VDH VIRGINIA DEPARTMENT OF HEALTH

Local and Regional Fatality Review: The development of Overdose Prevention Action Teams

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Executive Order 26: Section 10

- Directs the Department of Health to work with local health departments to assist localities in establishing Overdose Fatality Review teams in accordance with Virginia Code § 32.1- 283.7 within 180 days of this order. The teams will work with local law enforcement and the Department of Behavioral Health and Developmental Services to follow up on fentanyl overdose deaths to identify the source of the drug and recommend immediate actions to prevent further overdoses.

Winchester Model

- Near real-time identification and investigative model used in the Shenandoah Region.
- Developed in 2012 in partnership between Virginia State Police, the local health system, and community-based agencies.
  - This model utilizes the three “arms” to investigate a non-fatal or fatal overdose, treat the immediate needs of the victim, and provide longer-term treatment or support through linkage of the person to resources.
- Initial identification of the case begins with a call to a special task force in that jurisdiction by emergency medical services (EMS) or the local hospital.
  - Virginia State Police begins the process of identifying the source of the drugs and opening an investigation on the person who sold the drugs or provided the drugs to the person who overdosed, if known.
  - At the same time, the overdose victim is being treated and linked to resources.
- If the case is a fatal overdose, the process is similar, but family members and/or associates are questioned in the process, with the goal being to charge the person who is most responsible with the death and pursue criminal charges.

Traditional Fatality Review

- Under code section § 32.1-283.7 *Local and regional overdose fatality review teams established; membership; authority; confidentiality; immunity* (https://law.lis.virginia.gov/vacode/title32.1/chapter8/section32.1-283.7/), localities are allowed to establish local or regional overdose fatality review teams and the Office of the Chief Medical Examiner provides support to the teams, as specified in the relevant statute.
- Local and regional fatality review teams conduct retrospective reviews of fatal events in self-identified communities.
- Fatality review teams are autonomous, supported by a coordinator from the lead agency, and staffed by local members of their community.
    - Members can include local law enforcement, medical and social systems, criminal justice, school systems, etc.
- The Office of the Chief Medical Examiner does not have any legal authority or provide oversight to local and regional teams, but depending on specific statutory provisions, does offer a model, protocol, and/or technical assistance and training, through its Division of Death Prevention.
- Fatality review teams operate under confidentiality standards and protocols.
- Team data is only released in aggregate form.
- Fatality review is not investigative.

Developing Local or Regional Fatality Review

- Identified issues:
  - Local health departments were not included in the initial initiation of the Winchester model and centered mostly on law enforcement, EMS, and hospital systems.
  - There is no legal framework for information sharing and security.
  - There are no standard policies and procedures.
    - Currently, the Winchester Model operates without oversight or a standardized protocol.
  - Funding for each “arm” of the model is provided by each agency or jurisdiction for their own work within the model.
  - No defined meeting schedules, data collection process, or data archive among the partners.
  - Traditional reviews of fatalities are retrospective
    - They also need to be reviews of completely closed cases, including any criminal or court proceedings unless the Commonwealth’s Attorney allows the review to occur.
  - There are too many overdoses to review by local or regional teams, at once or even in particular time frame.
    - A review team can review 30-40 cases a year depending on how often they meet.

Developing Local or Regional Fatality Review

- Considerations:
  - Oversight:
    - To create a cohesive structure, oversight of the teams is necessary by one entity and a coordinator in each locality or a regional coordinator to support several localities. This will ensure an appropriate funding structure as well as cohesiveness throughout the review process.
  - Database Management:
    - A database is necessary to capture the data of all teams.
  - Training:
    - Training is necessary to the teams and a plan needs to be in place that includes who is trained, methodology, and who evaluates the outcomes of the training to ensure that the work is following standard protocols.
  - Data Sharing:
    - A plan for sharing local level data with stakeholders, such as OCME. This upstream data sharing is necessary to support macro, state-level work.

- Considerations continued:
  - Roles and Responsibilities:
    - Roles and responsibilities, especially as it relates to cross-agency collaboration.
  - State Overdose Review Team:
    - Currently there is not a state overdose fatality review team, so all work will be at the local level, which could create a fragmented system. There is value in both the macro and micro levels of review.
  - Funding:
    - Four classified regional coordinators and two statewide classified coordinators.
    - One classified epidemiologist position to develop and manage the centralized database, to maintain the database, organize the data, complete data analysis and write the reports for distribution of information gathered by the Teams.
    - A total of $934,000 would be needed to provide the initial foundation to create and continually support those regions that can establish a team.

Recommended Next Steps

- *Overdose Prevention Action Teams* would combine real-time identification and fatality review models to allow for more timely identification of non-fatal and fatal overdoses, retrospective review, as well as the provision of resources to prevent and reduce future overdoses.
  - A local team concept based on a modified Winchester Model is proposed.
  - Joint leadership would be between the local health departments, as directed by EO26 and law enforcement.
  - Consideration for the development of statewide database that could house all the data from local investigative and fatality review work.
    - The creation of this database is important as it will not only provide data upstream for broader work but will also standardize data collection across all the teams, thus creating more valid and reliable data for use by the Virginia Department of Health and their partners.
  - Develop partnerships between local health districts and Virginia State Police, enactment of legislation, and provision of financial support for the teams.