

A photograph of a clear plastic pill bottle lying on its side, with numerous white, round pills scattered on a light-colored surface. The image is slightly blurred and has a soft, teal-tinted overlay.

**RESPONSE TO OHIO'S
PRESCRIPTION DRUG
OVERDOSE EPIDEMIC:**

**DATA UPDATE AND OVERVIEW OF
2013 CORONER SURVEY RESULTS**

**2013 OHIO STATE CORONERS' ASSOCIATION MEETING
MAY 10, 2013**

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Director
Ohio Department of Health

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Program Administrator
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Ohio Department of Health

OVERVIEW



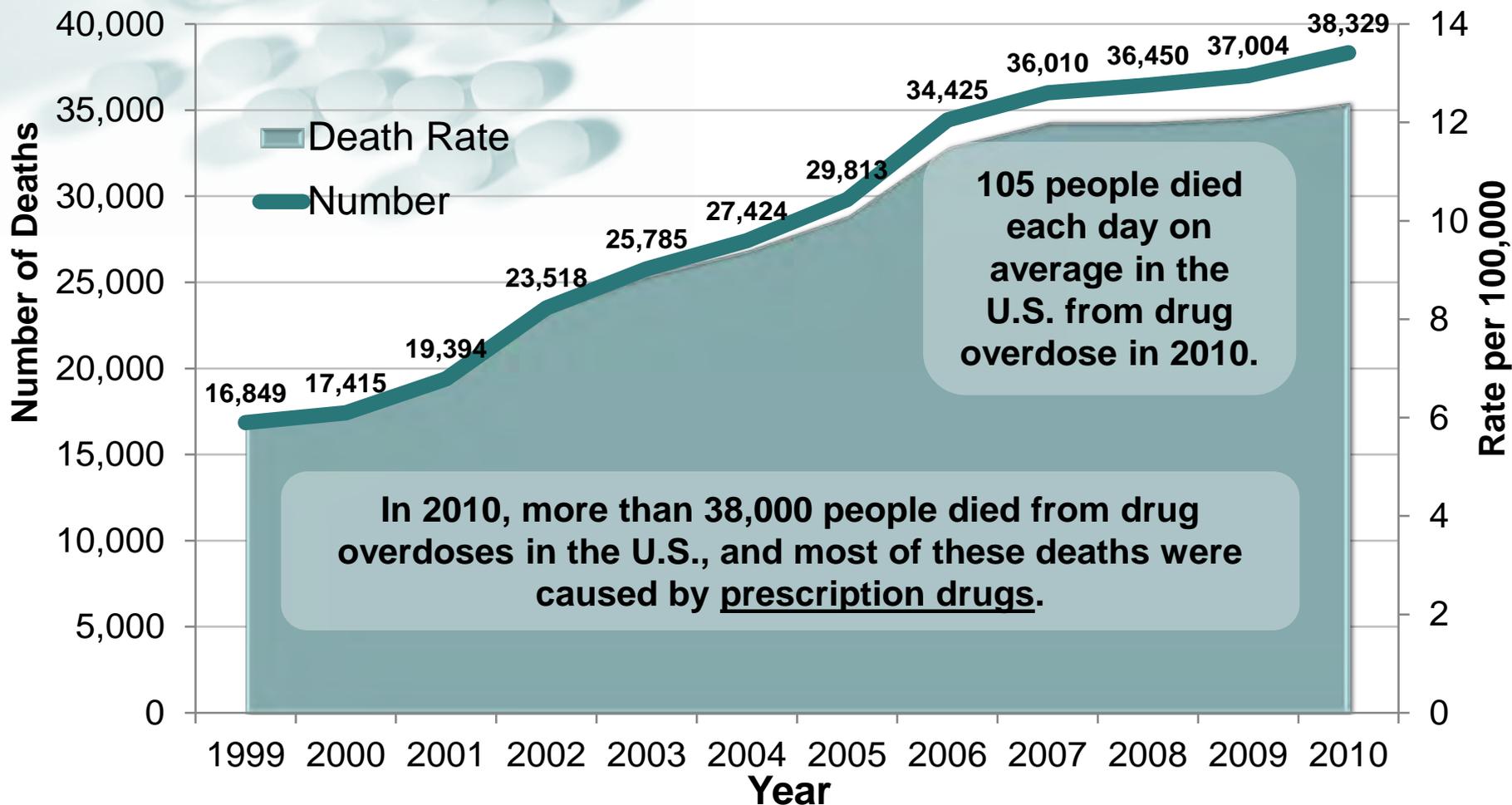
- Updates on Ohio Drug Overdose Deaths from Death Certificate Data
- Results of the 2013 Ohio Coroner Survey on Investigating Opioid Overdose Deaths
- NAME/ACTM Recommendations for Investigating Opioid Overdoses
- Discussion of Unspecified Drug Overdose Deaths
- State Response to the Epidemic
- Questions

DEATH CERTIFICATE DATA

UPDATED DRUG OVERDOSE DEATH DATA: NATIONAL AND OHIO

NATIONAL DATA

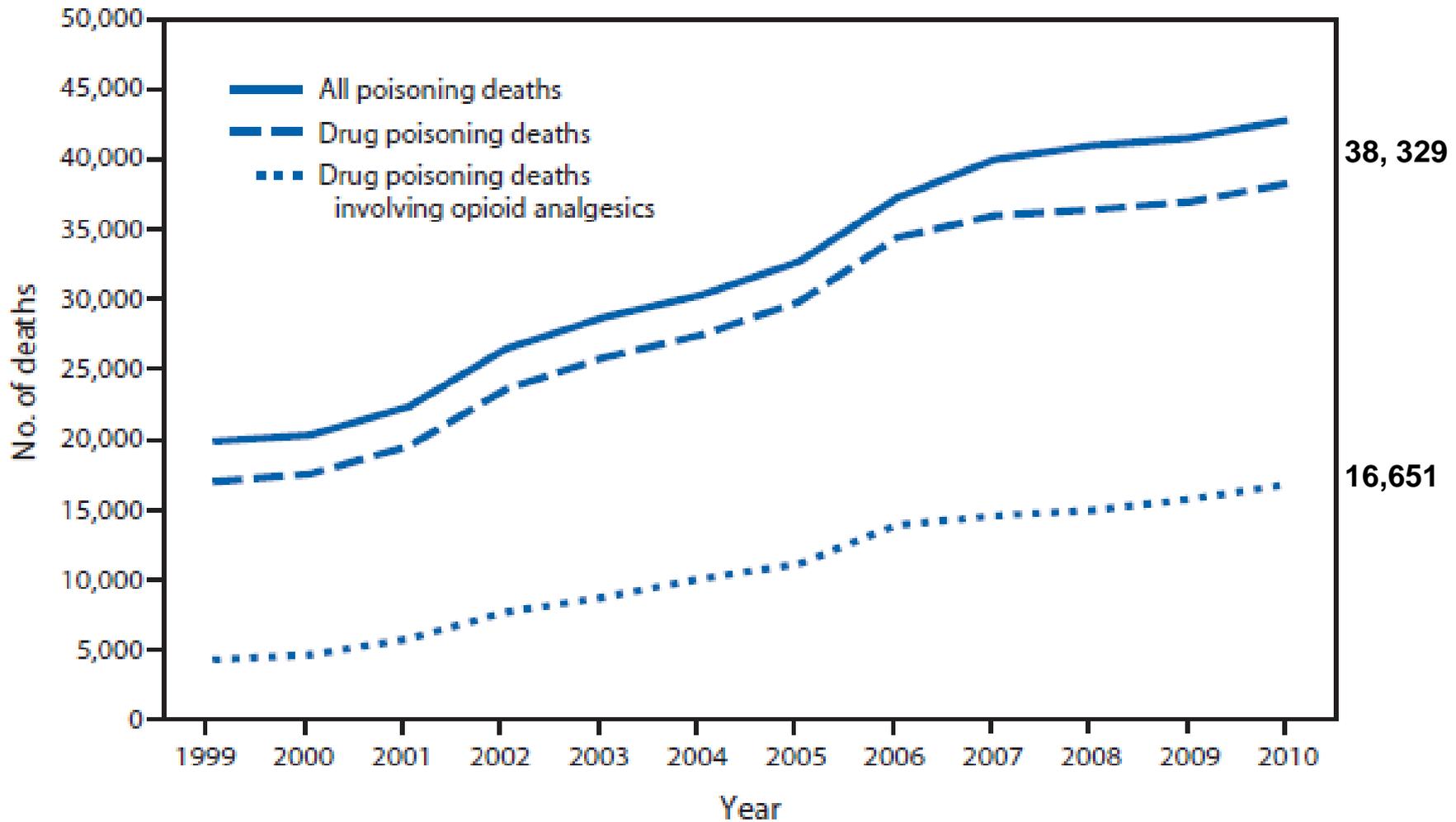
Number and Rate per 100,000 of Drug Overdose Deaths (all manners), U.S., 1999 – 2010*



*Source: CDC, WONDER Compressed Mortality File, NCHS

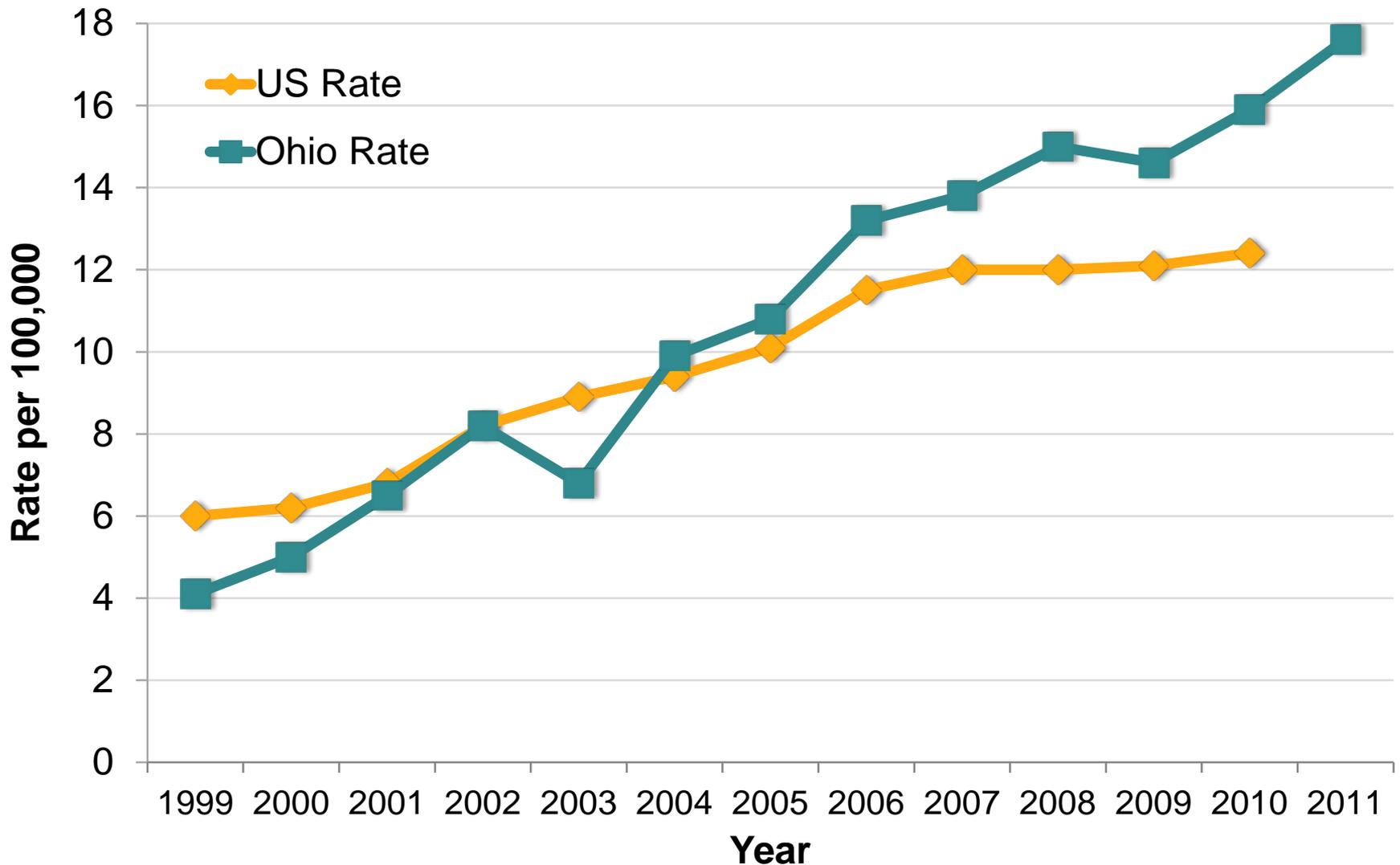
NATIONAL DATA:

All Poisoning Deaths, Drug Poisoning Deaths and Drug Poisonings involving Opioids, 1999 – 2010



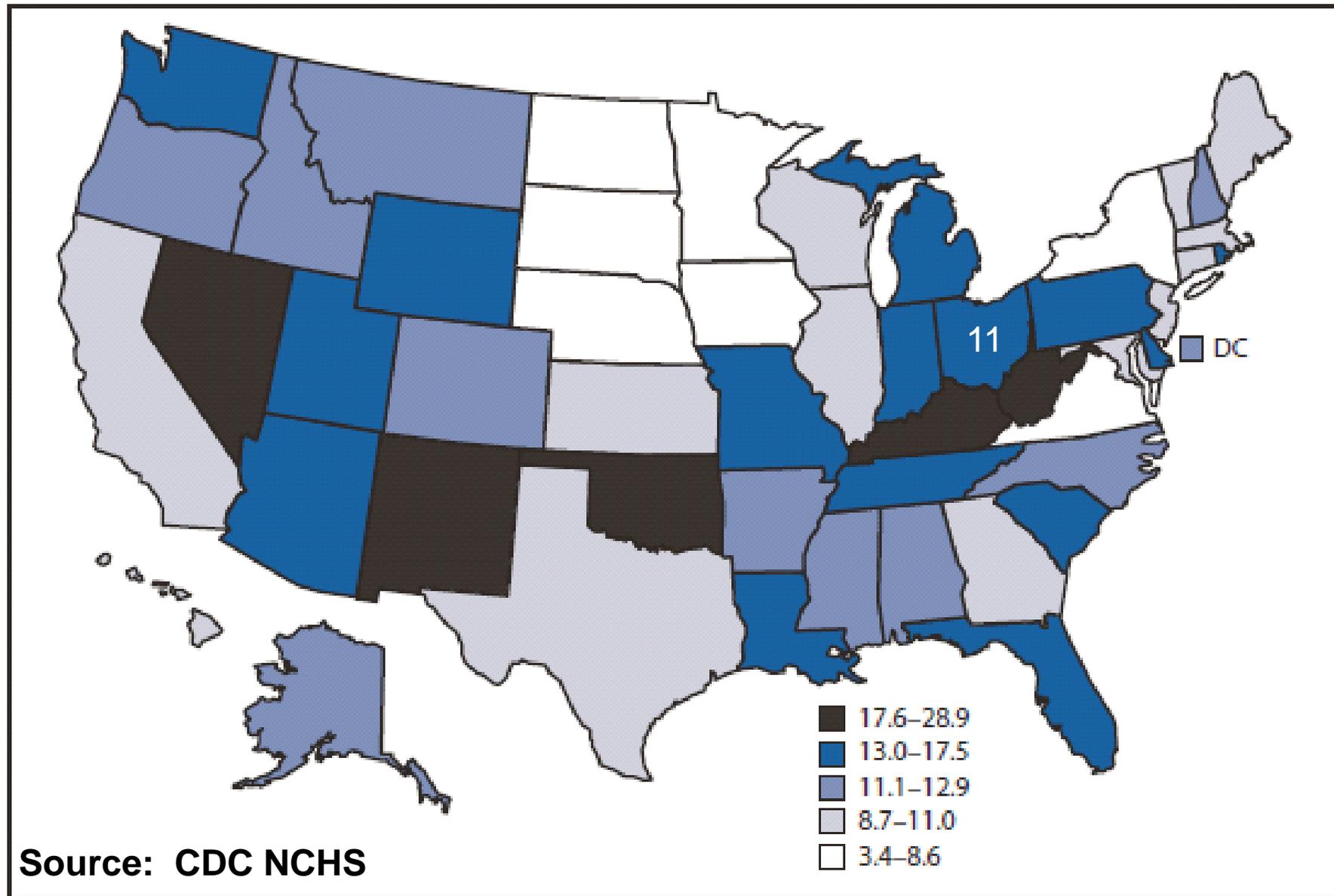
**Source: CDC, WONDER Compressed Mortality File, NCHS*

DEATH RATES PER 100,000 FOR DRUG POISONING (ALL MANNER), BY YEAR, OHIO VS. US, 1999-2011



¹Source: ODH Office of Vital Statistics

DRUG OVERDOSE DEATH RATES (ALL MANNER) PER 100,000 (2010), UNITED STATES



TOP 15 STATES LISTED BY DRUG POISONING (ALL MANNER) DEATH RATE PER 100,000, 2010*

	State	Number of Deaths	State Population	Death Rate
1	West Virginia	512	1,852,994	27.6
2	New Mexico	478	2,059,179	23.2
2	Kentucky	1,007	4,339,367	23.2
4	Nevada	578	2,700,551	21.4
5	Oklahoma	717	3,751,351	19.1
6	Arizona	1,098	6,392,017	17.2
7	Tennessee	1,080	6,346,105	17
8	Missouri	998	5,988,927	16.7
9	Florida	3,061	18,801,310	16.3
10	Delaware	145	897,934	16.1
11	Ohio	1,835	11,536,504	15.9
11	Rhode Island	167	1,052,567	15.9
13	Utah	433	2,763,885	15.7
14	Pennsylvania	1,916	12,702,379	15.1
15	Wyoming	85	563,626	15.1
	Total	38,329	308,745,538	12.4

*Source: CDC WONDER Compressed Mortality File, 2010: Accessed May 2, 2013

NATIONAL DATA: PUBLIC HEALTH IMPACT OF OPIOID OVERDOSE

In 2008, there were **14,800** prescription painkiller deaths.⁴

For every **1** death there are...



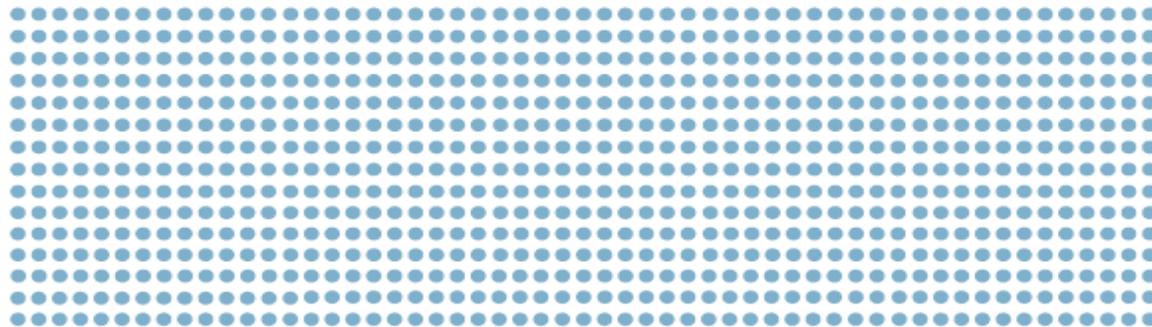
10 treatment admissions for abuse⁹



32 emergency dept visits for misuse or abuse⁶



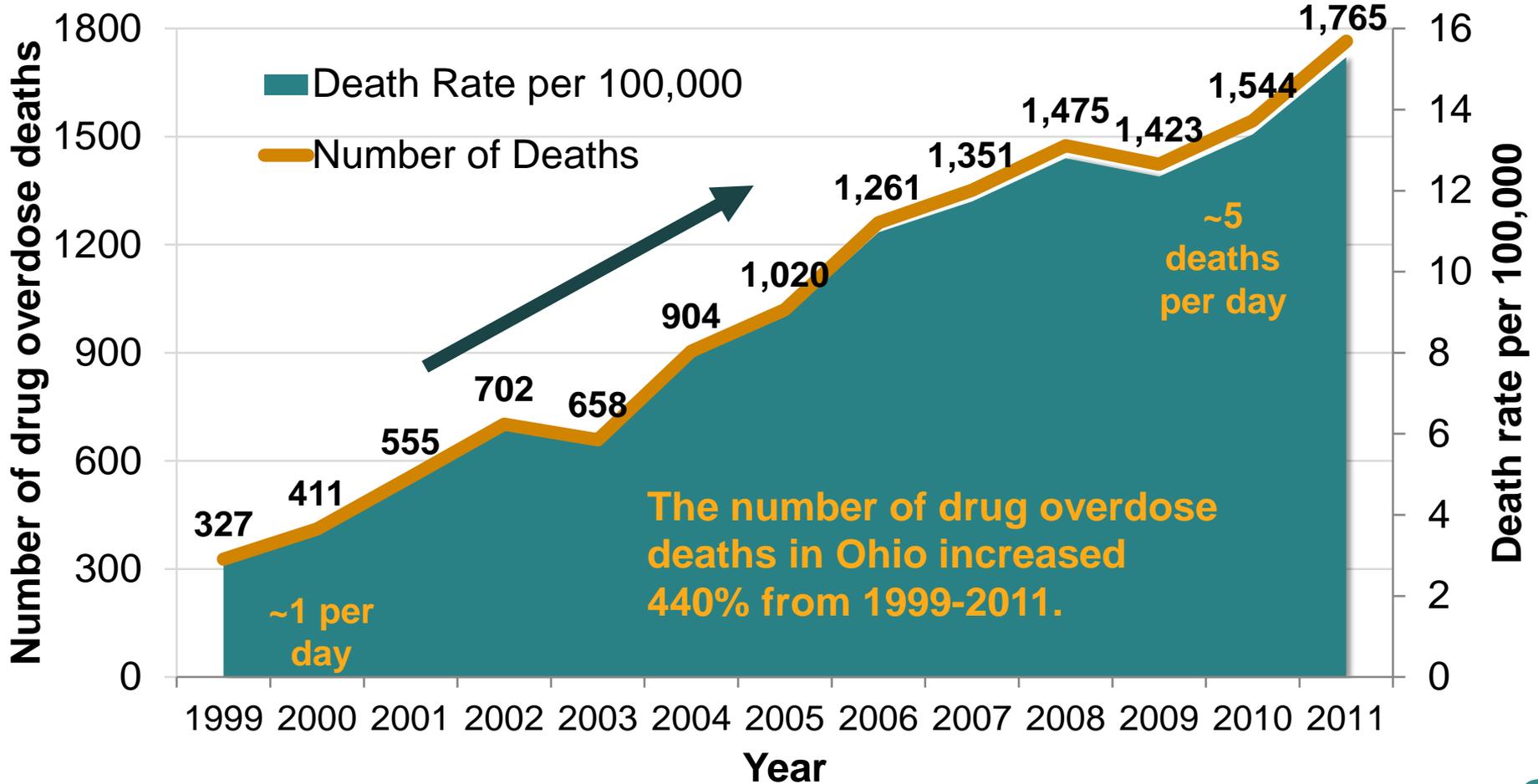
130 people who abuse or are dependent⁷



825
nonmedical
users⁷

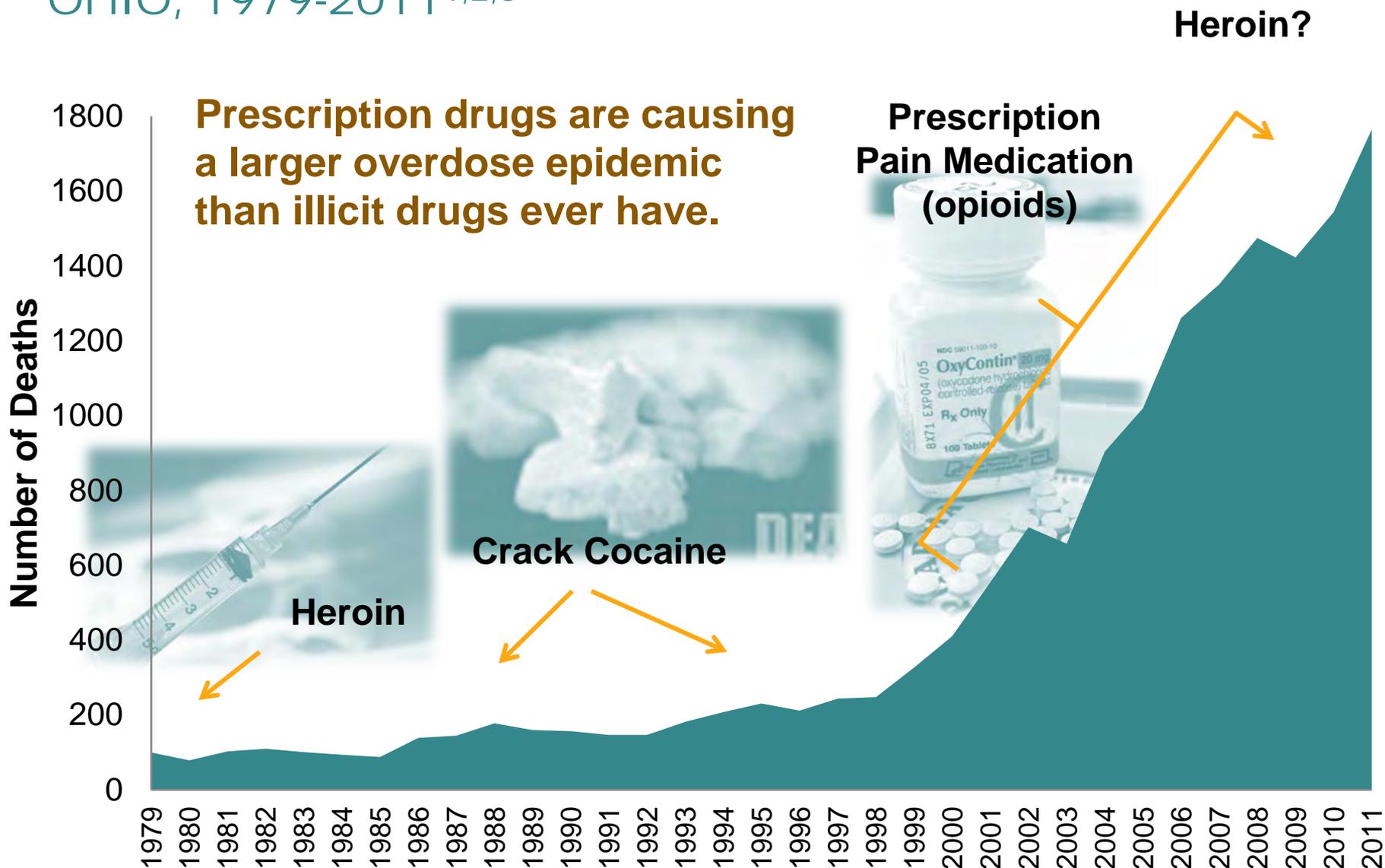
Sources: ¹SAMHSA Treatment Episode Data Set (TEDS); ²Drug Abuse Warning Network (DAWN); ³National Survey of Drug Use in Households (NSDUH)

OHIO DEATHS AND DEATH RATES PER 100,000 DUE TO UNINTENTIONAL DRUG OVERDOSE BY YEAR, 1999-2011¹



¹Source: ODH Office of Vital Statistics,

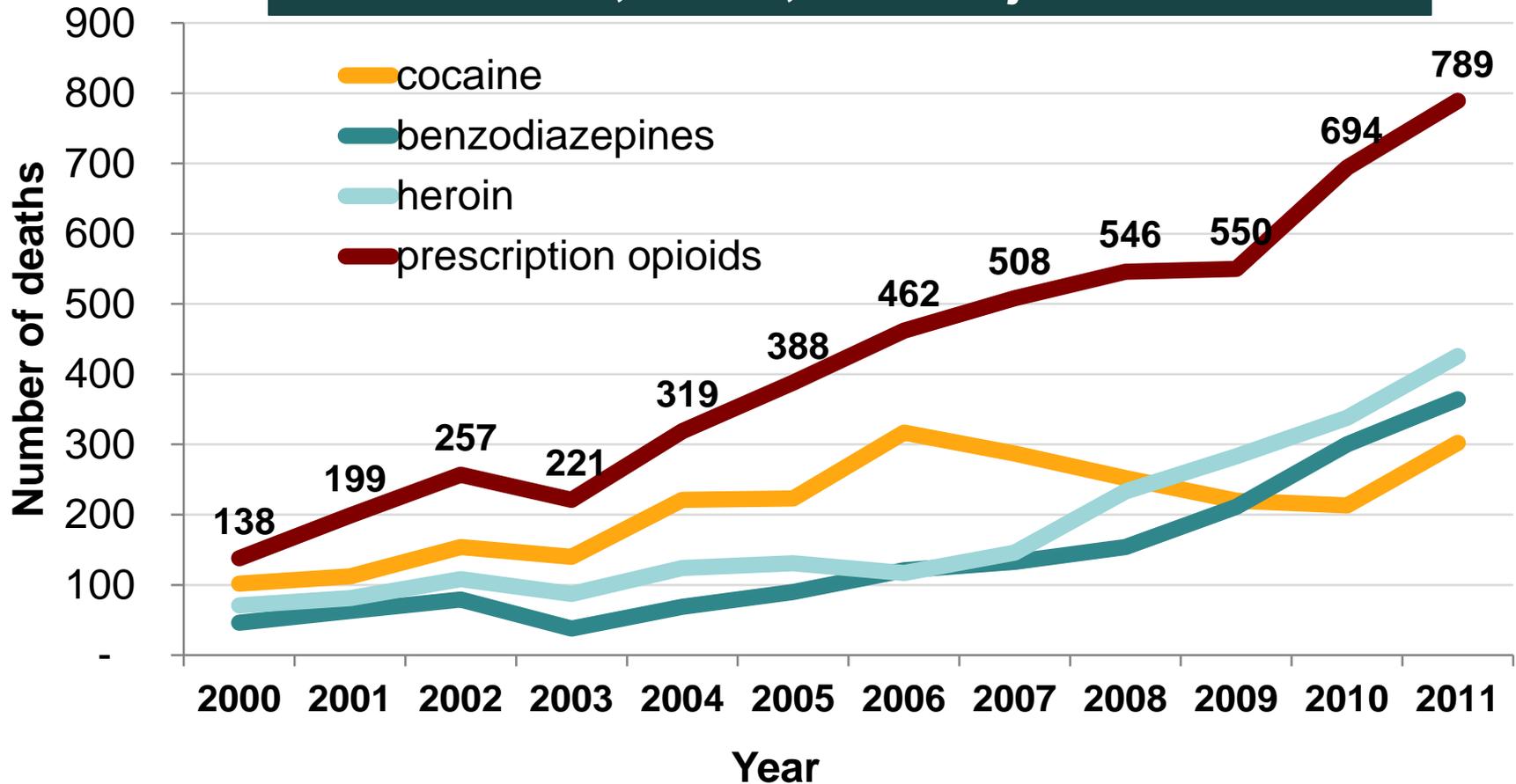
EPIDEMICS OF UNINTENTIONAL DRUG OVERDOSES IN OHIO, 1979-2011^{1,2,3}



Source: ¹WONDER (NCHS Compressed Mortality File, 1979-1998 & 1999-2005) ²2006-2011 ODH Office of Vital Statistics, ³Change from ICD-9 to ICD-10 coding in 1999 (caution in comparing before and after 1998 and 1999)

Unintentional drug overdose deaths of Ohio residents by specific drug(s) involved, by year, 2000-2011^{1,2}

Still more deaths from prescription opioids than from cocaine, heroin, and marijuana combined.

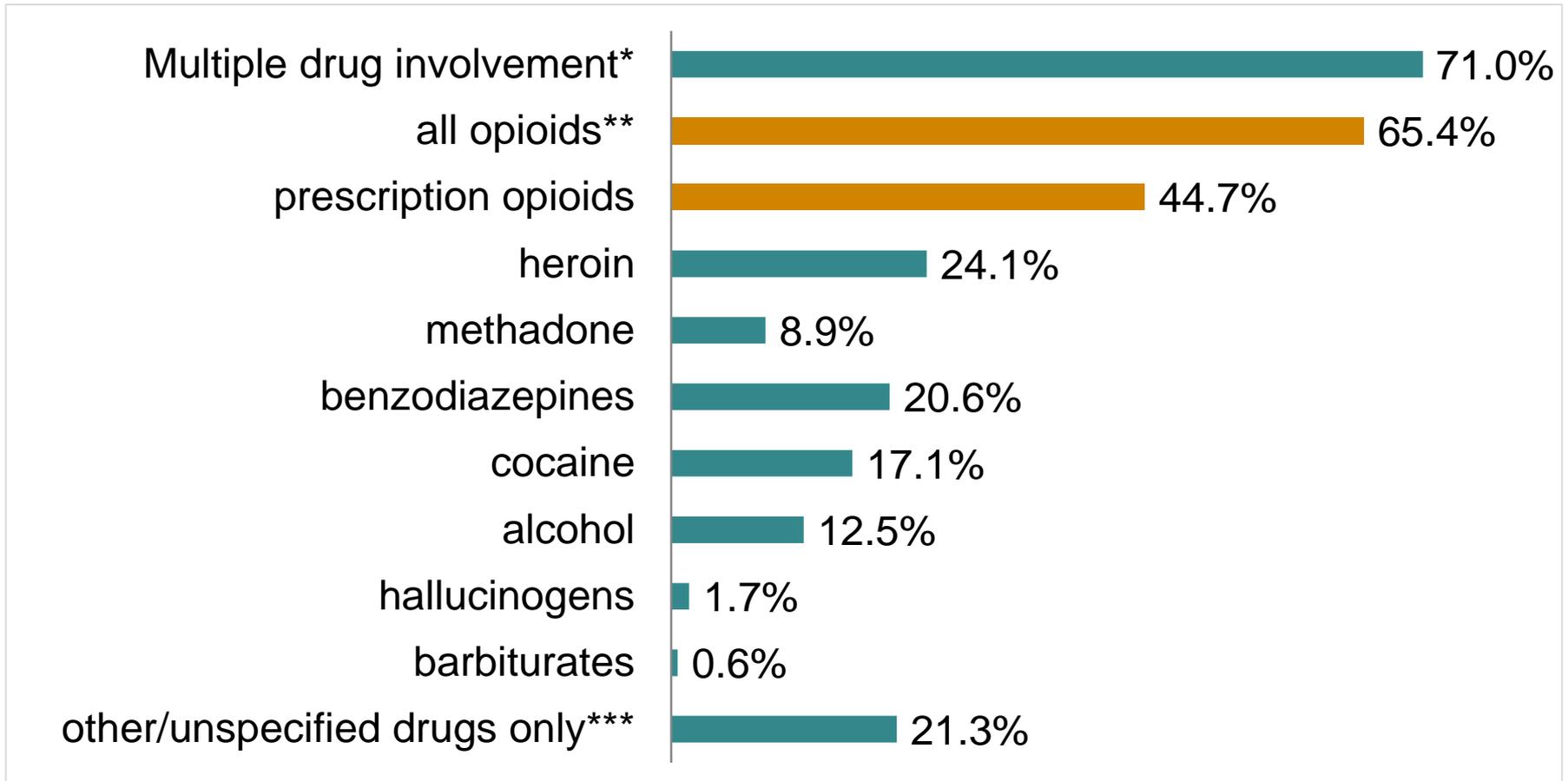


²Multiple substances are usually involved in one death.

PROPORTION OF ALL UNINTENTIONAL DRUG OVERDOSE DEATHS INVOLVING SELECTED DRUGS, OHIO, 2011^{1,2}

¹Source: ODH Office of Vital Statistics

²Multiple substances are usually involved in one death.



* Includes only deaths where the number of substances was specified; number unspecified in 21% of 2011 overdose deaths.

**Includes involvement of prescription opioids and/or heroin.

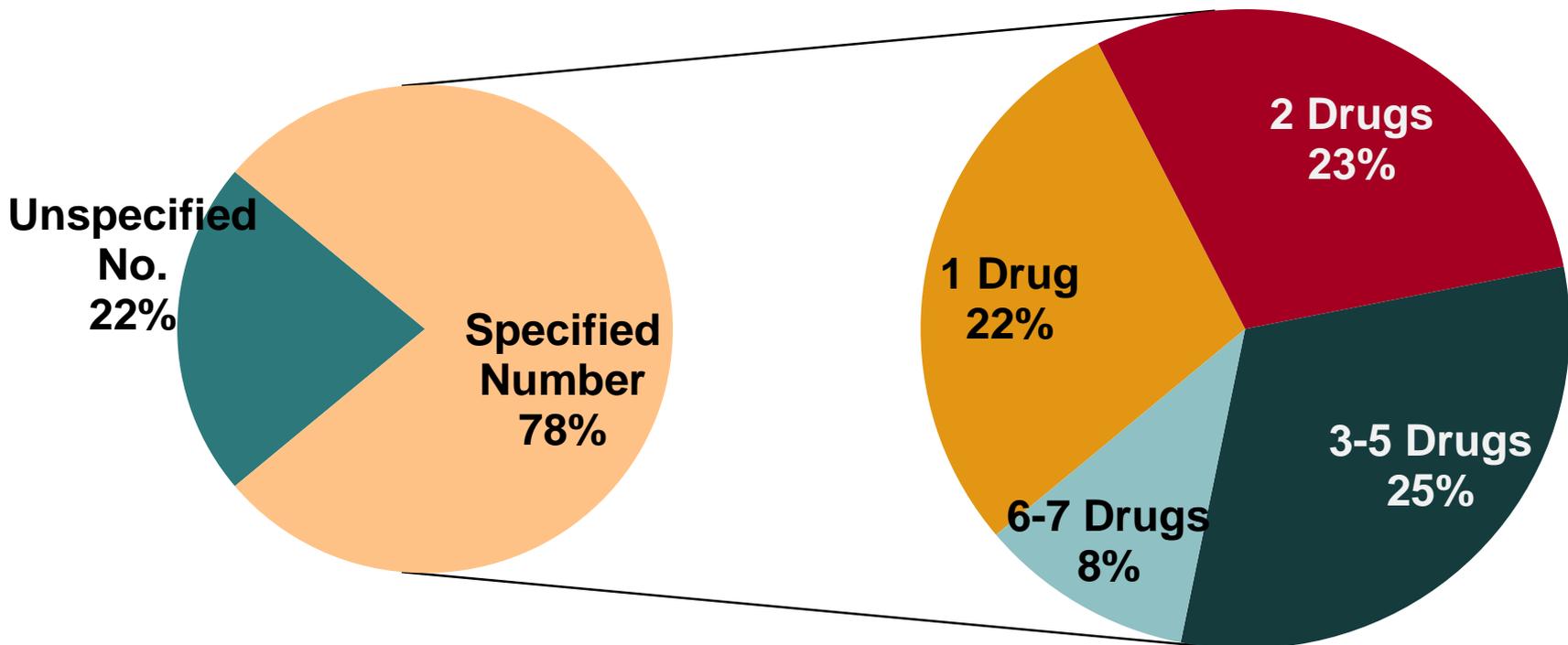
***No specific drug was identified



USE OF MULTIPLE DRUGS

Number of Drugs involved in Drug Overdose Deaths, Ohio Residents, 2011 (N=1,765)

- In 22% of deaths, the specific number of drugs was unknown.
- Multiple drugs are involved in most overdoses.
- Most involved 2-5 drugs. 22% had only 1 drug listed on the DC.

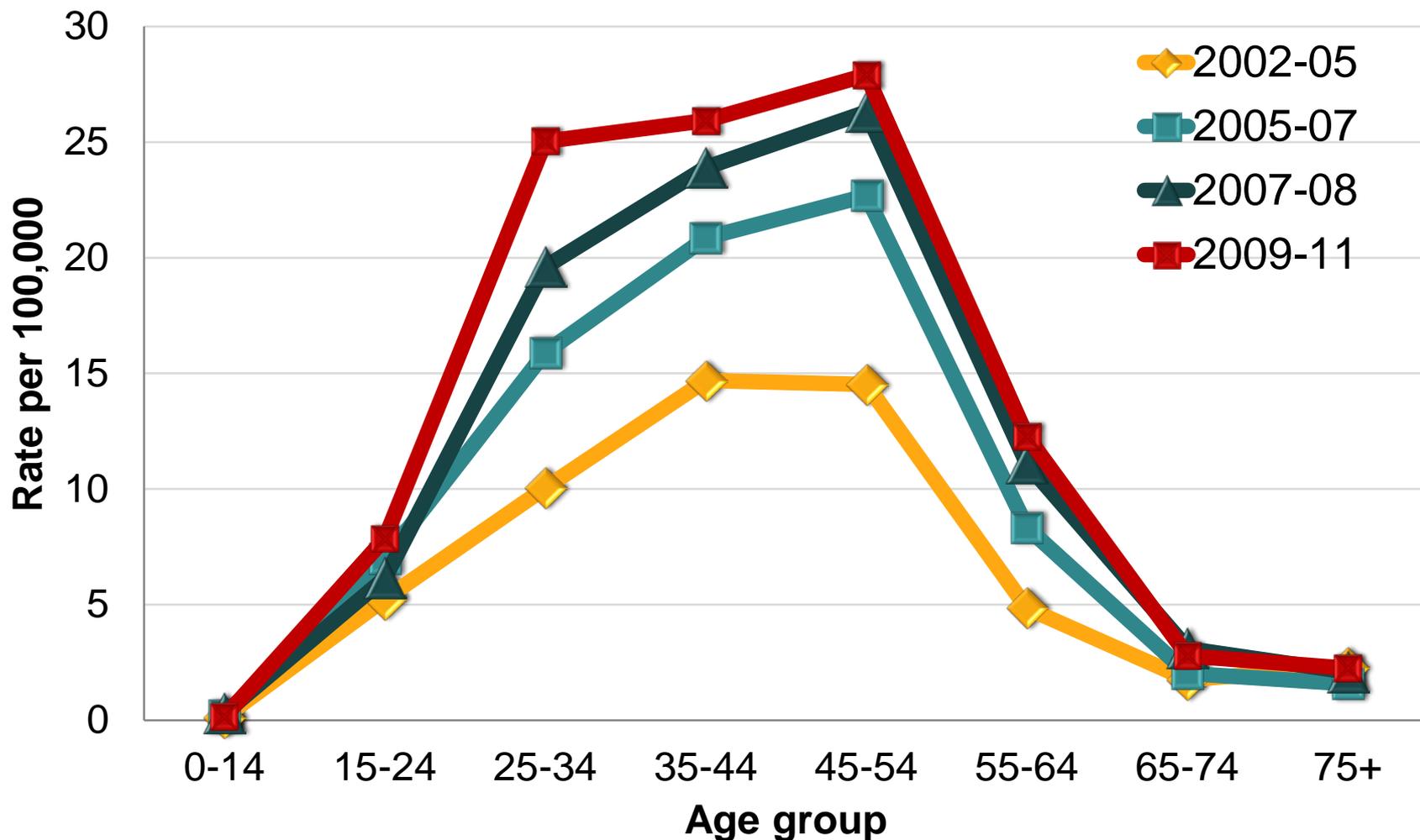


OHIO'S OPIOID EPIDEMIC

WHO IS IMPACTED?

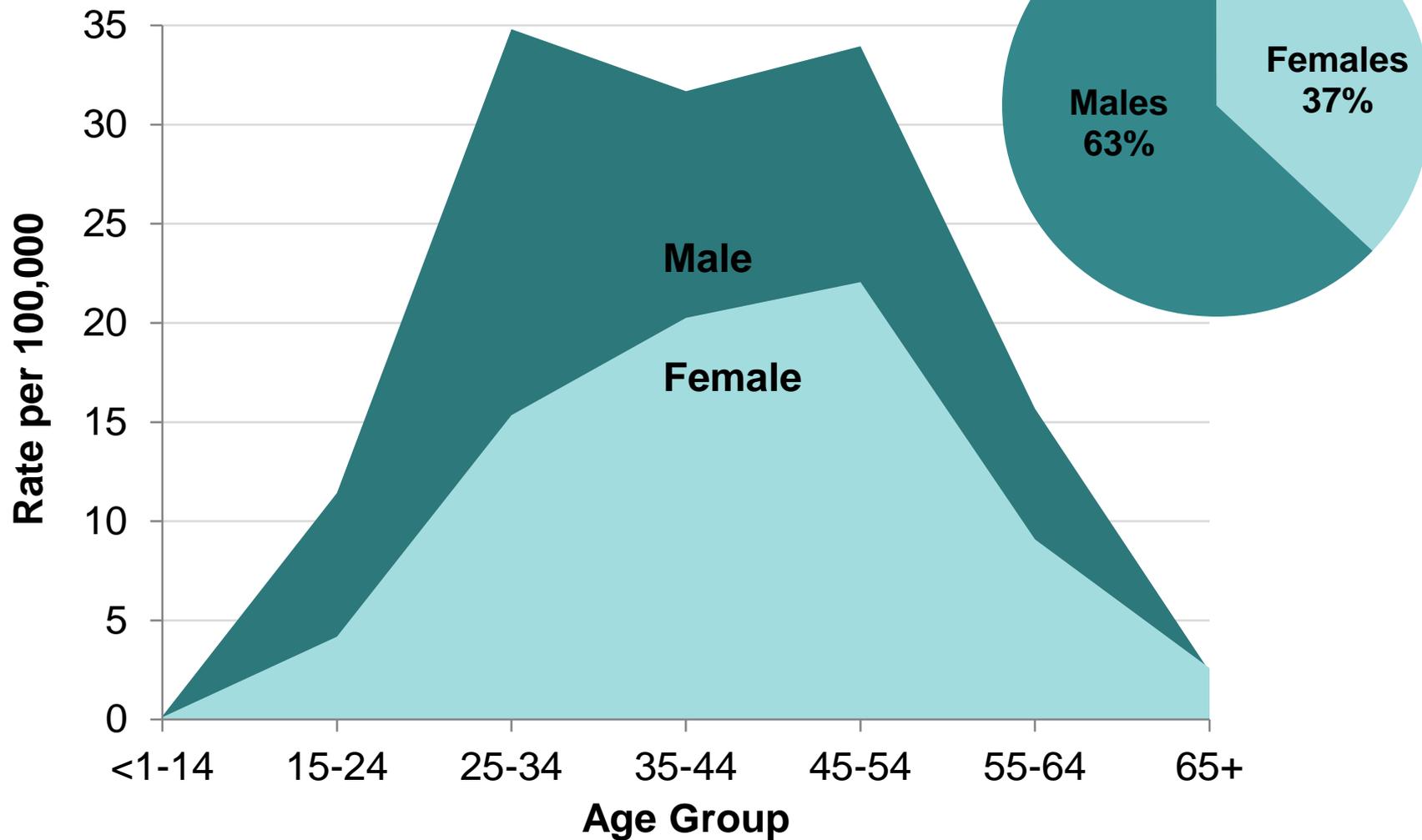


AVERAGE UNINTENTIONAL DRUG OVERDOSE DEATH RATE BY AGE GROUP, OVER TIME, OHIO RESIDENTS, 2002-2011



Source: Ohio Department of Health, Vital Statistics

Average Annual Unintentional Fatal Overdose Rate¹ by Sex, Age Group, Ohio, 2009-11



Source: Ohio Department of Health, Vital Statistics

HIGH RISK FOR OPIOID ABUSE AND DEATH

- **Using after a period in abstinence (i.e., change in tolerance)**
- **Using Alone**
- **Mixing with Other CNS Depressants**
- **People with co-morbidities (Illness)**



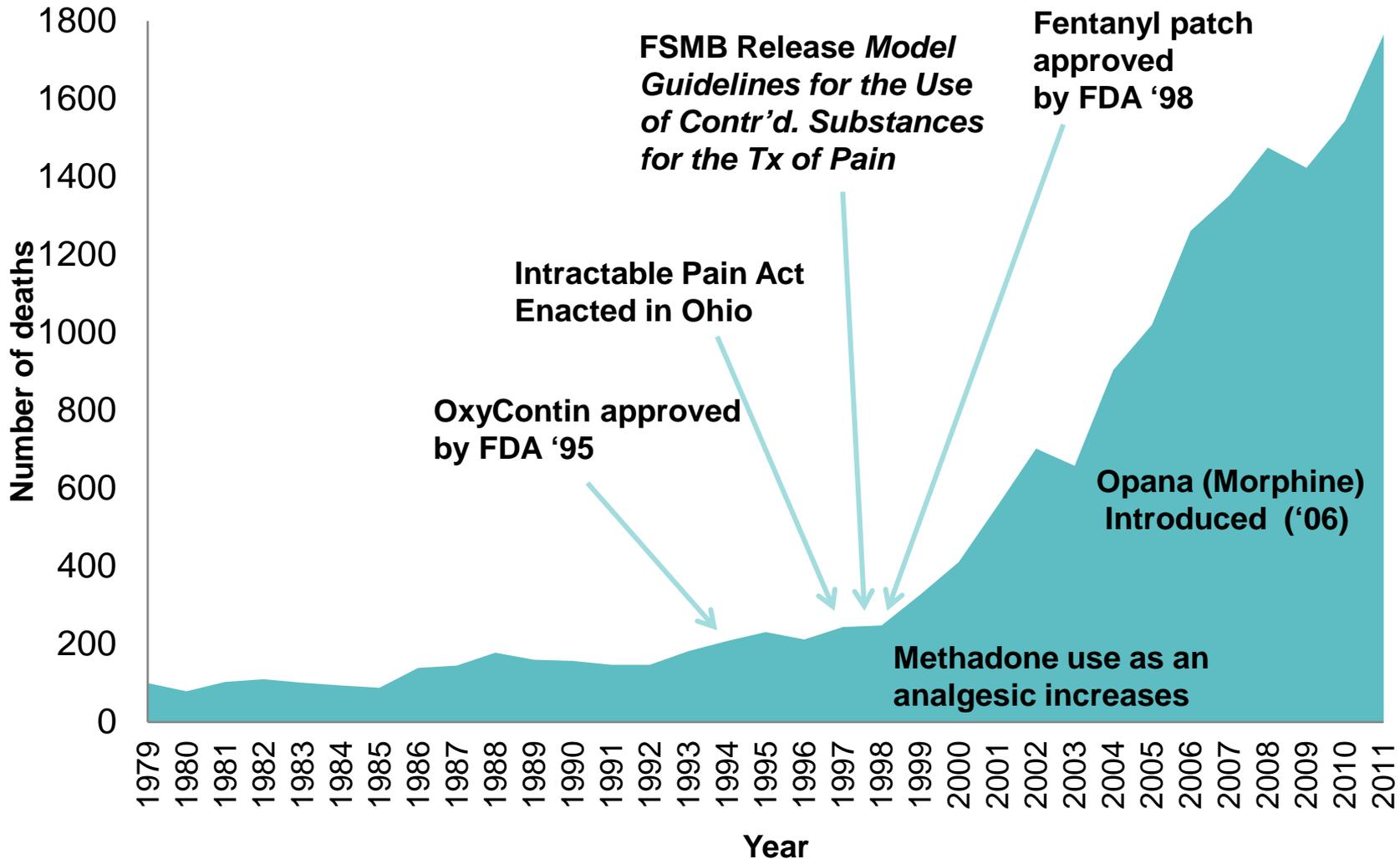
OHIO'S OPIOID EPIDEMIC

HOW DID
THIS
OCCUR?



CONTRIBUTING FACTORS:

EPIDEMICS OF UNINTENTIONAL DRUG OVERDOSE AND SIGNIFICANT EVENTS, OHIO 1979-2011^{1,2,3}



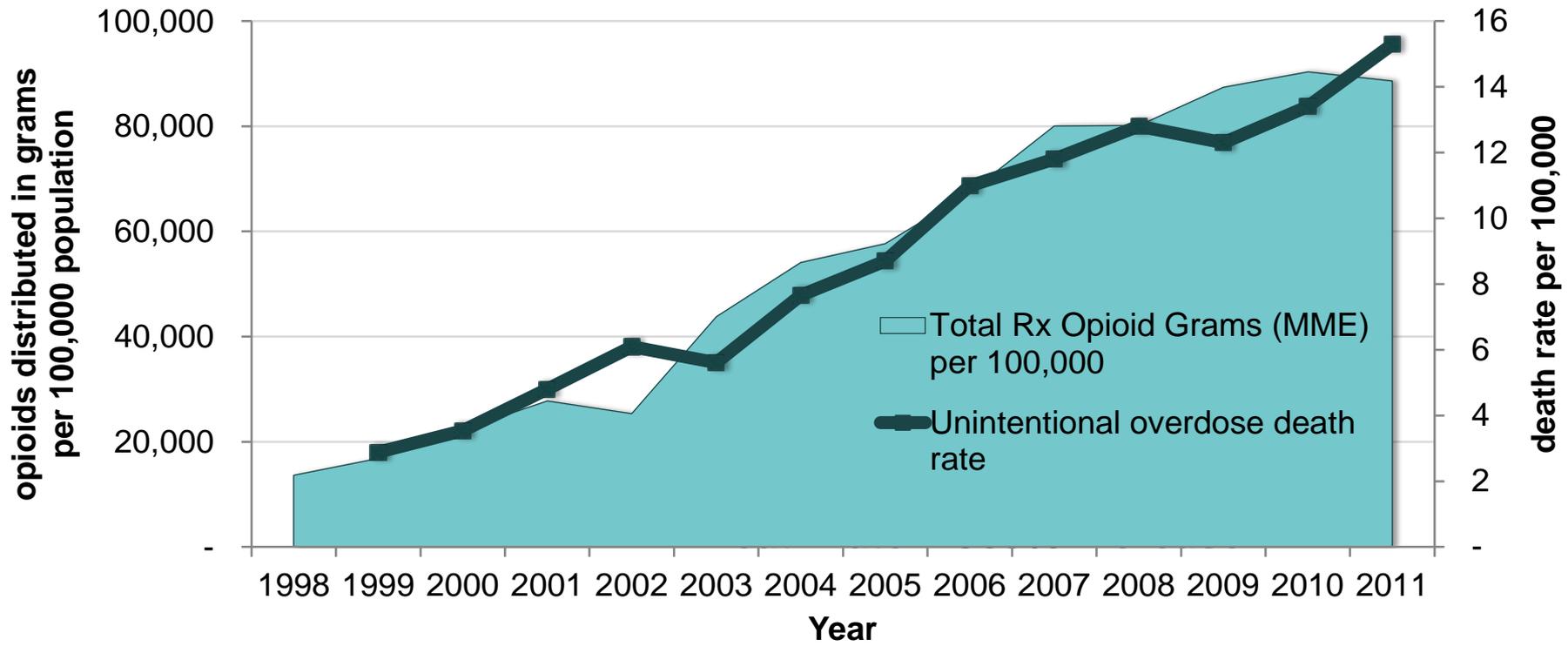
Source: ¹WONDER (NCHS Compressed Mortality File, 1979-1998 & 1999-2005) ²2006-2011 ODH Office of Vital Statistics, ³Change from ICD-9 to ICD-10 coding in 1999 (caution in comparing before and after 1998 and 1999)

CONTRIBUTING FACTORS:

OHIO DATA

There is a *strong* relationship between increases in exposure to prescription opioids and fatal unintentional overdose rates.

Unintentional drug overdose death rates and distribution rates of prescription opioids in grams per 100,000 population by year, Ohio, 1997-2011¹⁻³



Sources: 1. Ohio Vital Statistics; 2. DEA, ARCOS Reports, Retail Drug Summary Reports by State, Cumulative Distribution Reports (Report 4) Ohio, 1997-2007 http://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/index.html; 3. Calculation of oral morphine equivalents used the following assumptions: (1) All drugs other than fentanyl are taken orally; fentanyl is applied transdermally. 2) These doses are approximately equianalgesic: morphine: 30 mg; codeine 200 mg; oxycodone and hydrocodone: 30 mg; hydromorphone; 7.5 mg; methadone: 4 mg; fentanyl: 0.4 mg; meperidine: 300 mg; 4. US Census Bureau, Ohio population estimates 1997-2007; 5. preliminary data for 2007

OSCA/ODH 2013 OHIO CORONER SURVEY RESULTS



OVERDOSE DEATH INVESTIGATION PRACTICES

2013 OSCA/ODH CORONER SURVEY ON DRUG OVERDOSE DEATH INVESTIGATION PRACTICES

Goal: To collect information from Ohio coroners on death investigation practices for suspected drug overdose deaths in order to better understand challenges in light of Ohio's growing overdose epidemic.

FOR FULL CORONER SURVEY SUMMARY:

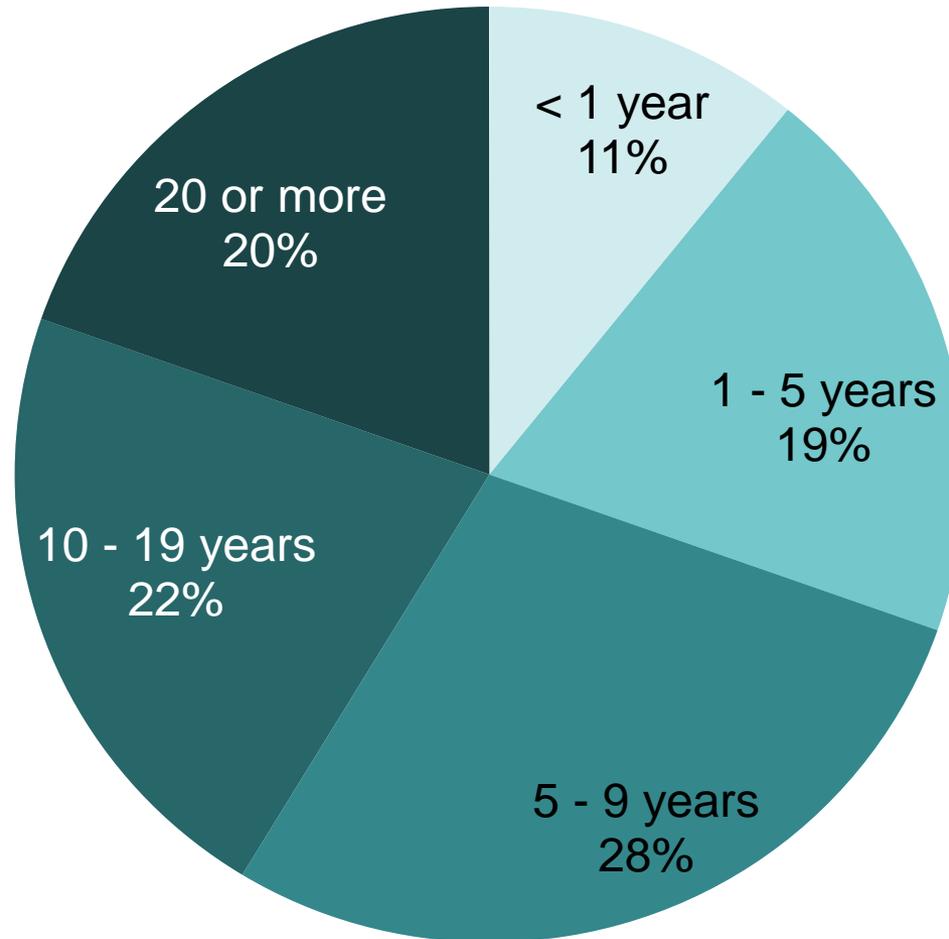
<http://www.healthyohioprogram.org/vipp/drug/coronerinfo.aspx>

2013 CORONER SURVEY – OVERALL FINDINGS

- 49 of 88 coroners responded (**56% response rate**)
- Fairly even distribution across the state by region
- Representation by urbanality:
 - 50% Rural,
 - 25% Suburban,
 - 15% Appalachian,
 - 10% Urban

OHIO CORONER SURVEY: RESPONDENTS BY TIME SERVING AS CORONER, 2013*

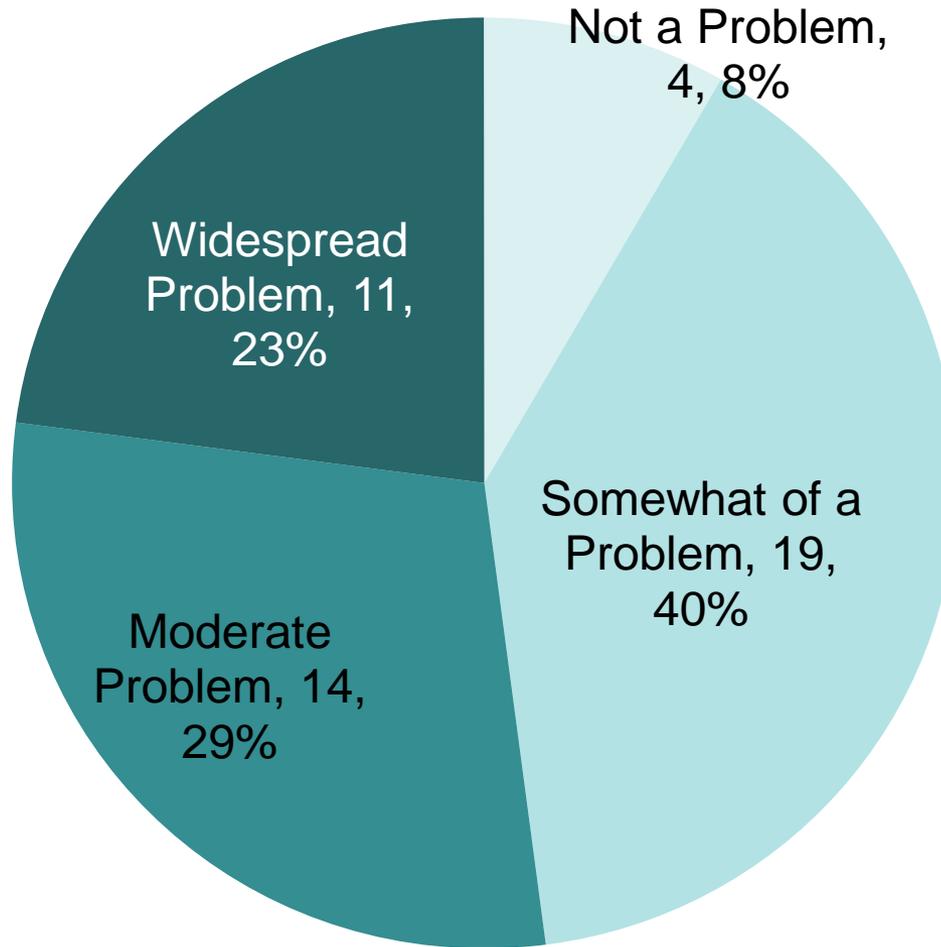
N=49



*Source: ODH/OSCA, 2013 Ohio Coroner Survey Investigation Practices on Opioid Overdose Deaths

To What Extent are Overdose Deaths a Public Health Problem in Your County?

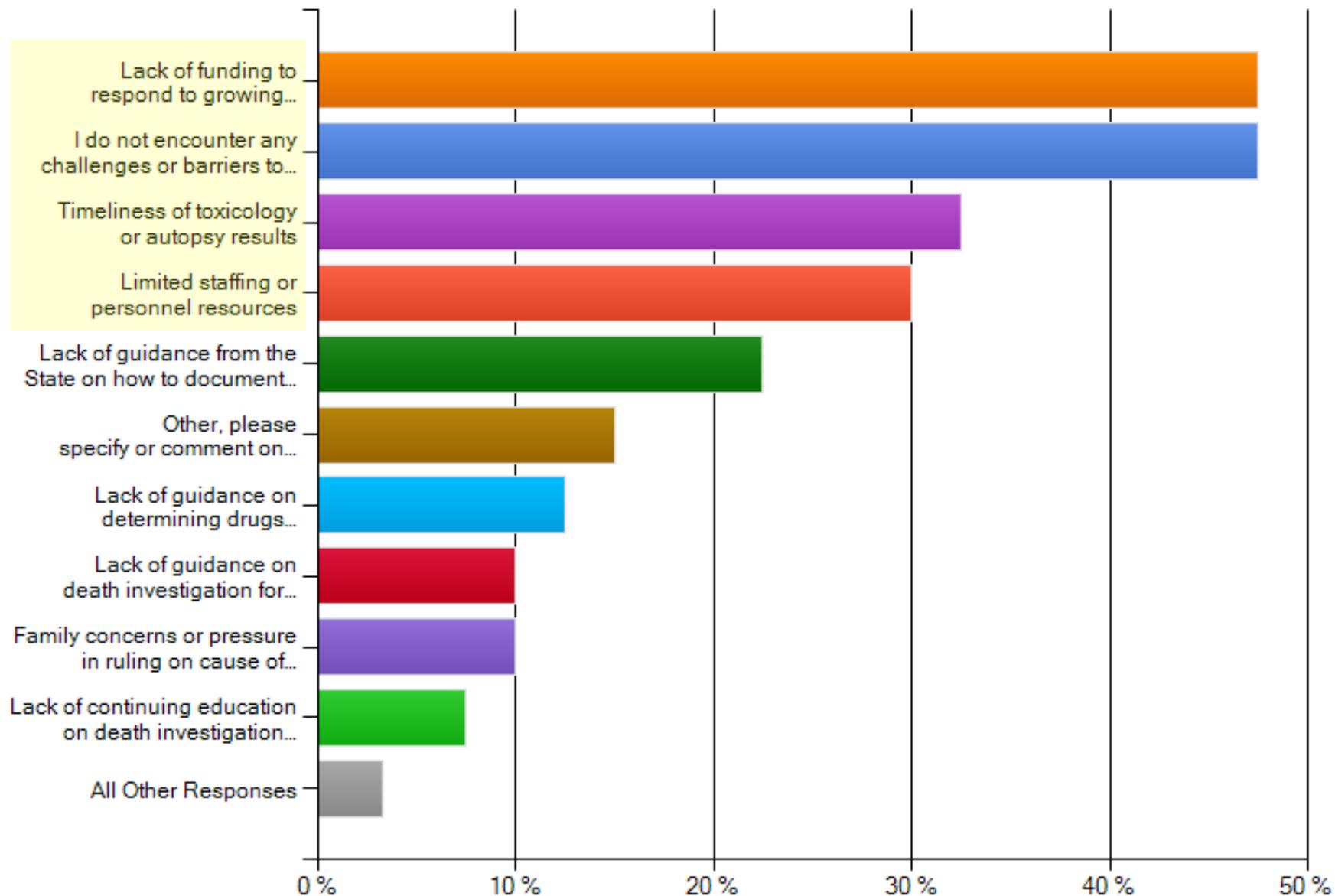
N=48



2013 CORONER SURVEY – OVERALL FINDINGS (N=49)

- **Nearly 2 out of 3 respondents (64%) received continuing education related to drug overdose death investigation in past 2 years**
- **60% have a standard protocol for investigating suspected overdose deaths; 40% do not.**

What are the 4 biggest challenges that you face when investigating a suspected overdose death? (Select top 4).



*Source: ODH/OSCA, 2013 Ohio Coroner Survey Investigation Practices on Opioid Overdose Deaths

NAME/ACMT RECOMMENDATIONS FOR DEATH INVESTIGATION PRACTICES AROUND SUSPECTED OVERDOSES

American College of Medical Toxicology (ACMT) and the **National Association of Medical Examiners (NAME)** convened an expert panel to generate evidence-based recommendations related to opioid death investigation.

Recommendations address:

- Practice of death investigation and autopsy
- Toxicological analysis
- Interpretation of toxicological findings
- **Death certification to improve the precision of death certificate (DC) data available for public health surveillance**

NAME/ACMT RECOMMENDATIONS FOR DEATH INVESTIGATION PRACTICES AROUND SUSPECTED OVERDOSES

- The panel provided 7 recommendations.
- Published in the Academy of Forensic Pathology Journal, March 2013.
- The remainder of the Ohio coroner survey results will be presented within the framework of those 7 recommendations.

Position Paper:

<https://netforum.avectra.com/temp/ClientImages/NAME/a8f3230e-d063-4681-8678-e3d15ce9effb.pdf>

RECOMMENDATION 1.

A complete autopsy is necessary for optimal interpretation of toxicology results, which must also be considered in the context of the circumstances surrounding death, medical history, and scene findings.

- An autopsy should be performed to determine cause and manner of death whenever intoxication is suspected as a possible COD.
- An autopsy be performed whenever intoxication is suspected.
- Jurisdiction receive sufficient personnel and funding to meet this standard.

1. A complete autopsy is necessary for optimal interpretation of toxicology results, which must also be considered in the context of the circumstances surrounding death, medical history, and scene findings.

Ohio Coroner Survey Results:

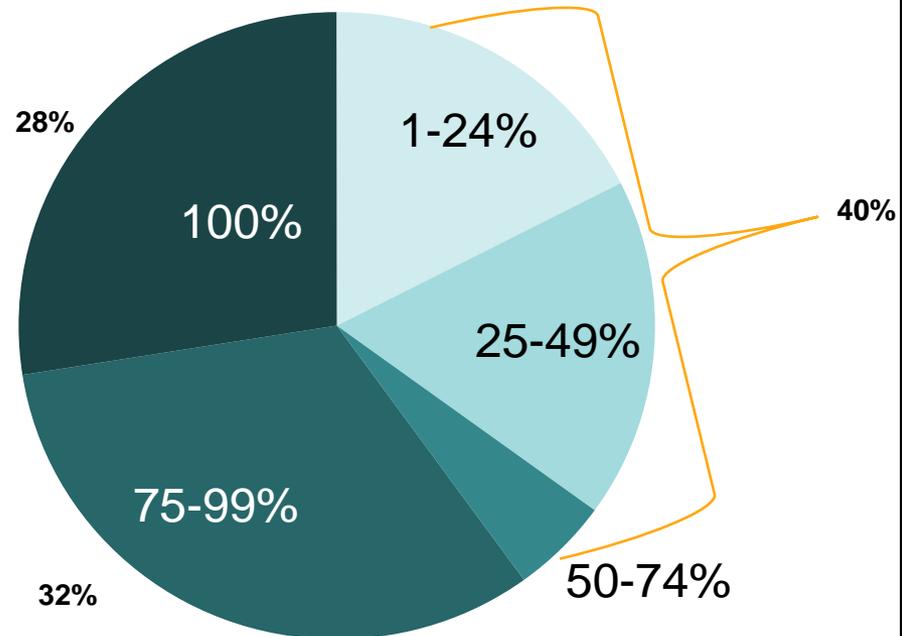
- **88%** do use autopsy results when investigating a suspected OD
- **63%** conduct autopsies on suspected ODs “always” or “most of the time”
- **23%** only “occasionally” conduct autopsies on suspected ODs.
- **76%** believe autopsies are not necessary for every suspected OD death (*e.g., those who were hospitalized prior to death*)

1. A complete autopsy is necessary for optimal interpretation of toxicology results, which must also be considered in the context of the circumstances surrounding death, medical history, and scene findings.

Ohio Coroner Survey:

- 28% conducted autopsies on all
- 32% on most (75-99%)
- 40% on less than 75%

Percent of 2012 Suspected Overdoses Receiving Autopsy

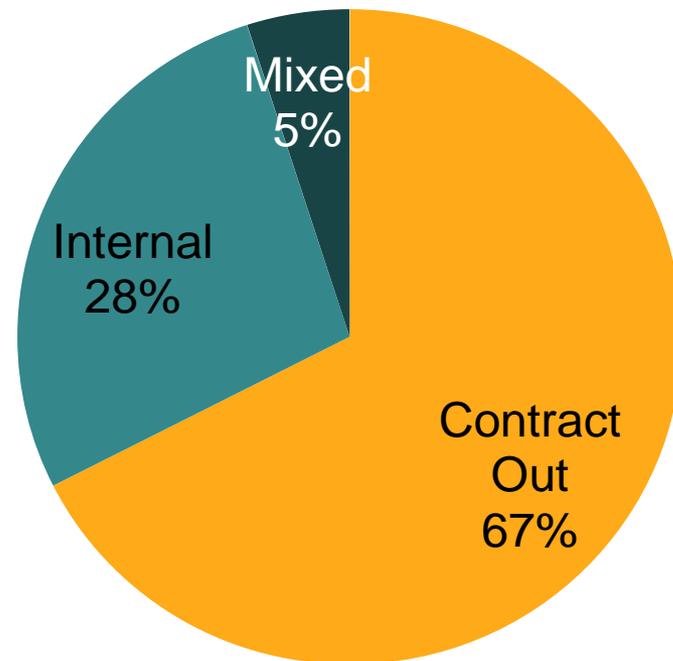


1. A complete autopsy is necessary for optimal interpretation of toxicology results, which must also be considered in the context of the circumstances surrounding death, medical history, and scene findings.

Ohio Coroner Survey

- 2/3 of respondents contract out their autopsies
- Most contracted to
 - Montgomery
 - Lucas
 - Franklin
 - Summit

Autopsies conducted internally or contracted out?



1. A complete autopsy is necessary for optimal interpretation of toxicology results, which must also be considered in the context of the circumstances surrounding death, medical history, and scene findings.

Ohio Coroner Survey Results:

- **For those contracting out –**
 - **83%** reported average cost of \$1,001-\$1,300;
 - **90%** reported average transport costs \$300 or less

Reported Barriers to Autopsies:

- **45%** reported lack of funding as a barrier
- **13%** reported limited staffing /personnel

RECOMMENDATION 2.

A complete scene investigation extends to reconciliation of prescription information and pill counts.

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

2. A complete scene investigation extends to reconciliation of prescription information and pill counts.

Ohio Coroner Survey Results:

- Most (88%) indicated “yes” or “sometimes” to collecting medication prescriber information when available.
- Most (88%) included “*prescription medication bottles (e.g., fill date, pill count and dosage instructions)*” in information used to determine the COD.

2. A complete scene investigation extends to reconciliation of prescription information and pill counts.

“If possible, seek information from state prescription drug monitoring programs, which have information that can be useful in the evaluation of deaths where opioid drugs are detected.

For this reason, the panel recommends that ME/Cs have access to the information available in prescription drug monitoring programs both in the decedent’s state and across state lines.”

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

2. A complete scene investigation extends to reconciliation of prescription information and pill counts.

Ohio Coroner Survey Results:

Use of the **Ohio Automated Rx Reporting System (OARRS)** – Ohio's prescription monitoring program, to investigate a suspected overdose death:

- Only **58%** of respondents indicated using OARRS data when investigating a suspected OD death.

Coroners **may** use OARRS in the course of investigating a death. Contact the Ohio Board of Pharmacy to register.

<https://www.ohiopmp.gov/portal/Default.aspx>

RECOMMENDATION 3.

Blood, urine, and vitreous humor, when available, should be retained in all cases.

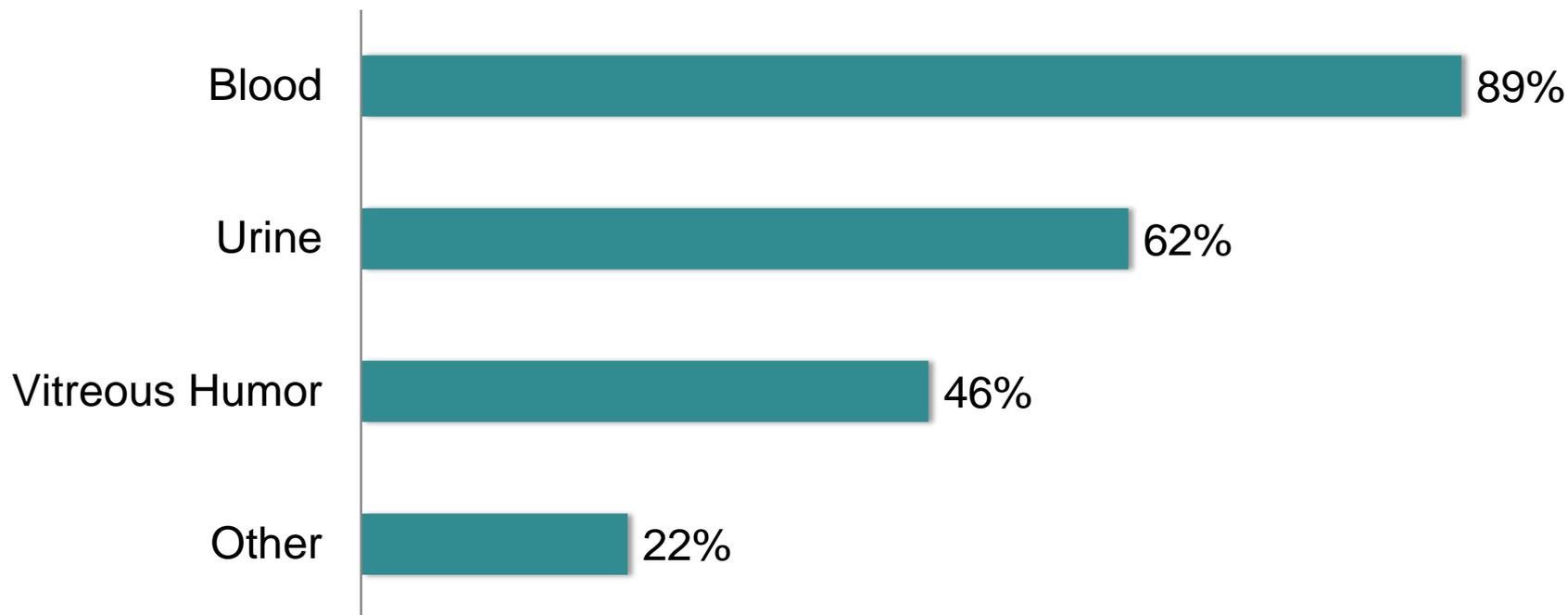
Blood from the femoral vein is preferable to blood from other sites.

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

3. Blood, urine, and vitreous humor, when available, should be retained in all cases. Blood from the femoral vein is preferable to blood from other sites.

Ohio Coroner Survey Results:

Type of toxicological panel ordered for suspected OD Deaths:



RECOMMENDATION 4.

A toxicological panel should be comprehensive and include opioid and benzodiazepine analytes, as well as other potent depressant, stimulant, and antidepressant medications.

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

4. A toxicological panel should be comprehensive and include opioid and benzodiazepine analytes, as well as other potent depressant, stimulant, and antidepressant medications.

Ohio Coroner Survey Results:

93% of respondents run toxicology tests on suspected ODs.

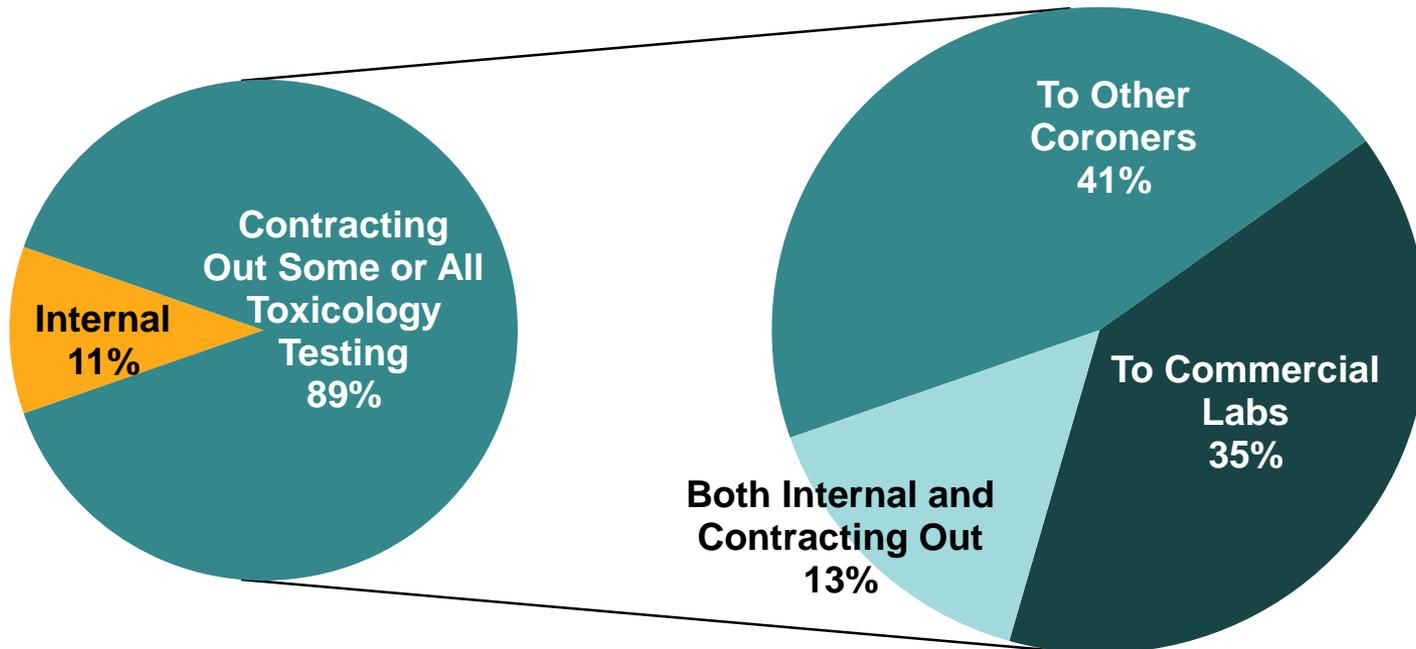
2012 deaths – toxicology on suspected overdoses;

- $\frac{3}{4}$ (78%) ran on all cases
- 11% on 75-99%;
- 11% on less than 75%.

4. A toxicological panel should be comprehensive and include opioid and benzodiazepine analytes, as well as other potent depressant, stimulant, and antidepressant medications.

Ohio Coroner Survey Results:

Contracting Toxicology Services



4. A toxicological panel should be comprehensive and include opioid and benzodiazepine analytes, as well as other potent depressant, stimulant, and antidepressant medications.

Ohio Coroner Survey Results:

Cost

- 49% reported average cost of \$250 or less
- 18% reported \$252-\$500
- 1/3 were not sure

Why Not Test All?

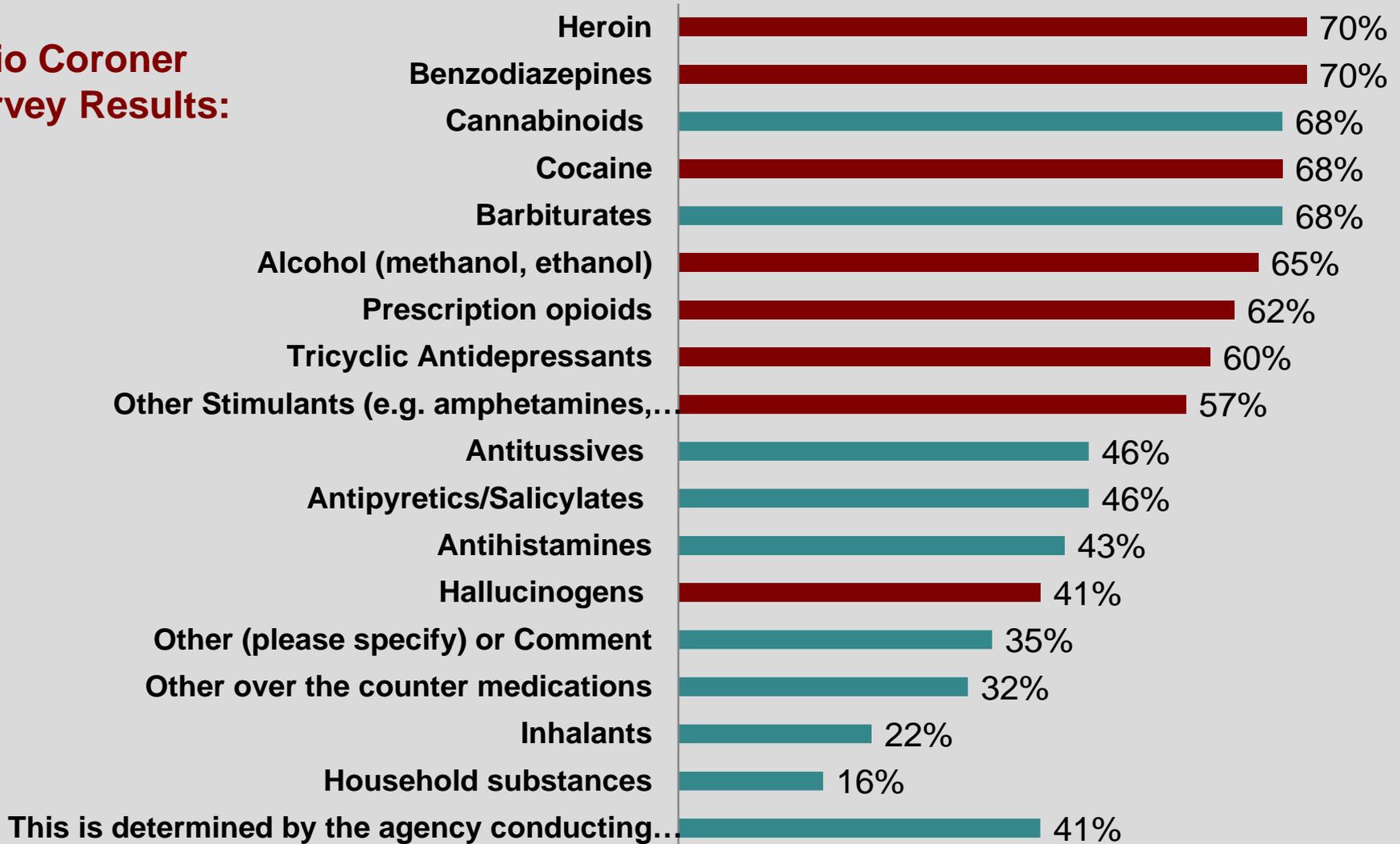
- 55% - toxicology tests are not necessary in every case; (e.g., prolonged hospitalization)
- 9% reported lack of funding

4. A toxicological panel should be comprehensive and include opioid and benzodiazepines, potent depressants, stimulants, and antidepressant medications.

What types of substances can be detected on the toxicology panels ordered (selected substances)?

N=37

Ohio Coroner Survey Results:



*Source: ODH/OSCA, 2013 Ohio Coroner Survey Investigation Practices on Opioid Overdose Deaths

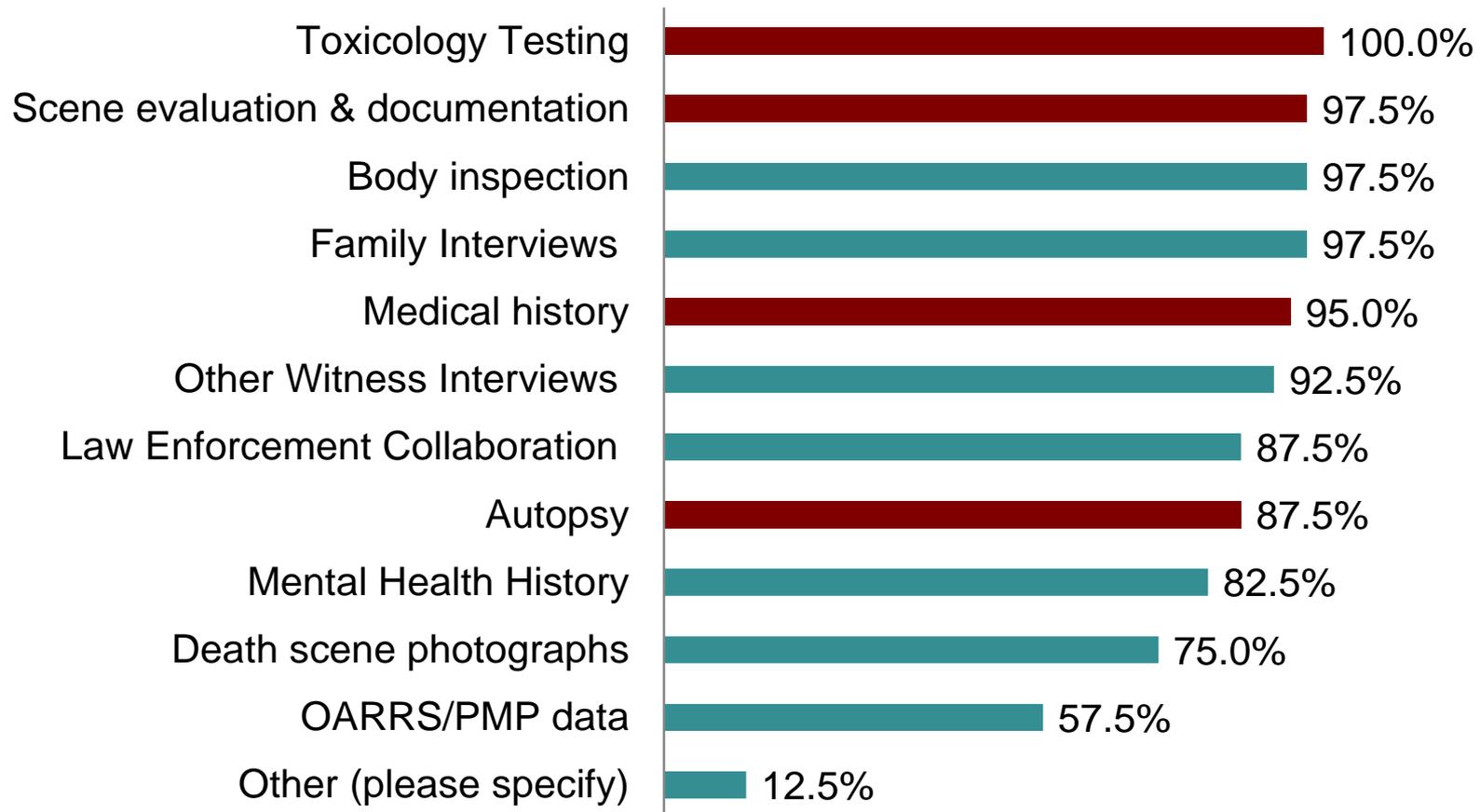
RECOMMENDATION 5.

Interpretation of postmortem opioid concentrations requires correlation with medical history, scene investigation, and autopsy findings.

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

5. Interpretation of postmortem opioid concentrations requires correlation with medical history, scene investigation, and autopsy findings.

What types of information do you use when investigating a suspected overdose death? *Select all that apply.**



5. Interpretation of postmortem opioid concentrations requires correlation with medical history, scene investigation, and autopsy findings.

Ohio Coroner Survey Results:

- For 74% of respondents, a toxicologist/pathologist provides recommendations to determine toxic and lethal drug concentrations based on unique case findings
- 41% also use peer-reviewed journals or texts

RECOMMENDATION 6.

If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

NOTE REGARDING TIMING...

- NAME/ACTM acknowledges that death certificates must be completed as quickly as possible before toxicology results are available;
- Recommends completing the death certificate with **the most detailed information available** about a given death and **amended when pending results return.**

DEATH CERTIFICATE DATA

Four sections of the death certificate apply to research and public health work on opioid-related deaths

- Cause of Death
- Other Significant Conditions Contributing to Death,
- Manner of Death (*Discussed in Recommendation #7*)
- “Describe How Injury Occurred”

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

6. If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

Cause of Death Section

- List generic name of all the chemical agents that pathologist considers responsible for causing death in the autopsy report and on the DC.
- Applies to drugs present in concentrations sufficient to have caused or contributed to death in a given case.
- Avoid vague, nonspecific descriptions such as
 - *mixed drug intoxication*
 - *polypharmacy*

Source: NAME Position Paper: Recommendations for Investigation, Diagnosis and Certification of Deaths related to Opioid Drugs. Academy of Forensic Pathology, 2013 3(1): 77-83.

6. If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

Ohio Coroner Survey Results:

- **58%** list specific substances in Part 1 of DC/EDRS
- **15%** document them elsewhere on DC/EDRS
- **18%** document them in coroner records only
- **35%** use *“multiple drug use”* (corresponds with Ohio overdose data)

*Source: ODH/OSCA, 2013 Ohio Coroner Survey Investigation Practices on Opioid Overdose Deaths

6 If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

Ohio Coroner Survey Results:

Why are Ohio Coroners not reporting the drugs on the DC?

- 33% - unaware of need/importance of listing specific drugs
- 25% - toxicology results are not available when completing DC
- 38% are not able to determine specific drugs involved - lots of reasons
- 33% indicated DC is a legal document and do not feel comfortable assigning responsibility for death to specific drugs when multiple drugs were involved.

6. If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

Other Significant Conditions Contributing to Death, “Part II” Section

- List significant pre-disposing conditions (e.g., obstructive sleep apnea, obesity, heart disease) that might have predisposed person to death but were neither *necessary* nor *sufficient* to cause death alone in this situation.

6. If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

How Injury Occurred Section

Include known information about:

- **History:** hx of chronic pain, hx or evidence of substance abuse, origin of pain (e.g., MV crash, fall, cancer, work-related injury etc.),
- **Route of administration:** Oral, IV injection, snorted, transdermal, etc
- **Drug source:** Rx, illicit street purchase, diverted, etc.
- **Type of drug formulation:** Long acting/extended release, immediate release if known
- **Other key details**

Drugs attributed to fatal overdose should be listed in COD (Part 1).

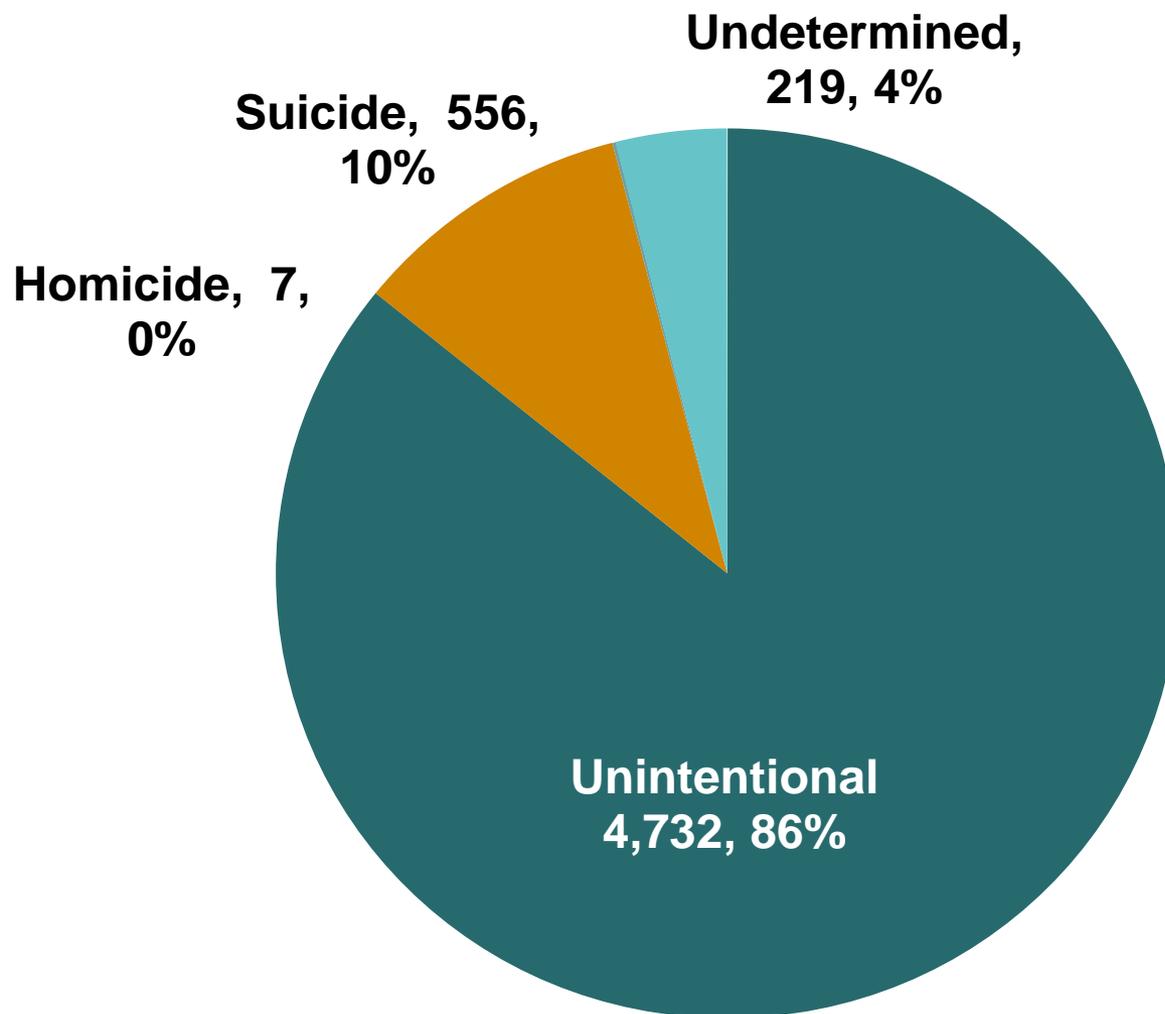
RECOMMENDATION 7.

The best classification for manner in deaths due to the misuse or abuse of opioids without any apparent intent of self-harm is "*accident.*"

Reserve "undetermined" as the manner for the rare cases in which evidence exists to support more than one possible determination.

Reserve "suicide" for those cases where the fatal injury is self-inflicted and indicates intent of self-harm (*intentional drug abuse does not alone qualify*)

DRUG OVERDOSE DEATHS BY MANNER, OHIO, 2009-11



¹Source: ODH Office of Vital Statistics,

SUMMARY RECOMMENDATIONS FOR OHIO CORONERS BASED ON SURVEY RESULTS AND NAME/ACTM PAPER

- **Adhere to NAME/ACMT recommendations** for investigating opioid overdose deaths.
- **Increase use of autopsies** when necessary and possible for suspected overdose deaths.
- Register for and **increase use of OARRS PMP data** to reconcile Rx information with investigative and toxicology findings.
- **Consider use of standardized toxicology panels** in Ohio with labs (commercial and public) to include opioid and benzodiazepine analytes as well as other potent depressant, stimulant and AD medications.
- Increase specificity and details included on the DC/EDRS for public health surveillance to include:
 - Increase specificity of substances listed on the DC/EDRS.
 - Increase specificity of other information about *other contributing conditions* and *how the injury occurred*.

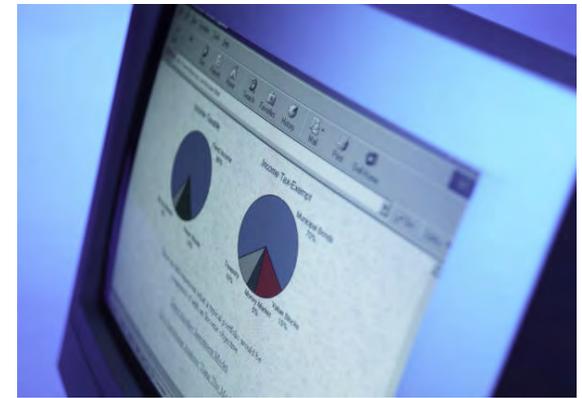


UNSPECIFIED DRUG DEATHS

More on Recommendation #6:

If death is attributed to any drug or combination of drugs (whether as cause or contributing factor), the certifier should list all the responsible substances by generic name in the autopsy report and on the death certificate.

MORE ON RECOMMENDATION #6: IMPORTANCE OF DRUG SPECIFICITY ON DC



As recognized by NAME/ACTM, death certificate data are used every day by public health agencies:

- For national, state and local surveillance efforts
- To rank states according to public health burden and identify priorities for funding.
- To identify state health and injury priorities for attention
- To drive prevention efforts

We appreciate the extra effort to enter the details!

OHIO DEATH RECORDS – FROM DEATH RECORD TO ODH DATA...

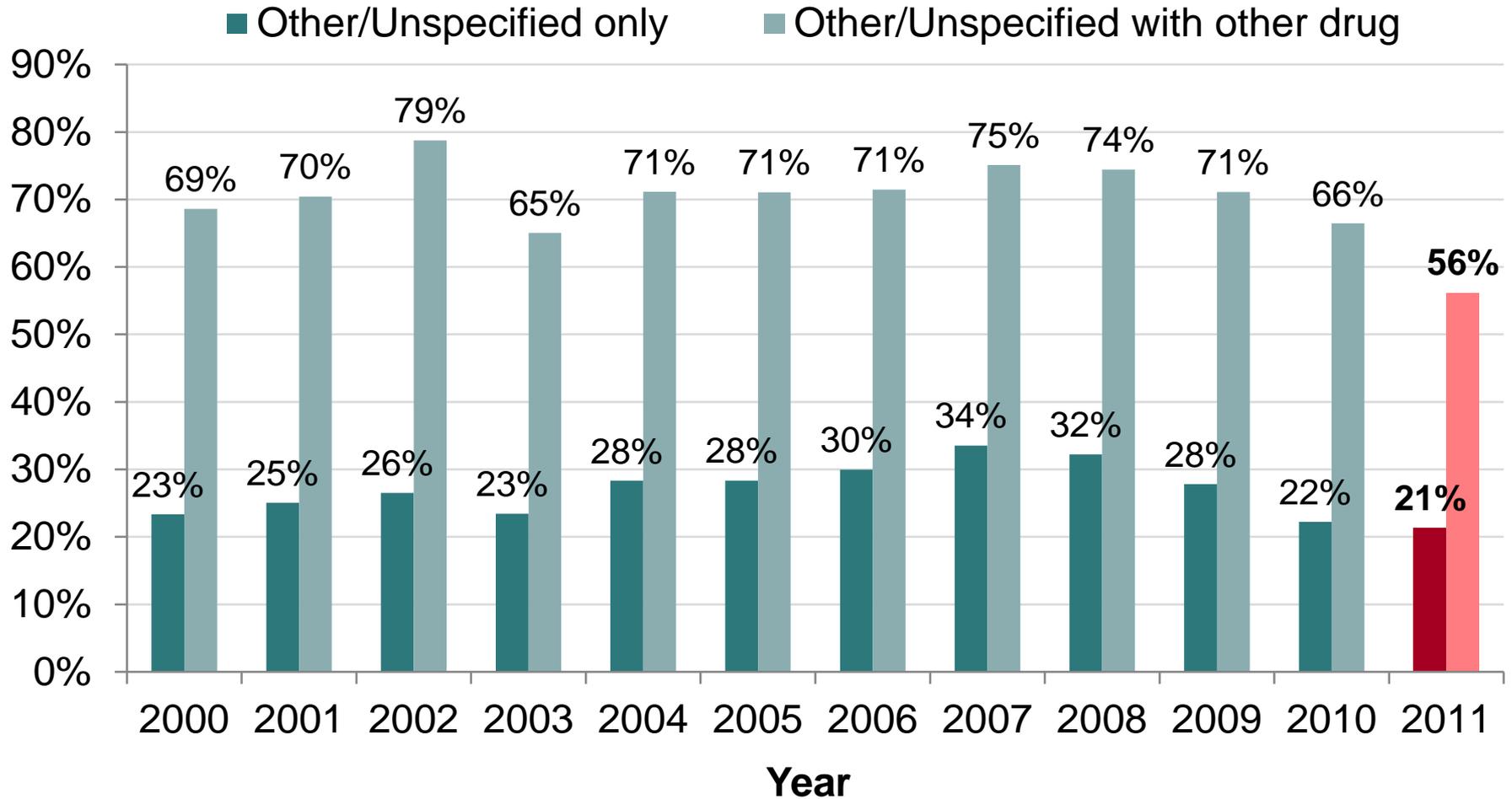
- Signed death certificates are received at ODH, processed and matched with EDRS records.
- EDRS files are batched (electronically) and sent to CDC/National Center for Health Statistics for ICD-10 coding.
- CDC codes the text strings provided in Part 1 COD and underlying factors (i.e., “List conditions leading to COD” section in EDRS).
- ICD-10 coded data are returned to ODH; an analysis file is created and data are used to examine disease/injury.

OHIO DEATH RECORDS – FROM DEATH RECORD TO ODH DATA...

- No ICD-10 code for “multiple drug death”.
- The following are coded to the “*Other/Unspecified*” category:
 - polysubstance intoxication
 - multiple drug intoxication
 - combined drug toxicity
 - acute polysubstance intoxication, etc.
- We cannot assume these deaths involve more than 1 drug; there are “other” drugs that also go into this category.
- Specific drugs involved are unknown so data are under-reporting drugs involved in Ohio OD deaths.
- We have little information about these “other/unspecified” overdoses and request inclusion of as much detail as you have available.

Proportion of unintentional drug overdose deaths where no specific drugs were indicated¹ or unspecified drugs were listed among other drugs², by year, Ohio, 2000-2011³

³Source: Ohio Dept of Health, Office of Vital Statistics



**includes cases where unspecified drugs are involved among at least one other drug

***includes only cases where no specific drug is listed

PROPORTION OF UNINTENTIONAL DRUG OVERDOSES INVOLVING SELECTED DRUGS, OHIO (2011) VS. MONTGOMERY (2011 - 2012)

	2011 Ohio¹ (1,765 deaths)	2011 Montgomery² (130 deaths reviewed)	2012 Montgomery³ (162 deaths reviewed)
Any Opioid	65%	88%	90%
Prescription Opioids	45%	62%	45%
Methadone	9%	33%	12%
Oxycodone	Unk.	19%	15%
Hydrocodone	Unk.	15%	9%
Benzodiazepines	21%	65%	43%
Cocaine	17%	41%	30%
Heroin	24%	35%	59%
Multiple Drugs	71%	82%	66%
Unspecified	21%	0%	0%

Sources: 1. ODH Office of Vital Statistics, 2. Wright State University

OHIO DEATH RECORDS

Entering COD Data into Electronic Death Reporting System (EDRS)

- Enter Drug Information in Part 1 of the Cause of Death Section
- Enter as much detail as possible (for all injury deaths; not just poisonings)

Decedent Cause of Death Disposition Flags

Coroner/Physician

26b. Time of Death (Military Time) Enter Range if approximate? 26c. Pronounced Dead Coroner Case Number Was Coroner Contacted?

14:38 03/18/2011 Y

Cause of Death (cont)

28. Number of Deaths Pending Investigation Pandemic Description

Accident N

28. Cause of Death (Part 1) Enter the chain of events that directly caused death.

a. Immediate Cause (Final disease or condition resulting in Death) Units Cause was due to Pandemic (Y,N,U)?

COMBINED DRUG TOXICITY HOURS

28. List Conditions leading to the Cause on line A.

b. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

c. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

d. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

Cause of Death (Part 2)

Other significant conditions contributing to death. Cause was due to Pandemic (Y,N,U)?

Other Information

29a. Autopsy? 29b. Were autopsy findings available to complete cause of Death? 30. Did tobacco use contribute to death? (Y,N,P,U)

Y Y U

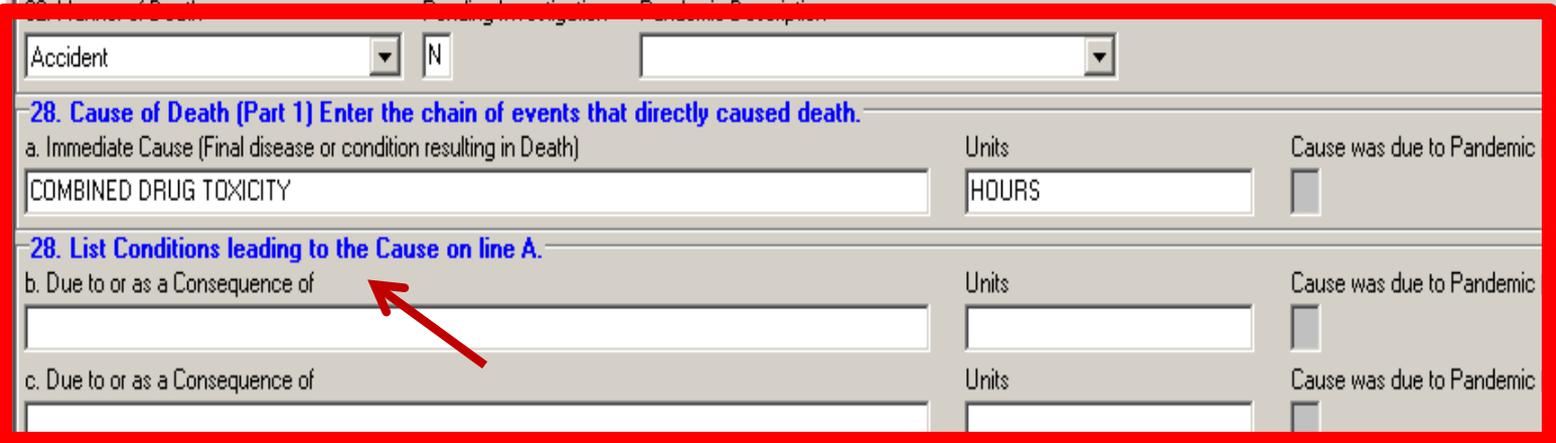
Cause of Death (Part 2)

31. Female Pregnant Status

9. UNKNOWN

Injury Ohio-Department of Health

33a. Date of Injury Enter Range? 33b. Military Time of Injury 33c. Place of Injury



Decedent Cause of Death Disposition Flags

Coroner/Physician

26b. Time of Death (Military Time) Enter Range if approximate? 26c. Pronounced Dead Coroner Case Number Was Coroner Contacted?
 12:55 [] 01/01/2011 [] Y

Cause of Death (cont)

32. Manner of Death Pending Investigation Pandemic Description
 Accident [] N []

28. Cause of Death (Part 1) Enter the chain of events that directly caused death.

a. Immediate Cause (Final disease or condition resulting in Death) Units Cause was due to Pandemic (Y,N,U)?
 ACUTE POLYPHARMACY INTOXICATION UNKNOWN []

28. List Conditions leading to the Cause on line A.

b. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?
 [] [] []

c. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?
 [] [] []

d. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?
 [] [] []

Other Significant Conditions (Part 2)

Other significant conditions contributing to death. Cause was due to Pandemic (Y,N,U)?
 Acute Pneumonia []

Other Information

29a. Autopsy? 29b. Were autopsy findings available to complete cause of Death? 30. Did tobacco use contribute to death? (Y,N,P,U)
 Y Y N

Cause of Death (Part 2)

31. Female Pregnant Status
 8. NOT APPLICABLE []

Injury

Ohio Department of Health
 33a. Date of Injury 33b. Military Time of Injury 33c. Place of Injury
 01/01/2011 [] 00:00 RESIDENCE

Coroner/Physician

26b. Time of Death (Military Time) Enter Range if approximate? 26c. Pronounced Dead Coroner Case Number Was Coroner Contacted?

04:00 APPROXIMATE 11/02/2011 Y

Cause of Death (cont)

32. Manner of Death Pending Investigation Pandemic Description

Accident N



28. Cause of Death (Part 1) Enter the chain of events that directly caused death.

a. Immediate Cause (Final disease or condition resulting in Death) Units Cause was due to Pandemic (Y,N,U)?

INTOXICATION BY THE COMBINED EFFECTS OF ACETAMINOPHEN, AMITRIPTYLINE, DEPHENHY MINUTES

28. List Conditions leading to the Cause on line A.

b. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

OXYMORPHONE, PREGABALIN, VALPORIC ACID, AND ZOLPIDEM MINUTES

c. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

d. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

Cause of Death (Part 2)

Other significant conditions contributing to death. Cause was due to Pandemic (Y,N,U)?

Other Information

29a. Autopsy? 29b. Were autopsy findings available to complete cause of Death? 30. Did tobacco use contribute to death? (Y,N,P,U)

Y N N

Cause of Death (Part 2)

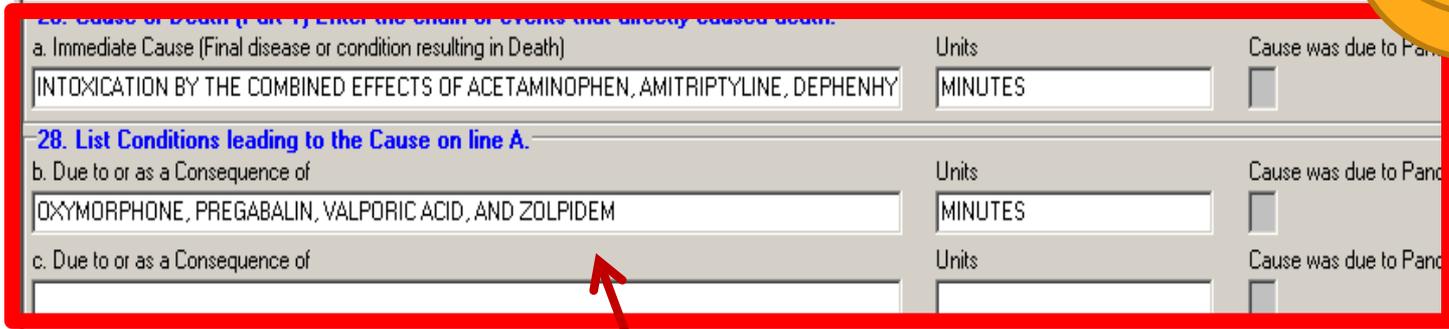
31. Female Pregnant Status

1. NOT PREGNANT WITHIN LAST YEAR.

Injury

33a. Date of Injury Enter Range? 33b. Military Time of Injury 33c. Place of Injury

11/02/2011 EARLY HRS OF A.M. 99:99 AT HOME



Decedent Cause of Death Disposition Flags

Coroner/Physician

26b. Time of Death (Military Time) Enter Range if approximate? 26c. Pronounced Dead Coroner Case Number Was Coroner Contacted?

UNKNOWN 02/23/2011 Y

Cause of Death (cont)

32. Manner of Death Pending Investigation Pandemic Description

28. Cause of Death (Part 1) Enter the chain of events that directly caused death.

a. Immediate Cause (Final disease or condition resulting in Death)

MULTIPLE DRUG TOXICITY MINUTES Cause was due to Pandemic (Y,N,U)?

28. List Conditions leading to the Cause on line A.

b. Due to or as a Consequence of

Alprazolam, Cocaine, Hydrocodone, Hydromorphone MINUTES Cause was due to Pandemic (Y,N,U)?

c. Due to or as a Consequence of

Cause was due to Pandemic (Y,N,U)?

d. Due to or as a Consequence of

Cause was due to Pandemic (Y,N,U)?

Cause of Death (Part 2)

Other significant conditions contributing to death.

Cause was due to Pandemic (Y,N,U)?

Other Information

29a. Autopsy? 29b. Were autopsy findings available to complete cause of Death? 30. Did tobacco use contribute to death? (Y,N,P,U)

Y N N

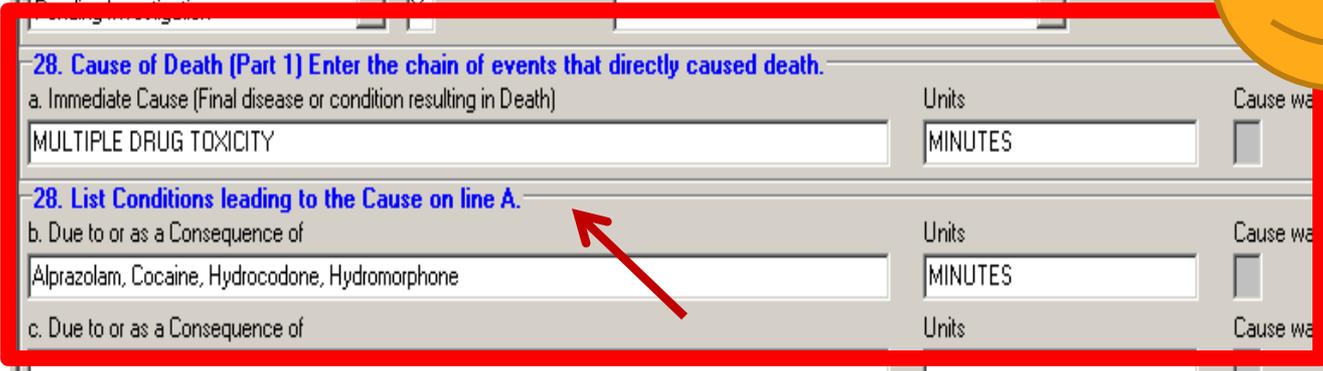
Cause of Death (Part 2)

31. Female Pregnant Status

8. NOT APPLICABLE.

Injury

33a. Date of Injury Enter Range? 33b. Military Time of Injury 33c. Place of Injury



Navigation icons: Home, Back, Forward, Print, Refresh, Stop, Search, and a dropdown menu.

Decedent Cause of Death Disposition Flags

Coroner/Physician

26b. Time of Death (Military Time) Enter Range if approximate? 26c. Pronounced Dead Coroner Case Number Was Coroner Contacted?

13:50 [] 01/04/2011 [] Y

Cause of Death (cont)

32. Manner of Death Pending Investigation Pandemic Description

Accident [N] []

28. Cause of Death (part 1) Enter the chain of events that directly caused death.

a. Immediate Cause (Final disease or condition resulting in Death) Units Cause was due to Pandemic (Y,N,U)?

ACUTE COMBINED METHADONE, COCAINE, OXYCODONE AND DIAZEPAM POISONING MINUTES []

28. List Conditions leading to the Cause on line A.

b. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

[] [] []

c. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

[] [] []

d. Due to or as a Consequence of Units Cause was due to Pandemic (Y,N,U)?

[] [] []

Cause of Death (Part 2)

Other significant conditions contributing to death. Cause was due to Pandemic (Y,N,U)?

[] []

Other Information

29a. Autopsy? 29b. Were autopsy findings available to complete cause of Death? 30. Did tobacco use contribute to death? (Y,N,P,U)

Y Y U

Cause of Death (Part 2)

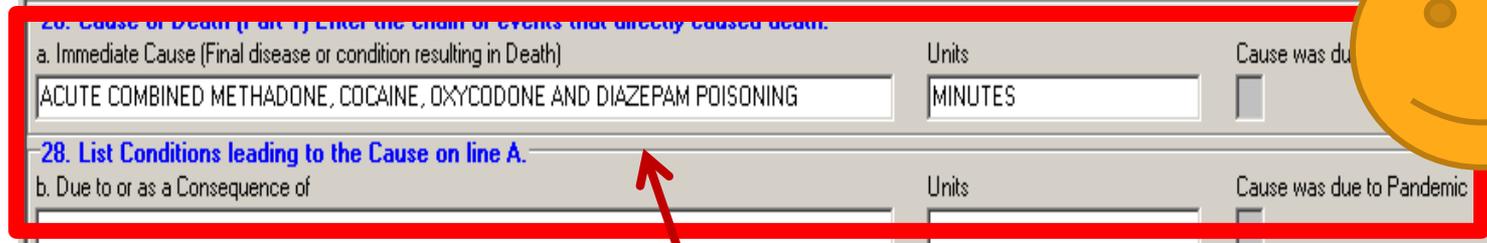
31. Female Pregnant Status

9. UNKNOWN

Injury

Ohio Department of Health

33a. Date of Injury Enter Range? 33b. Military Time of Injury 33c. Place of Injury



STATE RESPONSE TO EPIDEMIC

RESPONSE TO THE EPIDEMIC: PROFESSIONAL EDUCATION WORKGROUP - GCOAT

Co-Chaired by

- **Dr. Ted Wymyslo, Director, ODH**
- **Bonnie Kantor-Burman, Director, Ohio Department of Aging**

Two subcommittees formed:

- **Opioid Prescribing Guidelines for Ohio Emergency/Acute Care Facilities - Lead: Director Wymyslo**
- **Reforming Prescribing Practices in Ohio— Lead: Director Kantor-Burman**

OPIOID PRESCRIBING GUIDELINES FOR E.D.'S & ACUTE CARE FACILITIES

POCKET CARDS



Professional Education
Workgroup

**Ohio Emergency and Acute Care Facility
Opioids and Other Controlled Substances (OOCs)
PRESCRIBING GUIDELINES**

These guidelines are to provide a general approach in the prescribing of OOCs. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.

- OOCs for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.**
 - Doses of OOCs for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
 - Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCs prescription from another provider within the last month.
 - IV Demerol (Meperidine) for acute or chronic pain is discouraged.
- Emergency medical clinicians will not routinely provide:**
 - Replacement prescriptions for OOCs that were lost, destroyed or stolen.
 - Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.
 - Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).
- Prior to making a final determination regarding whether a patient will be provided a prescription for OOCs, the emergency clinician or facility:**
 - Should search the Ohio Automated Rx Reporting System (CARRS) database (<https://www.ohioamp.gov/portal/Default.aspx>) or other prescription monitoring programs, per state rules.
 - Reserves the right to request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care facility should photograph the patient for inclusion in the facility medical record.
 - Reserves the right to perform a urine drug screen or other drug screening.
- Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed.**

- Prior to making a final determination regarding whether a patient will be provided a prescription for an OOCs, the emergency clinician should consider the following options:**
 - Contact the patient's routine provider who usually prescribes their OOCs.
 - Request a consultation from their hospital's palliative or pain service (if available), or an appropriate sub-specialty service.
 - Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.
 - Request medical and prescription records from other hospitals, provider's offices, etc.
 - Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OOCs.
- Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community-care providers.**
- Except in rare circumstances, prescriptions for OOCs should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for re-evaluation.**
- Each patient leaving the emergency/acute care facility with a prescription for OOCs should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and, the appropriate storage and disposal of these medications at home. This information may be included in the Discharge Instructions or another handout.**
- Emergency/acute care facilities should provide a patient handout and/or display signage that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.**

Endorsed by:
Ohio Chapter of the American College of Emergency Physicians,
Ohio Association of Health Plans, Ohio Association of Physician Assistants,
Ohio Bureau of Workers' Compensation, Ohio Hospital Association,
Ohio Osteopathic Association, Ohio Pharmacists Association,
Ohio State Medical Association

Development Facilitated by:
Ohio Department of Health, Ohio Department of Aging

6/2012

Distributed in partnership with the Ohio Hospital Association and the Ohio Chapter, American College of Emergency Physicians, and upon request.

www.healthyohioprogram.org/ed/guidelines.aspx

SOME OF THE OHIO HOSPITALS ADOPTING THE ED GUIDELINES



www.healthyohioprogram.org/ed/guidelines.aspx

REFORMING PRESCRIBING PRACTICES COMMITTEE

- **Working on guidelines for prescribing opioids for the treatment of chronic, non-terminal pain**
- **80 mg morphine equivalent daily (MED) dose will be the maximum “trigger point” at which point the prescriber should “press pause” and conduct additional actions:**
 - Reestablish informed consent
 - Review patients functional status
 - Review progress toward treatment objectives
 - Re-check OARRS
 - Consider a patient pain agreement
 - Consider referral to a pain or other appropriate specialist
- **OARRS data will be used to determine MEDs and to address prescribers who are not following the guidelines.**



**OHIO INJURY PREVENTION
PARTNERSHIP**

Prescription Drug Abuse Action Group

STATE-LEVEL ACTIVITIES

PRESCRIPTION DRUG ABUSE ACTION GROUP (PDAAG)

Convened by the:

- **ODH, VIPP**
- **Ohio Department of Alcohol and Drug Addiction Services (ODADAS)**

Meets quarterly in conjunction with Ohio Injury Prevention Partnership Meetings

<http://www.healthyohioprogram.org/vipp/oipp/oipp.aspx>



OHIO INJURY PREVENTION
PARTNERSHIP

Prescription Drug Abuse Action Group

PRESCRIPTION DRUG ABUSE ACTION GROUP (PDAAG)

Subcommittees

- **Public Education** - Promote permanent drug disposal sites
- **Professional Education** - Encourage the use of SBIRT
- **Regulatory**
 - Recommend SBIRT Reimbursement through Medicaid - 15 other state Medicaid programs have activated SBIRT billing codes .
 - Address legal and regulatory barriers for implementation of Naloxone Distribution Programs (NDPs).
 - Obtain NDP-supportive policy statements from the medical, pharmacy and nursing boards.
 - Consider rules allowing all EMTs to dispense and administer naloxone.

ODH ACTIVITIES

Naloxone Distribution Programs

- In response to the growing fatal opioid overdoses, communities have implemented Naloxone Distribution Programs (NDPs).
- NDPs provide overdose training and take-home doses of naloxone to those who are deemed high-risk for an overdose.
- Programs have been established in 3 counties to date (Scioto, Hamilton and Cuyahoga) with additional counties (Montgomery) expressing interest.

Contact Christy.beeghly@odh.ohio.gov for more information

or visit:

<http://www.healthyohioprogram.org/vipp/drug/ProjectDAWN.aspx>

ACTIVITIES OF ODH VIPP

Pursuing Alternative and Sustainable Drug Disposal Options

- Ohio Prescription Drug Drop Box Program
- Collaboration among:
 - Ohio Attorney General's Office
 - Drug Free Action Alliance
 - ODH Violence and Injury Prevention Program
 - National Association of Drug Diversion Investigators
- In October 2012, this pilot project provided 66 community drug drop boxes to Ohio law enforcement agencies in high risk counties to encourage the disposal and destruction of unused medications.



ACTIVITIES OF ODH

Examine statewide data and produce materials to raise awareness about this issue:

- **Web page:**
<http://www.healthyohioprogram.org/vipp/drug/dpoison.aspx>
- Presentations
- Report
- Fact Sheet
- State and County level data

CONTACT ODH

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