ANNUAL REPORT 2019

OKLAHOMA OPIOID OVERDOSE FATALITY REVIEW BOARD

January 31, 2020

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BOARD MEMBERS

Mike Hunter Lori Carter *(Designee)*	Attorney General
Eric Pfeifer, M.D.	Chief Medical Examiner
Gary Cox Buffy Heater *(Designee)*	Commissioner, Oklahoma State Department of Health
Tracy Wendling, Ph.D.	Chief of Injury Prevention Services, Oklahoma State Department of Health
Jean Hausheer, M.D.	President, Oklahoma State Medical Association (Immediate past president)
John Scully (January 2019- June 2019) Bob Cook (July, 2019 to present)	Director, Oklahoma Bureau of Narcotics Dangerous Drugs Control
Terri White Jessica Hawkins *(Designee)* Andrea Hamor Edmondson *(Alt. Designee)*	Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services
Timothy Moser, D.O.	President, Oklahoma Osteopathic Association
Justin Brown Debi Knecht *(Designee)* Jennifer Postlewait *(Alt. Designee)*	Director, Oklahoma Department of Human Services
Rick Adams	Director, Oklahoma State Bureau of Investigation
Derek Manning	County Sheriff, Beckham County Sheriff's Office
Brandon Clabes (Co-Vice Chair)	Chief of Municipal Police Department, Midwest City Police Department
Linda Scoggins	Private Practice Attorney licensed in the state of Oklahoma
Chris Boring	District Attorney, District 26
Kevin Taubman, M.D. (Co-Vice Chair)	Physician with emergency medical training
Jason Beaman, D.O. (Chair)	Physician with experience in drug addiction treatment and recovery
Sheila St. Cyr, M.S., R.N.,N.P.D.-B.C.	Nurse
Paul Hesse	Member of the Judiciary
Lance Lang	Individual who currently receives or has been a consumer of addiction recovery services related to opioid use
Mike Maddox	Individual who currently receives or has been a consumer of addiction recovery services related to opioid use

Oklahoma Opioid Overdose Fatality Review Board Staff: Megan Wurzer, Senior Prevention Field Representative, Oklahoma Department of Mental Health & Substance Abuse Services; Alexandra Adkins, Assistant Attorney General , Office of Attorney General Mike Hunter.

INTRODUCTION

Background

From 2008-2018, more than 4,700 Oklahomans died of an unintentional overdose involving an opioid, including prescription and illicit opioids. At the height of the crisis, more than 500 Oklahomans died from an unintentional opioid overdose annually. Beginning in 2014, the number of unintentional opioid overdose fatalities began to decline suggesting Oklahoma's comprehensive efforts to prevent overdoses have made an impact. To further reduce overdose fatalities and other harm from opioids, advancement of evidence-informed prevention and treatment strategies is critical.

The Oklahoma Commission on Opioid Abuse and the Oklahoma legislature recognized the need for a multidisciplinary review of opioid overdose related fatalities in Oklahoma which led to the development of the Opioid Overdose Fatality Review Board via House Bill 2798 in 2018. The purpose of the Board is to reduce opioid overdose fatalities and better serve victims of unintentional overdose. The Board accomplishes this by: 1) analyzing data obtained through case reviews of persons eighteen (18) years of age or older who died due to licit or illicit opioid use; and 2) developing recommendations to improve policies, procedures, and practices within agencies and organizations that impact the lives of people using opioids.

The Board is comprised of a multidisciplinary team of subject matter experts in the following areas: forensic medicine, law enforcement, criminal justice, emergency medical services, public health, drug addiction treatment and recovery, and lived experience. Members meet quarterly to review cases and develop strategies to improve the state's response to opioid overdose.

Opioid Overdose Fatality Review in Oklahoma

The Board began its work on January 29, 2019 and met three additional times in 2019 to develop and adopt a purpose statement for the Board, examine variables that may affect the opioid overdose epidemic, outline methods for case review, and to review unintentional opioid overdose fatality cases.

The Board invited local experts to provide education and training on opioid overdose data in Oklahoma as well as processes followed by the Oklahoma Office of the Chief Medical Examiner and law enforcement related to opioid overdose fatalities. The information presented provided a foundation through which the Board developed the case review process.

The key components of the review process are anchored in the public health framework and are modeled after the Oklahoma Child Death Review Board and the Oklahoma Domestic Violence Fatality Review Board. These review board frameworks are based on national models and in alignment with technical assistance from national advisory groups including the United States Bureau of Justice Statistics. Oklahoma is one of few states that has an opioid overdose fatality review board and collaborates with other state partners to develop comprehensive review process standards.

Case Review

Cases for review by the Board were identified from a list of Oklahoma decedents provided by the Oklahoma Office of the Chief Medical Examiner who had unintentional opioid poisoning listed as the primary cause of death. Due to the high number of opioid overdose fatalities in a given year, the Board developed a set of guiding principles to select a subset of cases for case review to reflect priorities developed by the Board and represent a range of demographic and geographic perspectives.

Once the cases for review were identified, requests for records were sent to medical facilities, behavioral health service agencies, law enforcement agencies, correctional facilities, emergency medical service providers, the Homeless Management Information System, and other entities as appropriate. Board staff performed a preliminary review of records and information was abstracted to generate a timeline of documented events that preceded the individual's death. The cases were then brought to the Board where members conducted a comprehensive review of the available information during executive session[1]. The Board used data from the case review to observe trends, identify opportunities for detection or intervention, and develop recommendations to prevent fatal opioid overdose.

[1]The Board enters into executive session due to the confidential nature of the information considered in case review.

OVERVIEW OF UNINTENTIONAL OPIOID OVERDOSE FATALITIES IN OKLAHOMA

Data from the Oklahoma State Department of Health, Injury Prevention Service show that in 2018 there were 664 unintentional poisoning fatalities in Oklahoma; of those, 276 fatalities were due to prescription or illicit opioids. Prescription opioids were involved in 69% (191) of unintentional opioid overdose fatalities.

In 2018, the most common substances listed as the primary cause of death in unintentional poisoning fatalities included prescription opioids, benzodiazepines, antidepressants, muscle relaxants, alcohol, and illicit drugs. Methamphetamine accounted for the highest number of unintentional overdose fatalities followed by alcohol, heroin, oxycodone, and fentanyl (Figure 1).

Figure 1. Most Common Substances**by Year of Death, Unintentional Poisonings, Oklahoma, 2008-2018

	Number of Deaths										
Drug	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Hydrocodone*	116	133	141	127	152	155	145	103	78	60	36
Oxycodone*	121	129	135	130	161	165	158	130	126	84	60
Alprazolam	114	134	133	109	112	91	102	83	64	60	29
Methadone*	117	100	91	69	80	73	63	58	45	29	17
Morphine*	80	75	72	94	82	86	77	56	57	53	29
Fentanyl*	56	77	51	48	57	62	39	53	68	54	50
Diazepam	32	41	40	44	31	29	38	26	28	20	7
Carisoprodol	46	34	35	38	32	24	20	21	6	<5	<5
Tramadol*	24	22	23	30	40	25	27	25	20	17	9
Citalopram	20	22	27	22	13	10	12	5	10	<5	<5
Alcohol	98	104	110	115	90	121	126	91	101	118	84
Methamphetamine	37	68	96	101	123	178	159	227	278	307	339
Heroin*	11	18	6	16	29	28	25	33	52	56	80

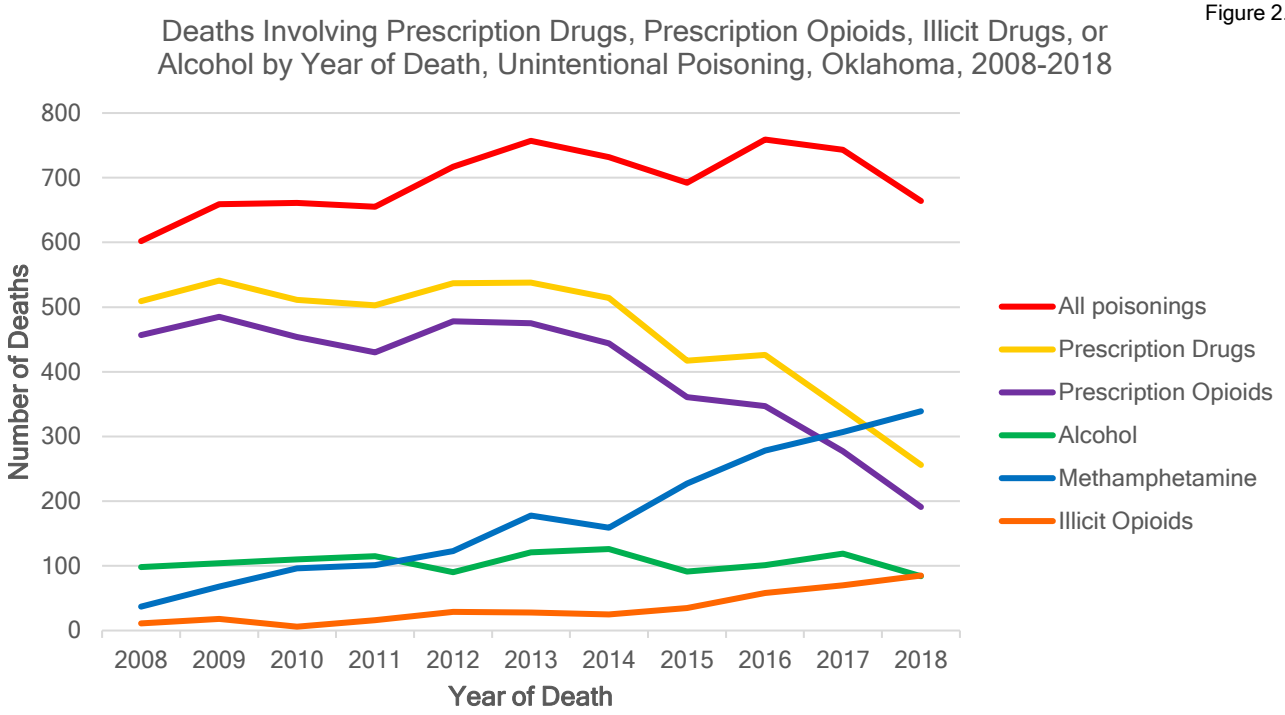
* Opioids
**Substances listed in cause of death

Source: OSDH, Injury Prevention Service, Fatal Unintentional Poisoning Surveillance System (Abstracted from Medical Examiner reports)

From 2012-2018, unintentional prescription opioid overdose fatalities decreased, but unintentional illicit opioid overdose fatalities increased (Figure 2). While these data show an overall decrease in fatal opioid overdoses, the increase in fatalities from illicit opioids

emphasizes the need for addiction prevention and treatment services, overdose prevention, and research.

Figure 2.



Source: OSDH, Injury Prevention Service, Fatal Unintentional Poisoning Surveillance System (Abstracted from Medical Examiner reports)

2019 BOARD FINDINGS

The Board reviewed 13 cases of individuals who died from unintentional opioid overdose in between January 2018 and September 2019.

Demographics

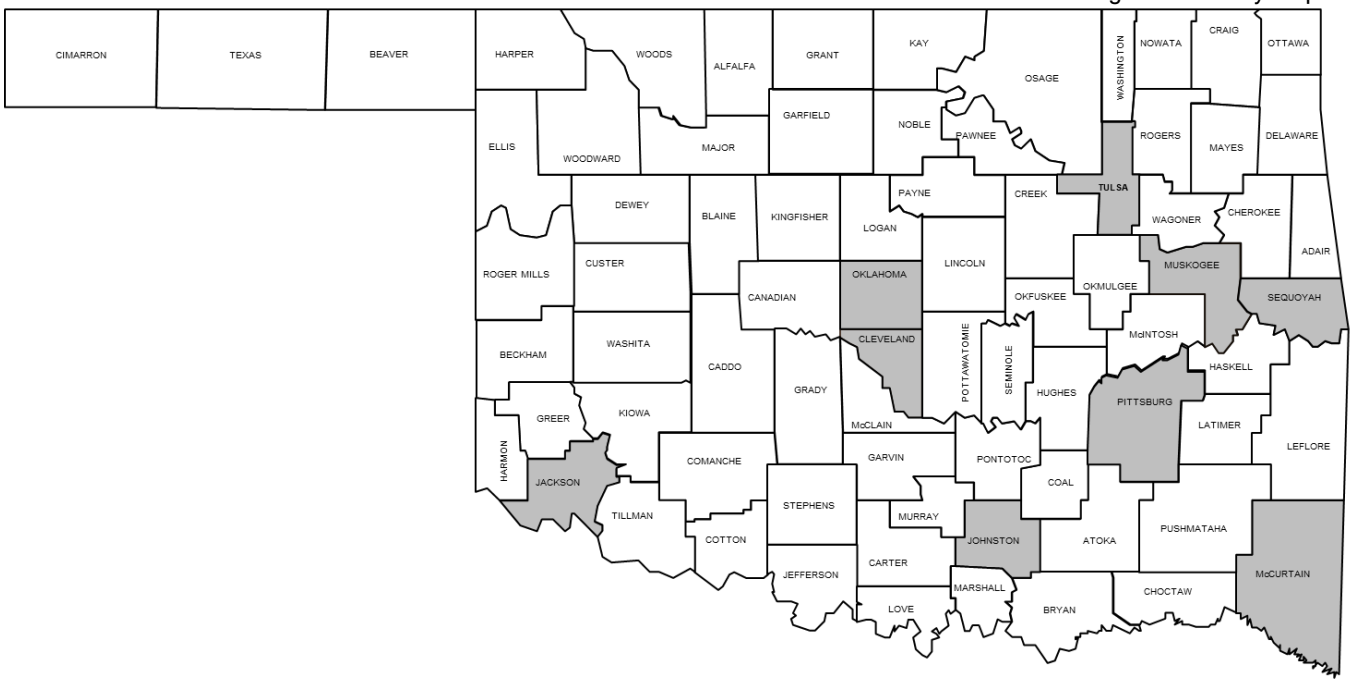
Of the cases reviewed, 54% (7) were men and 46% (6) were women. Decedents ranged in age from 19 to 43 years with the average age of 32 years. The majority of decedents reviewed were White (92%), and between the ages of 26 to 35 (54%) (Figure 3).

Decedents from reviewed cases resided in 9 Oklahoma counties: Cleveland (1); Jackson (1); Johnston (1); McCurtain (1); Muskogee (1); Oklahoma (2); Pittsburg (1); Sequoyah (1); and Tulsa (4) (Figure 4).

Figure 3. Demographics

Gender	Number	%
Female	6	46%
Male	7	54%
Race		
White	12	92%
African American	0	0%
Native American	0	0%
Hispanic	1	8%
Asian	0	0%
Other	0	0%
Age		
18 to 25	2	15%
26 to 35	7	54%
36 to 45	4	31%
46 to 55	0	0%
56 to 65	0	0%
66+	0	0%

Figure 4. County Map



Cause of Death by Drug Type

The Oklahoma Office of the Chief Medical Examiner investigates and determines manner and cause of death. The manner of death for all cases reviewed was accidental, and the primary cause of death included at least one opioid (illicit and/or licit).

Illicit opioids were listed as the primary cause of death in 8 cases, including heroin (5), fentanyl (2), and both heroin and fentanyl (1). Prescription opioids were listed as the primary cause of death in 5 of the cases reviewed. The majority of cases 69% (9) listed more than one drug as the primary cause of death. In 7 of the cases reviewed, additional substances were listed in the primary cause of death including an opioid plus methamphetamine (4) and an opioid plus benzodiazepines (3) (Figure 5).

Figure 5. Drugs Involved in Primary Cause of Death

Drug	Number of Deaths*
Heroin	6
Fentanyl	3
Hydrocodone	2
Hydromorphone	2
Methadone	1
Morphine	1
Oxymorphone	1
Oxycodone	1
Alprazolam	3
Methamphetamine	4

*One death may be counted in multiple drug categories if the primary cause of death on the Medical Examiner's report included more than one drug.

Education Level, Marital Status, and Military Service

It was reported that nearly 80% (10) of decedents in the cases reviewed had a high school diploma or less and 23% (3) had some college education, but no degree. The majority 69% (9) were never married; 15% (2) were married, but separated; 8% (1) were divorced; and 8% (1) were married at the time of their death. Of the 13 cases reviewed, only 1 decedent served in the military.

Criminal Justice Involvement

Of the cases reviewed, it was reported that 69% (9) of decedents had been incarcerated at least once in their lifetime, and 15% (2) were released from jail or prison within 30 days of their death.

Intimate Partner Violence

Sixty-two percent (8) of the decedents reviewed had a documented history of intimate partner violence. Of those 8 cases, 4 female decedents reported experiencing intimate partner violence and 4 male decedents were reported to be perpetrators of intimate partner violence.

Administration of Naloxone

Timely administration of naloxone[2] can prevent an opioid overdose fatality. Of the cases reviewed, naloxone was administered by law enforcement in 1 case, emergency medical responders in 5 cases, and at the hospital or emergency room in 4 cases. In 3 of the cases, naloxone was administered by more than one agency. Law enforcement and medical records were used to determine if an individual, other than the decedent, was present at the onset of overdose and if naloxone was administered by a bystander (such as a friend or family member) prior to arrival of emergency medical services or law enforcement. A witness was present at the time of the incident in 31% (4) of the cases reviewed. Of the witnessed events, naloxone was administered by a bystander in 1 of the cases.

[2] Naloxone is an opioid antagonist medication approved by the Food and Drug Administration (FDA) that is used to reverse an opioid overdose. It blocks opioid receptor sites, reversing the toxic effects of the overdose.

RECOMMENDATIONS

After careful consideration and analysis of the data obtained from the cases reviewed in 2019, the Board proposes the following recommendations:

Criminal Justice

The board recognizes the risk of overdose is dramatically increased for people exiting jail or prison and that people with substance use disorders are often involved in the criminal justice system. As such, the Board recommends:

1. Detention centers should implement of Overdose Education and Naloxone Distribution (OEND) programs and provide referrals to appropriate treatment services upon discharge from jails and prisons.
2. Detention centers should provide educational materials on overdose, accessing naloxone, and treatment and recovery services to incarcerated people.
3. Detention centers should use mental health and substance use disorder screening tools upon entry to jail or prison to increase the identification of substance use disorder and provide access to appropriate treatment services.
4. The legislature should create a task force to assist, evaluate, and provide oversight for jail and prison based treatment programs in Oklahoma.
5. The legislature should explore funding opportunities for substance use treatment programs in detention centers.
6. Develop, implement, and provide education on standardized protocols for death scene investigations.
7. Distribute information on local treatment and recovery resources to community members in need of services.

Public Health

Public health, human services, and substance abuse treatment providers have served on the front lines of recognizing and addressing the opioid crisis. As such, the Board recommends:

1. Encourage detention centers to provide educational materials on overdose, accessing naloxone, and treatment and recovery services to incarcerated people.
2. Improve monitoring and surveillance of opioids, including fentanyl and other highly potent opioids, to obtain real-time information of increased opioid overdose activity and respond with outreach and education.
3. Provide printed materials to law enforcement with information on local treatment and recovery resources.
4. Promote the use of mental health and substance use disorder screening tools in primary care and other healthcare settings to increase immediate interventions and make appropriate referrals for treatment for people with substance use disorders.
5. Promote the dissemination of information and materials about the Oklahoma Good Samaritan Law to community members.
6. Increase harm reduction efforts to reduce overdose deaths and other adverse consequences including providing materials, information, and education to support the health and safety of people who use drugs.

Healthcare

Healthcare providers address the health and wellness of people on an individual level, and are in a unique position to address opioid overdose. As such, the Board recommends:

1. Co-prescribe naloxone with opioid medications.
2. Follow evidence-based pain management practices and Oklahoma's Prescribing Guidelines if prescribing opioid medications.
3. Propose the addition of a feature to the Prescription Drug Monitoring Program (PDMP) that offers quick access to treatment and recovery resources.
4. Propose the addition of an automated alert to the PDMP that prompts prescribers to co-prescribe naloxone with opioid medications.
5. Support increased access to medication assisted treatment (MAT) in emergency departments, primary care, and other medical settings.

All Sectors

1. Increase access to MAT, sober living, and mental health services for vulnerable populations including law enforcement involved, child welfare involved, and un/under insured.
2. Enhance education on the availability and proper administration of naloxone to law enforcement, service providers, and community members.

The Opioid Overdose Fatality Review Board

1. Should evaluate the utility of death notification letters notifying clinicians of an opioid overdose death in their practice in the next year.
2. While the purpose of this board is to examine unintentional opioid overdose fatalities and enhance strategies to reduce those fatalities, the board recognizes that intentional opioid overdose is also a problem. As such, we support efforts to increase education for healthcare providers on the connection between substance use disorder and suicide.

These recommendations are based on the culmination of the first year of work both in setting up the board and reviewing cases. We look forward to continuing to work with stakeholders and further refining these recommendations in subsequent reports.