DEPARTMENT OF HEALTH

Overdose Fatality Reviews for Public Health and Safety Teams Implementation Guide

(UPDATED 5/01/2024)

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Introduction

This implementation guide is designed to provide an overview of what Overdose Fatality Reviews (OFRs) entail, how to facilitate OFRs, and managing an OFR team using the Public Health and Safety Team (PHAST) framework. This guide is specific to teams working in Minnesota. OFRs are an impactful prevention activity that local public health and safety teams can implement in their communities to reduce and prevent overdose deaths.

Implementation Guide Acknowledgement

The Minnesota Department of Health (MDH) would like to thank the Institute for Intergovernmental Research (IIR) (https://www.iir.com/) for developing the Overdose Fatality Review Practitioner's Guide (PDF) (https://www.cossup.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf), as well as the U.S. Centers for Disease Control and Prevention (CDC) (https://www.cdc.gov/) and CDC Foundation (https://www.cdcfoundation.org/) for developing the PHAST Toolkit (https://phast.org/), from which this guidance is adapted.

What Is the Overdose Epidemic?

Drug overdose is a leading cause of injury death in the United States with nearly 107,000 deaths in 2021. In 2022, preliminary data showed an average of three Minnesotans died each day from a drug overdose with a total number of 1,343 deaths. Of these deaths, 87% had at least one opportunity for intervention, including opportunities for linkage to care prior to death or implementation of a life-saving action at the time of overdose. Drug overdose deaths continue to be dominated by synthetic opioids (e.g., fentanyl), psychostimulants (e.g., methamphetamine), and cocaine. To learn more, please visit Statewide Trends in Drug Overdose (PDF) (https://www.health.state.mn.us/communities/opioids/documents/2022prelimdatareport.pdf).

Health Equity

While the epidemic reaches all corners of the state, there are communities in Minnesota that are disproportionately impacted by drug overdose. African American and American Indian Minnesotans experience the greatest burden of drug overdose in the state. In 2021, African American residents were more than three times as likely, and American Indian residents were ten times more likely, to die from drug overdose than white Minnesotans. Additionally, the statewide rate of fatal overdose was 23.8 per 100,000 residents. The Northwest, Northeast, and Metro regions saw the most significant rate of drug overdose in Minnesota, with overdose mortality rates higher than the state rate (34.8, 27.1, and 26.5 per 100,000, respectively).

The vision of MDH is for health equity in Minnesota, where all communities are thriving, and all people have what they need to be healthy. Achieving health equity means creating the conditions in which all people can attain their highest possible level of health. For more

information on health equity, please visit the MDH Center for Health Equity (https://www.health.state.mn.us/communities/equity/index.html).

Are Overdose Deaths Preventable?

Yes, overdose deaths can be prevented with coordinated strategies, timely implementation of evidence-based interventions, community mobilization, and supportive community, family, and friends. The shared understanding that overdose deaths are preventable guides the entire Overdose Fatality Review and Public Health and Safety Team process.

What Is an OFR?

An Overdose Fatality Review (OFR) is a nationally recognized model being used by a growing number of communities to strengthen their community-level responses to the overdose epidemic. The purpose of an OFR is to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies. In practice, OFRs involve a series of confidential individual fatality reviews by a multidisciplinary team.

A fatality review, also referred to as a "case review", examines the life of a person who died of an overdose in terms of drug use history, comorbidity, major health events, social-emotional trauma (including adverse childhood experiences), encounters with law enforcement and the criminal justice system, treatment history, and other factors, including local conditions (high school graduation, food security, income, etc.) to facilitate a deeper understanding of the missed opportunities for prevention and intervention that may have prevented an overdose death.

By conducting a series of reviews, communities begin to see patterns of need and opportunity, not only within specific agencies but across systems. Blending input from public health, public safety, healthcare providers, and the community, teams develop program and policy recommendations to improve coordination and collaboration between agencies and community conditions to prevent future overdose deaths. Examples of successful recommendations include the integration of peer recovery specialists into new settings, targeted naloxone distribution, and improved coordination of public safety and public health.

What is a PHAST?

The Public Health and Safety Team (PHAST) framework is a companion to OFRs that is designed to help communities plan, implement, and evaluate OFRs. The PHAST Framework is a set of guiding principles to assist jurisdictions in reducing overdose deaths by supporting multi-sector data-sharing and coordination in overdose prevention, with particular focus on leadership from public health and public safety. The goal of this collaborative public health and public safety strategy is to facilitate targeted, action-oriented intervention and problem-solving. The PHAST framework has four guiding principles:

- **Reducing Overdose Deaths.** This explicit, common goal is "The North Star" that grounds all PHAST work and its partners. Multiple sectors, often employing divergent viewpoints and approaches, are united in the principle of the protection of life.
- **Recognition of Opioid Use Disorder (OUD) as a Chronic, Treatable Disease.** With a shared understanding of OUD as a chronic disease, partners can be better equipped to combat stigma and tackle common challenges.
- **Responsible Use of Multi-sector Data to Inform Response Strategies.** Aggregate or population-level data are typically used to answer key investigation questions, whereas case-level data are necessary to conduct OFRs and post-overdose outreach or to establish linkages to care.
- **Continuous Improvement.** PHASTs use information and feedback to identify and implement program adjustments to improve processes and outcomes.

A PHAST is made up of partnerships between public health officials, law enforcement representatives, and other local groups dedicated to preventing overdose deaths. Public health and safety teams are well positioned to perform and support OFRs. PHAST teams work in tandem with review teams by identifying patterns and priority populations from aggregate data to help determine case selection criteria for individual fatality reviews. PHAST members may also take part in the review meetings or work with other subcommittee members to share common aggregate data.

Some possible local PHAST members may include:

- Behavioral and mental health treatment provider.
- Certified/Peer recovery specialist.
- County sheriff's office.
- Coroner's or medical examiner's office.
- Data analysts/epidemiologist.
- Emergency medical services (EMS) agency representative.
- Harm reduction service provider.
- Hospital representative.
- Housing/homeless services.
- Overdose Response Strategy (ORS) drug intelligence officer.
- ORS public health analyst.

Common Aggregate Data Shared:

- Nonfatal overdose data—emergency medical system and emergency department.
- Naloxone distribution (ODMAP).

- Harm reduction kits distributed.
- Drug-related arrests.
- Drug seizures.
- Social determinants of health.
- Overdose Deaths.

Addressing the Overdose Crisis

The enhanced OFR and PHAST framework encourages multisector collaboration, meeting structure, and data sharing to gain a better understanding of the local crisis, system-level factors that contribute to fatal overdoses, and opportunities for prevention by using the data-driven "SOS" process. In this context, SOS stands for:

- **Shared understanding.** Teams increase members' understanding of agencies' roles and services as well as the community's assets and needs, substance use and overdose trends, current prevention activities, and system gaps.
- **Optimized capacity.** Teams increase the community's overall capacity to prevent future overdose deaths by leveraging resources from multiple agencies and sectors to increase system-level responses.
- **Shared accountability.** Teams continually monitor local substance use and overdose death data as well as recommendation implementation activities. Status updates on recommendations are shared at each team meeting and with a governing committee, reinforcing accountability for action.

Thank You!

The work done by your local public health and safety team contributes to the statewide effort to prevent overdose deaths and improve our systems that serve Minnesotans with substance use disorder.

Contact MDH

To contact the MDH Injury and Violence Prevention Section's PHAST and OFR subject matter experts, a training and technical assistance request may be submitted through the Overdose Fatality Review TA Request Form (https://redcap.health.state.mn.us/redcap/surveys/?s=CH7CK9MJWWX88KX9). For all other inquiries, please send an email to: health.drugodprev@state.mn.us

To find the most recent statewide drug overdose and substance use data, please visit the MDH Drug Overdose Dashboard (https://www.health.state.mn.us/opioiddashboard). Other

Minnesota-specific online resources are listed below under Overdose Fatality Review Online Resources.

Module 1: Developing a Team

Who is on a team?

Review teams are comprised of a multidisciplinary group of individuals who can share information about a case being reviewed or contribute to the analysis of available data to make recommendations that will prevent future overdose deaths. Overdoses affect a variety of populations, neighborhoods, and communities. To effectively function and work toward the goal of preventing overdose deaths, teams need a diverse set of members from disciplines and sectors that represent the community. This enhanced framework is meant to facilitate diversity and inclusion of multiple perspectives on a review team.

Team members are dedicated professionals who share the understanding 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. Effective review teams have at least 10 members. 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. A list of potential team members is available below. Depending on the community, there might be other service providers and professionals that could be members of the team that are not included on the list below.

Potential OFR Members:

- Local health department official.
- Local law enforcement representative.
- Drug Taskforce members.
- Medical examiner/coroner.
- Prosecutor.
- Local human services department official.
- Substance use treatment provider.
- Culturally specific substance use treatment provider or peer recovery specialist.
- Medications for opioid use disorder (MOUD) treatment provider.
- Mental health social worker.
- Pain management clinician.
- Emergency department physician.
- Primary care provider.

- Pharmacist/toxicologist.
- High Intensity Drug Trafficking Area (HIDTA) public health analyst.
- Sheriff.
- Probation and parole officer.
- Corrections staff and medical providers.
- Emergency medical service provider.
- Drug treatment court representative.
- Patient advocate.
- Child protective services representative.
- Substance use prevention professional.
- School counselor.
- Tribal elder, traditional leader.
- Community leader.
- Housing authority representative.
- Harm reduction outreach professional.

Finding the appropriate partner agencies and professionals to become team members is essential in establishing an effective OFR. It is important to partner with agencies willing to:

- Provide quality services.
- Develop successful partnerships.
- Maintain consistent engagement.
- Be good stewards of data—following confidentiality standards.
- Engage in public policy or advocacy.

Each partner agency should identify staff members (frontline staff, mid-level supervisors, or executives) who have the most appropriate roles within the agency to be team members and who regularly attend and contribute to the reviews. All staffing levels are important and needed on a review team to ensure the most complete understanding of how agencies and systems work together, including what gaps exist and what steps may be needed to implement identified prevention recommendations. This level of engagement ensures that at least one person from each agency can be present at each meeting and helps build internal agency relationships and champions for change.

Some sectors, such as law enforcement agencies, may have more than one representative on the team. For instance, if there are multiple law enforcement agencies (sheriff's office, police

department, etc.) in the community, you may have both a sheriff's office and a local law enforcement representative. For some cases, team members may have had previous contact with a decedent or the decedent's family or social network. They may also represent an agency that provided services to the decedent or to others where the decedent lived or where the overdose incident occurred. The team members provide essential information about the conditions or environments in which the decedent was born, lived, and worked, to learn what may have contributed to the decedent's overdose death.

In addition to possibly providing services to the community and to the decedent, an effective team member will also have:

- An understanding of the impact of the overdose epidemic in his or her community.
- The ability to assess problems at the macro or system level and assess organizational practices or communitywide initiatives.
- Authority to make decisions for the agency he or she represents or direct access to decision makers.
- The ability to critique work of other agencies and raise questions without passing judgment.

Guest Members

Given the sensitive nature of the information shared and the need to build trusted relationships, case review meetings are closed and not open to the public. Sometimes, invited guests will participate or observe to learn more about OFRs. Most often, the invited professionals have information specific to the case and are called guest members.

A review meeting may focus on cases from a specific area in a geographic region where it would be beneficial to invite nonprofit agencies, faith-based organizations, and other community leadership or service agencies that are not consistent team members. Guest members can provide invaluable perspective, inform problem-solving discussion, and formulate realistic and community-specific prevention recommendations. In addition, individuals that have directly or indirectly served an overdose decedent may have valuable information and may be invited to attend as guest members.

Guest members representing agencies with information about the decedent may be identified from news coverage about the death or from medical examiner/coroner reports. Guest members could include elected officials, service providers not currently on the team, or someone who wants to observe and learn more about the review process.

Please keep in mind the size of an organization when reaching out to invite a guest member and adjust expectations for their participation appropriately. Smaller community-based organizations may take longer to respond or need more time to collect information prior to the review meeting than is usually provided. Participants from smaller nonprofit organizations may have limited time to prepare for reviews and limited staff capacity for meeting attendence.

To support the inclusion of staff from smaller organizations, the coordinator could offer to help a guest member write their case summary through a phone call or individual meeting, develop a set of questions for the guest member to answer that the coordinator can share with the team if the guest member cannot attend the meeting, or let the guest member share their case summary first if they cannot attend the entirety of the meeting.

Team Attendance

Encouraging team members to attend each review is important as it helps to build rapport and builds trust within the team. This trust allows for more open dialogue about each case and increases commitment to recommendations. Missing even one meeting can impact the team dynamics and members' understanding of the overdose issues and prevention strategies. If a member cannot attend, they may send a pre-approved designee.

Virtual Meetings:

It is always an option to have both in-person and virtual components to a meeting. Especially in greater Minnesota, the time and expense to travel to attend an in-person meeting can be a hindrance to smaller organizations. The lead agency should consider if it would be a requirement for their team that all members attend meetings in-person, attend at least one meeting in-person every year, or if exclusively virtual attendance will be permitted.

Team Structure and Roles

Every team should have a single lead coordinating agency to guide their work. The lead agency can be the local health department, human services department, prevention coalition, or other local agency that is seen as a neutral agency; typically, this agency is already involved as a leader in responding to the overdose epidemic.

The lead agency oversees the team by providing administrative support to fulfill three key leadership roles:

- Facilitator.
- Coordinator.
- Data manager.

The team leadership structure and roles may depend on funding availability to complete case reviews. Organizations with significant financial and political support may have up to three separate funded staff positions. In other organizations, one person might have multiple roles. Drafting a funding request highlighting the purpose, goals, and expected impact of your team in your community will help communicate operation needs with community leadership and funding organizations. A sample funding request letter is included in Module 1 Appendix.

The table below shows the tasks of each leadership role and more detailed information on each role is available in the Facilitator, Coordinator, and Data Manager sections. Depending on the

organization, PHAST and OFR teams work together, but they may meet separately to select case criteria and conduct case reviews.

Table 1. Leadership Role Tasks

Leadership Role	Tasks
Facilitator	• Facilitate review meetings. • Recruit team members. • Build and maintain trusting relationships with team members. • Orient new team members.
Coordinator	• Obtain and share case information with team members and do additional research when appropriate. • Review data and reports from team members. • Research information about cases that may not be provided by team members, such as reviewing social media, obituaries, media coverage, etc. • Draft meeting agendas, in partnership with the facilitator. • Manage meeting logistics (such as date and time, location, and technology support). • Take minutes during each meeting. • Document activities and track progress between meetings. • Update the governing committee. • Support and communicate with subcommittees.
Data Manager	• Enter case information and recommendations into review database. • Create and present data reports for teams and the governing committee. • Analyze case specific and aggregate data. • Lead discussions on data interpretation.

Facilitator

A representative from the lead agency should serve in the facilitation role. The facilitator is responsible for activities such as:

- Facilitating meetings.
- Recruiting team members.
- Building and maintaining relationships with team members.
- Orienting new team members.

Facilitating Meetings

Team meetings are facilitated using a problem-solving process to identify recommendations and to oversee implementation of developed recommendations. More information about the OFR facilitation role is available in Module 3. Facilitating a Meeting.

Recruiting Team Members

A key role for the lead agency is recruiting and retaining team members. Members may need to be recruited and engaged before being requested to provide data, participate in a review, or assist with developing or implementing a recommendation. Their perspectives and input may be valuable even if their organizations did not have direct contact with the decedent or service area related to the case. For example, a substance use treatment provider has a valuable perspective on standards of care, even if they did not provide services to the specific individual being reviewed. A toxicologist or pharmacist may assist with understanding the prescription drugs provided to the decedent, even if they did not interact with that individual.

Effective recruitment is all in the details. Ideally, the facilitator will meet one-on-one with new recruits to prepare members for what to expect when participating on a review team by:

- Explaining the goals and reviewing overall structure.
- Sharing stated and unstated group rules/norms.
- Emphasizing that the purpose of the meeting is not to blame or shame other participants.
- Addressing any data sharing or confidentiality concerns and having members sign a confidentiality agreement.
- Summarizing past and current recommendations relevant to their organization or area of work.
- Suggesting immediate ways members can participate in developing and implementing a recommendation.

Drafting a recruitment email with the above information, a meeting schedule, and a clear list of partner expectations will help communicate and recruit new active members. A sample recruitment letter is included in Module 1 Appendix.

Before recruited members can participate in a review, they will need senior leadership to sign an interagency agreement. Review the sample interagency agreement in the Module 1 Appendix for an example. Since Minnesota does not currently have OFR-specific legislation, a memorandum of understanding (MOU) from data-providing members may be needed. Please refer to the Module 4: Collect Your OFR Data section for more information specific to Minnesota.

Teams benefit from ongoing recruitment of new members to address staff turnover, address gaps in their membership, or identify new trends. Periodically reviewing team member commitment, organizations represented, and recruiting new members in response to changes in the community (i.e., new substance use treatment center or change in local substance use trends) can help to ensure that the team is continuously responsive to community need.

Building and Maintaining Relationships

Building and maintaining relationships can be achieved several ways. For example, the team can use meeting breaks as an opportunity to incorporate team building. This may involve as little as pulling aside a couple of participants and introducing them to each other and bringing up a shared interest or community connection. Encouraging members to stay after the meeting to network is another effective way to build trust and relationships.

A more formal way to help build team cohesion is to provide general agency or member updates at the beginning or end of the meeting that may result in partnerships during and outside of the fatality review experience. Keep in mind that if the relationship with the agency is new, attending agency events and asking to observe the program may help you get a sense for what the agency does and will build rapport.

Orienting New Team Members

Every team member will come to the table with different experiences, knowledge, prejudices, and ideas about substance use and its impact on their work and the community. It will be the facilitator's responsibility to lead meetings in a way that elevates all voices, addresses stigma or misinformation, and prioritizes a shared understanding. To prepare for this task, the team facilitator may expect each member to obtain certain knowledge or training ahead of participating in a meeting.

Recommended trainings include the following:

- Overcoming Stigma, Ending Discrimination Resource Guide (https://www.samhsa.gov/sites/default/files/overcoming-stigma-ending-discrimination-resource-guide.pdf)
- Why Addiction Is a 'Disease' and Why It's Important (https://www.samhsa.gov/power-perceptions-understanding/webcasts)
- Social Determinants of Health: Know What Affects Health (https://www.cdc.gov/socialdeterminants/index.htm)
- Review table of recommendation types in Module 5 Appendix.
- Review the MDH Drug Overdose Prevention website (https://www.health.state.mn.us/communities/opioids/index.html).

  Other MDH webpages to review include:

- Social Determinants of Substance Use and Overdose Prevention (https://www.health.state.mn.us/communities/opioids/prevention/socialdeterminants.html)
- Differences in Rates of Drug Overdose Deaths by Race (https://www.health.state.mn.us/communities/opioids/data/racedisparity.html)
- Promising Overdose Prevention Practices (https://www.health.state.mn.us/communities/opioids/prevention/promisingpractices.html)

Drug overdose death data come from Minnesota death certificates. After a death occurs, a death investigation is completed, along with an autopsy (94% of drug overdose deaths had an autopsy completed in 2016), and a medical examiner or coroner determines the cause and manner of death. The cause of death information is then typed into the corresponding sections of the death certificate. Once the medical examiner certifies and completes a death certificate, the information is then sent to the Office of Vital Records (OVR) at the Minnesota Department of Health (MDH).

Utilizing Stigma-reducing Language

The process of developing a shared understanding of the opioid overdose crisis requires time to identify shared terminology upon which the collaborative working relationship will operate. This will likely happen organically over time, but having a process or plan for how to navigate those issues is advisable. Discussing how the use of certain terms can perpetuate myths and stigma may be one way to introduce new ways of thinking and speaking about the opioid overdose crisis and to help foster a shared understanding of non-stigmatizing language for substance use. To learn more, visit the MDH webpage How to Talk about Drug Use (https://www.health.state.mn.us/communities/opioids/basics/languagesud.html).

Table 2. Alternatives to Stigmatizing Terms and Phrases

Language to Avoid	Language to Use
• Alcoholic • Addict • User • Abuser • Junkie	• Person with a substance use disorder
• Addicted babies / born addicted	• Babies with an opioid dependency

Language to Avoid	Language to Use
• Drug habit • Abuse • Problem	• Substance use disorder or addiction • Use, misuse • Risky, unhealthy, or heavy use
• Clean	• Person in recovery • Abstinent • Not taking drugs
• Substitution or replacement therapy • Medication-Assisted Treatment • Clean, dirty	• Treatment or medication for addiction • Medication for Opioid Use Disorder (MOUD) • Positive, negative (toxicology screen results)

More information on non-stigmatizing language can be found in the following resources:

- National Institute on Drug Abuse, Words Matter: Preferred Language for Talking About Addiction (https://www.drugabuse.gov/drug-topics/addiction-science/words-matter-preferred-language-talking-about-addiction)
- Shatterproof (https:/www.shatterproof.org/our-work/ending-addiction-stigma)
- Indiana University: Combating Stigma (https://research.impact.iu.edu/our-strengths/social-sciences/end-stigma.html)

Coordinator

A representative from the lead agency should serve in the coordination role. The coordinator is responsible for activities such as:

- Obtaining and sharing case information with team members.
- Receiving data and reports from team members.
- Researching information about cases that may not be provided by members, such as reviewing social media, obituaries, media coverage, etc.
- Drafting meeting agendas in partnership with the team facilitator.
- Managing meeting logistics (such as date and time, location, and technology support).
- Taking minutes during each meeting.
- Documenting activities since the last meeting.
- Updating the governing committee.
- Supporting and communicating with subcommittees.

More information about the coordination role is available in Module 2. Planning a Case Review Meeting.

Data Manager

A representative from the lead agency should serve in the data manager role. On some teams, the data manager role will be built into the coordinator or facilitator role depending on team capacity. The data manager is primarily responsible for entering case information and recommendations into the Minnesota OFR REDCap database. More information about the data manager role is available in Module 4. Collect Your OFR Data and Module 5. Build a Recommendation Plan.

In addition to entering data, there may be a need for analyzing data from other data sources and/or the case data for team meetings, governing committee updates, and annual reports. While the data manager primarily records data, data analysis and frequently reviewing data sources are the responsibility of all team members. Team members benefit from staying up to date on new data and research.

Subcommittees

The bulk of the work of a PHAST and OFR may occur between meetings at the subcommittee level. Subcommittees may determine case selection criteria or how a recommendation may achieve a policy change. For example, if a review team identified improving care coordination among inpatient and outpatient treatment providers as a need, a subcommittee of local treatment providers, social workers, and patient advocates might convene to discuss gaps in care, identify partner agencies, and develop recommendations, an implementation plan, and a timeline for completion.

Subcommittee membership may include members of the governing committee, the team, and outside experts (e.g., experts related to addiction, homelessness, veterans' affairs, or family survivors). Subcommittees meet separately from the review team and report to other members at fatality review meetings on their aims and progress. Subcommittees are formed and disbanded as needed, so they may serve an ongoing or a temporary purpose. To learn more about subcommittees, see below Forming a Subcommittee to Develop Recommendations.

Governing Committee

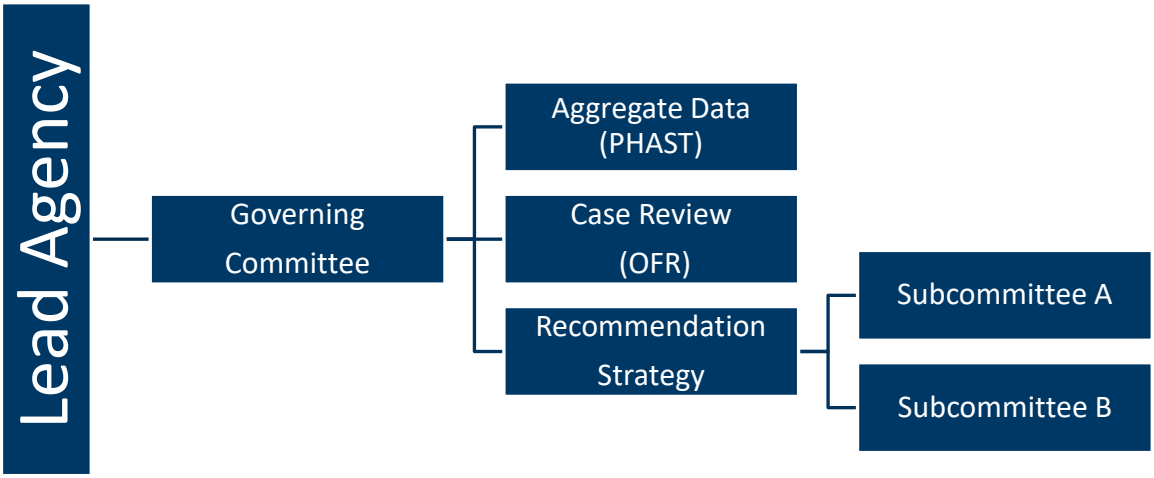
In addition to the lead agency and subcommittees, the review team needs a committee to provide leadership and support for implementing recommendations it has identified. This committee is referred to as a governing committee. Depending on the community, the governing committee may be an already existing local drug prevention task force or may be formed solely to support the PHAST and OFR initiative.

The governing committee is composed of senior-level representatives of city, county, and state agencies and community partner organizations. Some possible governing committee members for a local team may include:

- Chief of police.
- Mayor.
- Local or state health department leadership.
- Researchers at a local university.
- District attorney.
- School superintendent.
- Medical examiner/coroner.
- Chief executive officers at local hospitals.
- County sheriff.
- Attorney general.
- Department of Corrections leadership.
- Behavioral health administrator.

To learn more about how the team interacts with the governing committee, review Updating the Governing Committee.

Figure 1. Possible Display of Team Structure



Module 2: Planning a Case Review Meeting

Meeting Logistics

Planning a successful case review meeting requires thoughtful preparation by the coordinator, facilitator, and data manager to ensure that all meeting attendees receive all information necessary prior to the meeting, the meeting space is comfortable and accessible, and all required documentation is collected. As a reminder, given the sensitive nature of the information shared and the need to build trusted relationships, the meetings are closed and not open to the public. If leadership or a team member feel it would be helpful to invite a guest member, they should work with the facilitator to invite the guest member and orient them to the OFR process.

Meeting Schedule

The meetings are held when and where most members can attend. The schedules and locations of the entire year's meetings should be developed at the beginning of the year so that team members can plan accordingly. Meeting at minimum quarterly, and more frequently if possible, would be a good expectation for teams. A typical meeting will be two to three hours in length and each case will take about an hour, depending on the complexity of the case and the review team's experience.

Virtual Meetings

There are many reasons why a virtual review might be preferred instead of an in-person meeting, including widespread illness, such as the COVID-19 pandemic or influenza, and weather events that could make travel dangerous for team members.

When scheduling all meetings for the year, the lead agency should explore whether they would like to provide a virtual meeting option for all scheduled meetings.

When planning for a virtual meeting, the lead agency should consider adding additional time at the beginning of the meeting for technology troubleshooting. If possible, the lead agency could dedicate an additional team member to monitor meeting chat and resolve technological issues to allow the facilitator to focus on facilitating.

Meeting Room Layout

The meeting room layout is important for group dynamics and inclusion. Hosting the meeting in a circle or a hollow rectangle layout gives everyone an equal position at the table and allows for face-to-face interactions by all participants. In addition to having adequate space for desired layout, it is ideal to have a whiteboard in the meeting room for taking notes and displaying the created timeline of significant life events leading up to the decedent's overdose death.

Meeting Preparation: Coordinator's Activities

Successful fatality reviews depend on thoughtful preparation by the coordinator, beginning a month or two before a fatality review meeting. A list of coordinator activities and a timeline is provided below and in the Coordinator's Meeting Preparation Checklist provided in Module 2 Appendix.

Selecting Cases

Beginning two months before the meeting, the cases to be reviewed at the upcoming meeting need to be selected. Having timely data is critical for a successful case review meeting.

The medical examiner or coroner's office can be an excellent source for identifying overdose cases and initial case information. If possible, have someone with access to the medical examiner or coroner's data on the case selection subcommittee and the review team. Ideally, this person will gather information about overdose fatalities as they occur.

MDH staff can support the selection of cases with specific circumstances or factors that could have impacted the death. MDH could review death certificates for specific circumstances and provide the team with cases meeting criteria the review team has provided. These circumstances could include the recent release from an institution, fentanyl-involved death, or having naloxone administered, among others.

Once cases are identified by the medical examiner or coroner, allow enough time for toxicology results to be known and police officers to investigate an overdose before selecting the case for review. In Minnesota, it is recommended that teams do not choose decedents that have passed away at minimum six months prior to the planned review meeting. This will enable the data to be collected and organized for a more complete fatality review.

Case Selection Criteria

It may not be feasible for a local team to review every overdose death in their community. In this situation, the coordinator may task a subcommittee within the team with developing case selection criteria and/or selecting cases for the next review based on patterns or priority populations identified from aggregate data.

To help select cases, the following may need to be decided:

- Community inclusion—residents from the community or deaths within the community.
- Substances involved—all overdose deaths or only deaths from a specific substance will be included, for example, opioid-involved deaths.
- Cause of death—only unintentional overdoses; include all (suicides and undetermined deaths) overdoses, or drug-related injuries, such as car crashes or hypothermia complicated by opioid use.
- Cases under investigation—exclude cases in which there is an open law enforcement investigation.

- Social determinants and racial equity—consider residents from the community or deaths within the community that are disproportionately impacted by overdose.

Once the core case criteria are determined, further case selection criteria may be needed to narrow the selection of cases to a feasible number. Criteria may include the following:

- Geographical neighborhoods with high overdose rates.
- Populations with recent increases in deaths (e.g., young adult white females).
- Substances involved in most recent overdose deaths (e.g., fentanyl).
- Populations with known system interactions that may benefit from review (e.g., overdose deaths after recent release from incarceration or treatment).

Teams should ensure that the decedent cases selected are representative of diverse racial, ethnic, economic, and educational backgrounds and that exclusion criteria are not inadvertently excluding decedents from a specific group. Culturally specific review teams can be formed to address overdose deaths within a community that is disproportionately impacted by the overdose crisis. These teams can benefit from having a narrower focus and providing recommendations applicable to the unique circumstances and characteristics of these communities.

Upon selecting criteria for individual case reviews, MDH is available to support teams with identifying priority populations for case-selection from aggregate data sources. Applying a health equity lens to case selection criteria may have a meaningful impact in communities that are disproportionately impacted by drug overdose.

Recruit Guest Members

Beginning six weeks before the meeting, the coordinator needs to identify guest members, in addition to case review team members, that they need to recruit. Agencies that are not already members and that may have provided services to the decedent (such as a behavioral health provider) or that serve the community in which the decedent lived (such as social services or housing and employment supports) may be recruited to participate in a specific fatality review. The agencies to participate may be identified from the medical examiner's or coroner's report or from news coverage about the death.

Case review team members might also identify potential guest members that can contribute to the review or individuals who would like to participate in a review to learn more about the process. Each coordinator and lead agency should develop a protocol for identifying guest members and how guest members will be contacted.

Before the coordinator can discuss case details or request information from a guest member, interagency data sharing and confidentiality agreements must be reviewed and signed.

Request Case Information

Once interagency agreements are in place about a month before the meeting, case-specific information should be requested of all team members. The information should be protected in accordance with confidentiality standards. If possible, use an encrypted email to request information about the case.

The email requesting case information should include the decedent's information listed below and guidance on what information is requested from members, including what specific data members should report out. The coordinator should email team members to make data requests four to six weeks before the next review to allow ample time for team members to collect, prepare, and share case information. A sample case email, a member's guide to collecting case information, and a list of agency-specific data elements are included in the Module 2 Appendix.

Decedent information:

- Name, aliases.
- Date of birth, date of death.
- Demographics (age, race, sex).
- Address of residence.
- Incident location, date, and time.

MDH staff can provide data from the State Unintentional Drug Overdose Reporting System (SUDORS). SUDORS includes data on the decedent's demographics, injury and death, life circumstances, toxicology testing, and history of prior overdoses. To request SUDORS data from MDH, teams must be able to provide the name and date of death. The deaths should have occurred at least six months prior to the overdose fatality review.

Send Meeting Reminder Email

Two weeks prior to the review, an email including the following should be sent to team members:

- Brief summaries of cases.
- List of meeting participants.
- Meeting agenda.
- Meeting date, time, and location.

Summarize Case(s)

Prior to the meeting, the coordinator will want to summarize in a PowerPoint presentation or handout additional information identified by reading the obituary, news coverage, or social

media posts. A template for creating and presenting a case summary is included in Module 2 Appendix.

Next of Kin (NOK) Interviews

Interviews with family members or social contacts can be included in reviews to expand their understanding of the life experiences of a decedent and identify non-traditional touchpoints or systems that may not be represented by the team members. The process of interviewing family members and social contacts is called a social autopsy. The Bureau of Justice Assistance (BJA), Office of Justice Programs (OJP), U.S. Department of Justice (DOJ and the U.S. Centers for Disease Control and Prevention (CDC) have created the Next-of-Kin Interviews: A Practioner's Guide to Implementation (PDF) (https://preview-ofr.azurewebsites.net/Content/Documents/OFR/Next_of_Kin_Toolkit.pdf) to support fatality review teams with information needed to identify, conduct, and report on a NOK interview.

Document Activities since Last Meeting

Two weeks prior to the meeting, reach out and follow up with partner agencies that were responsible for previous action items or recommendations to get a status update to share during the review meeting. Teams should consider having a standing agenda item to provide updates on tasks completed since the last meeting. Documenting and sharing this information helps build accountability of all members and subcommittees.

Print Agendas and Meeting Materials

The coordinator is responsible for developing the meeting agenda with input from the facilitator (if this is a different person). More information on developing a meeting agenda is located in Module 3: Facilitating a Meeting, and a sample meeting agenda is included in Module 2 Appendix.

The coordinator will print and bring agendas, handouts, data use agreements, and any other materials needed during the review meeting. Documents need to be saved in a secure, restricted-access folder. If copies of the summary information are distributed at the meeting, the facilitator is responsible for collecting them at the end of the meeting to ensure security and confidentiality.

Virtual Meetings

When reviews are held virtually, case information will need to be shared electronically through an encrypted email or as attachments in Skype, Microsoft Teams, or WebEx meetings.

The coordinator and facilitator should work in partnership to remind team members that any case information that is shared electronically and downloaded needs to be deleted immediately after the meeting. The coordinator can offer technical assistance to ensure that all attendees are able to successfully delete any documents they might have downloaded.

The documents that are shared could also be password protected. The coordinator could provide the password to team members at the beginning of the meeting. By only providing the password to team members, if a document is not deleted after the meeting it would only be accessible to someone with the password.

Meeting Preparation: Member Activities

Team members include core team members and invited guests. Members begin preparing a month prior to the review meeting. The more prepared the members are, the more engaged they will be, resulting in a more comprehensive understanding of the incident and what could have been done to prevent it.

Receive and Review Case Information

Members will receive an email one month prior to the meeting containing the basic decedent information listed below. Most review meetings will cover more than one case.

Decedent information:

- Name, aliases.
- Date of birth, date of death.
- Demographics (age, race, sex).
- Address of residence.
- Incident location, date, and time.

Consider Implications

Members will want to think about each case and any implications it might have for their organizations or agencies and for public policies affecting specific target populations, neighborhoods, or communities, and/or topic areas (such as co-occurring mental illness and substance abuse).

Identify Agency's Contact

Members will need to determine whether their organizations or agencies had contact with the decedents, decedents' families or social networks, or whether they provided services to the neighborhoods where the decedents lived or where the incidents occurred.

Follow up with the coordinator if more information is needed to determine whether your organization or agency had contact with or provided services to the decedent(s).

Prepare a Summary

If a member's organization or agency had contact with someone involved in the case or the incident area, they should prepare a summary to verbally share during the discussion.

There are no hard-and-fast rules about what information will be useful in identifying a problem and possible solutions to prevent similar overdose deaths from a systems perspective. However, preparing for the review by answering the questions provided by the coordinator, along with reading the basic decedent case information, is a good starting point.

A member's guide to collecting case information and agency-specific data element recommendations are available in Module 2 Appendix. Some members may choose to read a prepared summary and others may choose to read from an available case file. Ideally, team members will bring their summary and records to be able to reference during the meeting to allow additional details to become available as the discussion progresses.

Preparing for a Successful Meeting

Schedule your day so you can arrive early and stay a few minutes after the review to meet other team members. It is a good networking opportunity and a great way to continue the discussion with other colleagues.

Bring paper or a laptop to take notes on the discussion, observations, prevention activities, or strategies you want to remember for your agency. Do not document any identifying information about a case that would be considered confidential.

Module 3: Facilitating a Meeting

Facilitator's Role

An effective facilitator is a neutral convener who is a good listener, develops trust with partners, encourages group participation and engagement, leads but does not direct discussion, and guides the group towards collective problem solving to craft recommendations. The facilitator will ensure that social determinants and a racial equity lens are incorporated into the reviews. For some members, considering an overdose death a preventable event may be a significant cultural shift. The facilitator can support team members participating in the fatality review by reminding all members of a shared common goal to reduce overdose deaths and reiterating the ground rules.

Meeting Agenda

Opening Remarks and Introduction

- This step should include member introductions, updates from previous meetings, upcoming events, data presentation, review case selection criteria, and other announcements.
- Member introductions: Attendees share their names, titles, and their agencies' names and roles in preventing overdose fatalities.
- Updates from previous meetings: Members share status updates on any delegated action items or recommendations from previous meetings.
- Data presentation: At the beginning of the year, present an overview of the prior year's fatal and nonfatal overdose deaths. At each subsequent meeting, present the year-to-date number of overdose fatalities and any noticeable trends (e.g., changes by overall numbers, demographics, or substance type).
- MDH publishes nonfatal and fatal overdose reports on the Opioid Overdose Prevention Resources webpage (https://www.health.state.mn.us/communities/opioids/opioid-dashboard/resources.html#data). Data is also available from the MDH Drug Overdose Dashboard (https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html) and the Minnesota Injury Data Access System (MIDAS) (https://www.health.state.mn.us/communities/injury/midas/index.html).
- Teams are also welcome to contact MDH Overdose Prevention staff for specific data requests.
    - Understanding who is at risk for overdose fatalities and where overdose deaths are happening requires an ongoing and real-time analysis of overdose trends to track where resources and immediate response may need to be available (e.g., using and uploading suspected overdose data to the Overdose Detection Mapping Application Program (ODMAP)).

  - Using a standard report will help partners understand long-term trends in fatalities and allow them to plan and develop new strategies or modify existing ones.
  - Data and analysis from these reports can also be invaluable for promoting public awareness and outreach, as well as for applying for grant funding. A sample summary data report is included in Module 3 Appendix.

- Review case selection criteria: If not all overdose deaths within a jurisdiction are being reviewed, remind the review committee about which criteria were used to select the case(s).

Goals and Ground Rules

The facilitator is responsible for ensuring that members agree with the following guiding principles:

- The "North Star" (a shared goal of reducing overdose deaths).
- Overdose deaths are preventable.
- Substance use disorder is a chronic, treatable disease.
- Use of multisector data can inform response strategies.
- The review process and prevention activities can be continually improved.

Visit the CDC Foundation's Public Health and Safety Team (PHAST) Toolkit (https://phast.org/) to learn more about these guiding principles.

At the beginning of the meeting, the facilitator reads aloud the meeting goal(s), guiding principles, and ground rules included on the agenda handout. Ask participants whether they want to add any new ground rules. A sample meeting ground rule is included in Module 3 Appendix.

Confidentiality

The facilitator or coordinator collects members' signed confidentiality forms and answers any related questions. Confidentiality is discussed in more detail in Module 4. Collect Your OFR Data.

- Confidentiality agreement: This essential form needs to be signed at the beginning of each review by the members present. A sample confidentiality agreement is included in Module 3 Appendix.
- If more than one case is reviewed at a meeting and some members arrive mid-meeting, the facilitator needs to make sure that they sign and submit the confidentiality agreement when they arrive.
- Interagency agreement: This agreement needs to be signed by senior leadership of each participating agency (including any ad hoc agencies) before they participate in any

reviews. The agreement states the role of the agency in the reviews. A sample interagency data sharing agreement is included in Module 1 Appendix.

- The facilitator is responsible for reminding team members that the meeting is closed and that the information shared in the meeting shall not be discussed outside the meeting, as outlined in the agreements they have signed.

Case Presentation

The facilitator presents the decedent's basic case information and the case summary developed by the coordinator. If each member is given a summary document, all documents should be collected at the end of the meeting.

Member Report-outs

The facilitator calls on each member to share what they know about the decedent, the decedent's social connections, and the overdose incident. The information shared helps members understand more about where the decedent lived, socialized, and worked to help identify risk factors and missed opportunities for prevention and intervention that may have contributed to the overdose death.

The facilitator calls on members with information about the overdose death incident to share their summary reports, starting with the medical examiner and first-responder agencies. The facilitator will then determine the best approach to receive report outs from the remaining members, based on the specific case. When creating a timeline, best practice is to have team members report out in reverse chronological order beginning with the decedent's date of death.

Group Discussion

The facilitator actively guides the group discussion by encouraging members to ask questions. The group discussion will clarify the timeline of significant life events and identify missed opportunities for prevention and intervention. The facilitator may want to use the strategies outlined in Meeting Facilitation Strategies.

Case and Timeline Summarized

The facilitator summarizes significant case information and draws a timeline of key activities. A whiteboard, large post-it notes, or a similar visual tool is ideal for displaying the timeline for all members to review. The facilitator should take a picture of the timeline for review after the meeting.

Formulate Recommendations

The facilitator leads a problem-solving discussion as outlined in Figure 2 to identify recommendations for change in practices or policies that could have prevented this overdose death and may prevent those in the future. Review teams may generate a variety of

recommendations, ranging from agency-specific to state-level recommendations. The recommendations generated by review teams will be shared with the Minnesota OFR State Advisory Workgroup.

Figure 2. Questions to ask team members during problem-solving process to identify recommendations.

Source: COSSUP, Overdose Fatality Review Practitioners Guide (PDF)
https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf

Summarize and Adjourn

The facilitator reviews and clarifies actionable recommendations, assigns individuals responsible for any action items, reflects on the meeting's process and findings, and collects any participants' handouts containing case information.

- The facilitator recaps how the meeting went and relates the day's review to other cases or to a larger context, such as by saying, "Today's case involved heroin-laced fentanyl, and there has been an increase in such reported cases in recent months from this area of the city."
- The team determines whether the investigation is complete or whether more information is needed.
- Remind members of confidentiality and collect any papers with confidential information.
- Remind members of the time and location of the next meeting.

Meeting Facilitation Strategies

A case review meeting is a combination of information sharing, group brainstorming and problem solving, strategic planning, and decision making. The meeting facilitator actively participates in the discussion, moving it from information sharing to problem solving using the strategies listed below.

Teams have a responsibility to honor the decedent's life and to respect surviving family members and loved ones. This can be accomplished by:

- Holding a place at the table for the decedent or taking a moment of silence.
- Trying to understand the decedent's experience through their eyes.
- Protecting confidentiality of the fatality review proceedings.
- Using appropriate and sensitive language when discussing the case.
- Avoiding judgment of the decedent's decisions.
- Considering all factors that contributed to the decedent's substance use and overdose.

At the beginning of each meeting, the facilitator should lead introductions and ask all members to share their preferred first name and ask members to share area(s) where they have a lot of knowledge and would be comfortable being called on as "subject matter experts." The facilitator should encourage persons with expertise or agencies that specialize in an area to help direct a discussion. They may help by framing the nature of the problem, summarizing the results of past initiatives, explaining a new concept or practice, or proposing possible future recommendations.

Virtual Meetings:

Many virtual meeting platforms have chat, question and answer, and "raise hand" features. Internet connection issues and lag time during virtual meetings can pose challenges when multiple people try to speak at the same time. The facilitator could explore using meeting management features to determine a process to call on a team member.

Summarize and Solicit a Variety of Solutions

To ensure that main points are heard, the facilitator may restate or summarize members' comments, when possible, making connections clearer and stronger between members' points and potential implications for changing a system. For example, if a school administrator discusses the lack of prevention programming for teachers and later a social worker mentions prevention training they received, the facilitator could say, "It seems like behavioral health professionals have more access to and experience with prevention training. Could they share resources so educators could explore these options?"

Summarizing members' comments and transitioning the conversation to developing solutions and recommendations requires actively encouraging strategies beyond standard enforcement and intervention-centered approaches. This approach will steer the group towards more upstream or primary prevention activities. For example, if a member provides a recommendation that more healthcare providers give patients prescriptions for naloxone along with an opiate prescription, the facilitator could ask, "What can we do to reduce the number of opiate prescriptions in general?"

It is crucial that the facilitator remains neutral by acknowledging and giving equal consideration to all suggested solutions and demonstrating how each suggestion is part of a continuum of response to prevent overdose.

Creating an Engaging Discussion

The facilitator should ask primarily open-ended questions, which helps participants (1) understand the "bigger picture," (2) examine the underlying issue, and (3) develop their own solutions.

To build shared understanding, the facilitator might need to ask clarifying questions. The facilitator may ask members to explain agency-specific or sector-specific acronyms or labels so that everyone understands the material being presented. It is best not to assume that people already know or understand specific information. Asking clarifying questions helps team members become familiar with the internal processes of different organizations. The facilitator can also ask team members to define acronyms they are using in conversations, so all team members understand clearly and are using a shared language.

Pausing and asking reflective questions allows members to look at the case and information shared and to identify missing information or partners. Questions that may be useful include, "Do we have all the information we need to identify the problem or solution?" and "Are there any organizations missing from this discussion?"

Throughout the meeting, the facilitator should call on members who are less engaged or who do not readily speak up during the meeting. The facilitator can share at the beginning of the meeting that they will be calling on people throughout the meeting that are not participating as much as others to ensure that all voices have the opportunity to be heard.

Incorporate Social Determinants and a Racial Equity Lens

The facilitator should ensure that social determinants and a racial equity lens are incorporated into the reviews. Social determinants of health are the social and community networks and the socioeconomic, cultural, and environmental conditions in which residents live, as well as the health and social systems available. Every community has assets and conditions that impact the health status of its residents.

Politely Redirect Members

If the conversation becomes repetitive or irrelevant, the facilitator should ask questions or change focus to keep the conversation moving forward. For example, if a member makes a comment such as, "This overdose could never have been prevented," the facilitator should politely redirect members in a direction towards prevention. This may be as simple as saying, "While this case may be difficult to review, we have identified a few service gaps. Let's start with one of those and think about what improvements may benefit others."

Address Misinformation

While the facilitator does not need to be an expert, they should identify and correct misinformation when apparent. If there is disagreement over the accuracy of a statement, it can be paused for further research after the meeting to shift the focus back to the task at hand. Attention to accurate information will inspire standards of information quality. This is important for the development of meaningful recommendations and can reduce stigma that is based on misinformation.

Managing Difficult Conversations

Disagreements, arguments, competing agency interests, and other personal and professional conflicts need to be anticipated and resolved prior to or during the meeting so the discussion can feel safe and fruitful for everyone. Much of the work happens outside of the review meeting. It is often necessary for the facilitator to reach out to members after a meeting to address any conflicts that arise during the review process and, when the facilitator anticipates conflicts, to reach out ahead of the meeting to mitigate any possible conflicts.

To help limit and manage difficult conversations, the facilitator may also want to use the other strategies listed below.

Anticipate Possible Areas of Tension or Bias

Including in the ground rules how the team will address unprofessional or disparaging statements from others will build trust. It is important that everyone understands the need to stay focused on working together to identify possible strategies for preventing future overdoses.

Limit Tension Between Team Members

To help members collaborate, the facilitator may want to make suggestions such as, "Let's try to build a solution together that will meet everyone's needs." If there is competition between service agencies, it can be useful to highlight the value each organization brings to the table.

Notice Possible Political Issues

In researching a case for the review meeting, the facilitator may notice something that could result in one agency coming under fire. The facilitator should give the agency a heads-up prior

to the meeting, setting up the conversation and expectations in a way that allows for respectful, honest, transparent discussion to identify and correct any issues to mitigate future problems.

Be Alert for Individual Member Triggers

If a member of the meeting said something that was obviously disrespectful, the facilitator will need to remind members to be respectful. If the statement was stated respectfully, but another member took offense or is sensitive to the statement, the facilitator might restate the comment in a way that decreases the negative impact and encourages problem solving and collaboration.

Put a Conversation on Hold Until After a Meeting / Create a "Parking Lot"

Acknowledge when a conversation is drifting or irrelevant and ask that members put it on hold until after the meeting. Sometimes disagreements benefit from a pause, which provides an opportunity for additional research to inform conflict resolution. The facilitator can tactfully ask members to pause the discussion and move on to the next case or agenda item.

Remain Neutral and Objective

It is very important that the facilitator remain neutral and objective. Do not take sides in any dispute. Instead, ask members to focus on the facts of the case and the goal of the review—to prevent future overdose deaths. The facilitator may need to end a possible escalating discussion by making a statement such as, "It appears we have reached a stalemate. Let's move on and discuss other issues we identified."

Measuring Meeting Success

The facilitator wants to make sure that meetings are as successful as possible. The review process is always evolving in response to members' needs and changes in data trends. In addition, the identified recommendations impact large system issues, and it may take time to effectively make noticeable improvements. Therefore, it may be helpful to have some short-term measures to determine whether the reviews are successful.

How Do You Know If a Meeting Is Successful?

- Agencies continue to send staff members to the reviews.
- Members contribute to the discussion.
- Members are open to feedback and are not defensive.
- Members come more prepared for each meeting.
- Members linger after the meeting has formally ended to network with other members.

- Members begin to see connections between seemingly unrelated overdose deaths and develop a shared analysis.
- Agencies report that the information is useful to their daily work.
- Each agency is working on at least one recommendation during the year.

In addition to the above measures of success, the facilitator will want to connect with members between meetings to get feedback on the overall case review process and identify strategies for improvement.

Meeting Notes

The coordinator typically takes notes during the review. If the team does not have both a coordinator and a meeting facilitator, the facilitator will want to delegate someone to take notes during the case review meeting. Notes help to document tasks that need follow-up and to track recommendations. Sometimes, notes are summarized and included in future meeting handouts or meeting minutes.

Post-Meeting Tasks

While the case review meeting forms the foundation of the process, follow-up events are equally important. The meeting discussion, case information, and identified recommendations must be documented and momentum maintained.

Immediate post-meeting activities (on the same or next day) include the following:

- Preparing meeting minutes and securely storing them electronically with the other case records. A Meeting Minutes Template is included in Module 3 Appendix.
- Capturing the case information that was shared and collected at the review meeting, often using an OFR database. Learn more about the database in Module 4. Collect Your OFR Data.
- Working on follow-up activities and reaching out to any identified partner agencies.
- Drafting and sending updates to the governing committee, as requested.
- Following up via email with all team members to thank them for their contribution and offer support with de-briefing following the meeting.

Updating the Governing Committee

Summarizing review activities to update the governing committee should be done after each review meeting. Most often, the coordinator is responsible for communicating with the chair of the governing committee to determine what is expected from a report-out from the team.

Depending on the jurisdiction's team structure, some governing committees receive updates annually on priority recommendations and implementation status of prior recommendations.

Other governing committees may request more frequent updates on review activity and findings, for instance, on a quarterly basis.

An update may be a short summary on a standing agenda or a full-length presentation or report. A sample governing committee report is included in Module 3 Appendix.

Preventing Case Review Burnout

Reviewing overdose fatalities can affect review team members emotionally and psychologically. These effects are known as secondary trauma and compassion fatigue. Compassion fatigue is the emotional strain of working with those suffering from the consequences of traumatic events. First responders may experience compassion fatigue as a result of encountering repeated overdose cases. The effects can be reduced by:

- Inviting experts in secondary trauma to present to the team.
- Identifying and understanding attendee reactions to potentially upsetting information.
- Acknowledging that everyone experiences stress from reviewing overdose fatalities.
- Sharing professional self-care resources and strategies with team members.
- Reporting on and celebrating successes such as implemented recommendations generated by the review process.
- Reminding members of the purpose and effectiveness of case reviews.
- Allowing members to rotate out after a period of service to the team, if requested.
- Recognizing many members of the team are first responders, behavioral health, and health care providers and may have compassion fatigue.

Consider using The Vicarious Trauma Toolkit (https://ovc.ojp.gov/program/vtt/introduction) (U.S. Office of Justice Programs, Office for Victims of Crime) to address and prevent secondary trauma.

Other resources for compassion fatigue and the need for responder wellness include: The Code Green (https://www.codegreencampaign.org/) and CDC Tips for Emergency Responders (https://emergency.cdc.gov/coping/responders.asp).

Module 4: Collect Your OFR Data

Confidentiality

Confidentiality is essential for successful fatality reviews. It maintains the trust of participating members and of the community in which the review process takes place. Maintaining confidentiality requires understanding state privacy laws, adhering to organizational privacy policies, writing data sharing agreements, and completing confidentiality agreements for all team members. All team members (including guest members and observers) must sign a confidentiality agreement to attend.

Relevant Privacy Laws

All teams must understand and adhere to the Health Insurance Portability and Accountability Act (HIPAA) (https://www.hhs.gov/hipaa/index.html) and the Family Educational Rights and Privacy Act (FERPA) (https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html). HIPAA allows the disclosure of protected health information (PHI) for certain public health activities, and housing a team within a state or local public health authority makes it easier to apply this provision.

MDH cannot provide teams with legal advice, and teams should consult their own legal counsel as necessary to understand their own independent obligations under applicable data privacy laws.

Information sharing can be a challenge for review teams and their members. To assist teams in capturing as much information as possible about a decedent to make meaningful recommendations for prevention, Legislative Analysis and Public Policy Association (LAPPA), in partnership with IIR, developed the Information Sharing Toolkit (https://preview-ofr.azurewebsites.net/toolkits/information-sharing-toolkit). These fact sheets provide teams an understanding of what members legally can and cannot share regarding federal law.

Minnesota Department of Health Authority to Collect Data

Health care providers and other entities who have records about overdose deaths sometimes ask for information about the authority to collect such data. As the state's health agency, MDH has the authority to conduct health reviews, to collect health data, and to analyze health data (Minnesota Statutes, sections 144.05, 144.053). This statute means that MDH has the authority to collect data for the purposes of fatality reviews. Additionally, it may be helpful to refer health care providers to 45 C.F.R. § 164.512(b)(1)(i), which authorizes entities covered by HIPAA to provide protected health information to a public health authority for certain public health-related purposes without an individual's authorization. This statute means that healthcare providers can legally provide information on a person to MDH without the person's authorization for public health-related purposes, such as OFRs.

Persons or entities that provide data to MDH in connection with a public health review aimed to reduce disease or death from health conditions or concerns are protected from civil liability

(Minnesota Statutes, section 144.053, subdivision 3). MDH has the authority to contract with other entities to conduct such public health reviews on MDH's behalf or assist MDH with a public health review.

Local public health, Tribal Nations, and other organizations have their own specific authorizing and governing statutory authority and should have their legal offices or counsel review and advise them.

MDH does not enforce data privacy practices but strongly recommends that all organizations involved in fatality reviews maintain data privacy as much as possible out of respect to the decedent. As MDH is not an enforcing agency, there is implicit and explicit trust that all partners will use data appropriately and maintain data privacy. All PHAST and OFR partners could sign a commitment to data privacy to do no harm with the data and use the data according to the purposes of the review as a form of explicit agreement to protect data and respect confidentiality. An example commitment to data privacy is included in Module 4 Appendix.

Interagency Data Sharing Agreement

An interagency data sharing agreement is signed by the senior leadership of each participating agency/member that outlines the responsibilities of each party. In an interagency data sharing agreement, all parties agree to share certain information on an established timeline, adhere to certain data protection standards, and identify communication expectations. A sample interagency data sharing agreement is included in Module 1 Appendix. Interagency data sharing agreements should be updated annually and amended as new members are added to the team. It might be appropriate to work with lawyers from each agency when developing a data sharing agreement. The state of Minnesota does not have any specific OFR legislation that mandates a memorandum of understanding (MOU) between organizations, but organizations might decide to develop a MOU to clearly state roles, requirements, and responsibilities.

Confidentiality Agreement

A confidentiality agreement needs to be signed by members at the beginning of each review. This agreement is at the person-level and includes the objectives of the OFR. In contrast, the data sharing agreement is at the organization-level. It prohibits dissemination of information beyond the purpose of the review. A sample confidentiality agreement is included in Module 3 Appendix. It is recommended that you create a data sharing protocol for the distribution of case information and record-keeping expectations. A sample data sharing protocol is included in Module 4 Appendix.

Team members will receive decedent information from the coordinator. When sharing data at or before the fatality review, team members should be careful to not share names and specific identifying data if not necessary for fatality review. Ideally, all relevant information for a fatality review would be printed, available for partners during the meeting, and collected immediately after for disposal. However, for many fatality reviews, it will be necessary to share data electronically. When sharing data electronically, email should be avoided if possible. If email is

necessary, all information sent via email should be encrypted. To protect confidentiality, it is recommended that the decedent's name and aliases are listed separately from the rest of the case summary in a case key. An incident number should be assigned to each case and be used in place of names on case summary documents. Encryption settings vary by email provider. Telephone, Skype, WebEx, Teams, ZoomPro, and Google Duo are all secure, approved platforms to use for data sharing.

Virtual Meetings

When fatality reviews are held virtually, be sure to use a secure, approved platform to host the meeting. Secure platforms allow hosts to upload documents that can be shared with meeting participants rather than sharing through email.

Tips for protecting data privacy during online meetings:

Do not record the meeting. Designate a note-taker that can share notes if requested.

Use a meeting password. This prevents people that have not been invited by the meeting host from joining the meeting. The coordinator can confirm at the beginning of the meeting that only invited attendees are on the call.

Ask meeting attendees to attend the meeting from a private space, if possible. A private space prevents others from over-hearing personal health information and conversations between partners.

Confirm that documents with private information have been deleted. Ask all attendees at the end of the meeting to delete copies of meeting attachments that they downloaded. The coordinator can offer technical assistance to ensure all attendees are able to delete.

Data Collection Process

Before the Meeting

Data collection for a case review begins prior to the fatality review meeting and is a key responsibility of the coordinator. The coordinator will request case information, summarize the case, and collect all relevant files. The coordinator is responsible for collecting and storing records and files securely.

Team members will need to prepare a summary of their agency's interaction with the decedent to verbally share during the fatality review discussion. A team member's guide to collecting case information and agency-specific data elements are available in Module 3 Appendix.

During the Meeting

The data collection process during the case review meeting begins as the members report out and ask questions. The designated note taker (often the coordinator) will want to be familiar with the Minnesota Overdose Fatality Review REDCap database to make sure to capture

pertinent information discussed in the meeting. The coordinator might find it helpful to print copies of the Minnesota Overdose Fatality Review REDCap database forms to ensure that all necessary information is being collected.

After the Meeting

The data manager is responsible for managing the collection and entry of the data on reviewed cases and developed recommendations. The facilitator or coordinator may be responsible for data entry. The person responsible for entering data needs to ensure that the data is entered consistently and accurately. After the meeting, all the data from the meeting needs to be entered into the Minnesota Overdose Fatality Review REDCap database as soon as possible. The data manager may need to follow up with members to get missing data or information that needs more research outside of the review meeting and enter this information into the Minnesota Overdose Fatality Review REDCap database.

Minnesota Overdose Fatality Review REDCap Database

Teams may utilize the Minnesota Overdose Fatality Review REDCap database to record data collected about the cases reviewed and the recommendations developed. This database has been created in REDCap to support the presentation, collection, and storage of crucial information about the decedent that may arise during a review meeting. It also helps organize the solutions and recommendations that are produced as a result. These recommendations will be shared with state leaders from the Minnesota OFR State Advisory Workgroup, who can support state-level implementation of recommended changes from local teams.

REDCap is a secure, web-based application for managing data. Data entered into REDCap will only be accessible by authorized personnel at MDH and the authorized user(s) from the lead agency that entered the data. MDH has a record retention policy of 10 years or the completion of a project, whichever occurs sooner. All teams will be able to access and download their own OFR data at any time and will be notified by MDH in a timely manner prior to record deletion.

Please review the Minnesota Overdose Fatality Review REDCap database guide for information on how to enter data into the REDCap database. MDH is available to provide REDCap training and technical assistance to team members.

OFR Data Reporting by MDH

Deidentified OFR data will be aggregated and shared with the Institute for Intergovernmental Research (IIR), a funded contractor of the Centers for Disease Control and Prevention, as a requirement by MDH to complete fatality reviews. Deidentified, aggregated data will be pooled with OFR data from other states across the country to provide a summary of OFR case characteristics and recommendations developed to inform further development of the OFR model. Notes written into the REDCap database will not be shared with IIR and are for site use only.

Data Sharing Across State Lines

If an OFR concerns a Minnesota resident who died of an overdose that occurred in another state, partners can make inquiries to the relevant law enforcement agency in that state to see if they are able to share information for purposes of the OFR.

Best Practices for Protecting OFR Data Confidentiality

Teams must safeguard data and protect it from unauthorized disclosures. Teams may not share data collected/generated for OFR with any person or entity other than members of the team. Before participating in an OFR, all members at the review meeting should have signed a confidentiality agreement agreeing to not share any information they see, learn, or discuss through their work with the team. Any disclosure of such data must comply with all applicable law.

Unencrypted email is **not** a secure method of transmission, and OFR data should **not** be transmitted via **unencrypted** email. Encrypted email, however, may be used to communicate key information about the selected case prior to a review meeting. Virtual review meetings must use a platform that ensures the security of data and discussions. For virtual review meetings, it is recommended that partners use platforms that meet HIPPA technical specifications. Skype, WebEx, Teams, ZoomPro, and are all secure, approved platforms to use for data sharing that are HIPPA compliant.

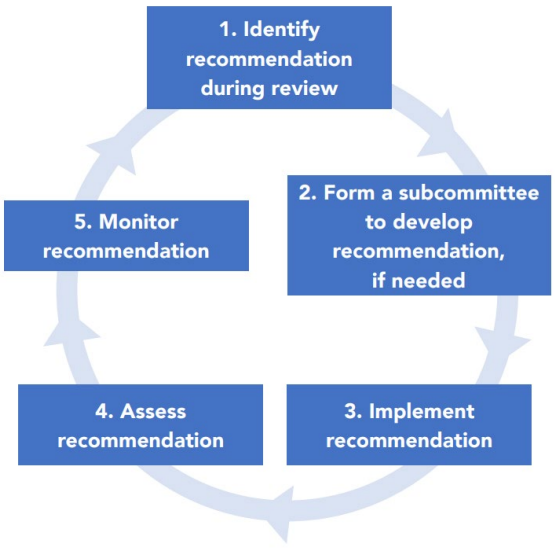
Module 5: Build a Recommendation Plan

Identifying Recommendations During the Case Review

The review process is driven by an action-oriented partnership. Data comes from partners/grantee representing multiple agencies. Each team member gathers and provides potentially sensitive information that informs the understanding of the overdose problem and potential solutions. Successful fatality reviews rely on active engagement by team members beyond the detailed case discussions, including the formation, implementation, assessment, and continuation of prevention strategies. It is important that the facilitator reinforce that recommendations can be identified and implemented through the team's collaborative, data-driven, problem-solving process. Learn more about this process Formulate Recommendations in Module 3: Facilitating an OFR Meeting.

Problem solving occurs during a collaborative process that fosters accountability and transparency. Identified solutions usually involve a multi-partner response that reduces duplication and information silos. The process is best served if it prioritizes addressing systems issues and making recommendations for improvement. Review teams may generate a variety of recommendation types across the continuum of care or systems as outlined in the table of recommendation types in Module 5 Appendix.

Figure 3. Building a Recommendation Plan



Source: COSSUP, Overdose Fatality Review Practitioners Guide (PDF)
https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf

Documenting Recommendations

The initial team recommendations are captured in the meeting minutes and in the recommendation section of the Minnesota Overdose Fatality Review Database. More detailed recommendation-related information captured in the OFR database includes:

- A public summary of the recommendation.
- Priority Level.
- A working summary of the recommendation.
- Date recommendation identified.
- Cases related to the recommendation.
- Data sources shared at the review meeting.
- Team members present at the review meeting.
- Type of recommendation (e.g., agency-specific, capacity-building, research-related, etc.).
- Level of prevention.
- Population or community of focus.
- Jurisdiction level responsible for implementing the recommendation (e.g., local, state, federal, or tribe).
- Partner or agency responsible for implementing the recommendation.

- Status of recommendation.
- Recommendation strategies (short, medium, and long-term).
- Recommendation implementation accomplishments.
- Notes regarding any media coverage.
- Lead agency contact information responsible for implementing the recommendation.

Forming a Subcommittee to Develop Recommendations

Recommendations can be diverse, and some are easier to implement than others. Teams are going to develop recommendations that vary in scope and may involve multiple partners or could be completed by just one agency, but all are important. Planning and implementing recommendations is a very rewarding process that can have immediate and tangible results. Some recommendations maintain momentum, and others may slowly lose support. The process can be challenging when factors outside of team control impact progress. Creating subcommittees to focus and implement specific recommendations can maintain momentum by building sustained internal and external support for the strategy.

Subcommittees may be necessary for recommendations that involve multiple agencies or larger systems changes but might not be for recommendations that involve one agency or can be accomplished internally. If a recommendation does not require a subcommittee, it does not mean that it is not important or crucial to overdose prevention. Forming a subcommittee is best practice, but it is recognized that not all teams will have the capacity to develop subcommittees. When developing a subcommittee, a team can follow four steps:

- Identify a subcommittee lead.
- Identify and recruit key partner agencies.
- Host meetings.
- Assign roles and responsibilities.

The coordinator will designate a lead for the subcommittee. The subcommittee lead needs to be a neutral convener, to avoid possible competition among agencies for future grant opportunities or services provided, and in a leadership position that will ensure progress in implementing the recommendation.

The success and momentum of recommendation development rests largely on who is participating on the subcommittee. Each subcommittee will want a champion who provides energy around the focused problem or solution. Subcommittee membership may include members from the governing committee, the PHAST and OFR team, and outside experts.

One or several subcommittee meetings may need to be scheduled. Ideally, meetings will happen in person versus over the phone and at times and locations that work best for committee members.

Subcommittee Roles and Responsibilities

Subcommittees meet separately from the review team and report out at fatality review meetings on their aims and progress. Subcommittees are formed and disbanded as needed, serving temporarily or on an ongoing basis. It takes multiple stakeholders/partners to effectively develop, implement, and monitor recommendations. This section reviews the roles and responsibilities of the coordinator, facilitator, and subcommittee members in reference to recommendations.

Coordinator and Facilitator Roles and Responsibilities

The process for developing and implementing recommendations is collaborative and fluid. Success is possible only with open communication, timely information sharing, and trust building. Trust must be established in both the process and the other partners involved.

The coordinator must be able to manage competing agendas, interagency conflicts, and unpopular or criticized recommendations and to ensure partners that the process is fair, data-driven, and likely to produce results.

The coordinator is responsible for designating the subcommittee lead, recruiting participants, supporting the subcommittee, and checking regularly with the subcommittee as needed, and checking regularly with the subcommittee on the status of the development and implementation of recommendations.

Subcommittee member's roles and responsibilities:

- **Lead**—The coordinator assigns a subcommittee lead. The lead is responsible for setting the agenda, facilitating subcommittee meetings, taking notes, sending reminders, monitoring activities, and reporting to the facilitator and others as identified, and providing a verbal progress report during fatality review meetings.
- **Researcher**—The coordinator designates a team member to present data trends such as overdose deaths, substances, hot spots, and related prevention and risk factors, as well as policy practices, or procedures for a system or agency. The researcher can find updated information on the MDH Drug Overdose Dashboard (https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html) and MDH Drug Overdose Prevention Resources (https://www.health.state.mn.us/communities/opioids/opioid-dashboard/resources.html#data). This information helps inform decisions and guide the implementation and recommendations.
- **Champion**—Any member who provides motivation, political will, and energy around the focused problem or solution is a champion.

Implementing a Recommendation

Team members develop recommendations. Once recommendations are developed, it is the responsibility of the subcommittee lead to move the recommendation forward. The subcommittee lead will identify the actions needed to implement the recommendation as well as offer other team members the opportunity to identify measures of success. A recommendation timeline will be established by the subcommittee lead and in coordination with the coordinator. A sample recommendation work plan is included in Module 5 Appendix.

Monitoring the Status of a Recommendation

Plans for tracking the status of a recommendation need to be developed at the beginning of the review process. Steps for regularly updating and tracking the status of the recommendations include the following:

- **Updating the status of a recommendation**—The subcommittee lead checks regularly with subcommittee members on the status and implementation of assigned tasks.
- **Reporting the status of a recommendation to the coordinator**—Prior to each fatality review and scheduled governing committee meeting, the subcommittee lead will provide the coordinator with status updates on the implementation of a recommendation as well as the plan for tracking the status of a recommendation. The subcommittee lead will likely provide a verbal progress report during the fatality review meeting.
- **Tracking the status of a recommendation**—Documenting the implementation status of a recommendation is encouraged. The coordinator, in partnership with the subcommittee lead, is responsible for systematically monitoring the status of recommendations. If the coordinator is not involved throughout the recommendation implementation process, they will need to follow up with partners (for example, the subcommittee lead to learn the status of the recommendation. The coordinator will work with the data manager to ensure the status of the recommendation is tracked in the Minnesota Overdose Fatality Review REDCap database. Recommendation data elements are included in the Minnesota Overdose Fatality Review database. The Minnesota Overdose Fatality Review REDCap database is introduced in Module 4: Collect Your OFR Data.

Overdose Fatality Review Online Resources

Overdose Fatality Review Resources
(https://www.ofrtools.org/resource/library)
Online learning resources on Overdose Fatality Reviews developed by the Institute for Intergovernmental Research.

Minnesota Drug Overdose Dashboard
(https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html)
Minnesota data on fatal and non-fatal drug overdose, substance use, and co-occurring conditions.

MDH Opioid Overdose Prevention Resources
(https://www.health.state.mn.us/communities/opioids/opioid-dashboard/resources.html)
Minnesota-specific data and reports, overdose prevention resources, and more.

Substance Use in Minnesota
(http://sumn.org/)
Minnesota data on alcohol, drugs, risk and protective factors, and mental health by region and demographics.

Minnesota Injury Data Access System (MIDAS)
(https://www.health.state.mn.us/communities/injury/midas/index.html)
Injury and violence data for Minnesotans by county, type of injury, gender, timeframe, and other factors.

Minnesota Coroners' and Medical Examiners' Association
(http://mncmea.org/)
Information about the Minnesota Coroner' and Medical Examiners' Association, including forensic groups and programs, and links to MN Statutes Chapter 390—Coroner, Medical Examiner and Chapter 13.83—Medical Examiner Data.

Minnesota Prescription Monitoring Program (PMP)
(https://mn.gov/boards/pharmacy-pmp/)
PMP annual reports and monthly data.

Harm Reduction and Overdose Prevention resource sheet (PDF)
(https://www.health.state.mn.us/communities/opioids/documents/sudresourcesheet.pdf)
Information on syringe service programs, safe use, overdose prevention and treatment resources in Minnesota.

MDH Resource Library for Advancing Health Equity in Public Health
(https://www.health.state.mn.us/communities/practice/resources/equitylibrary/index.html)
Use these tools, templates, and resources to build your public health department's health equity capacity.

Appendix Module 1: Developing a Team

Sample Recruitment Letter

[*Date*]
[*Invitee Name*]
[*Invitee Organization*]
[*Address*]
[*City, State, Zip code*]

Subject: Invitation to serve on the [*Overdose Fatality Review-Public Health and Safety Team Name*]

Dear [*Invitee name*]:

You have been recommended to us as a [*subject matter expert/recovery support specialist/community leader/etc.*] to serve on the [*Overdose Fatality Review-Public Health and Safety Team Name*] led by the [*Overdose Fatality Review-Public Health and Safety Team Lead Agency*]. An overdose fatality review (OFR) is an innovative and collaborative data-sharing process to address drug-related overdoses in our community. The purpose of an OFR is to conduct a thorough review of an overdose death in order to better understand the circumstances of overdose deaths and to develop recommendations to prevent future overdose deaths. Special attention is given to healthcare access, recovery supports, substance use history, and social determinants of health. Your professional interest and experience would be an invaluable contribution to this process.

The [*Overdose Fatality Review-Public Health and Safety Team Name*] is enabled through a collaboration with the Minnesota Department of Health Injury & Violence Prevention Section. If you would like to participate in the [*Overdose Fatality Review-Public Health and Safety Team Name*], please complete the attached interagency data sharing and confidentiality agreements.

The [*Overdose Fatality Review-Public Health and Safety Team Name*] is scheduled to meet [*monthly/quarterly*] beginning on [*first OFR Date*] at [*time*]. The [*Overdose Fatality Review-Public Health and Safety Team Name*] will be held at [*address of location of OFR*].

If you are able to participate in the review, please confirm your interest in participating through [*emailing the coordinator/the acceptance of the electric calendar appointment/both*].

Thank you so much for your willingness to consider this investment of your time and expertise as we work towards the goal of reducing overdose deaths in our community. If you have any questions about the OFR process or would like more information on the [*Overdose Fatality Review-Public Health and Safety Team Name*], please don't hesitate to reach me directly at [*coordinator email*] or [*coordinator phone number*]

Sincerely,

[*Coordinator Name*]
[*Coordinator Title*]
[*Overdose Fatality Review-Public Health and Safety Team Name*]

Sample Interagency Data Sharing Agreement

OVERDOSE FATALITY REVIEW INTERAGENCY DATA SHARING AGREEMENT

This cooperative agreement is made on this _____ day of _ [*month, year*]__ among the following agencies:

[*Overdose Fatality Review-Public Health and Safety Team Lead Agency*]

Office of the Medical Examiner/Coroner

County Prosecutor

Minnesota Department of Health

City/County Law Enforcement

City/County Health Department

Recovery Services

Healthcare system

(Others as needed)

WHEREAS; the parties are vested with the authority to promote and protect the public health and safety and to provide services which will improve the well-being of children and their families.

WHEREAS; the parties agree that they are mutually served by the establishment of a multiagency, multi-professional overdose fatality review team, and the outcomes of the reviews will be the identification of preventable overdose deaths and recommendations for interventions and prevention strategies.

WHEREAS; the objectives of an overdose fatality review team are agreed to be:

Accurate identification and uniform reporting of the cause, manner, and relevant circumstances of every overdose death with special emphasis on those features that relate to potential preventability.

Improved communication and coordination of agency responses to overdose deaths in the investigation and delivery of services.

Design and implementation of cooperative, standardized guidelines for the investigation of certain categories of overdose death.

Identification of needed changes in legislation, policy and practices, and expanded efforts to prevent overdose deaths.

WHEREAS; the parties agree that all members signing this agreement are essential to an effective review.

WHEREAS; the parties agree that the review process requires case-specific sharing of records, and that confidentiality is inherent in many of the involved reports so that there will be clear measures taken to protect confidentiality, and no case review will occur without all present abiding by the confidentiality agreement.

NOW THEREFORE; it is agreed that all team members and others present at a review will sign a confidentiality agreement which prohibits any unauthorized dissemination of information beyond the purpose of the review process. The review team will not create any files with case-specific identifying data. Case identification will be utilized only to enlist interagency cooperation in the investigation, delivery of services, and development of prevention initiatives. It is further understood that there may be an individual case which requires that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. It is further understood that a participating agency may use information obtained at the review in accordance with the mandated responsibilities of that agency. It is also understood that team review data may be entered into Minnesota Overdose Fatality Review REDCap database where it will be maintained for the purpose of establishing a state central registry for overdose death data. This data will not include case-specific names. The registry will include standardized data from overdose fatality review teams throughout Minnesota.

Sample Funding Request Letter

[*Date*]
[*Facilitator Name*]
[*Lead Organization*]
[*Address*]
[*City, State, Zip code*]

Subject: Funding request to operate an Overdose Fatality Review and Public Health and Safety Team

Dear [*Leadership Name/Funding Organization*]:

Drug Overdoses are a leading cause of death in Minnesota. [A *sentence or two on recent drug overdose trends in your jurisdiction*.] An Overdose Fatality Review (OFR) brings together multi-disciplinary community partners under the Public Health and Safety Team (PHAST) Framework to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies. Reviews involve a series of confidential individual death reviews, or "case reviews," that examine a decedent's life cycle to facilitate a deeper understanding of the missed opportunities for prevention and intervention in the community that may have prevented an overdose death. Our team will work to identify patterns of need and opportunity within specific agencies and across systems, as well as develop recommendations for implementation.

We request *[$XXXX.XX]* total to implement a local team within our jurisdiction, starting on [*Date*] through [*Date*]. Partners include community stakeholders, public health, and public safety team members. Through individual reviews, patterns in the community will be identified to address missed opportunities within specific agencies and across systems to implement overdose prevention and intervention strategies. This local team will meet regularly and will relay recommendations produced to the Minnesota OFR State Advisory Workgroup for review to contribute to both local and state-level overdose prevention efforts in Minnesota.

Thank you so much for your willingness to consider this investment into your community as we work towards the goal of reducing overdose deaths. If you have any questions about the funding request or would like more information on the [*Overdose Fatality Review-Public Health and Safety Team Name*], please don't hesitate to reach me directly at [*facilitator email*] or [*facilitator phone number*]

Sincerely,

[*Facilitator Name*]
[*Facilitator Title*]
[*Overdose Fatality Review-Public Health and Safety Team Name*]

Appendix Module 2: Planning a Meeting

Agency Specific Data Elements

Minnesota Department of Health

- Statewide and county data trends (fatal and nonfatal overdoses)
- State Unintentional Drug Overdose Report System (SUDORS) data
- Death certificates

Medical Examiner/Coroner

- Autopsy results
- Death scene investigation
- Toxicology report

Law Enforcement

- Justice system involvement
- Treatment history
- Location of incident

Department of Corrections (DOC)

- Justice system involvement
- History of supervision
- Treatment history
- Mental health history
- Medications

Treatment providers (public safety, health professionals, mental health professionals, substance use treatment)

- Treatment history
- Medications
- Trauma

Prescription Drug Monitoring Program

- Number of annual and quarterly prescriptions by county
- Rates of prescribing by county

Coordinator's Meeting Preparation Checklist

This sample preparation checklist contains tasks to complete before a fatality review. Your team will most likely have additional tasks to add to this list or will assign these tasks to other team leaders besides the coordinator.

Task	**Deadline**	**Complete?**
Select cases	2 months before review meeting	x
Recruit guest members	1 month before review meeting	x
Case information requested	1 month before review meeting	x
Meeting reminder email	2 weeks before review meeting	x
Case information summarized	1 week before review meeting	x
Activities since last meeting document for sharing at meeting	1 day before review meeting	x
Agendas and other meeting materials printed/emailed to team members	1 day before review meeting	x

Review Case Email

[*Date*]

Dear [*Team Member Name],*

You are invited to participate in the next Overdose Fatality Review meeting on [*date and time*] at [*meeting location*].

We will be reviewing the [*attached*] case(s) at the review. Keep this and all information you prepare about the case confidential. The case summaries are de-identified in order to enhance data privacy and security. A case identification key will be sent in a separate email.

Please be prepared to share any information you have about the individual, the community, and your services as it relates to the overdose death. See the attached guide to collecting case information and agency-specific data elements to summarize the information.

If you need additional information about the decedent for identification in your records, feel free to contact me at [c*oordinator phone number*].

Sincerely,

[C*oordinator Name*]

Sample Meeting Agenda

Meeting Agenda

Date, Time, Location

1. Opening Remarks and Introduction
    a. Members' introduction
    b. Updates from previous meeting
    c. Upcoming events
    d. Data presentation
    e. Review case selection criteria
    f. Other announcements
2. Goals and Ground Rules
    a. Read goals and ground rules
    b. Ask for any additional ground rules
3. Confidentiality
    a. Read confidentiality statement
    b. Collect signed forms
4. Case Presentation
5. Member Report-Outs (reverse chronological)
6. Group Discussion
7. Case and Timeline Summarized
8. Formulate Recommendations
9. Summarize and Adjourn
    a. Members reflect on how the meeting went
    b. Collect any paperwork with confidential information
    c. Remind members of confidentiality
    d. Encourage members to take time for self-care

Next meeting: date, time, and location

Team Member Guide to Collecting Case Information

Guiding questions for collecting information about the case:

1. What was the nature and timing of your agency's contact with the decedent in the overdose death?

2. What interactions did your organization or agency have with the decedent, and when?

- What services, if any, was the decedent accessing around the time of his or her death?
- What services, if any, were provided to the decedent's family members? What can we learn about the decedent's life through the agency's interaction with the family?
- Did the decedent transition between service providers? Did any gaps in service occur, or were any service needs unmet? What were the reasons for those gaps? Were referrals made? What communication occurred among providers?
- What were some missed opportunities in intervening or providing services?
- What were the anticipated benefits of those services?
- How did the decedent/family/neighborhood respond to services?
- Was an intervention completed or in progress at the time of the death?
- What were the outcomes of the interaction(s)?

3. What were the strengths or protective factors of the decedent, the decedent's family/social network, or environmental context at the time of your agency's interaction?

- Neighborhood, support system, social network, family, peer support, access to services, employment history, housing history, health insurance, environmental safety, education

4. What were the risk factors of the decedent, the decedent's family/social network, or environmental context at the time of your agency's interaction?

- Neighborhood, environment, exposure to violence, trauma or abuse, discrimination, injustice, criminal activity, loss of employment, abandonment, acute or chronic illness, injury, disability, transience

5. What services or programs were being offered in the area during the incident? Were they available to the decedent?

6. What public policies (such as criminal justice, health, economic, and social welfare) were most likely impacting the individuals and neighborhoods involved in the overdose death at the time of the incident?

Template for Creating and Presenting a Case Summary

This outline is an example of what the coordinator will present to team members. Teams can add other categories of information as wanted. To protect confidentiality, it is recommended that the decedent's name and aliases are listed separately from the rest of the case summary in a case key. An incident number should be assigned to each case and be used in place of names on case summary documents.

- Incident Number
- Name, aliases listed separately in case key
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time
- Obituary summary information
- Pertinent news coverage information
- Relevant social media posts
- If your team is including interviews with the decedent's family members and social contacts, details from those interviews

Appendix Module 3: Facilitating a Meeting

Sample Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

The purpose of the overdose fatality review (OFR) is to conduct a thorough review of all preventable overdose in [county] to better understand how and why the decedent died from an overdose. The objective of the review team is to better understand the circumstances of overdose deaths and how to act to prevent future overdose deaths in Minnesota.

To ensure a coordinated response that fully addresses all systemic concerns surrounding overdose deaths, all relevant data should be shared and reviewed by the team, as permitted by law, and as agreed upon through the confidentially agreement, including historical information concerning the decedent, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure by law and by privacy statutes in Minnesota Statute 144.05, 144.12, 144.053, and others. These statutes provide MDH with the ability to collect and analyze health data from multiple sources such as death certificates, law enforcement, hospitals, and social services.

By signing this confidentiality agreement, team members agree not to disclose any information regarding the fatality review or the decedent. In no case should any review team members disclose any information or fatality review discussions outside of the review meeting, other than pursuant to team confidentiality guidelines. Therefore, fatality reviews are closed to the public, and confidential information cannot be lawfully discussed unless the public is excluded. Public statements about the general purpose of the overdose fatality review process may be made, as long as they are not identified with any specific case.

The undersigned agrees to abide by the terms of this confidentiality policy.

Name:

Agency:

Signature:

Date:

Sample Summary Data Report

There are many other data sources that could be included in a summary data report, including data from the MDH Drug Overdose Dashboard (https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html).

Summary data:

Medical examiner's/coroner's office: Year to date, we had [*number*] overdoses, [*number*] of which met our case selection criteria. Since our last review, there have been [*number*] overdose deaths. Compared to the same time last year, the cases are [*compare number, substances, and demographics*].

EMS data: Year to date they responded to [*number*] overdoses, and since our last review, they responded to [*number*] overdoses. Compared to the same time last year, the cases are [*compare number, substances, and demographics*].

Sample Governing Committee Report Out

- General statistics report-out
    - Year-to-date, number of deaths
    - Since last meeting, number of deaths
    - Prior year same time frame, number of deaths
    - Any other aggregate data available
- Activities since last review meeting
- Review team meeting schedule and list of attendees
- Number and types of cases reviewed
- Any planned new work (since the last review meeting)
    - Recommendations
    - Recruiting new members
    - Any changes in case selection criteria

Sample Meeting Ground Rules

- Listen actively to what other the members are saying.
- Be respectful—no mocking or attacking other team members' ideas.
- Everyone on this team is valuable. No favoring team members with leadership roles.
- Maintain and protect confidentiality.
- Use culturally appropriate and sensitive language when discussing the case.
- Use person-first language, such as "a person addicted to drugs" instead of "a drug addict," "person involved in the justice system" instead of "suspect" or "inmate."
- Avoid judging the decedent's decisions. Try to understand the decedent's experiences through his or her eyes.
- Consider all factors that contributed to the decedent's substance use and overdose.

Additional ground rules for virtual meetings include: log in to the meeting on time at the beginning of the meeting and when coming back from breaks, click the "raise your hand" icon or request to speak in the chat if you have something to share, and only one person speaks at a time.

Meeting Minutes Template

Overdose Fatality Review – Public Health and Safety Team Meeting

Date:

Attendees Present: [Name, Agency]

Updates:

Incident #:

Date of incident:

Time of incident:

Address of overdose:

Case narrative:

Partner/agency reports (add/remove partners):

- Medical examiner's/coroner's office:
- Emergency medical services:
- Public Safety department:
- Department of corrections:
- Health department:
- Substance use disorder treatment provider(s):
- Hospital:

Themes:

Recommendations:

Appendix Module 4: Collect Your OFR Data

Example Commitment to Data Privacy

COMMITMENT TO DATA PRIVACY

This commitment is made on this _____day of _____ among the following agencies

1. Office of the Medical Examiner/Coroner
2. County Child Protective Services
3. Office of the Prosecuting Attorney
4. Sheriff's Department
5. Public Safety Department
6. County Health Department
7. [Others as Needed]

WHEREAS; the parties are vested within the authority to promote and protect the public health and to provide services which will improve the well-being of children and families.

WHEREAS; the parties agree that they are mutually served by the establishment of a multiagency, multi-professional overdose fatality review team, and the outcomes of the reviews will be the identification of preventable overdose deaths and recommendations for interventions and prevention strategies. Accurate identification and uniform reporting the cause, manner, and relevant circumstances of every overdose death with special emphasis on those features that relate to potential overdose prevention. Improved communication and coordination of agency responses to overdose deaths in the investigation and delivery of services. Design and implementation of cooperative, standardized guidelines for the investigation of certain categories of overdose death. Identification of needed changes in legislation, substance use policy and practices, and expand efforts to prevent overdose deaths.

WHEREAS; the parties agree that all members signing this committee are essential to an effective overdose fatality review.

WHEREAS; the parties agree that the overdose fatality review process requires case-specific sharing of records, and that data privacy is inherent in many of the involved reports so that there will be clear measures taken to protect data privacy, and no case review will occur without all attendees abiding by the confidentiality agreement.

NOW THEREFORE; It is agreed that all team members and others present at an overdose fatality review will sign a confidentially agreement which prohibits any unauthorized dissemination of

information beyond the purpose of the overdose fatality review process. The team will not create any files with case-specific identifying data. Case identification will be utilized only to enlist interagency cooperation in the investigation, delivery of services, and development of prevention initiatives. It is further understood that there may be an individual case which requires a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. It is further understood that a participating agency may use information obtained at the review in accordance with the mandated responsibilities of the agency. It is also understood that review data may be entered into the Minnesota Overdose Fatality Review REDCap Database, where it will be maintained for the purpose of establish a state central registry for overdose death data. This data will not include case-specific names. The database will include standardized data from overdose fatality review teams throughout Minnesota.

Sample Data Sharing Protocol

Data Storage

- Upon receipt of the fatality review data from team members, how will the data be stored and for what period of time?

Data Transfer

- What information will be transferred to team members and in what format (email or letter)?

Data Security

- How will confidential information be protected during transfer to team members?

Data Sharing

- How will team members share information?
- If sharing prior to the review, how will information and records be transferred to the data manager and how will information and records be protected?
- If sharing at the reviewing, what format will the data be in and will it be kept by the data manager after the meeting?

Appendix Module 5: Build a Recommendation Plan

Table of Recommendation Types

Recommendation Type	Target Audience	Definition	Example
Systemic	Professionals, agencies, and organizations	Addresses a gap, weakness, or problem within a system or across systems	Improve communication between inpatient treatment providers upon discharge to an outpatient, medication for opioid use disorder (MOUD)-formerly known as medication-assisted treatment (MAT)-provider by establishing an automated alert system.
Agency-specific	Only one sector or partner agency	Addresses a service gap or failure	Give Naloxone to people who have been released from incarceration. Local health department to provide training to all hotel staff members on how to administer Naloxone.
Research	Organizations that research overdose deaths or evaluate programs or policies	Recommendation to research a topic or issue area	Determine the number of deaths from prescription opioids for those who had a prescription for an opioid. Establish a process for fatality review outcomes to inform research priorities.
Team Quality Assurance	Review team	Improve the fatality review process	Increase the length of meetings to allow for more time developing recommendations.
Population-specific	Individuals and groups at increased risk	Evidence-based intervention that will reduce a specific risk factor for overdose	Increase access to buprenorphine among incarcerated populations.

Sample Recommendation Work Plan

Recommendation	Activity/Action Steps	Lead Agencies	Timeline
x	x	x	x
x	x	x	x
x	x	x	x
x	x	x	x