

LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

# MODEL OVERDOSE FATALITY REVIEW TEAMS ACT

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**LAPPA**

LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

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# MODEL OVERDOSE FATALITY REVIEW TEAMS ACT

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## SECTION I. SHORT TITLE.

This Act may be cited as the “Model Overdose Fatality Review Teams Act,” the “Model Act,” or “the Act.”

### Commentary

Overdose fatality review (OFR) teams are commonly referred to by a number of names, including, but not limited to, overdose fatality review boards, panels, committees, or commissions. The Model Act’s drafters chose to use the term “team” for this model because it more accurately reflects the ideals behind the purpose of an overdose fatality review; that is, a group of multidisciplinary individuals coming together to achieve a common goal of overdose prevention in a setting in which everyone offers a unique perspective to the case review process.<sup>1</sup> Additionally, some jurisdictions will use the term “death” as opposed to “fatality.”

## SECTION II. LEGISLATIVE FINDINGS.

- (a) The [legislature]<sup>2</sup> finds that substance use disorder and drug overdose are major health problems that affect the lives of many people, multiple services systems, and lead to profound consequences, including permanent injury and death.
- (b) Overdoses caused by heroin, fentanyl, other opioids, stimulants, controlled substance analogs, novel psychoactive substances, and other legal and illegal drugs are a public health crisis that stress and strain the financial, public health, health care, and public safety resources in [state].
- (c) Overdose fatality reviews, which are designed to uncover the who, what, when, where, why, and how a fatal overdose occurs, allow jurisdictions to examine and understand the circumstances leading to a fatal drug overdose.
- (d) Through a comprehensive and multidisciplinary review, overdose fatality review teams can better understand the individual and population factors and characteristics of potential overdose victims.<sup>3</sup> This provides a locality with a greater sense of the strategies and multiagency coordination needed to prevent future overdoses and results in the more

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<sup>1</sup> Erin Hass, *et al.*, *Local Overdose Fatality Review Team Recommendations for Overdose Death Prevention*, 20 HEALTH PROMOTION PRAC. 553, 554 (Sept. 2018) <https://doi.org/10.1177/1524839918797617>.

<sup>2</sup> This Act contains certain bracketed words and phrases (*e.g.*, “[legislature]”). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

<sup>3</sup> *More states authorizing the use of overdose fatality review teams*, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS (Aug. 23, 2018), <https://www.astho.org/StatePublicHealth/More-States-Authorizing-the-Use-of-Overdose-Fatality-Review-Teams/08-23-18/>.

productive allocation of overdose prevention resources and services within the jurisdiction.<sup>4</sup>

### **SECTION III. PURPOSE.**

This Act:

- (a) Creates a legislative framework for establishing county-level, multidisciplinary overdose fatality review teams in [state];
- (b) Provides overdose fatality review teams with duties and responsibilities to examine and understand the circumstances leading up to a fatal overdose so that the teams can make recommendations on policy changes and resource allocation to prevent future overdoses; and
- (c) Allows overdose fatality review teams to obtain and review records and other documentation related to a fatal overdose from relevant agencies, entities, and individuals while remaining compliant with local, state, and federal confidentiality laws and regulations.

### **Commentary**

Overdose fatality review (OFR) is a powerful tool that can be used to identify and respond to community-specific patterns related to drug overdose deaths. While overdose deaths occur nationally, OFRs established at the local level allow for the identification of challenges unique to a local area.<sup>5</sup> “OFR is a useful model to analyze data, trends, and garner interdisciplinary support to reduce the number of preventable deaths.”<sup>6</sup>

The concept of OFR is based on child death reviews, which were first established in 1978 in Los Angeles, California, and can now be found in almost every state.<sup>7</sup> The use of child death reviews are endorsed as a best practice by the American Academy of Pediatrics, and they provide an effective model for other types of fatality review.<sup>8</sup> Jurisdictions now use fatality reviews in a variety of situations, including fatalities related to mothers, fetuses and infants, traffic accidents, domestic violence, suicide, and homicide.

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<sup>4</sup> *Id.*

<sup>5</sup> Andrea Janota, *et al.*, *Indiana Drug Overdose Fatality Review*, IUPUI RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH (Oct. 2018), <https://fsph.iupui.edu/doc/research-centers/overdose-fatality-review-20181010.pdf>.

<sup>6</sup> *Id.*

<sup>7</sup> Hass, *supra* note 1, at 561.

<sup>8</sup> *Id.*

Maryland first authorized local OFR teams via legislation in October 2014 after the state conducted an OFR pilot program in three counties in 2013.<sup>9</sup> According to public health researchers, “[a]s a result of their OFR program, Maryland reports improved care referral systems, enhanced services for diverse client needs, and increased knowledge within participating agencies of community resources available to assist at-risk populations.”<sup>10</sup> By reviewing overdose cases, OFR teams can make recommendations for local and state policies that better support people at risk for overdose. For example, in Maryland, several local OFR teams discovered that fatal overdoses frequently occurred in hotels and motels.<sup>11</sup> Based on this information, the teams recommended that hotel and motel staff be trained in using of naloxone.<sup>12</sup>

Statewide OFR legislation that establishes county-level OFR teams provides several benefits as compared to establishing OFR teams independent of legislation. First, legislation can directly authorize OFR teams’ access to certain types of confidential information via statutory language. Without legislation, the OFR team—and the individuals and entities from whom it requests information—are bound to their own interpretations of the confidentiality provisions of the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2, and state or local confidentiality laws. This may result in an unwillingness to provide the requested information due to unduly restrictive interpretations and/or confusion caused by varying conclusions among jurisdictions. Second, OFR legislation helps to enhance the legitimacy of OFR teams, especially in areas where some community members may be reluctant to establish a team on their own. Finally, legislation promotes uniformity and consistency among the local teams within the state.

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<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> Hass, *supra* note 1, at 556.

<sup>12</sup> *Id.* at 561.

**SECTION IV. DEFINITIONS.**

*[States may already have definitions in place for some or all of the following listed terms. In such case, states are free to use those definitions in place of those listed below.]*

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:

- (a) Drug.— “Drug” means a substance which produces a physiological effect when ingested or otherwise introduced into the body. A drug can be an illicit or legal substance.
- (b) Health care provider.— “Health care provider” means a physician, advanced practice nurse practitioner, or physician assistant who is licensed to practice medicine in the state.
- (c) Local team.— “Local team” means the multidisciplinary and multiagency drug overdose fatality review team established for a county, a group of counties, or a tribe. A “local team” includes a multicounty team created pursuant to Section V, subsection (b).
- (d) Mental health provider.— “Mental health provider” means a psychiatrist, psychologist, advanced practice nurse practitioner with a specialty in psychiatric mental health, clinical social worker, professional clinical counselor, or marriage and family therapist who is licensed to practice in the state.<sup>13</sup>
- (e) Multicounty team.— “Multicounty team” means a multidisciplinary and multiagency drug overdose fatality review team jointly created by two or more counties in the state.
- (f) Next of kin.— “Next of kin” means the person or persons most closely related to a decedent by blood or affinity.<sup>14</sup>
- (g) Overdose fatality review (OFR).— “Overdose fatality review” means a process in which a multidisciplinary team performs a series of individual overdose fatality reviews to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies.
- (h) Overdose.— “Overdose” means injury to the body that happens when one or more substances is taken in excessive amounts. An overdose can be fatal or nonfatal.

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<sup>13</sup> This definition is modeled after Cal. Bus. & Prof. Code § 865 (2019).

<sup>14</sup> This definition is from a commonly used legal dictionary. *Next of kin*, BLACK’S LAW DICTIONARY (11<sup>th</sup> ed. 2019).

- (i) [State agency].— “[State agency]” means the [agency designated by the Legislature]. The [State agency] is responsible for overseeing the overdose fatality review teams’ grant program established in Section X.
- (j) Substance use disorder treatment provider.— “Substance use disorder treatment provider” means any individual or entity who is licensed, registered, or certified within [state] to treat substance use disorders or who has a Drug Addiction Treatment Act of 2000 waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) to treat individuals with substance use disorder using medications approved for that indication by the United States Food and Drug Administration.
- (k) Substance use disorder.— “Substance use disorder” means a pattern of use of alcohol or other drugs leading to clinical or functional impairment, in accordance with the definition in the Diagnostic and Statistical Manual of Disorders (DSM-5) of the American Psychiatric Association, or in any subsequent editions.

### Commentary

The Model Act’s drafters are aware that individual states likely have currently-in-force statutory definitions for many of the terms contained in Section IV and that lawmakers understandably will default to that language. Nevertheless, this Act contains illustrative definitions designed to articulate the intended scope of each term.

The definition of “local team” is modeled after Maryland law.<sup>15</sup> The definition of “overdose fatality review” is modeled after language used to describe OFR teams by the Bureau of Justice Assistance’s (BJA) Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP).<sup>16</sup>

There are a variety of definitions of “overdose” that could be used, which span from the simple to the more involved. The version used in the Model Act is very simple and is based on a definition listed on the website of the Centers for Disease Control and Prevention.<sup>17</sup> Also worth noting is the intentional choice to use “substance” in the definition of overdose, rather than “controlled substance” or “drug.” The drafters’ intent is for the Model Act to contain an inclusive definition of overdose as opposed to a more exclusive one, especially when overdoses are often the result of a combination of substances. If the definition allows only a “controlled substance” to cause an overdose, then one could argue that certain overdoses do not qualify for case review;

<sup>15</sup> Md. Code Ann., Health – Gen. § 5-901 (2014).

<sup>16</sup> Melissa Heinen and Mallory O’Brien, *Overdose Fatality Review: A Practitioner’s Guide to Implementation 2* (BJA’s Comprehensive Opioid, Stimulant, and Substance Abuse Program, July 2020).

[https://www.cossapresources.org/Content/Documents/Articles/Overdose\\_Fatality\\_Review\\_Practitioners\\_Guide.pdf](https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf).

<sup>17</sup> *Opioid Overdose: Commonly Used Terms*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last modified January 26, 2021), <https://www.cdc.gov/drugoverdose/opioids/terms.html>.

for example, would an overdose involving alcohol, a new synthetic drug that is not a controlled substance analog (thus, not treated as a controlled substance under state law) or kratom (not scheduled in most states) qualify?

## **SECTION V. ESTABLISHMENT OF OVERDOSE FATALITY REVIEW TEAMS.**

- (a) In general.— Subject to subsection (b) of this section, each county within [state] may establish a multidisciplinary and multiagency overdose fatality review local team. Any local team that is created shall be done so pursuant to the provisions of this Act.
- (b) Multicounty teams.— Two or more counties may agree to jointly establish a single multicounty team.
- (c) Memorandum of understanding.— Multicounty team members shall execute a memorandum of understanding between the counties regarding team membership, staffing, and operations.

### **Commentary**

The provisions of this section are modeled after Maryland law.<sup>18</sup> The Model Act provides counties the option of creating their own local OFR team or creating a multicounty local team with one or more counties in the state. The multicounty local team option enables counties that may not have the means to establish a local team on their own, such as rural counties, to combine resources with other counties to establish a more well-rounded team.

The Act permits, but does not require, localities to establish OFR teams. While all counties are encouraged to establish a local team, it may not be feasible for every county, even with the option of creating a multicounty team. If a county decides to establish a local team, however, it must do so pursuant to the provisions of this Act. This requirement ensures a level of uniformity between the local teams throughout the state.

As drafted, the Model Act does not establish a state-level position associated with OFR teams. Nevertheless, this does not prevent a state from setting up such a position. For example, Indiana has a full-time employee in the Indiana Department of Health that helps to coordinate and establish local teams. As introduced, Indiana's OFR team legislation<sup>19</sup> contained language that included a state position. However, legislators removed this provision before enactment due to concerns that the legislation would not pass if it included a budget allocation for the position. The Indiana drafters felt that it was more important to pass local team legislation, even if it meant no state oversight position in the statute.

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<sup>18</sup> Md. Code Ann., Health – Gen. § 5-902(a) (2014).

<sup>19</sup> Ind. Code §§ 16-49.5-1-1 through 15 (2020).

## **SECTION VI. COMPOSITION OF OVERDOSE FATALITY REVIEW TEAMS.**

(a) Local team composition.—

- (1) Required members.— Local teams shall consist of the following individuals, organizations, agencies, and areas of expertise, if available:
  - (A) The county health officer, or the officer’s designee;
  - (B) The director of the local [department of social services], or the director’s designee;
  - (C) The local state attorney, or the attorney’s designee;
  - (D) The [director of behavioral health services] in the county, or the director’s designee;
  - (E) A state, county, or municipal law enforcement officer;
  - (F) A representative of a local jail or detention center;
  - (G) The local medical examiner/coroner, or designee;
  - (H) A health care provider who specializes in the prevention, diagnosis, and treatment of substance use disorders;
  - (I) A mental health provider who specializes in substance use disorders;
  - (J) A representative of an emergency medical services provider in the county.
  - (K) The director of the [department of children and family services], or the director’s designee; and
  - (L) A representative from parole, probation, and community corrections.
- (2) Potential additional members.— Local teams should consider including the following individuals, organizations, agencies, and areas of expertise, if available, as either permanent or auxiliary team members:
  - (A) The local superintendent of schools, or the superintendent’s designee;
  - (B) A representative of a local hospital;
  - (C) A health care provider who specializes in emergency medicine;
  - (D) A health care provider who specializes in pain management;
  - (E) A pharmacist with a background in prescription drug misuse and diversion;
  - (F) A substance use disorder treatment provider from a licensed substance use disorder treatment program;

- (G) A poison control center representative;
  - (H) A mental health provider who is a generalist;
  - (I) A prescription drug monitoring program administrator;
  - (J) A representative from a harm reduction provider;
  - (K) A recovery coach, peer support worker, or other representative of the recovery community;
  - (L) A representative from the local drug court; and
  - (M) Any other individual necessary for the work of the local team, recommended by the local team and appointed by the chair.
- (b) Chair.—
- (1) The chair of the local team shall be [an easily identifiable person (*e.g.*, county health officer or his/her designee) within the organization that houses the local team].
  - (2) If a local team is a multicounty team, the members can vote on which [easily identifiable person within the organization that houses the local team] they wish to serve as chair, or the [easily identifiable persons within the organization that houses the local team] can serve as co-chairs.
- (c) Responsibilities of the chair.— The chair of the local team shall be responsible for the following:
- (1) Soliciting and recruiting the necessary and appropriate members to serve on the local team based on subsection (a);
  - (2) Facilitating each local team meeting and implementing the protocols and procedures of the local team;
  - (3) Ensuring that all members of the local team and all guest observers sign confidentiality forms as required under Section IX;
  - (4) Requesting and collecting the information needed for the local team’s case review;
  - (5) Filling vacancies on the local team when a member is no longer able to fulfill his or her duties and obligations to the local team. When a member leaves, he or she should be replaced with an individual from the same or equivalent position or discipline; and
  - (6) Serving as a liaison for the local team when necessary.

- (d) Compensation.— Members of the local team shall not receive compensation but shall be reimbursed for necessary travel and other reasonable expenses incurred in connection with the performance of their duties as members.

### Commentary

Subsection (a) is modeled after Maryland law,<sup>20</sup> with additional members added based upon OFR legislation in other states. To be successful, OFR team members should be individuals from multiple agencies and multiple disciplines. OFR team members customarily include law enforcement, emergency responders, health care providers, public health, social services, medical examiners, and others.<sup>21</sup> Having a diverse membership allows an OFR team to properly explore the systems with which a person came in contact throughout his or her lifetime to identify opportunities where improvements to such systems, policies, or services might help prevent future overdose deaths.<sup>22</sup> The perspectives and input of the members will be valuable even if the individual or organization did not have direct contact with the decedent.<sup>23</sup> Effective OFR teams typically have 15-35 members.<sup>24</sup>

The Act contains a list of individuals and entities that should be required members of the local team, if available, and a list of individuals the local team should consider adding to the local team or call on when necessary for proper case review. This format is modeled after Virginia law.<sup>25</sup> Having a set of required individuals and entities on the local team ensures that, at minimum, the local team is composed of the individuals who could conduct a proper review in most situations. If the individuals listed in paragraph (a)(1) are available, they should be a part of the local team. However, in some jurisdictions, health care shortages may make it difficult to recruit all of the suggested required health care members.

The list of additional suggested team members in paragraph (a)(2) allows local teams the ability to expand their team with specialists and other individuals and entities as either permanent team members or auxiliary members who may provide needed insight for particular case reviews. Each case subject to review is different and may require different expertise to parse out where improvements to local resources can be made. This is the type of situation where having auxiliary members can be beneficial. Subparagraph (a)(2)(M) under this section is a catch-all provision that allows local teams to bring in additional members who are not listed in statute when certain circumstances arise. For example, if a local team notices a pattern of cases involving veterans, it may be beneficial for the team to add a representative from the state's department of veteran affairs. Counties with tribal communities should add a representative from tribal leadership to the local team. Other potential examples include representatives from specific

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<sup>20</sup> Md. Code Ann., Health – Gen. § 5-902(b) (2014).

<sup>21</sup> Janota, *supra* note 5.

<sup>22</sup> *Id.*

<sup>23</sup> *Recruit Your OFR Members*, BJA'S COMPREHENSIVE OPIOID, STIMULANT, AND SUBSTANCE ABUSE PROGRAM, (last visited Sept. 30, 2020), <https://www.cossapresources.org/Tools/OFR/Recruit>.

<sup>24</sup> Heinen, *supra* note 16, at 6.

<sup>25</sup> Va. Code Ann. § 32.1-283.7 (2018).

social services within the state or county, such as Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), or Medicaid.

Subsection (b) addresses the chair of the local team. The chair can be thought of as the coordinator or facilitator of the local team. The drafters did not designate a specific person to be the chair, but instead suggest that the chair be an easily identifiable person within the organization that houses the local team. The organization which houses the local team may vary by jurisdiction, and can include, but is not limited to, the county health department, the county behavioral health department, the local state attorney's office, or the medical examiner's office. If a local team within a jurisdiction is housed within the local state attorney's office, for example, then the chair of the local team would be the state attorney, or the attorney's designee. By not naming a specific person as the chair, local teams have more flexibility to designate a chair that is supportive of, and invested in, the local team. Strong leadership and ownership of the local team is key to the success of an OFR team. Subsection (c) identifies the responsibilities of the chair, including the responsibility to solicit and recruit team members and ensure that the team is composed of members relevant to the jurisdiction and case load. The chair is also responsible for making requests for information (*e.g.*, requesting the decedent's medical records) on behalf of the local team and is the individual to whom such information should be initially submitted.

Subsection (d) is modeled after Pennsylvania law, with similar language found in both Arizona and Oklahoma.<sup>26</sup> Providing compensation for travel and reasonable expenses to members of the local team allows individuals and organizations to commit to being a part of a team without having to worry about the ability to finance the costs associated with their participation. States likely already have guidance in the form of statutes or policies on what constitutes a reasonable expense.

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<sup>26</sup> 71 Pa. Cons. Stat. § 1691.3(d) (2013); Ariz. Rev. Stat. § 36-198(D) (2018); and Okla. Stat. Ann. tit. 63, § 2-1002(B) (2018).

## **SECTION VII. DUTIES AND RESPONSIBILITIES OF OVERDOSE FATALITY REVIEW TEAMS.**

- (a) In general.— The purpose of each local team is to:
- (1) Promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities;
  - (2) Develop an understanding of the causes and incidence of drug overdose fatalities in the jurisdiction where the local team operates;
  - (3) Plan for and recommend changes within the agencies represented on the local team to prevent drug overdose fatalities; and
  - (4) Advise local, regional, and state policymakers about potential changes to law, policy, funding, or practice to prevent drug overdoses.
- (b) Duties.— To achieve its purpose, each local team shall:
- (1) Establish and implement protocols and procedures;
  - (2) Conduct a multidisciplinary review of information received pursuant to Section VIII regarding a decedent, which shall include, but not be limited to:
    - (A) Consideration of the decedent’s points of contact with health care systems, social services, educational institutions, child and family services, the criminal justice system, including law enforcement, and any other systems with which the decedent had contact prior to his or her death; and
    - (B) Identification of the specific factors and social determinants of health that put the decedent at risk for an overdose;
  - (3) Recommend prevention and intervention strategies to improve coordination of services and investigations among member agencies to reduce overdose deaths; and
  - (4) Collect, analyze, interpret, and maintain local data on overdose deaths.
- (c) Meeting format.— Meetings of the local team may be conducted in person, by telephone, or virtually using a secure web-based platform.
- (d) Non-fatal overdoses.— In addition to the duties specified in subsection (b) of this section, a local team may investigate non-fatal overdose cases that occur within the local team’s jurisdiction.

- (e) Annual report.— Each local team shall submit an annual de-identified report containing the information in subsection (g) to:
  - (1) The [county department of health] for the local jurisdiction or jurisdictions served by the local team; and
  - (2) The state [department of health].
- (f) Data analysis.— The state [department of health] shall analyze each annual report submitted pursuant to subsection (e) and shall create a single report containing an aggregate of the data submitted and shall submit that report to the governor and the [appropriate committees] of the state legislature.
- (g) Contents of annual report.— The annual report provided for in subsection (e) shall include, but not be limited to, the following information:
  - (1) The total number of fatal overdoses that occurred within the jurisdiction of the local team;
  - (2) The number of fatal overdose cases investigated by the local team;
  - (3) Any recommendations for state and local agencies or the state legislature to assist in preventing fatal and non-fatal overdoses in the state; and
  - (4) Assessable results of any recommendations made by the local team, including, but not limited to, changes in local or state law, policy, or funding made as a result of the local team’s recommendations.
- (h) Public access to reports.— Reports submitted pursuant to this section are not confidential and may be shared with the public.
- (i) Discussion of confidential matters.— Members of a local team and other individuals in attendance at a local team meeting, including, but not limited to, experts, health care professionals, or other observers:
  - (1) Shall sign a confidentiality agreement as provided for in Section IX;
  - (2) May discuss confidential matters and share confidential information during such local team meeting without violating [state privacy laws/rules]; however, no confidential information disclosed during a local team meeting may be further disclosed outside of the meeting;

- (3) Are bound by all applicable state and federal laws concerning the confidentiality of matters reviewed by the local team; and
- (4) Shall not be subject to civil or criminal liability or any professional disciplinary action for the sharing or discussion of any confidential matter with the local team during a local team meeting. This immunity does not apply to a local team member or attendee who negligently discloses confidential information or who knowingly and willfully discloses such information in violation of this Act or any state or federal law.

### Commentary

The provisions of subsection (a) and (b) are modeled after a portion of Maryland law.<sup>27</sup> The duties of the local team, listed in subsection (b), are generally to allow for specific policies and procedures to be described in regulation or in a local team's bylaws. These policies and procedures may include protocols for requesting and receiving information on a decedent and data system guidelines. Because jurisdictions vary greatly in the number of overdose deaths they experience, it is best left up to the local team to determine the number of times they meet per year and how they select cases for review. For instance, a team situated in a highly populated metropolitan area may want to meet as often as monthly, while a team in a more rural county may only need to meet quarterly or semi-annually.

Based on feedback from Model Act reviewers, subsection (c) provides local teams with the option to hold teleconferences or virtual meetings when meeting in person is not possible. The COVID-19 pandemic demonstrates the need for individuals to be adaptable to a virtual meeting environment, and OFR teams are no exception to this. If holding virtual meetings, local teams should use a secure web-based platform that is compliant with HIPAA and other privacy regulations. Subsection (c) also allows members of the local team to participate in the team meeting by telephone or virtually when they cannot physically attend an in-person meeting.

If the situation arises, a local team may wish to review non-fatal overdose cases in addition to fatal overdose cases. Subsection (d) gives teams the ability to do so. In 2017, amendments to Maryland's OFR statute allowed for the review of non-fatal overdose cases.<sup>28</sup> A local team may choose to review non-fatal overdose cases if there are a limited number of fatal overdoses in the jurisdiction. Additionally, reviewing non-fatal overdose cases may be beneficial to identify differences in trends between fatal and non-fatal overdoses.

The language in subsections (e), (f), and (g) is modeled after Oklahoma law.<sup>29</sup> The main goal of an OFR team is to use the information gained from the cases reviewed to improve local and statewide policies, procedures, and health outcomes related to substance use disorders.<sup>30</sup> Local teams must summarize and share recommendations and findings in an annual report to the

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<sup>27</sup> Md. Code Ann., Health – Gen. § 5-903(a) and (b) (2014).

<sup>28</sup> Hass, *supra* note 1, at 561.

<sup>29</sup> Okla. Stat. Ann. tit. 63, § 2-1001(D) (2018).

<sup>30</sup> Janota, *supra* note 5.

local and state department of health or comparable agency within the jurisdiction. The state department of health is then required to analyze, summarize, and combine all local team reports before submitting its report to the governor and the state legislature. This multi-step process allows the governor and state legislature to process information more easily and avoids reviewing numerous individual reports from the local teams. All information contained in the report must be de-identified in order to comply with state and federal confidentiality laws.

The language in subsection (h) is modeled after Maryland law.<sup>31</sup> The local team's de-identified annual report is public information that can be used by the local team or the state for a variety of purposes, including evaluation, policy consideration, and program enhancement.<sup>32</sup> The local team may share its annual report with local media, policymakers, county councils, executive bodies, and other partners.<sup>33</sup>

The language in subsection (i) is modeled after Indiana law.<sup>34</sup> It is vital that the members of the local team and any non-member attendee understand the confidential nature of OFR team meetings. During a meeting of the local team, members and guests should feel comfortable with speaking candidly on the matters up for review by the local team without fear of repercussion for doing so.

## SECTION VIII. ACCESS TO INFORMATION.

- (a) Request for information.— Subject to subsection (d), but notwithstanding any other provision of state or local law to the contrary, on written request of the chair of a local team, and as necessary to carry out the purpose and duties of the local team, the local team shall be provided with the following information:
- (1) Information and records regarding the physical health, mental health, and treatment for substance use disorder, maintained by a health care provider, substance use disorder treatment provider, hospital, or health system for an individual whose death or near death is being reviewed by the local team; and
  - (2) Information and records maintained by a state or local government agency or entity, including, but not limited to, death investigative information, medical examiner investigative information, law enforcement investigative information, emergency medical services reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records, and information and

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<sup>31</sup> Md. Code Ann., Health – Gen. § 5-906(c) and (d) (2014).

<sup>32</sup> Hass, *supra* note 1, at 561.

<sup>33</sup> *Id.*

<sup>34</sup> Ind. Code Ann. § 16-49.5-2-11(a) and (b) (2020).

- records of a social services agency, including the [department of family and children’s services], if the agency or entity provided services to:
- (A) An individual whose death or near death is being reviewed by the local team;
  - (B) The family of the decedent being investigated.
- (b) Persons providing information.— The following persons, agencies, or entities shall comply with a records request by the local team made pursuant to subsection (a):
- (1) Coroner/medical examiner;
  - (2) Fire department;
  - (3) Health system;
  - (4) Hospital;
  - (5) Law enforcement agency;
  - (6) Local or state governmental agency, including, but not limited to, the [department of children and family services], [department of health], [department of mental health], the state attorney’s office, the state or local public defender’s office, the [department of corrections], and the [department of probation and parole];
  - (7) Mental health provider;
  - (8) Health care provider;
  - (9) Substance use disorder treatment provider;
  - (10) School, including an elementary, secondary, or post-secondary institution;
  - (11) Emergency medical services provider;
  - (12) Social services provider;
  - (13) Prescription drug monitoring program;
  - (14) Any other person or entity who is in possession of records pertinent to the local team’s investigation of an overdose fatality.
- (c) Cost to provide records.— A person or entity subject to a records request by a local team under subsection (b) may charge the local team a reasonable fee for the service of duplicating any records requested by the local team.
- (d) Disclosure of substance use disorder records.— The disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment

services, without the authorization of a person in interest, is subject to any limitations that exist under [state law], 42 U.S.C. § 290dd-2, or 42 C.F.R. Part 2.

- (e) Provision of information.— Information requested by the chair of the local team shall be provided within five business days of receipt of the written request, excluding weekends and holidays, unless an extension is granted by the chair. Written requests may include a request submitted via email or facsimile transmission.
- (f) Administrative subpoena.— Notwithstanding any law to the contrary, the local team shall not need an administrative subpoena or other form of legal compulsion to receive the requested records. This subsection, however, shall not be interpreted to negate any right the OFR team has to obtain an administrative subpoena or other form of legal compulsion.
- (g) Consent form.— The chair of the local team, or the chair’s designee, may request the individual whose overdose is under review or, if deceased, the individual’s next of kin, to sign a consent form for the release of confidential information.
- (h) Sharing of information.— So long as each individual present at a local team meeting has signed the confidentiality form provided for in Section IX, any information received by the chair in response to a request under this section may be shared at a local team meeting with local team members and any non-member attendees.
- (i) Liability.— An individual, entity, or local or state agency that in good faith provides information or records to the local team shall not be subject to civil or criminal liability or any professional disciplinary action as a result of providing the information or record.
- (j) Family and friend interviews.— A member of the local team may contact, interview, or obtain information by request from a family member or friend of an individual whose death is being reviewed by the local team.

### Commentary

Each OFR team case review relies on the quality of the data available to the local team, which is often contingent on the amount of interaction the decedent had with various systems.<sup>35</sup> Information that OFR teams consider critical to a case review includes medical records, substance use disorder treatment records, medical examiner reports, criminal justice records, and social services records. Using these records, the local team can piece together a timeline of services offered to the decedent, including whether sufficient referrals were generated, if gaps in

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<sup>35</sup> Janota, *supra* note 5.

service existed, and what missed opportunities were present. Additionally, information may be gathered on family members related to the decedent to further look at the social determinants of health that influenced the decedent's behavior and decision making. Local teams may also wish to interview surviving family members to hear their stories and to assist with the team's investigation into the death.<sup>36</sup> All data that the local team receives should be identified data, so that the team can establish the most complete and accurate timeline for the investigation.

Subsection (a) provides a non-exhaustive list of information that can be requested by the local team.<sup>37</sup> It is necessary to list this information in the statute to make use of provisions within many state and federal confidentiality laws that allow disclosures without patient consent where required by state law. It should be noted, however, that depending on the law of the jurisdiction, a local team may need to enter into a memorandum of understanding or a data use agreement with the information provider in order to receive the requested information. The intent of subsection (a), via use of the phrase "notwithstanding any other provision of state or local law to the contrary," is to supersede any state or local law or ordinance that could conflict with (a)(1) or (a)(2). While this language on its own is sufficient, states may prefer to amend their confidentiality laws when enacting the Model Act to further solidify the local team's ability to access certain information. For example, in Delaware and Maryland, there are state confidentiality provisions outside of the OFR law that specifically indicate that protected health information can go to OFR teams.<sup>38</sup>

Subsection (b) provides a list of individuals or entities who are required to comply with record requests made by the local team. Provision (b)(14) acts as a catch-all provision to include an individual or entity that has relevant information for the local team's investigation that is not explicitly mentioned in subsection (b). Using an enumerated list of required reporters in statutory language prevents individuals and entities from refusing to provide the local team with information. An individual or entity that is required to comply with a record request by the local team may request a reasonable fee from the local team for the costs associated with duplicating the records per subsection (c). For certain individuals or entities, such as a local non-profit organization, the cost associated with complying with a record request may be burdensome. By paying the fee, the local team helps to ease that burden and will allow the individual or entity to comply with the record request more easily. Per subsection (e), information requested by the local team must be provided within five business days of the request, excluding weekends and holidays, unless an extension is granted by the chair. The five-day turnover requirement ensures that information is provided to the local team within a timely manner and avoids delays.

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<sup>36</sup> *Id.*

<sup>37</sup> OFR teams face at least two types of barriers – legal and interagency – in obtaining certain personal information on decedents. The purpose of Section VIII is to eliminate, as much as is possible, those legal and interagency barriers to accessing that information. One resource that will become available in the coming months is a series of documents posted to the Bureau of Justice Assistance's Comprehensive Opioid, Simulant, and Substance Abuse Program (COSSAP) website (<https://www.cossapresources.org/>) regarding the different types of records available for review by OFRs and the different ways in which OFR teams can obtain those records.

<sup>38</sup> 16 Del.C. § 1212(d)(12) and MD Code, Health - General, § 4-306(b)(11).

Based upon the directive contained in subsection (a), many medical records can be disclosed to the local team without the authorization of the patient or, if deceased, the person's next of kin, without violating HIPAA. Authorization, however, may be necessary in states that have additional state laws related to the disclosure of mental health records. Additionally, patient or next of kin authorization will be required for substance use treatment records covered under 42 U.S.C. § 290dd-2 and its implementing regulation, 42 C.F.R. Part 2. This is the purpose of including subsection (d) in the Model Act. 42 C.F.R. Part 2 regulations "impose restrictions upon the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program."<sup>39</sup> The restrictions on disclosure apply to any information disclosed by a federally assisted alcohol and drug abuse program (Part 2 program), as defined in the regulation, that would identify a patient as having a substance use disorder.<sup>40</sup> Generally, a Part 2 program may disclose any information about a patient if the patient or, if deceased, the patient's next of kin authorizes the disclosure by signing a valid consent form.<sup>41</sup> The consent must be in writing and include the information identified in 42 C.F.R. § 2.31.

Much of the language contained in Section VIII is based on currently-in-force statutes. The language in subsections (a) and (d) is modeled after Maryland law.<sup>42</sup> The language in subsections (b), (c), and (i) is modeled after Indiana law.<sup>43</sup> The five-day information turnover requirement in subsection (e) and subsection (j) is based on Arizona law.<sup>44</sup>

## **SECTION IX. CONFIDENTIALITY.**

- (a) Team meetings.— Local team meetings in which confidential information is discussed shall be closed to the public.
- (b) Confidentiality form.— All local team members and any non-member individuals in attendance at a meeting shall sign a confidentiality form and review the purpose and goal of the local team before they may participate in the review. The form shall set out the requirements for maintaining the confidentiality of any information disclosed during the meeting and any penalties associated with failure to maintain such confidentiality.
- (c) Discovery.— All information and records acquired by a local team are confidential and are not subject to subpoena, discovery, or introduction into evidence in a civil or criminal proceeding or disciplinary action. Information and records that are otherwise available

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<sup>39</sup> 42 C.F.R. § 2.3(a) (2017).

<sup>40</sup> 42 C.F.R. § 2.12(a) (1) (2020).

<sup>41</sup> 42 C.F.R. § 2.15(b)(2) (2018).

<sup>42</sup> Md. Code Ann., Health – Gen. § 5-904(a) and (d) (2014); Md. Code Ann., Health – Gen. § 4-306(a)(11) (2014).

<sup>43</sup> Ind. Code § 16-49.5-2-8 (2020); Ind. Code § 16-49.5-2-8(c) (2020); Ind. Code § 16-49.5-2-8(b) (2020).

<sup>44</sup> Ariz. Rev. Stat. § 36-198.01(A) (2017); Ariz. Rev. Stat. § 36-198.01(F) (2017).

from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because the information or record was presented to or reviewed by a local team.

- (d) Public access.— Information and records acquired or created by a local team are not subject to [insert citation to state public inspection or open records laws] .
- (e) Redisclosure of information.— Substance use disorder treatment records requested or provided to the local team are subject to any additional limitations on redisclosure of a medical record developed in connection with the provisions of substance use disorder treatment services under state or federal law, including, but not limited to, 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2.
- (f) Civil or criminal proceedings.— Local team members and any individuals who present or provide information to a local team may not be questioned in any civil or criminal proceeding or disciplinary action regarding the information presented or provided. This subsection does not prevent a person from testifying regarding information obtained independently of the local team or as to public information.
- (g) Civil liability.— The confidentiality of information provided to the local team shall be maintained as required by state and federal law. Any person damaged by the negligent or knowing and willful disclosure of such confidential information by the local team or its members may maintain an action for damages, costs, and attorney fees pursuant to [state tort law].
- (h) Criminal liability.— A person who violates the confidentiality provisions of this Act is guilty of a [misdemeanor/felony] and on conviction thereof is subject to a fine not to exceed [maximum amount of fine] or imprisonment for a term not to exceed [maximum time period], or both.
- (i) Attendance at meetings.— This section shall not be construed to prohibit a local team from requesting the attendance at a team meeting of a person who has information relevant to the team’s exercise of its purpose and duties.

## Commentary

Confidentiality is essential for successful overdose fatality reviews because it maintains the trust of participating members and of the community in the OFR team process.<sup>45</sup> OFR teams must understand and adhere to HIPAA, the Family Educational Rights and Privacy Act, and 42 C.F.R Part 2, in addition to the confidentiality policies of other government and private institutions that serve children and other vulnerable populations to protect confidential decedent information.<sup>46</sup> Some states may also have additional privacy laws for medical, substance use disorder, and mental health records.<sup>47</sup> Subsection (b) requires all members of the local team and any non-member attendees to sign a confidentiality agreement prior to participating in the review. The agreement should include the objectives of the OFR team and prohibit the dissemination of confidential information beyond the purpose of the review.<sup>48</sup> The BJA's COSSAP considers the signing of a confidentiality agreement prior to participating in an OFR team meeting to be a best practice.<sup>49</sup>

The language in subsection (b) is modeled after Indiana law.<sup>50</sup> The language in subsection (c) is modeled after Arizona law; similar language is found in Maryland and Oklahoma.<sup>51</sup> The language in subsections (e), (f), (h), and (i) is modeled after Maryland law.<sup>52</sup> The language in subsection (g) is modeled after Oklahoma law.<sup>53</sup>

## SECTION X. FINANCIAL CONSIDERATIONS.

- (a) Fund established.— There is established within the [state] Treasury an overdose fatality review teams grant program fund.
- (b) Overdose fatality review teams grant program.—
  - (1) In general.— The [state] overdose fatality review team grant program is established and shall be administered by the [state agency]. Grants provided under the program shall be used to fund the local teams established under this Act.
  - (2) Guidelines and requirements.— The [state agency] may adopt guidelines and requirements to direct the distribution of funds for expenses related to local teams.

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<sup>45</sup> Heinen, *supra* note 16, at 29.

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* at 30.

<sup>49</sup> *Id.* at 29-30.

<sup>50</sup> Ind. Code § 16-49.5-2-5 (2020).

<sup>51</sup> Ariz. Rev. Stat. §36-198 (F) (2017); Md. Code Ann., Health – Gen. § 5-906(g) (2014); Okla. Stat. Ann. tit. 63, §2-1001(B)(7) (2018).

<sup>52</sup> Md. Code Ann., Health – Gen. § 5-904(b) (2014); Md. Code Ann., Health – Gen. § 5-906(f) (2014); Md. Code Ann., Health – Gen. § 5-905(e) (2014); Md. Code Ann., Health – Gen. § 5-905(d) (2014).

<sup>53</sup> Okla. Stat. Ann. tit. 63, §2-1001(B)(6) (2018).

- (3) Eligible activities.— Activities eligible for funding under this Act may include, but are not limited to, the following:
- (A) Administrative costs;
  - (B) Local team member compensation for travel and expenses associated with participation;
  - (C) Record fees; and
  - (D) Software for tracking case data and recommendations.
- (c) Budget allocation.— The legislature will appropriate [\$\_\_\_\_\_ for fiscal years \_\_\_\_\_] to the overdose fatality review teams grant program for the purpose of funding, in whole or in part, the initial start-up and ongoing activities required as part of this Act.
- (d) Pursuit of funding.— The [state agency] and local teams shall pursue all federal funding, matching funds, and foundation funding for the initial start-up and ongoing activities required under this Act. Any funds received by the [state agency] pursuant to this subsection shall be deposited into the overdose fatality review teams grant program fund.
- (e) Acceptance of gifts.— The [state agency] and local teams may accept such gifts, grants, and endowments, from public or private sources, as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expand the same or any income derived from it according to the term of the gift, grant, or endowment. Any funds received by the [state agency] pursuant to this subsection shall be deposited into the overdose fatality review teams grant program fund.

### Commentary

Funding sections in model laws can be complicated, as states fund projects through legislation in a variety of ways, and there is no one size fits all. However, if the Model Act omits the funding discussion altogether, then the legislation gives the appearance of an “unfunded mandate.”

Since it is impractical to have funding language that requires the appropriation of funding to individual OFR teams, the drafters determined that the best solution is the inclusion of a state grant program using language modeled after Illinois and Pennsylvania legislation.<sup>54</sup> If a state is hesitant to pass legislation that includes a funding mandate, states should feel free to exclude this section from their OFR teams act legislation.

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<sup>54</sup> 5 Ill. Comp. Stat. 820/35 (2019); Pennsylvania House Bill 424 (introduced March 1, 2019) (Section 5(b)).

**SECTION XI. SEVERABILITY.**

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

**SECTION XII. RULES AND REGULATIONS.**

The [State agency] may promulgate such rules and regulations as are necessary to effectuate this Act.

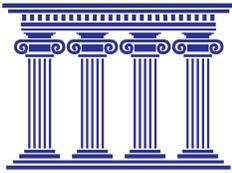
**SECTION XIII. EFFECTIVE DATE.**

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

## ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces timely model laws and policies that can be used by national, state, and local public health, public safety, and substance use disorder practitioners who want the latest comprehensive information on law and policy as well as up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to fact sheets. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.



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