DEPARTMENT OF HEALTH

Overdose Fatality Reviews in Minnesota

AN EVALUATION OF IMPLEMENTATION

Overdose Fatality Reviews in Minnesota

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In Memorial

The Minnesota Department of Health (MDH) acknowledges and honors the lives lost to overdose and the friends, family, and communities mourning these losses that have been reviewed during Overdose Fatality Reviews (OFRs). People who have lost their lives to overdose were loved, valued, and are missed. MDH is committed to honoring their memories through continued community-informed work to prevent future overdose deaths.

White Earth Nation Memorial Statement

As a community, we mourn the deaths of those taken by opioid addiction. These mothers, sons, sisters, and uncles should be remembered as whole people who have experienced hardships, love, and joy. Our relatives' deaths remind us of all the work and healing still needed in our community. Minjimenim giinitamawind inawemaaganag: remember our relatives.

Executive Summary

Overdose Fatality Reviews (OFRs) are a public health prevention tool used to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies to reduce fatal overdoses. An OFR examines the life of a person who died of an overdose to facilitate a deeper understanding of the missed opportunities for prevention professionals and healthcare providers to identify people at risk for overdose and provide interventions that may have prevented an overdose death. Through the Centers for Disease Control and Prevention (CDC) Overdose Data to Action grant awarded to the Minnesota Department of Health (MDH), 10 community-based organizations received funding to facilitate and implement OFRs in their communities. MDH has not previously funded organizations to facilitate OFRs, thus requiring an evaluation of the implementation focusing on the process of developing and maintaining OFR teams.

The evaluation identified several successes of MDH-supported OFR implementation, including:

- An increased appreciation for the in-depth fatality review model as a prevention tool to identify opportunities for intervention.
- The development and maintenance of increased connections between healthcare, prevention, and public safety professionals.
- An expanded understanding of the diverse array of prevention strategies that can reduce substance use, misuse, and overdose.

Many challenges impacted OFR implementation and were described throughout evaluation activities with OFR-implementing organizations providing potential solutions to reduce barriers in future implementations. Challenges primarily related to limited staff capacity to facilitate OFRs as well as access to data on decedents. Many of the solutions to reduce implementation barriers can be enacted by community-based organizations, although the continued successful implementation of OFRs in the state of Minnesota would benefit greatly from the adoption of the following recommendations:

- Establish legislative statute supporting OFRs as a public health surveillance tool allowing for secure methods of collection of personal health information and to reduce barriers related to data sharing.
- Select and fund agencies that already have established connections in a community, relationships with prevention partners, and the ability to dedicate several full-time staff positions to OFR coordination to adhere to implementation best practices.
- Develop an OFR oversight board or committee within MDH and a process for local OFR teams to share larger systems-level recommendations with MDH, the Opioid Epidemic Response Advisory Council (OERAC), and other entities with the resources needed to implement statewide interventions or enact policy changes.

Overdose Fatality Review (OFR) Background

The purpose of an OFR is to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies. In practice, OFRs involve recruiting and convening a multidisciplinary team to review the circumstances surrounding a person's death to identify opportunities for prevention, healthcare, and social services systems improvement. The concept of an OFR is based on child death reviews. Minnesota has been conducting child death reviews for more than 30 years. An overdose fatality review examines the life of a person who died of an overdose including details such as substance use history, major health events, social-emotional trauma (including adverse childhood experiences), encounters with law enforcement and the criminal justice system, treatment history, and other social determinants of health (high school graduation, food security, income, etc.) to facilitate a deeper understanding of the missed opportunities for healthcare providers, social service systems, and prevention to identify people at risk for overdose and provide interventions that may have prevented an overdose death.

By conducting a series of OFRs, communities begin to see patterns of need and opportunity, not only within specific agencies but across systems. The goal of an OFR team is to develop program and policy recommendations to improve coordination and collaboration between agencies and community conditions to prevent further overdose deaths. These recommendations are made by bringing together public health, public safety, health care providers, and community members. Examples of successful recommendations include the integration of peer recovery specialists, targeted naloxone distribution, and improved coordination of public safety and public health.

OFR Team Structure and Process

The recommended best practice for OFR teams is to have a single lead coordinating agency that oversees the OFR team and provides administrative support by filling three key leadership roles: facilitator, coordinator, and data manager.[1] These leadership members are responsible for recruiting OFR team members, conducting the review meetings, and collecting and organizing data on the decedents, meaning the people who have died by overdose. OFR teams are intended to be multidisciplinary and include individuals who can share information about a decedent or contribute to the analysis of available data to make recommendations that will prevent future overdose deaths. The ideal OFR team members are dedicated professionals who believe that overdoses are preventable, who are well-regarded in the field, and who have time to attend regular meetings and participate in follow-up activities.[2] More important than the number of team members is representation from all necessary fields and perspectives, including people from the same racial and ethnic community as the decedent. Overdoses affect a variety of populations, neighborhoods, and communities. To effectively function and work toward the goal of preventing overdose deaths, OFR teams need a diverse set of members from disciplines and sectors that represent the community, potentially including but not limited to:

- Local health department official
- Local law enforcement representative
- Medical examiner
- Culturally specific substance use treatment provider or peer recovery specialist
- Medication-assisted treatment (MAT) provider

- Mental health social worker
- Pain management clinician
- Emergency department physician
- Primary care provider
- Pharmacist/toxicologist
- Probation and parole officer
- Emergency medical service provider
- Drug treatment court representative
- Child protective services representative
- School counselor
- Tribal elder, traditional leader

Once people have been recruited to an OFR team, they are asked to attend review meetings and provide any information they may have on the person who has died of an overdose, referred to as a decedent. OFR team members are asked to share data from their agency's records as well as information that is publicly available including:

- Behavioral health records
- Criminal justice records
- Social services records
- Medical care records
- Information gathered from conversations with family and friends of the decedent
- Social media and obituary reviews

When OFR team members can bring a wide array of information about a decedent's life from several different fields, OFR teams are more likely to develop a set of actionable, community-specific, and holistic recommendations that can address the root causes of substance use.[1]

OFRs in Minnesota

The Minnesota Department of Health (MDH) Injury and Violence Prevention Section (IVPS) piloted OFRs in partnership with the City of Minneapolis Police Department, the Hennepin County Sheriff's Office, and the Minneapolis Health Department in 2019 with technical assistance funded through the Bureau of Justice Assistance. This pilot was an exploration of the utility of OFRs as a potential prevention tool to fund more widely. This pilot identified that channels of communication between prevention professionals, local government, and public safety were severely lacking, but that connection and communication could be improved by bringing diverse fields together to complete fatality reviews and develop cross-disciplinary recommendations.

> *"**The opioid crisis is such a significant crisis and so many people are working on it but there is not great coordination at the local level**. I think the state is starting to figure out how to bring together programs and people." – OFR Team Member*

The MDH utilized resources from the Institute of Intergovernmental Research to create the [Overdose Fatality Review Implementation Guide (PDF) (https://health.state.mn.us/communities/opioids/documents/ofrimplementationguide.pdf)](https://health.state.mn.us/communities/opioids/documents/ofrimplementationguide.pdf) to support OFR implementation in Minnesota.

A total of 10 partners have been funded by the MDH IVPS to serve as OFR coordinating agencies between 2021 and 2023. Each of the eight emergency medical services (EMS) regions in Minnesota received funding to facilitate OFRs through the Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program (BJA COSSAP). The eight EMS regions functioned as five work groups listed below:

- Western EMS work group (Northwest EMS, Southwest EMS, and West Central EMS)
- Northeast EMS
- Metropolitan EMS
- Central EMS
- Southern EMS work group (South Central and Southeast EMS)

The Centers for Disease Control and Prevention Overdose Data to Action (CDC OD2A) grant funded two culturally specific organizations, White Earth Nation and Alliance Wellness Center, to facilitate OFRs in tribal and Somali communities respectively. These culturally specific organizations were selected because of the disparate rates of fatal overdose among Indigenous and Black people living in Minnesota. In 2021, American Indian Minnesotans were ten times as likely to die from a drug overdose than white Minnesotans.[2] Black Minnesotans were more than three times as likely to die from drug overdose than white Minnesotans.[2] White Earth Nation was the only funded partner that had implemented OFRs prior to MDH funding. White Earth Nation had facilitated OFRs previously in 2019 through a partnership with the University of Minnesota Medical School, Duluth Campus, with funding support from the National Drug Early Warning System (NDEWS).[3]

Through increased OFR implementation with partners across the state, MDH hoped to achieve the following goals:

- **Short term goals** (to achieve within one year of OFR implementation): Build support for OFRs as a prevention tool; use data to guide recommendation development, engage professionals and community members from diverse fields as OFR team members; and improve communication between community-based organizations.
- **Medium term goals** (to achieve within 2-4 years of OFR implementation): Maintain engagement through recommendation implementation; expanded knowledge and awareness of prevention strategies to address the root causes of substance use and overdose; successful implementation of recommendations; and increased trust between state government, local public health, and public safety.
- **Long term goal** (to achieve within five years of OFR implementation): Reduce rates of overdose and increase governmental support for OFRs.

The MDH has not previously funded OFRs beyond the initial pilot in 2019. As such, the evaluation was primarily focused on process measures and assessing how an OFR team is established, organized, and functions. A summary of the evaluation purpose and methodology can be found in the Appendix: Evaluation Purpose and Methodology below.

Decedent Characteristics

As of December 2022, a total of 35 OFRs have been completed for which data has been provided in the MDH-managed database. Teams selected decedents to review from a random selection of all overdoses that occurred in their community in the last two years. Additional characteristics included:

- The average age of decedents was 34 years old.
- 23 (70%) decedents were identified as male and 10 (30%) identified as female.
- Most decedents were White (20, 60%), followed by Black or African American (7, 21%) and American Indian or Alaska Native (5, 15%).
- Hispanic or Latino identity was known for 3 (9%) of the decedents.
- The employment status at time of death was unknown for 15 (47%) of the decedents.
- A total of 9 (28%) of the decedents were known to have children under age 18 at the time of death. Most decedents (15, 45%) had completed high school.
- 27% (9) had completed some college credit or earned a degree, and 18% (6) had completed some high school credit but had not received a diploma.
- Most decedents (29, 88%) were housed at the time of death with the remainder (4, 12%) known to be homeless or unstably housed.

Characteristics at scene of death

Review Characteristics	Number of Decedents	Percentage of Incidents
No substance found	12	36%
Prescription for decedent	9	27%
Route of administration: ingestion	10	30%
Route of administration: injection	9	27%
Route of administration: snorting or sniffing	7	21%
At least one bystander present	21	60%
911 called immediately by bystander	11	52%
EMS called	23	--
No pulse when EMS arrived	12	52%
Naloxone* administered	12	39%
EMS or fire administered naloxone*	9	82%
Autopsy performed	28	85%
Toxicology testing completed	30	91%
Fentanyl (potent synthetic opiate) found in toxicology report	21	66%

*Naloxone is a medication that can reverse or reduce the effects of opioids.

As a result of difficulties gathering data described later in this report, the number of decedents with information provided on in-depth medical, social, and mental health history is more

limited than that provided through death records or medical examiner reports. Of the decedents for whom additional information was reviewed, most decedents did not have any known life stressors (e.g., job loss, eviction or loss of housing, food insecurity) within the 14 days prior to death (24, 77%). Within the 12 months preceding death, 22 (63%) decedents had at least one interaction with the healthcare system through an appointment with a medical provider, an emergency department visit, and/or an EMS call. Two decedents experienced nonfatal overdoses that were responded to by EMS within the 12 months preceding death.

Of the 31 decedents with mental health and substance use history provided, 19 (61%) had a known history or diagnosis of a mental health problem, 28 (90%) had a known history of substance use disorder or diagnosis, and eight (26%) had a known prior nonfatal overdose. The most known substance that decedents had a history of using was alcohol (16, 62%).

Of the 25 decedents with information provided on treatment or care for substance use disorder at the time of death, only four decedents were known to be currently in care. No decedents were connected with a recovery coach or peer support specialist at the time of their death. Within 14 days of death, three decedents were known to have returned to substance use according to information shared during the OFR.

Among those who had criminal justice information available (27, 77%), 17 (63%) had a known history of arrest, community supervision, incarceration, post-adjudication programs, or diversion programs. Of the 24 (68% of all cases) decedents with trauma history provided, seven (29%) had a known history of experiencing adverse childhood experiences with the most common being substance abuse in the household (5, 71%).

OFR Team & Meeting Characteristics

A total of 27 meetings were held resulting in 35 decedent reviews. The data sources that are most reviewed during OFRs were criminal justice records (24 cases, 69%), death certificates (24, 69%), and medical care records (20, 57%) although the completeness of medical records reviewed was noted as a challenge by many OFR coordinators.

OFR team members

Member	Number	Percentage of team
Hospital staff	25	71%
Local police	24	69%
County sheriff's office	23	66%
Emergency medical services	23	66%
Emergency department staff	21	60%
Public health departments	20	57%

Most OFR teams reviewed one decedent per meeting, but at least five OFR meetings were held in which multiple decedents were reviewed. OFR teams ranged in size from 3 to 22 members with the average size being 12 members. Some of the least represented fields were prescription drug monitoring program staff, faith-based or healing leaders, and toxicologists.

Successes

OFR implementation in multiple communities around the state experienced unique successes and barriers, however several successes were experienced by all OFR teams resulting in positive changes in OFR facilitation skills, increased awareness of effective prevention strategies, and strengthened community connections.

Increased readiness through training

Implementation of OFRs had several positive impacts on coordinating agencies and team members alike, beginning with the successful training of EMS and culturally specific partners in OFR implementation through a community of practice using the Overdose Fatality Review Implementation Guide (PDF) (https:// health.state.mn.us/communities/opioids/documents/ofrimplementationguide.pdf). As OFRs were a new tool for MDH to fund with community-based organizations, it was necessary to adapt OFR training materials from national subject matter experts on OFR facilitation, namely the Institute for Intergovernmental Research. Preparedness, confidence, and skills in conducting OFR facilitation tasks were measured using a pre and post survey completed by community of practice participants. Of the 12 skill areas determined to be crucial for successful implementation that were assessed in the survey, there were increases in 10 skill areas with participants moving from “fair” to “very good.” All the community of practice sessions were recorded and shared, along with national resources, which participants noted were very helpful for their learning.

Appreciation for the value of in-depth fatality reviews

All the team members that completed the OFR team member survey either agreed or strongly agreed that OFRs are a valuable prevention tool. Very few of the funded partners had coordinated or participated in an OFR before, let alone heard of OFRs as a practice, and OFRs had not been widely implemented across the state. **A notable early and sustained successful outcome was an appreciation for the value of fatality reviews that examine a decedent’s life to better understand the multiple factors that influence substance use, access to treatment, and well-being.** OFR teams were asked to collect information on numerous topics to create a full picture of a decedent’s life from childhood through adulthood including information on the decedent’s health care access, trauma history, social services history, and education.

> *“I love the idea of OFRs. I love the idea of all death review committees. Coming from hospice where we did interdisciplinary team meetings every week on every client, I know the benefit of pulling together truly interdisciplinary groups of people to bring new perspectives.* ***I think the difference between an OFR and looking at data is incredibly powerful… you look at trends and no one’s moved in the same way as when you talk about a person’s story.****” – OFR Team Member*

OFRs allow for community members to come together, honor the life and memory of someone who lost their life to a preventable overdose, and engage in community healing. This in-depth investigation of a person’s life and the areas for improvement that can hopefully prevent future deaths gave OFR team members motivation to continue building their

knowledge of prevention strategies and connections with other community organizations to create a network of support for people who use substances.

> *"We don't ever have another opportunity to process these deaths. Even though it is very sad and hard to process, it gives us that.* ***We wouldn't have an opportunity to do that, to go through the process of grieving and processing this loss of life.*** *I do think it gives me some motivation to do things in my own work and learn about how others respond to situations. I can figure out if there is some way that I could be in that process to make a difference. It helps with navigating systems and how we could all work together." – OFR Team Member*

Meaningful and sustainable community connections

Of the 39 people that completed the OFR team member survey, 97% (38) of respondents felt that the connection to their community has increased after participating on an OFR team. **A total of 30 (81%) OFR team members reported connecting with organizations that they did not have a relationship with previously because of their participation on the OFR team.** An OFR team member and governing committee member both summarized the impact of OFRs in facilitating new connections by sharing:

> *"It's amazing because we'll get into a room and people will not know what the other person is doing so it was really, really helpful to get a sense of how other groups function… That was one of the biggest strengths. Meeting these people.* ***The ways the OFRs were structured you had an opportunity to get to know people, stay in touch, and follow up outside of that space.****" – OFR Team Member*

> *"I've seen OFRs as very positive because we are able to connect not just to the partners that our department usually speaks with, but we've actually then been able to meet other people in the community that have other types of resources that I haven't been aware of, so I think* ***it's really opened up avenues for working with others, understanding their perspective, I think that's really huge****." – OFR Governing Committee Member*

An OFR coordinator shared that in addition to learning about other resources and making new connections, OFRs were a great tool to learn about the perspective of other organizations and how they approach their work. The vulnerability that OFR team members brought to team meetings coupled with the coordinator role in establishing a non-judgmental, non-blaming environment allowed for people to share their opinions and reasonings for conducting prevention work in specific ways that built a respect for different approaches and breaking down assumptions held by other team members.

> *"I went into OFRs with an assumption with how police and fire would show up. I was surprised they are really invested in wrap-around services and follow-up care that they want to do but can't because it's not their job. I thought they'd want more Narcan,* ***but they are heartbroken about the number of overdose calls they are getting and so interested in prevention.****" – OFR Team Member*

An example of a tangible, sustainable outcome from a culturally specific OFR fostering new connections is the inclusion of staff members from a culturally specific treatment center in a city's work group that will determine how opioid settlement dollars will be allocated. Prior to

the OFR process, a connection did not exist between the treatment center and city staff. Including treatment center staff in the work group will ensure that the perspective of providers, people in recovery, and people who are currently using substances is included in funding allocation decisions.

Increased awareness of existing services and gaps

Bringing together community members working across different fields had the positive impact of increasing awareness of the type of services and resources that are already available. A significant success of OFRs that has been heard through OFR team member evaluation interviews and through the OFR team member survey was **an appreciation of how many new resources were learned about simply by being in the same space as other service providers or community-based organizations and the improved communications pathways that developed because of this relationship building.** A total of 75% of OFR team members agreed with the statement that "I shared resources with community providers or organizations that I had not previously shared with." Developing a thorough understanding of all the potential resources that can support a person with substance use challenges, unstable housing, mental health challenges, or trauma takes a remarkable amount of time and investment in developing relationships to maintain a working knowledge of programs.

A theme heard in all OFR evaluation conversations with both coordinators and team members was an improvement in and the importance of connection, both among service providers and as a theme in the recommendations identified. **This improvement in connection resulted in new relationships between service providers, increased knowledge of different programs and resources, and a better understanding of how to connect people to these resources.** OFR teams learned about the resources available, where more resources were needed, and highlighted the importance of creating new systems of connecting people to resources in a timelier, streamlined way.

> *"Learning about all the different things and programs that are out there and already available to people who are struggling with overdose. **I wasn't aware that we had all these things out there.**" – OFR Coordinator*

> *"All of these different disciplines are learning much more details about what other disciplines are doing and how that relates to substance use and overdoses." – OFR Coordinator*

> *"**[Our recommendations] are all just different wording for increasing connections.** Being sure we are connecting people at risk of overdose to resources. In one form or another, they all sort of fall under this bucket." – OFR Coordinator*

Learning about the resources that are already present in a community also allowed OFR teams to better understand where gaps exist and to work collaboratively to address these gaps. An example shared by an OFR team member working in public housing is that the OFR team identified that there was a lack of housing stability vouchers for people who are currently unhoused and need somewhere safe to stay while waiting for a Section 8 housing voucher or other emergency housing services. This OFR team member was able to apply for crisis housing vouchers through federal housing and urban development funds with letters of support from other OFR team members that represented different organizations providing services to people who are not stably housed. This example shows the benefit of OFR team members connecting with one another to discuss gaps, use assets unique to their organizations, and offer support to

access and share new resources that can be accessed quickly without having to put forward a formal recommendation for implementation.

> *"We are so often communicating at leadership and systems level, which is great, but so rarely pre-OFR did we get down to things that were actually happening on the ground." – OFR Coordinator*

Expanded understanding of prevention approaches

One individual outcome experienced by many OFR team members was an increase in knowledge of prevention strategies, as represented in 84% of team members agreeing with the statement "Compared to when I first joined the OFR team, my knowledge of overdose prevention strategies has increased." An impactful learning among OFR coordinators and team members alike was the increased attention paid to primary and tertiary prevention in developing recommendations and discussion of how to prevent deaths most effectively. Many OFR team members and coordinators shared that their work has focused on secondary prevention strategies, which are intended to detect signs of problematic substance use, prevent substance misuse from occurring, and maintain abstinence from substances. Secondary prevention strategies include screening at medical appointments or offering recovery support groups. Conversely, primary prevention involves intervening before substance use occurs. Primary prevention of substance use can include increasing access to mental health providers to address childhood trauma before an individual begins using substances or increasing provider knowledge of non-narcotic pain management technologies to reduce opiate prescriptions. Tertiary prevention, also referred to as harm reduction, focuses on preventing substance use related harms like infectious disease or death and not necessarily focused on reducing or preventing substance use. Providing clean syringes or fentanyl testing strips is an example of tertiary prevention.

> *"**Prevention happens way earlier, way before people even use opioids.** It felt like the big theme in OFRs was that all of our reactions were just reactive like 'let's make sure they are just alive,' but we did nothing to stop it from happening again and then what happened? They died." – OFR Coordinator*

> *"I was an early promoter of medication assisted treatment and all that, but the other harm reduction issues like needles or fentanyl test strips, I think I supported them but now **I really feel more educated, and I know that the science is there behind it, and I know that it would be powerful to save lives.** Harm reduction can be hard to sell to other people, so I think **[OFRs] really supported the need to educate people and communicate about [harm reduction] and for me professionally to really accept and embrace it as an option for people.**" – OFR Team Member*

In addition to recognizing a need to focus future prevention activities on primary and tertiary prevention strategies, OFR team members also shared an **increased understanding of how their work relates to overdose prevention.** For example, an OFR team member that works in housing shared during an evaluation conversation that they weren't initially sure of how they could contribute to overdose prevention efforts but quickly learned that lack of stable housing was commonly experienced among decedents and that increasing the number of housing vouchers available in the community could help to reduce this overdose risk factor. As substance use prevention is a multifaceted issue that requires addressing risk factors and

promoting protective factors across many different fields, increasing knowledge and awareness of strategies across the prevention spectrum is necessary to create holistic community overdose prevention responses that address the root causes of substance use and overdose.

Implementation Challenges and Potential Solutions

As OFR implementation was a new project for MDH and most of the funded partners, this evaluation was designed to examine barriers to successful implementation experienced by OFR teams and identify solutions that can improve future implementation A few major challenges and solutions identified by OFR partners have been highlighted below.

Limited staff capacity and time intensive work

The OFR implementation guide explains that having staff members from the coordinating agency fulfill three distinct leadership roles is best practice: coordinator, facilitator, and data manager. The MDH learned from other jurisdictions with a history of implementing OFRs that creating and sustaining three different positions was not always possible and that many OFR teams were able to hold successful reviews with fewer personnel. The COVID-19 pandemic amplified capacity challenges as healthcare systems and first responders were stressed managing an increased need for services, thus reducing the time available to focus on OFR development. OFR teams that were not coordinated by emergency medical services organizations were less impacted by the competing priorities posed by the COVID-19 pandemic. The MDH provided funding to organizations already in existence, and some organizations decided to add OFR duties to already embedded staff duties, while others decided to hire new staff to complete this work. **The OFR teams that hired new staff had additional capacity to coordinate, facilitate, and collect data, but challenges related to data acquisition and recruitment remained regardless of greater staff capacity.**

Orienting to OFRs as a prevention strategy, recruiting team members, learning data collection systems, gathering information, facilitating meetings, and developing recommendations are all time intensive activities that resulted in most OFR teams extending their implementation timelines. An OFR coordinator that had been managing an overdose prevention work group prior to receiving funding to implement OFRs was able to evolve the work of this group to facilitate OFRs. A benefit of this approach to developing an OFR team was that "90% of people in the OFR have met 20 times in the past two years, so everybody knew each other and there was comfort. We didn't start totally fresh with building trust in one another, so people were open to giving suggestions and recommendations."

To reduce staff labor and time necessary to establish OFR teams, OFR partners suggest that future teams:

- Establish an OFR coordinator position with most duties focused on OFR facilitation and community relationship development.

  As stated by an OFR coordinator who was employed by a large community-based non-profit organization and was contracted with an EMS region to manage OFR work: "This is my only role — to convene partners to build a community to reduce overdose deaths and substance use in our community." This team with an OFR coordinator who was not balancing other roles has completed the highest number of OFRs and successfully implemented recommendations.

- Utilize an already established group in the community to recruit OFR team members or to implement OFRs. This strategy can reduce the amount of time necessary to develop relationships and establish trust.

> *"… with proper funding and infrastructure, I could see doing mini OFRs across the region, but they are really labor intensive to do well. I would need help, support, and infrastructure to continue these. The infrastructure would be somebody who can really devote some time to coordinating and interacting with this. It's space [to meet], finding people who have time, being able to make connections." – OFR Coordinator*

Developing and implementing actionable recommendations

Transitioning from in-depth fatality reviews with data collected from multiple service providers and healthcare records to developing and implementing feasible, achievable, and appropriate recommendations was the area of greatest challenge and learning for OFR coordinators and MDH alike. Prevention strategies for overdose prevention are numerous and can be implemented by individuals, families, community-based organizations, healthcare systems, and policymakers. **OFR coordinators shared that trying to identify and agree upon recommendations that could be acted on by the coordinating agency or participating organizations was at times dispiriting, as many recommendations identified by OFR teams focused on larger social determinants of health outside of the scope of influence of EMS agencies or culturally specific organizations.** For example, several recommendations developed by a few OFR teams focused on increasing housing and access to intensive case management. An OFR team member shared that the lack of housing was a theme identified by their team:

> *"In most of the cases reviewed, the individuals were either transitioning from a halfway house back to the general population or from incarceration back to a halfway house. **You can't fix anything else that is going on with an individual until they have stable housing.** Once they have stable housing, that is satisfying a basic need." – OFR Team Member*

This OFR team member and coordinator shared feeling stuck on developing recommendations that could address the lack of housing in their region and noticed some pessimism among OFR team members who felt that they did not have the resources to address this root cause of substance use and overdose. A different OFR coordinator shared that their team focused on a lot of recommendations that would be policy related or require additional funding, such as increasing a network of warm hand-off case managers available to support people re-entering the community from incarceration and increasing guidance counselor staff in schools.

While all OFR team member survey respondents felt that recommendations were developed that would reduce overdoses, only 13 (33%) felt that the recommendations would address the root cause of substance use. This disconnect between developing recommendations that can prevent overdose and recommendations that can prevent substance use in general is also a theme that was heard in evaluation conversations. There has been some confusion or concern among OFR teams about the feasibility of moving large-scale, systems level recommendations forward and the role of coordinating agencies in this process. **A lack of clarity or process on how to move these recommendations forward from development to implementation resulted in stalled OFRs or team members leaving as they were no longer sure of their role in the OFR process.** The MDH OFR implementation guide stated that a best practice was to recruit OFR team members from diverse fields, but the guide lacked suggestions for also recruiting

team members that were skilled in program development or management to support recommendation implementation in addition to data sharing and recommendation development. An OFR team member summarized this challenge by sharing:

> *"The group as a whole, the professions that came together, are reporters. They take in information and put it out — they aren't necessarily strategists. Their job is not to jump into that next step. That's where people like me that don't have technical expertise come in but who might be more helpful in the development.* ***Intentionally recruit people whose contributions are around that strategy and action planning space who can be there from the beginning to make sure that that element is represented.****" – OFR Team Member*

Recruitment, understanding of role, and maintaining engagement

OFRs are a relatively new prevention strategy to address overdoses, although fatality reviews have long been recognized and practiced as effective public health prevention tools. The MDH has facilitated fatality reviews focused on maternal mortality, suicide, and sudden unexpected deaths among infants and youth for several years, but knowledge of these practices has been relatively limited to those participating and widespread awareness has not existed. Recruiting people to join the OFR as team members was more challenging than expected as potential recruits did not immediately understand what their role would be or the purpose of an OFR. **The lack of widespread knowledge of or prior engagement with OFRs and building buy-in among potential team members and data sharing organizations was much more difficult than anticipated.**

> *"****OFRs are not well-known, unlike CPR classes. Nobody knows what an OFR is really going to look like or feel like****, so being able to be very transparent with not being experts and bring our group together to coalesce before starting reviews was really helpful." – OFR Coordinator*

Prior experience working in prevention programming, knowledge of substance use disorder and harm reduction, and interest in reducing overdose deaths were all identified by OFR coordinators as crucial characteristics of OFR team members that were more likely to be committed to the process and maintain engagement. There were some challenges with maintaining engagement if an OFR team member did not have information on the decedent(s) to share. Several OFR coordinators shared that if team members did not have any data to share on the decedent that they would not attend the OFR, but their absence resulted in a lack of their and their organization's perspective in the review and recommendation development. As OFRs are intended to convene perspectives from different fields, losing the perspective of a team member can hinder the development of holistic recommendations addressing prevention activities across the community.

Engagement was a struggle at times as the process of an in-depth fatality review can be very emotionally taxing and potentially traumatizing. Providing resources and support to OFR team members who worked with the decedent directly and are grieving the preventable loss of life is paramount to protecting the well-being of team members and creating an experience that did not result in emotional distress.

> *"It definitely impacted people. We are a small community, so a lot of people were at least acquaintances with some of the people if not an actual friend, and a lot of people*

remembered them, even if they didn't work with them one on one, remembered them coming into their services." – OFR Coordinator

OFR partners and team members identified solutions to build organization buy-in, improve team member engagement, and sustain engagement:

A significant challenge that impacted many of the OFR teams was difficulty acquiring data from team members spread across a large region. OFR best practices encourage coordinating agencies to collect data from a wide array of sources including information from behavioral health providers, the criminal justice system, prescription drug monitoring programs, and medical examiners. EMS OFRs were originally intended to be regional in scope, but **OFR coordinators quickly learned that to improve recruitment of team members that were most likely to have had a connection with the decedent and therefore data to share on the decedent's life, it was necessary to limit the geographic area when selecting cases to review and recruiting team members.** For example, an EMS OFR team had initially planned to select decedent cases from their 11-county service area, home to over half a million people. Recruiting team members from such a large area appeared to reduce the likelihood that team members had direct contact with the decedent and meaningful, detailed information to bring to the OFR meeting.

The MDH has statutory authority to collect personal health information for the purposes of public health surveillance to monitor health outcomes and epidemics, including the opioid epidemic. However, this statute is general in language and does not include OFRs explicitly. **This absence of clear inclusion of OFRs in the statute language resulted in a hesitation or refusal of some recruited team members and their employers to share information.** Several OFR coordinators noted that the healthcare systems in their communities participated in most OFRs but were unable or unwilling to share information on the decedents being reviewed, therefore hindering the ability of an OFR team to review comprehensive medical records or learn many details about prior interactions with the hospital or emergency department. The MDH developed a document detailing its statutory authority and the mechanisms of how this protects funded partners, but some potential partners were still hesitant to provide data.

> *"We really struggled with being able to get information released to us. They [healthcare agencies] would answer questions we asked, but they wouldn't provide much more than yes or no answers or a little bit of other information but only if we clearly asked for it… **Most healthcare agencies didn't want to provide anything and if there isn't a release for a patient or designated representative, they won't give it. They didn't think that state authority trumped HIPPA requirements.**" – OFR Coordinator*

> *"One of the big things that would help a lot is if we can **solidify the legal basis for the data collection** so that we can get through that barrier of "I'll only share the absolute minimum" whether that is sending out information to law enforcement in these areas as to why we are asking, or something else, so it gives us a little validity so that when we call them it's just another project the state has going on. I don't know if right now they really buy in to OFRs as a real valid project." – OFR Coordinator*

OFR coordinators were able to get quite a bit of information from MDH epidemiologists with access to the CDC's State Unintentional Drug Overdose Reporting System (SUDORS). Through the CDC's Overdose Data to Action grant, MDH staff collect and abstract data for drug overdose

deaths from death certificates and medical examiner reports for entry into a web-based CDC platform that is shared with the National Violent Death Reporting System (NVDRS). SUDORS allows local agencies like MDH to be better informed about the characteristics of decedents' circumstances surrounding an overdose death, and to use this information to inform prevention and response efforts. MDH epidemiologists were able to enter decedent information directly into the OFR REDCap database and attend OFRs to verbally share SUDORS data with the team members.

An unexpected challenge was the discovery during an OFR of additional data sources to access or service providers with whom connection was needed to provide the fullest picture of a decedent's life. Recognizing gaps in information necessary to conduct a thorough review required establishing a process to bring back and share additional information later. Developing this process resulted in improved richness of information but impeded the OFR team's ability to move from case review to recommendations within a single meeting. MDH epidemiologists had the advantage of having access to all SUDORS data prior to a review and ability to share this information ahead of time, which other OFR team members did not necessarily have. An OFR coordinator noted that meeting virtually helped to mitigate this challenge:

> *"Aside from us being biologically safe, [meeting virtually] had the end result of people sitting at their desks so if a question came up they could say 'I don't know let me check.' It's like being able to leave the room and pull the file. Immediate access to information was helpful. If we had all been in the same space, that would have been an open question and we would have needed to follow up.* ***We can just look at something virtually and share orally instead of having to create a document that needs to be kept confidential.****" – OFR Coordinator*

OFR partners identified several solutions to address data acquisition challenges:

- Limit the scope of an OFR team to a defined geographic area, such as a county or city.
- Limit the scope of an OFR team to a specific population that would have similar strengths and challenges regardless of geographic location, such as immigrants, refugees, or people of a specific cultural group like Somali or Hmong.
- Update Minnesota statute to explicitly include OFRs in the list of public health surveillance practices for which personal health information can be collected.
- Involve a county attorney in the development of data sharing agreements and include a letter of approval from the county attorney in data requests to reduce organizational and team member concerns related to data sharing.
- Establish recommendation subcommittees and provide a dollar amount to enact the recommendations. This can be helpful in identifying and implementing recommendations that are achievable for the OFR team.
- Maintain connection to policymakers and influential decision makers in the community, such as a county attorney or sheriff to improve recommendation implementation and buy-in for change.
- Develop and disseminate MDH branded materials describing OFRs and sharing evaluation information on the value of OFRs as a prevention strategy to increase knowledge and awareness of OFRs.

- Be intentional in recruiting OFR team members that already have a vested interest in substance use and overdose prevention.
- Host an initial meeting during which a case is not reviewed to onboard OFR team members to the OFR process, meet other team members, and ask questions of the facilitators. This type of initial meeting can improve team member comfort and contribute to establishing a shared understanding of the goal of OFRs.
- Share the expected timeline for the entirety of the OFR process transitioning from case review to recommendation implementation and the different type of skills required for these distinct phases of OFR work.

Recommendations for Continuation and Sustainability

The process-focused evaluation of initial statewide facilitation of OFRs by funded partners has revealed numerous potential opportunities for MDH to support the continued use of OFRs as a public health tool, advance implementation of identified recommendations, and continue expanding the diversity of prevention strategies to reduce substance use and overdose. The recommendations for continuation and stability differ from experience challenges as these recommendations would require action from MDH as an agency in partnership with funders, other state agencies, and policymakers to enact.

1. Establish legislative statute supporting OFRs as a public health surveillance tool allowing for secure methods of collection of personal health information and to reduce barriers related to data sharing.
2. Select and fund agencies that already have established connections in a community, relationships with prevention partners, and the ability to dedicate several full-time staff positions to OFR coordination to adhere to implementation best practices.
3. Develop an OFR oversight board or committee within MDH and a process for local OFR teams to share larger systems-level recommendations with the MDH, the Opioid Epidemic Response Advisory Council (OERAC), and other entities with the resources needed to implement statewide interventions or enact policy changes.
4. Identify sources of continued funding at either the state or federal level so that existing OFRs can continue reviewing cases and implementing recommendations.

   "I think the one thing that is my worry is that it has taken a lot of time and talent and energy to get this spinning up. It takes a lot to get it in motion. My worry is that we will get it in motion and then it will be the end of the funding. ***We've got all this momentum, but do we have the resources to continue? Keeping the ball in motion is less work, but it'd be awful to drop it and have to rebuild from there.****" – OFR Coordinator*

5. Explore opportunities to expand OFR teams to include persons with action planning and program implementation experiences, persons with lived experience, and information from next of kin interviews. Including the perspective of persons with lived experience as well as in-depth information from next of kin interviews could provide a more detailed picture of opportunities for prevention and barriers that people who use substances experience in accessing resources.

*"**I think that voice [of people with lived experience] was missing**, and it's so tricky to do this well, to have people that are there as community representatives and people with lived experience. I think it is really important and powerful. It is tricky to find someone who will be comfortable in a space with law enforcement discussing a death, power dynamics of working with government, and for someone who can feel like they are an equal power holder in that setting" – OFR Team Member*

Conclusion

MDH's evaluation of OFR implementation has confirmed the value of OFRs as a prevention tool that can build connections within communities, identify opportunities to reduce overdose deaths, and expand an awareness of the diverse strategies available to reduce substance use and its associated harms. Enacting recommendations that would require additional funding or policy change has proved challenging and represents an area of strategic growth for MDH. Continued funding would allow for the continued exploration of OFR implementation best practices, strengthening the connection between MDH and community-based organizations, and further evaluation of emerging recommendations that can reduce overdose deaths across the state.

References

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3. Greenfield, B., Russell, E., Youngdeer, H., Walls, M., and Alexander, C. (2019, December). *Reducing opioid overdose deaths in Minnesota: Insights from one tribal nation.* https://ndews.org/wordpress/files/2020/07/MinnesotaHotSpotReport-December-2019-FINAL.pdf

Appendix: Evaluation Purpose and Methodology

The purpose of the process-focused evaluation was to broadly determine if OFRs are a promising prevention tool to implement in Minnesota and support with continued funding. The goals of the evaluation were to:

- Demonstrate the value of OFRs as a prevention strategy that identify and address social determinants of health.
- Describe how OFRs contribute to strengthening connections between community organizations.
- Identify best practices and crucial components to establish successful OFR teams.

To accomplish these goals, an evaluation plan was developed centered on the following questions:

- How are OFRs being established? Who is involved with OFRs? What is the process like for developing an OFR team?
- What makes an OFR successful?
- Are OFRs valuable prevention tools? How do members, leadership, and community view OFRs?

Evaluation methods included collecting data on decedents through a REDCap database managed by MDH staff; key informant interviews with OFR coordinators, team members, and governing committee members; and a survey of OFR team members conducted via REDCap.