



*"Striving Toward a **Healthier** Community."*

OVERDOSE FATALITY REVIEW ANNUAL REPORT 2023





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PURPOSE AND OBJECTIVES

The primary goal of the overdose fatality review (OFR) committee is to reduce the incidence of overdose deaths in Stark County. This will be completed through a multidisciplinary and comprehensive review of individual overdose deaths. The OFR committee will identify, evaluate, and make recommendations to improve community programs and systems that serve Stark County residents.

The Ohio Revised Code 307.643 states "The purpose of the overdose fatality review committee is to decrease the incidence of preventable overdose deaths by doing all of the following:

- (A) Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities engaged in overdose prevention, education, or mental health treatment efforts.
- (B) Maintaining a comprehensive database of all overdose deaths that occur in the county or region served by the review committee in order to develop an understanding of the causes and incidence of those deaths.
- (C) Recommending and developing plans for implementing local service program changes and changes to the groups, professions and agencies, or entities that serve local residents that might prevent overdose deaths.
- (D) Providing the department of health with aggregate data, trends, and patterns concerning overdose deaths."

This report will provide feedback and recommendations that community leaders and partners have recommended after analyzing overdose deaths that occurred in 2022 and 2023.



OFR MEETING FREQUENCY AND STRUCTURE

Frequency of Meetings

Meetings are held quarterly to review data and individual cases, four meetings were held in 2023.

Structure

The county commissioners appointed a health commissioner to establish the OFR committee. ORC 307.632 states, "The review committee shall consist of the following:

- 1.The chief of police of a police department in the county or region or the county sheriff or a designee of the chief or sheriff;
- 2.A public health official or the official's designee;
- 3.The executive director of a board of alcohol, drug addiction, and mental health services or the executive director's designee;
- 4.A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery."

The committee also chose to invite the county coroner and other partners. Each invited member has the same duty and responsibility as the appointed members.

COMMITTEE MEMBERS

Amanda Uhler, MPH, RN
Public Health Official

Chief Deputy Oliver
Stark County Sherriff

Dr. Maureen Ahmann, D.O
Physician

Justina Gorman
Coalition & Community Development Coordinator of
Stark County Mental Health & Addition Recovery

Kirkland Norris, R.E.H.S, MPH
Health Commissioner

Michelle Schoonover, MSN, RN
Drug Overdose Coordinator

PARTNER AGENCIES

- Alliance City Health Department
- Alliance Family Health Center
- Aultman Hospital
- AVO Behavioral Health and Recovery
- Canton City Public Health
- Cleveland Mercy Medical Hospital
- Colman
- CommQuest
- Direction Home
- Healing Communities Study
- Local Police & Fire
- Massillon City Health Department
- Stark County Coroner's Office
- Stark County Jobs and Family Services
- Stark County Mental Health and Addiction Recovery
- Stark County Sherriff's Office Metro Narcotics Unit
- Stark County's Treatment Accountability for Safer Communities

OFR REVIEW PROCESS AND DATA SOURCES

The OFR committee is focused on decedents of overdose who died in Stark County. Recognizing overdose as a public health issue is founded on an understanding of substance use behavior arising from contextual, biological, environmental, systemic, and social stressors. This approach focuses on prevention by addressing the known factors that increase or decrease the likelihood of overdose.

For each death by overdose selected for individual case review, the committee will collect age, sex, race, ethnicity, the year the death occurred, the location of the death, the cause of death, factors that contributed including legal and social issues, medical records and any other pertinent information. Aggregated data on all deaths is presented at each meeting which includes age, sex, race, educational attainment, marital status, class of drugs indicated in cause of death, and other information relevant to the picture of drug overdose deaths in Stark County.

The cases reviewed in this report were deaths that occurred in 2023 and include only residence of Stark County. Each case review is discussed among the team to gather a comprehensive understanding of the context of the decedent's life and the events and actions that led to the fatality. The discussions highlight potential contributing factors, intervention implications and recommendations for systemic improvements.

Data sources include: ODH Secure Mortality Warehouse, behavioral health records, medical records, criminal justice records, death certificates, prescription drug records, emergency medical services reports, and substance use assessment and treatment records.

OFR ANNUAL REPORT DATA FINDINGS

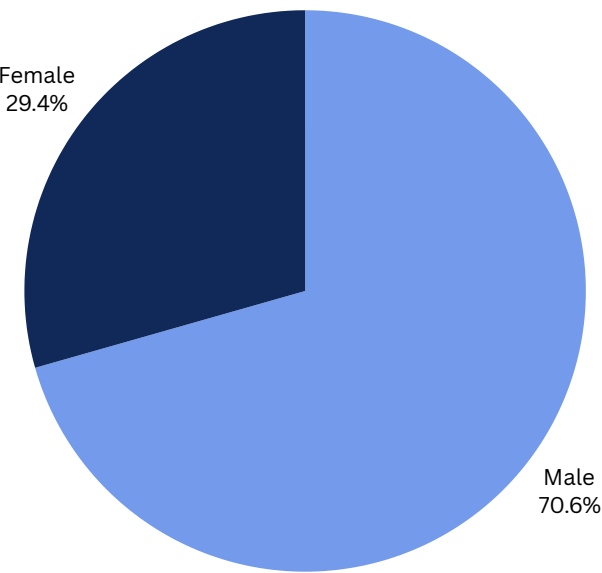
Table 1: County Metrics

Total number of cases occurred in 2023*	152	Total number of cases reviewed by OFR Committee	17
Total number of 2023 cases <u>not reviewed</u> by OFR committee	143	Total number of 2023 cases involving opioids	102
Total number of cases involving opioids <u>reviewed</u> by OFR committee	14	Total number of 2023 cases involving opioids <u>not reviewed</u> by OFR committee	95

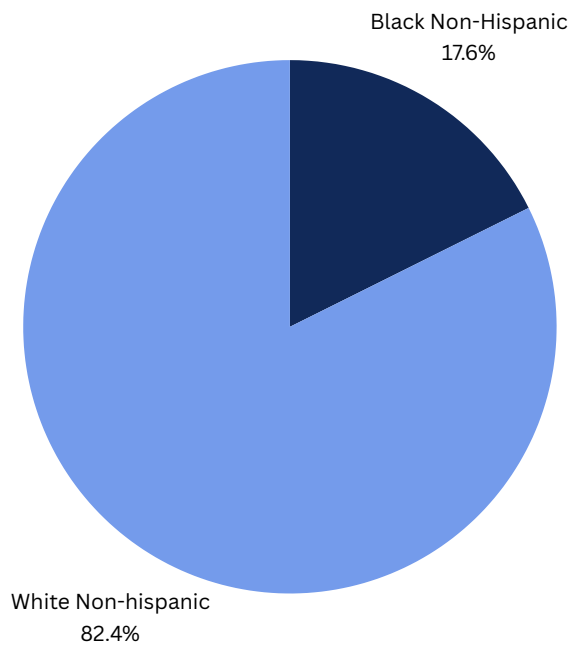
Cases reviewed occurred in 2022 and 2023
*Per ODH Warehouse Data on March 19, 2024

DATA ON ALL REVIEWED CASES (2022 AND 2023 DEATHS)

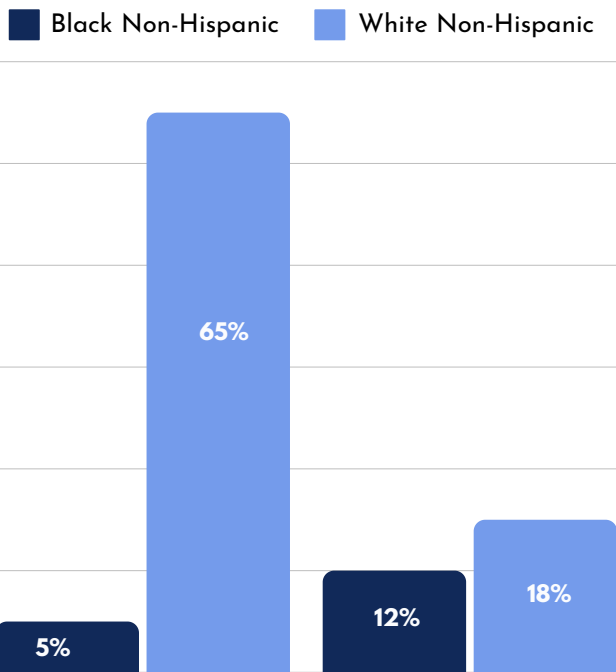
Graph 1: Sex Metrics



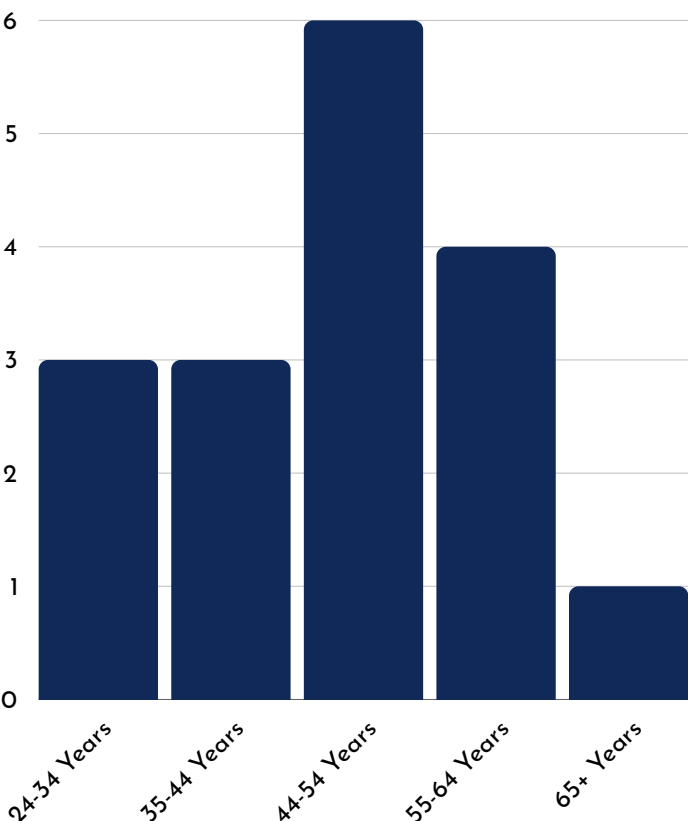
Graph 2: Race/Ethnicity Metrics



Graph 3: Race/Ethnicity/Sex Metrics



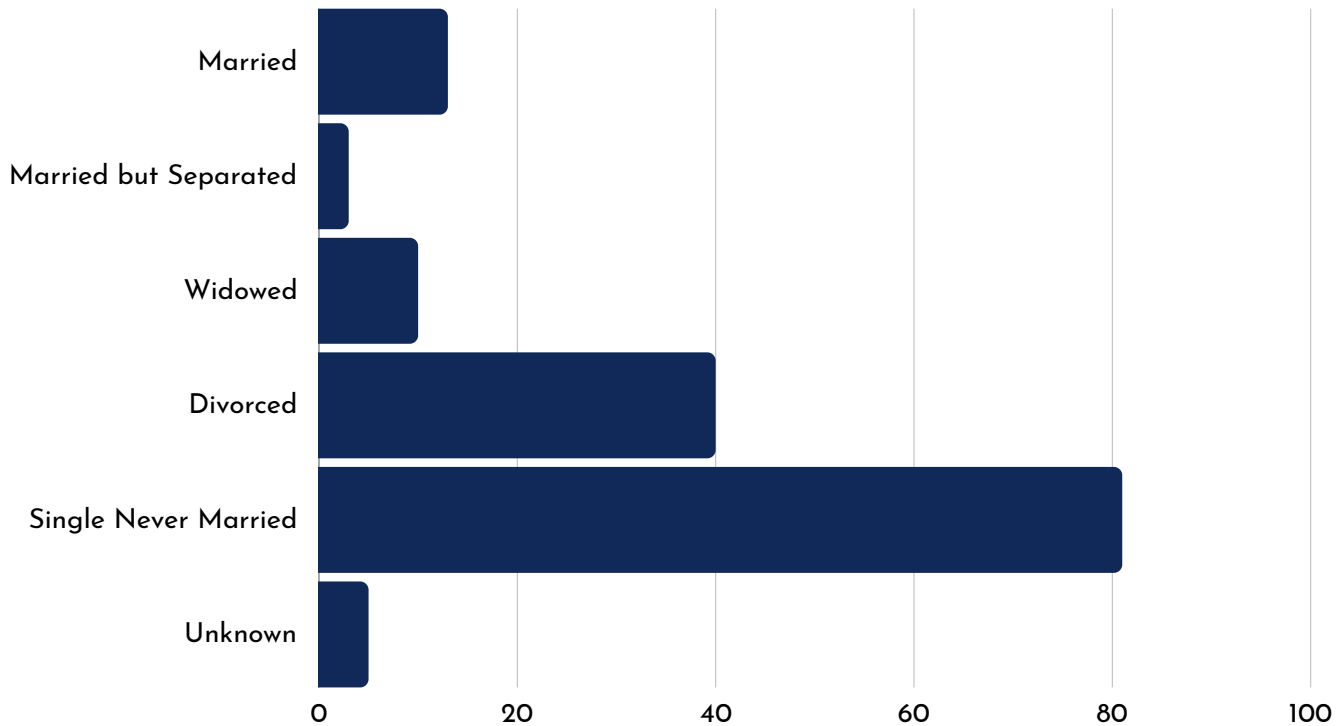
Graph 4: Age Metrics



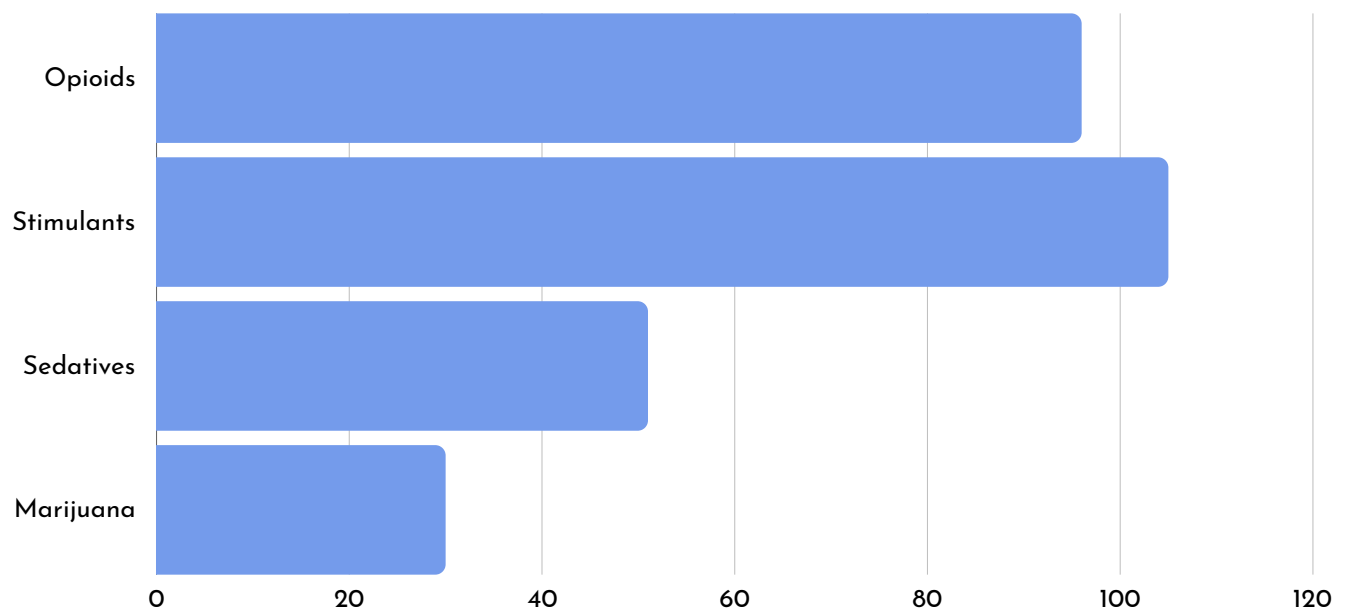
DATA ON ALL DEATHS OCCURRING IN 2023* ONLY

*Data accessed and current as of 3/26/24

Graph 5: Marital Status (Count)



Graph 6: Drug Class Prevalence (Count)



Trends/Patterns

The Stark County OFR identified a number of trends in overdose deaths and used these identified trends to choose cases to review individually at the 2023 meetings. Trends were identified when reviewing aggregated data from the Ohio Department of Health's Secure Mortality warehouse. Trends include:

1. Increase in overdose deaths among population aged 50 years and older.
2. Increase in overdose deaths involving stimulants.
3. Continued increase in overdose death rates among the Black population.
4. Increase in non-Stark residents dying from overdose in Stark County.

Some trends are newly identified or seen in Stark County while others continue on the same trendline as previously identified. Aside from Stark County, increases in deaths of individuals 50 years and older and deaths involving stimulants have been identified as national trends in the United States in recent years, adding to the cumulative need for new strategies and additional resources.

2023 Recommendations

The following is a list of recommendations made by the Overdose Fatality Review Committee. The committee is made up of multi-sector partners currently engaging with substance use patients within the Stark County community. Recommendations are divided into the following categories: systemic, agency-specific, population-specific, and OFR process improvement and should be implemented by utilizing evidence-based practices and/or strategies.

Systemic

- Advocate for increased gender-affirming mental health treatment at residential, jail settings correctional facilities which includes staff education on trauma-informed care and motivation interviewing to help participation engagement and/or retention in treatment such as prior to client leaving AMA
- Encourage improved deliverance of wrap-around services throughout the county to include: increased engagement with clients related to housing, expansion of food pantry and mental health service hours
- Increase naloxbox availability in targeted areas

2023 Recommendations Continued

Agency-Specific

- Implement buprenorphine initiation and naloxone leave-behind programs in the ERs.
- Distribute leave-behind cards for EMS, QRT, and ED with several resources to give to patients
- Provide low threshold treatment, increase counselor availability and promote polysubstance use education while in residential treatment
- Increase education in bars in targeted locations on counterfeit pills and other resources/advocate for a law requiring this
- Education for ER staff and EMS on first responder fatigue syndrome
- Education provided on overdose education through Drivers Intervention Programs
- Explore Motivational Interviewing for ER staff as needed
- CIT training for EMS
- Increase available peer supports in MHA housing
- Increase education on OARRS availability to pharmacies and prescribers to help increase usage

Population-Specific

- Advocate for legislation to allow children to access mental health services without parental consent
- For individuals removed by CPS- encourage and provide access to mental health services
- Offer mental health services to all individuals diagnosed with HIV/AIDS
- Increase testing of Hepatitis C and follow-up
- For those prescribed MOUD, education should be provided related to decreased opioid tolerance with naloxone being distributed
- Increase outreach to the 50+ population through home health agencies and social activities

OFR Process Improvements

- Continue to add additional members such as probation office or from the juvenile court system to the OFR team
- Add Next of Kin interviews to OFR process
- Remove out-of- county residents from final decedent counts, but include in a separate count due to the utilization of services.

2023 Summary of Implementation

- Coroners office brings OARSS reports to quarterly meetings on cases being reviewed individually
- Local harm reduction committee coordinated the increased availability of naloxboxes in targeted areas
- Increase in pocket guides with local resources being distributed through Law Enforcement and ER
- Increase in screenings and peer support referrals in ER
- Promotion and participation of First Responder training through OPN
- Education to Pharmacist provided by the Healing Community Study
- Improved linkages to care and MAT induction within criminal justice system through the Healing Community Study and local treatment provider
- Increase awareness of concussion protocols through the TBI subcommittee within CIAG
- Increased awareness of prevention resources for opiate and e-cigarettes through school nurse and counselor support groups
- Increased harm reduction activities to identified populations through Stark County HealthMobile (mobile unit)
- Out of county residents removed from decedent counts
- HealthMobile provided targeted naloxone distribution at YMCAs to older adults.
- Focus group discussion at Permanent Supportive Housing through StarkMHAR
- Increase membership of the OFR committee

Next Steps

Steps are being taken to review and improve the OFR by utilizing the CDC evaluation profile. [OD2A_EvalProfile_OverdoseFatalityReviews_508.pdf \(cdc.gov\)](#). As a part of the profile, a Mentimeter survey will be given to the committee during the May 2024 meeting and the results will be used to improve processes and procedures. Goals for next year include implementing the results of the evaluation, partnering with the local mental health and addiction board to provide forensic investigation which will bring more in-depth reviews and provide the committee with deeper insight to the complex issue of overdose and addiction. Additionally, ideas for how the committee can share information about the individual case reviews ahead of the meetings is being looked at in the form of a platform or SharePoint option. Beginning May 2024, the committee members will stay after the meeting to engage more with the recommendations and a new spreadsheet format is being considered.



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