Legislative Analysis

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OVERDOSE FATALITY REVIEW TEAMS

Senate Bill 133 (S-1) as passed by the Senate
Sponsor: Sen. Sean McCann
House Committee: Health Policy
Senate Committee: Health Policy
Complete to 11-2-23

SUMMARY:

Senate Bill 133 would create a new act, the Overdose Fatality Review Act, which would allow a county, or a group of counties,[1] to establish an overdose fatality review team to do all of the following with the goal of reducing or preventing drug overdoses and drug overdose fatalities:

- Conduct ***individual overdose reviews*** and overdose fatality reviews.[2]
- Identify the incidence and potential causes of drug overdose fatalities in the county.
- Promote cooperation and coordination among agencies involved in investigating drug overdose fatalities.
- Recommend and plan for changes in agencies represented on the review team.
- Propose potential changes to law, policy, funding, or practices.
- In consultation with the Department of Health and Human Services (DHHS), implement procedures to do all of the following:
    - Recruit any of the following individuals (or, as appropriate, their designees) to participate in ***individual overdose reviews*** and ***community overdose reviews***:
        - A prepaid inpatient health plan chief executive officer or the prepaid inpatient health plan substance use disorder director.
        - The superintendent of a school in the county.
        - A representative of a hospital in the county.
        - A health care provider specializing in emergency medicine.
        - A health care provider specializing in pain management.
        - A pharmacist with expertise in addressing drug misuse and diversion.
        - A representative of a poison control center.
        - A mental health provider (i.e., a psychologist, a licensed professional counselor, a marriage and family therapist, or a licensed bachelor's or master's social worker).
        - A prescription drug monitoring program administrator.
        - A representative of a harm reduction provider.
        - A recovery coach, peer support worker, or other representative of the recovery community.
        - A representative of a drug court in the county.
        - A substance use disorder prevention specialist or representative.

[1] Tribes are also implicitly authorized to establish an *overdose fatality review team* by their inclusion in the definition of that term, but they are not explicitly authorized in the bill's substantive provisions.

[2] These are not explicit duties of an overdose fatality review team, but duties the team is implicitly charged with by their inclusion in the bill's definition of the term *overdose fatality review team*. Note that the phrase "overdose fatality review," used here, is not itself defined or used elsewhere in the bill except in the name of the teams. It is thus unclear whether, or how, an overdose fatality review would differ from an individual overdose review.

        - The director of the DHHS office in the county.
        - Any other individual necessary for the team to complete its duties.
    - Plan and facilitate meetings.
    - Collect, maintain, analyze, and interpret data on drug overdose fatalities in the county.
    - Build a recommendation plan.
- Recommend prevention and intervention strategies to improve the coordination of services and investigations among agencies represented on the review team, focusing on evidence-based strategies and promising practices.

Individual overdose review would mean the case review of an individual who has died as the result of a drug overdose, including at least a review of both of the following:

- Consideration of the individual's points of contact, if any, with health care systems, social services, educational institutions, child and family services, the criminal justice system (including law enforcement), and any other system.
- Identification of the specific factors and social determinants of health that put the individual at risk of a drug overdose.

Community overdose review would mean performing a series of individual overdose reviews to identify systematic barriers to innovative overdose prevention and intervention strategies for that community.

Members

Any of the following (or, as appropriate, their designee) could be a member of an overdose fatality review team:

- The county health officer.
- The prosecuting attorney.
- The director of the community mental health agency.
- The county medical examiner.
- A law enforcement officer of the Department of State Police, of the county or counties, or of a municipality in the county or counties.
- A representative of a jail or detention center in the county.
- A health care provider specializing in the prevention, diagnosis, and treatment of substance use disorders.
- A mental health provider specializing in the treatment of substance use disorders.
- A substance use disorder treatment provider.
- A representative of an emergency medical services provider in the county.
- A representative of the Department of Corrections with experience with parole, probation, or community corrections.
- An epidemiologist from a local health department or an organization in the county.
- A Child Protective Services caseworker.
- A representative of DHHS who is involved with Adult Protective Services issues.
- A representative of a hospital with a service area in the county.
- Any other individual necessary for the team to complete its duties.

Meetings

Meetings of an overdose fatality review team could be conducted remotely through a secure platform. At its first meeting, the team would have to elect a member as chairperson and any other officers it considers appropriate. The chairperson would have to do all of the following for the team:

- Call meetings and implement team procedures.
- If a vacancy occurs, appoint another member from an equivalent position or discipline.
- Oversee the signing of confidentiality forms as described below.
- Solicit and recruit additional individuals to participate in individual overdose reviews and community overdose reviews.
- Request and collect information needed to conduct individual overdose reviews and community overdose reviews.
- Make written requests for information necessary to carry out the duties of the team.

Confidentiality

Except as otherwise expressly prohibited by federal or state law, team members and individuals invited to participate in overdose reviews could discuss confidential matters and share confidential information, as outlined in data sharing agreements, during an overdose fatality review team meeting. However, the bill would not authorize the disclosure of that confidential information outside of the meeting. In addition, an individual who has not signed a confidentiality form could not participate in or observe an overdose fatality review team meeting or an individual or community overdose review. A confidentiality form would have to summarize the purpose and goal of the meeting or review, the requirements for maintaining the confidentiality of any information disclosed during the meeting, and any consequences for the failure to maintain confidentiality.

Except for information in the annual report described below, information obtained or created by or for an overdose fatality review team would confidential and not subject to discovery, subpoena, or the Freedom of Information Act (FOIA). The fact that documents and records otherwise available from other sources were presented to or reviewed by an overdose fatality review team would not in itself exempt those documents and records from discovery, subpoena, or introduction into evidence from those other sources. An overdose fatality review team would have comply with federal and state laws pertaining to confidentiality and the disclosure of substance use disorder treatment records, including 42 USC 290dd-2[3] and 42 CFR part 2.[4] If an overdose fatality review team member knowingly discloses confidential information in violation of this act, a person aggrieved by that violation may bring a civil action for damages and any costs and reasonable attorney fees allowed by the court.

Information

Except as otherwise expressly prohibited by federal or state law, a health care provider, substance use disorder treatment provider, hospital, or health system would have to provide the chairperson with information and relevant records regarding the physical health, mental health, or treatment for substance use disorder of an individual who is the subject of an individual

[3] https://www.law.cornell.edu/uscode/text/42/290dd-2
[4] https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

overdose review of the overdose fatality review team within 30 business days after the written request of the chairperson for the information.

Except as otherwise expressly prohibited by federal or state law, a person shall provide the chairperson with the following within five business days after receiving the written request of the chairperson:

- The following information or records regarding an individual who is the subject of an individual overdose review:
  - Death investigative information.
  - Medical examiner investigative information.
  - Law enforcement investigative information.
  - Emergency medical services reports.
  - Fire department records.
  - Prosecuting attorney records.
  - Parole and probation information and records.
  - Court records.
  - School records.
  - Information and records regarding resources provided by a social services agency.
- Information and records regarding resources provided by a social services agency to a family member of an individual who is the subject of an individual overdose review.

A health care provider or other person that provides the chairperson records or information under the above provisions could charge the overdose fatality review team a fee in the same manner as a public body may charge a fee under section 4 of FOIA.[5]

In addition, if a family member or friend of an individual who is the subject of an individual overdose review requests to submit information to an overdose fatality review team, a member of that team could contact, interview, or obtain the information about the individual from that family member or friend.

Annual report

The overdose fatality review team would have to submit an annual report to the public, the applicable local health department, and DHHS that does not contain any identifying information and includes all of the following:

- The total number of drug overdose fatalities that occurred in the participating county.
- The number of individual overdose reviews conducted by the overdose fatality review team.
- Any recommendations.

FISCAL IMPACT:

Senate Bill 133 would not have a significant fiscal impact on state expenditures to the Department of Health and Human Services. The bill would increase costs for local units of government that choose to create an overdose fatality review team by an indeterminate amount. According to DHHS, the estimated cost to counties to create an overdose fatality review team

[5] See http://legislature.mi.gov/doc.aspx?mcl-15-234

is between $13,500 and $19,500 per year. These estimates are largely dependent on staffing availability and support, which varies by county.

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.