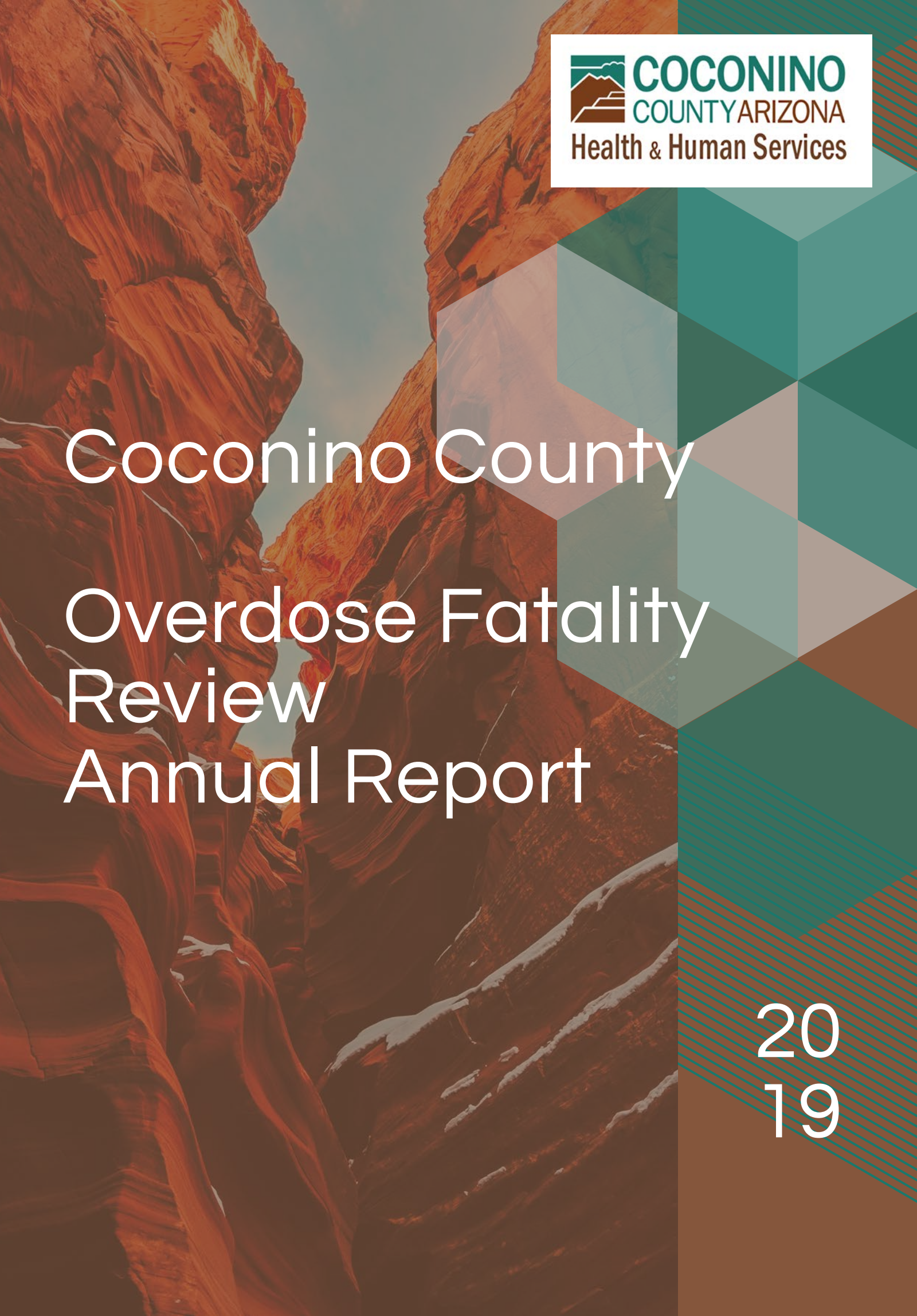


COCONINO COUNTY ARIZONA
Health & Human Services

# Coconino County

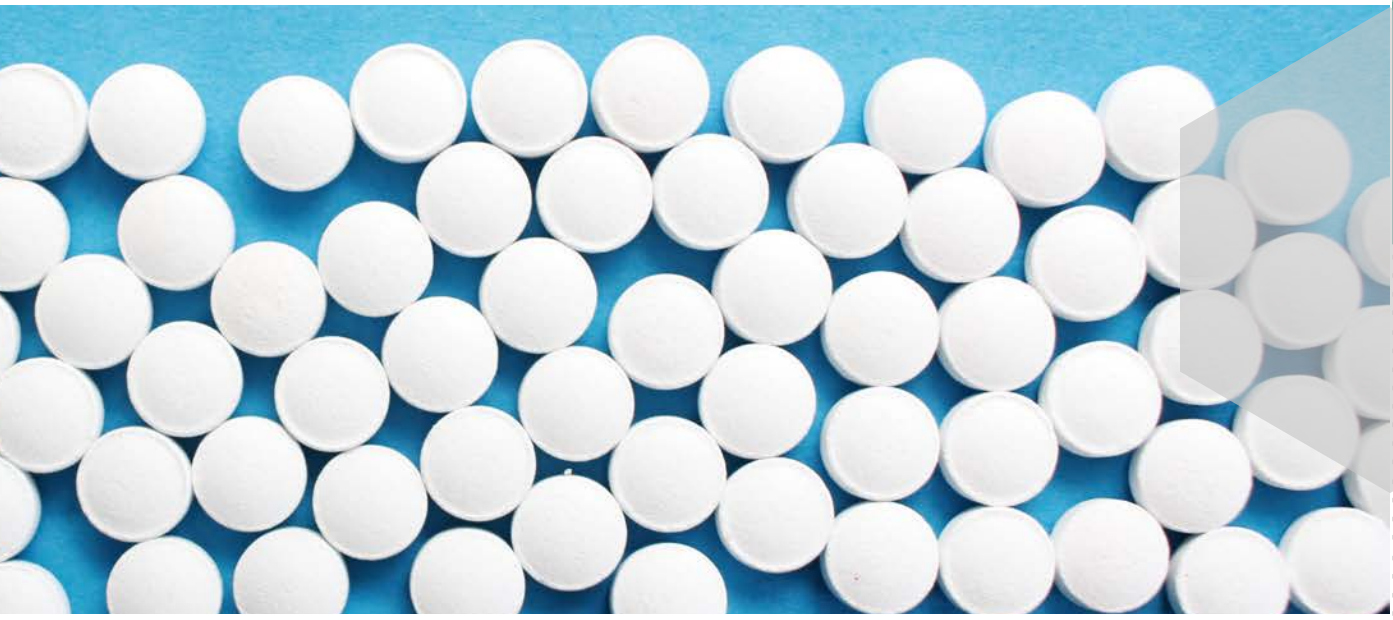
# Overdose Fatality Review Annual Report

2019

ANNUAL REPORT

# Content

# Introduction



## BACKGROUND

Coconino County Health and Human Services (CCHHS) convened its first Drug Overdose Fatality Review (OFR) team meeting in June of 2019. The OFR was established as a component of the statewide response to the opioid epidemic following Governor Ducey's declaration of a public health emergency in April of 2017. The Arizona Department of Health Services (ADHS) administers a statewide OFR program and supports local county OFR teams, as established under A.R.S. §36-198.

This legislation granted counties the authority to request records from various entities, including the County Medical Examiner (ME), local law enforcement, and the courts system, in order to review the documented circumstances surrounding each death.

## GOALS

The goal of the OFR Board is to reduce preventable drug overdose deaths by participating in a systematic review that engages multidisciplinary partners to share data and assess the circumstances of overdose deaths. Through this process of collaborative information sharing and analysis, the group develops a deeper understanding of the causes and factors that predict drug overdose deaths and proposes data-driven recommendations for public policy and programmatic interventions to prevent overdose fatalities. Central to the aim of preventing future drug-related deaths though a multidisciplinary team is to examine opportunities to strengthen cross-system care, mitigate risk factors, and maximize opportunities for prevention. The group also analyzes trends and common traits among decedents in order to identify points of intersection across systems of care.

## OVERDOSE FATALITY REVIEW BOARD

# Members

Coconino County Health and Human Services

Coconino County Adult Probation

COCONINO COUNTY ARIZONA

Coconino County Attorney's Office

Coconino County Sheriff's Office

Coconino County Detention Facility

Northern Arizona University Police Department

Flagstaff Police Department

Native Americans for Community Action

The Guidance Center

Southwest Behavioral & Health Services

Northern Arizona Healthcare

# METHODOLOGY FOR CASE REVIEW

Coconino County's OFR team utilizes the following procedure to conduct its case review.

## 1 STEP 1: CASE IDENTIFICATION

Identify cases through the Office of the Coconino County Medical Examiner (ME) on a quarterly basis.

## 2 STEP 2: OBTAIN RECORDS

Obtain all pertinent records from the ME, Law Enforcement, and Courts for overdose deaths.


## 3 STEP 3: CREATE CASE SUMMARIES

Prepare summary reports based on all the records obtained.

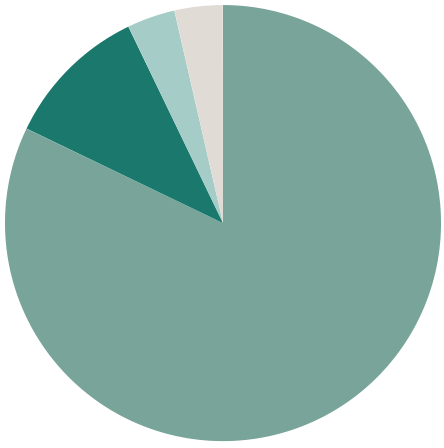
## 4 STEP 4: CONVENE QUARTERLY MEETINGS

Convene quarterly meetings in which select cases are reviewed and discussed in greater detail. The team's discussion focuses on understanding the medical, social and behavioral health circumstances surrounding each death in an effort to identify prevention measures. The team asks itself two key questions:

1) What possible changes could have been made in this person's life?
2) What points of contact, connection, systems changes, education, etc. could have prevented this death?

## Coconino County 2019

# Summary of Data



White (82.14%) Native American (10.71%)
Middle Eastern (3.57%) African American (3.57%)

## Race

Comparing race among the 28 overdose fatalities reviewed:

- 23 were white
- 3 were Native American
- 1 African American
- 1 Middle Eastern

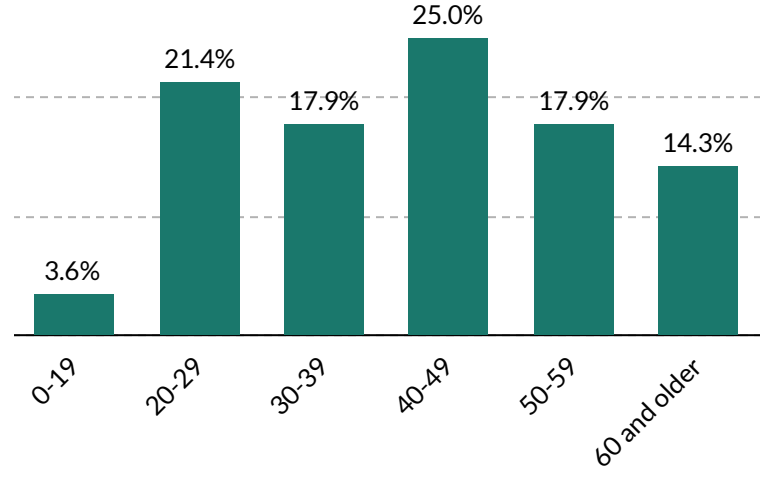
It is important to note that during review, a person's Hispanic ethnicity is often undetermined, which explains why this ethnic group is underrepresented in documentation of overdose fatality reviews.

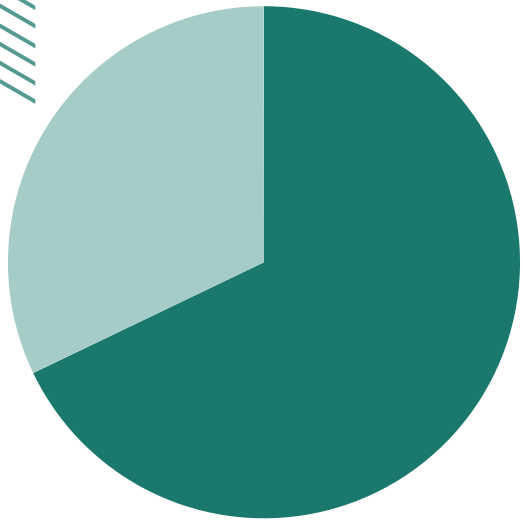
## Age

Among the 28 overdose fatalities reviewed, the distribution of age (by age groups) was relatively even across five of the six age categories:

- 40-49 years old = 7 cases
- 20-29 years old = 6 cases
- 50-59 years old = 5 cases
- 30-39 years old = 5 cases
- 60 and above = 4 cases

Fatalities under the age of 20 were the smallest age group, as there was only one case that fell in this category between October 2018 and December 2019.



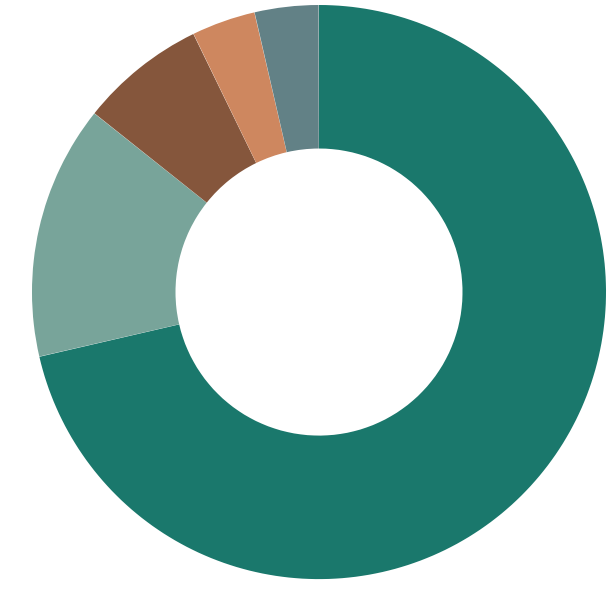



Male (67.9%) Female (32.1%)

## Sex

The majority of the 28 overdose fatality reviews were among men (23 cases).

Data collected from Coconino County Medical Examiner October 2018-December 2019




# Location

Of the 28 overdose fatalities reviewed, 20 (71.4%) occurred within the Flagstaff area.

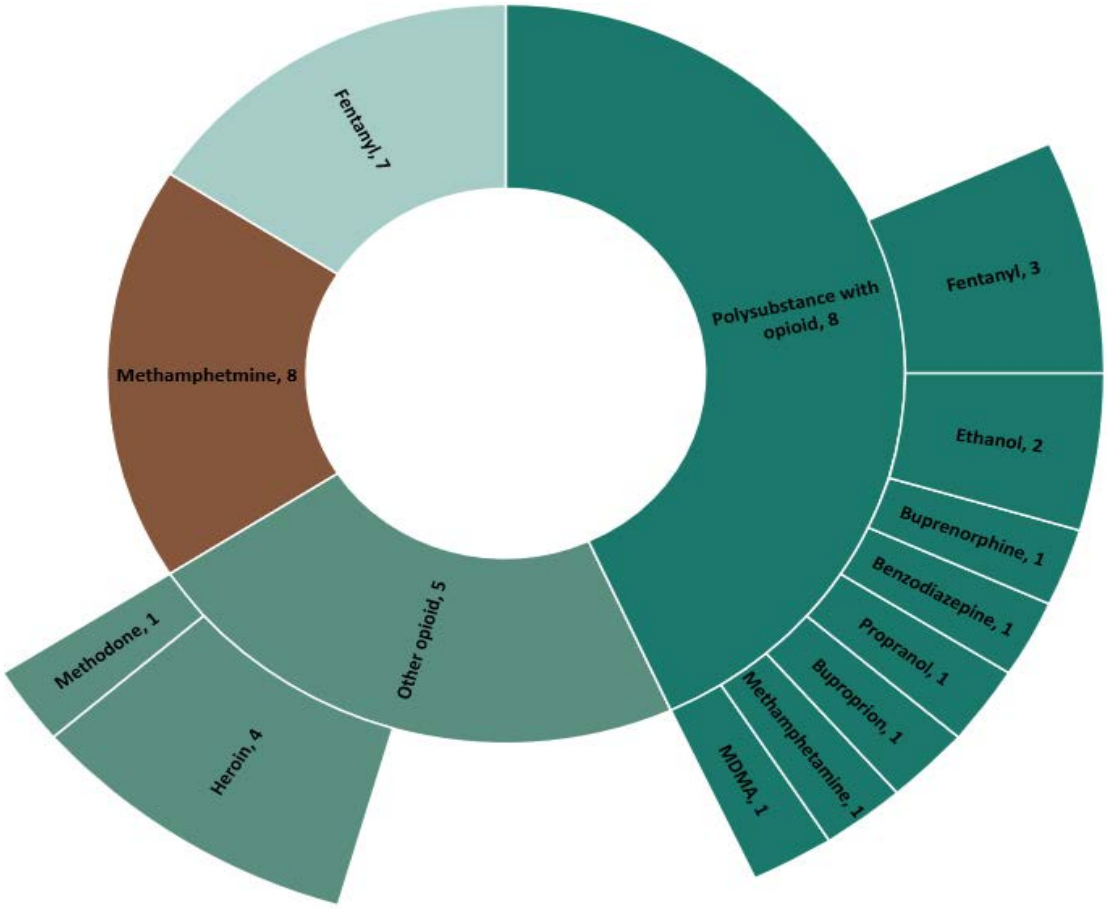
The remaining overdose fatalities investigated occurred in Coconino County's smaller communities. Of those communities:

- Williams had 4 cases
- Fredonia had 2 fatalities
- Page had 1 case
- Valle had 1 case

# Substances

Substances associated with overdose deaths were identified during the overdose fatality review. The three most common substances identified were:

- Fentanyl - associated with 10 (35.7%) of the 28 deaths (7 single substance and 3 polysubstance overdoses)
- Methamphetamines - identified in 9 (32.1%) of the 28 deaths (8 single substance and 1 polysubstance overdoses)
- Heroin - associated with 4 (14.3%) of the 28 deaths (4 single substance overdoses)




Data collected from Coconino County Medical Examiner October 2018-December 2019

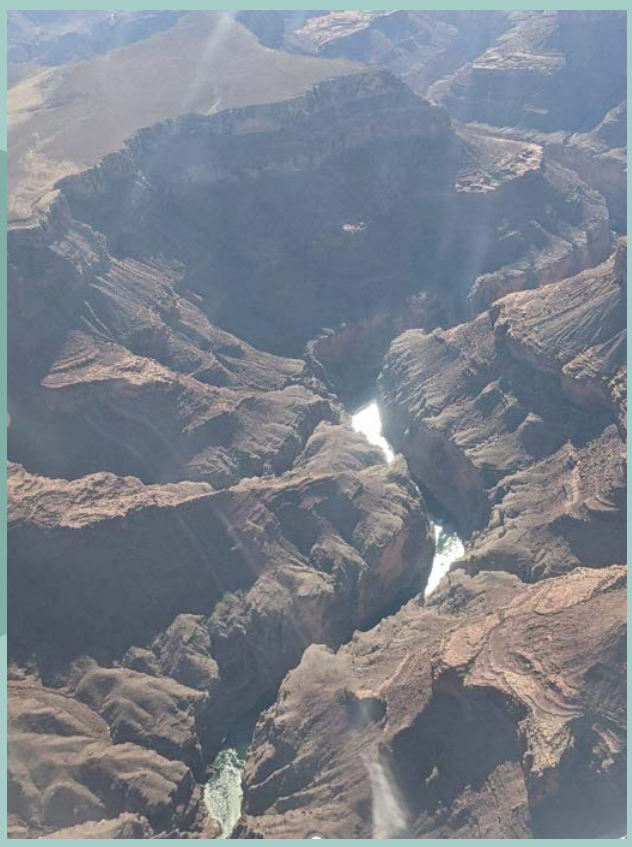
# Findings and Commonalities

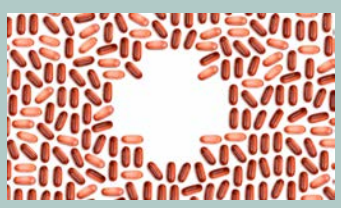
## Summary of Findings and Commonalities for 28 Cases

Commonalities are shared attributes or life events. They are tracked for each person who dies of an overdose in Coconino County. Commonalities do not indicate causation, but an analysis of common traits and experiences may provide opportunities to gauge risk of a fatal overdose or identify points of contact to engage individuals who are at risk.

Because HHS is not always able to obtain complete records for each overdose fatality, it is often difficult to ascertain whether a particular trait, or risk factor, exists for each individual. Therefore, it should be assumed that while the commonalities reported are confirmed, they may also exist for other cases, but could not be confirmed.

These data highlight not only individual risk factors experienced by decedents, but also the disproportionate likelihood that experiencing a single risk factor can lead to another. This is evident in the fact that 18 decedents, or about 64% of cases reviewed, experienced two or more of the commonalities indicated below. This means that the most common trait among decedents was having experienced a multitude of risk factors.





**13** had record of significant medical issues / chronic pain


**9** had a reported mental health diagnosis

**10** had record of prior treatment for substance use disorder – 5 inpatient; 7 outpatient; and 3 Medication Assisted Treatment/Opioid Agonist Treatment

**9** had history of physician prescribed opioids

**9** had record of involvement with the Criminal Justice System

**3** were unhoused or had experienced homelessness

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# 6 Overdose Fatality Review: Six Recommendations for Prevention

**Each Prevention Domain interacts with and builds upon the others, yet stigma reduction emerged as an overarching value & theme.**

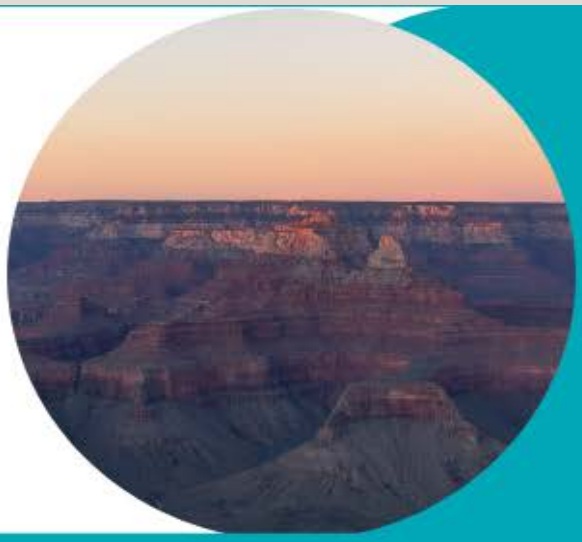
**The Overdose Fatality Review board identified six key "Prevention Domains" that illustrate the need for multidisciplinary collaboration and systems change. The bulleted list below shows the highlights.**

## 1 STIGMA REDUCTION

- Decrease stigma towards individuals experiencing SUD or people who use drugs by using and normalizing person-first language.
- Decrease stigma of Medication Assisted Treatment (MAT) by increasing access to this evidence-based treatment.
- Decrease stigma of harm reduction strategies by promoting & implementing targeted naloxone distribution.


## 2 HARM REDUCTION

- Conduct targeted outreach to increase access to naloxone for:
  1) people who use drugs
  2) family members of people who use drugs
  3) individuals released from incarceration
  4) physicians who prescribe opioids
  5) pharmacists
  6) service industry employees



## 3 EDUCATION

- Develop and implement an education campaign focused on **3 key messages**:
  1) Tolerance decreases after periods of abstinence.
  2) Illicitly manufactured fentanyl (IMF) is in our community, and it's dangerous. It's laced in heroin, counterfeit pills, and even stimulants.
  3) Never use alone!

## 4 PRESCRIBER & PAIN MANAGEMENT ENGAGEMENT

- Collaborate to develop protocol for tapering opioid doses for pain patients.
- Provide physicians with literature about overdose risk factors as a guide for conversations with patients.
- Provide physicians with information about how patients can access peer support or treatment for opioid dependence.
- Ensure adherence to Controlled Substance Prescription monitoring Program (CSPMP).

## 5 ACCESS TO CARE

- Increase access to evidence-based treatment, including MAT, in correctional settings.
- Expand access to Peer Support services.
- Increase knowledge of trauma-informed care and response.
- Increase access to harm reduction tools & interventions as overdose prevention strategies.

## 6 ENHANCED CARE COORDINATION

- Minimize barriers to care coordination for individuals with SUD due to HIPAA compliance, as HIPAA regulations can impede the ability to provide prompt, high quality, outcome-driven care .
- Strengthen utilization of the statewide Health Information Exchange (HIE) tool for individuals with a substance use diagnosis to ensure that they receive the most appropriate and cohesive care.
- Develop coordinated discharge and release plans from the hospital and jail to ensure individuals with OUD/SUD have access to naloxone and a warm hand-off to other supports.

# RECOMMENDATIONS FOR THE OFR BOARD

In addition to the six Prevention Domains that anchor the recommendations developed by the OFR board, the team also identified internal recommendations aimed at making the fatality review process more robust. The following list reflects goals and next steps for the OFR board's operational processes:

- Conduct an analysis of the Relative Contribution to Death that different substance(s) had on each fatality to better understand the relative lethality of substances.
- Begin conducting family interviews to gain a more complete picture of the social and familial history of decedents.
- Engage representation from a pain management specialist on the OFR board to identify opportunities for prevention and intervention.
- Gain access to a reliable data source for non-fatal overdoses so that analysis of non-fatal overdoses can also inform prevention opportunities.

# CONCLUSION

As Coconino County's Overdose Fatality Review team completes its first annual report, which reviewed deaths that occurred between October 2018 and December 2019, it would be remiss to not mention the COVID-19 pandemic, which affected almost every conceivable aspect of life in 2020. The OFR's key recommendations related to stigma reduction, harm reduction, and care coordination were further illuminated in the wake of the dual epidemics of COVID-19 and the opioid crisis. During 2020, while the community coped with quarantine and separation from social support networks, among other stressors, the innate need for human connection has never been clearer. Yet, it was also fractured because of the pandemic, thus heightening vulnerability and risk of overdose.

The OFR's findings and recommendations confirm the importance of collaborative and integrated care that identifies and takes advantage of multi-sector support services that engage individuals at-risk of overdose.  The OFR team is committed to ongoing and multi-disciplinary analysis that identifies both gaps and prevention opportunities.

Together, the OFR team and Coconino County Health and Human Services are also committed to promoting evidence-based overdose prevention strategies identified by the Centers for Disease Control and Prevention (CDC). These strategies include targeted naloxone distribution and expanded access to Medication Assisted Treatment (MAT). By promoting these strategies and simultaneously working to overcome the stigma directed towards people who use drugs and promoting harm reduction efforts that save lives, Coconino County Opioid Overdose Prevention Programs and the Overdose Fatality Review Board will continue to play a positive role in reducing overdose deaths.

For more information about evidence-based strategies for overdose prevention, see the CDC's document: Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States, 2018 (cdc.gov)

# APPENDIX A

## Unabridged Recommendations

**Stigma Reduction**

- Decrease stigma towards individuals experiencing Substance Use Disorder (SUD) and individuals who use drugs. Promote greater understanding of addiction as a chronic, relapsing brain disease that is not a moral failure. Use and normalize person-first language as a strategy to reduce stigma.
- Decrease stigma of Medication Assisted Treatment (MAT)/Opioid Agonist Treatment (OAT) by promoting access to evidence-based treatment. Promote understanding of its efficacy and work to counter myths related to MAT/OAT.
- Decrease stigma of harm reduction services by promoting and implementing targeted naloxone distribution. Promote understanding of how harm reduction strategies can prevent overdose deaths and reduce transmission of communicable diseases like HIV and hepatitis C.

**Harm Reduction**

- Conduct targeted outreach to ensure broad access to naloxone by tailoring outreach efforts to distinct populations, including:
  - People who use drugs
  - Family Members
  - Behavioral Health Providers
  - Residents in housing units designated for Severe Mental Illness (SMI) or SUD
  - Individuals recently released from incarceration
  - Physicians who prescribe opioids
  - Pharmacists
  - Service industry employees
- Develop protocol within local hospitals to ensure that anybody who is treated for an opioid overdose receives a naloxone kit upon discharge and a referral for peer support.
- Develop protocol within local correctional facilities to ensure that anybody who has SUD receives a naloxone kit upon release and a referral for peer support.

**Education**

- Develop and implement Public Health Education Campaigns focused on key messages for overdose prevention:
  - Tolerance decreases after periods of abstinence and heightens risk of overdose.
  - Illicitly Manufactured Fentanyl (IMF) is increasingly prevalent in the community; it is unregulated, illegal and highly dangerous. It can be found laced in counterfeit pills and also laced in illicit drugs such as heroin and stimulants.
  - Never use alone.
  - Pre-existing conditions such as asthma or COPD heighten risk of overdose.
- Conduct education campaign aimed at reducing stigma and to communicate the effectiveness of harm reduction strategies.

**Prescriber and Pain Management Engagement**

- Provide education tools and messages for patients
  - Engage physicians who prescribe opioid medications to develop protocol for tapering opioid doses for pain patients. Provide education about how sudden discontinuation of pain medications can heighten risk of fatal overdose due to decreased tolerance and risk that a patient would seek illicit or counterfeit drugs.
  - Provide physicians who prescribe opioids with literature about overdose risk factors so they have an easy to use education tool for patients. The tool will include risk factors related to behavior and underlying health conditions, such as asthma.
  - Provide physicians who prescribe opioids with information about how to connect patients to peer support or treatment for Opioid Use Disorder (OUD) if they have patients exhibiting signs of dependence or OUD.
- Maximize use of the Controlled Substance Prescription Monitoring Program (CSPMP)
  - Engage with local prescribers to ensure adherence to the CSPMP and address any identified training needs.
  - Explore resources for integrating the CSPMP into Electronic Health Records (EHR).

# APPENDIX A

## Unabridged Recommendations Continued

**Access to Care**

- Evidence-Based OUD Treatment
  - Increase availability of evidence-based treatment for OUD in correctional settings, including access to MAT/OAT.
- Peer Support
  - Expand access to Peer Support services for individuals at-risk of an overdose by creating channels to access peer support through hospitals, pain management providers, behavioral health homes, and the criminal justice system.
- Trauma-Informed Care and Response
  - Increase knowledge of trauma-informed care and response among all OFR member agencies and strengthen community capacity to offer comprehensive response to individuals who have experienced trauma.
- Harm Reduction
  - Increase understanding of harm reduction strategies and increase community capacity to offer harm reduction as an overdose prevention strategy.

**Enhanced Care Coordination**

- Advocate to reduce the barriers to care coordination for individuals struggling with substance use that result from HIPAA regulations. While protecting privacy of healthcare records is important for ongoing engagement of services, the ability to coordinate care in a timely, smooth and consistent manner improves success and retention in treatment, reduces risks that lead to adverse events and provides quality, outcome driven care. Coordination of care is an evidence-based practice shown to strengthen adherence to treatment.
- Strengthen utilization of the statewide Health Information Exchange (HIE). The HIE is a tool for practitioners, individual clinicians, and large hospital systems to maintain access to treatment records in order to support continuity of care among all service providers. Utilization of the HIE for individuals with a substance use diagnosis is a critical step to ensuring that those individuals receive the most appropriate and cohesive care.
- Develop coordinated discharge and release plans from hospitals, Crisis stabilization Units (CSU), or custodial settings to ensure that individuals with OUD/SUD have access to overdose prevention tools, including naloxone, and a warm hand-off to peer support and/or SUD treatment.

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**Coconino County Health and Human Services**
**Opioid Overdose Prevention**
https://coconino.az.gov/2040/Prescription-Drug-Overdose-Prevention-Pr