of the special populations that are served by the existing case

reviews have shared risk factors for death. Therefore, embedding the review of overdose within these existing committees can also promote the integration of behavioral health, addiction, and harm reduction interventions across many sectors and populations.

The state may also want to consider convening one joint fatality review, in which selected or appointed members of existing fatality review committees convene to review selected overdose cases and make missed opportunity recommendations to the state's opioid overdose programming leadership.

- **Dedicated Resources to Support Fatality Review**

    - **Facilitation and Documentation Support**

    Having a strong meeting facilitator is considered a best practice for fatality reviews. A facilitator recruits and maintains relationships with committee members. They can help to collect and compile case information, they can also help to facilitate and pull information out of committee members during the case review (Heinen & O'Brien, 2020). Dedicated support for facilitation of the review can help to improve the quality of the recommendations. Additionally, dedicated resources that can support documentation can support a timely release of the recommendations.

    - **Dedicated Resources or Policy Changes related to Information/ File Collection**

    The OD2A program recommends using the OSP's Committee to Review Suicide Fatalities as a way to leverage existing enabled statute, staff, and processes to understand what may be needed to hold an overdose fatality review. Unfortunately, the case documentation provided to the committee for review was very limited. This was a result of agencies or organizations not responding to the request for documents. Having a dedicated OFR

administrative staff support can help to ensure that a more comprehensive set of case documents is available for committee review.

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