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BILL ANALYSIS

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Senate Bill 133 (as introduced 3-2-23)
Sponsor: Senator Sean McCann
Committee: Health Policy

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INTRODUCTION

The bill would create the "Overdose Fatality Review Act", which would allow a county or counties to establish an overdose fatality review team. A team could consist of specified individuals, including county officials and individuals in law enforcement and from public health backgrounds. Among other things, a team would be responsible for identifying potential causes of drug overdose in its jurisdiction and recommending law or policy changes for the prevention of those causes. A team could accomplish this by collecting information needed to conduct individual and community overdose reviews and supporting partnerships with the community. The bill generally would require information that a team used to remain confidential. Finally, the bill would require a team to submit an annual report to the Department of Health and Human Services (DHHS), and the DHHS would have to compile that information into an annual report to the Legislature and Governor.

FISCAL IMPACT

The bill would have a minor negative fiscal impact on the DHHS and an indeterminate fiscal impact on local units of government. The requirement that the DHHS compile and submit an annual report to the Legislature would result in a minor increase in administrative costs.

The fiscal impact on a county would depend on if the county chose to implement an overdose fatality review team. If a county chose not to do so, there would be no fiscal impact. However, a county that implemented an overdose fatality review team would face increased costs resulting from administrative support to the review team, fees consistent with Section 4 of the Freedom of Information Act (FOIA) for access to records or information to support the work of the review team, and any approved reimbursement for review team member activities. The magnitude of these costs would depend on the number of community and individual overdose reviews undertaken by the overdose fatality review team, as well as the specific charges for access to records or information. The Department estimates that the cost to a county to implement an overdose fatality review team would range from $13,500 to $19,500, with yearly costs decreasing after the review team was established.

PREVIOUS LEGISLATION

(Please note: This section does not provide a comprehensive account of all previous legislative efforts on the relevant subject matter.)

The bill is a reintroduction of Senate Bill 1080 from the 2021-2022 Legislative Session.

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CONTENT

The bill would enact the "Overdose Fatality Review Act" to do the following:

- **-- Allow a county or multiple counties to establish an overdose fatality review team and prescribe its membership.**
- **-- Identify and prescribe the individuals that could be invited to participate in an individual overdose review or community overdose review.**
- **-- Prescribe the duties and responsibilities of an overdose fatality review team, including identifying potential causes and incidence of drug overdose fatalities and proposing potential changes to law, policy, or funding for prevention.**
- **-- Require an overdose fatality review team to submit an annual report to the public, the local health department of the participating county, and the DHHS.**
- **-- Prescribe certain confidentiality requirements for members of an overdose fatality review team.**
- **-- Require the DHHS to submit to the Governor and the Legislature an annual report that aggregated the information provided by overdose fatality review teams in their annual reports.**

Definitions

"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.

"County health officer" would mean a local health officer as that term is defined in Section 1105 of the Public Health Code: the individual in charge of a local health department or his or her authorized representative.

"Data sharing agreement" would mean an agreement that identifies the data that are shared and how the data are used.

"Drug" means that term as defined in Section 7105 of the Public Health Code: a substance recognized as a drug in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the US, or official national formulary, or any supplement to any of them; a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings or animals; a substance other than food intended to affect the structure or any function of the body of human beings or animals; or, a substance intended for use as a component of any article specified in this subsection. The term does not include a device or its components, parts, or accessories.

"Drug overdose" would mean that term as defined in Section 7403 of the Code: a condition including extreme physical illness, decreased level of consciousness, respiratory depression, coma, mania, or death, that is the result of consumption or use of a controlled substance or a controlled substance analogue or a substance with which the controlled substance or controlled substance analogue was combined, or that a layperson would reasonably believe to be a drug overdose that requires medical assistance.

"Identifying information" would mean any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means.

"Individual overdose review" would mean the case review of an individual who has died as the result of a drug overdose, including 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.

"Mental health provider" would mean any of the following individuals:

-- A psychologist.
-- A licensed professional counselor.
-- A marriage and family therapist.
-- A licensed bachelor's social worker.
-- A licensed master's social worker.

"Multidisciplinary team" would mean a group of professionals from a variety of fields of study or sectors who work together toward a shared purpose.

"Participating county" would mean a county that, by itself or with one or more other counties, establishes an overdose fatality review team.

"Recovery coach" would mean a professional who provides assistance to support long-term recovery from a substance use disorder.

"Substance use disorder" would mean a pattern of using alcohol or other drugs that leads to clinical or functional impairment.

"Substance use disorder treatment provider" would mean an individual or entity that is licensed in the State to treat an individual with substance use disorder using medications that are approved by the US Food and Drug Administration to treat substance use disorder.

Overdose Fatality Review Team

The bill would allow a county to establish an overdose fatality review team. Two or more counties could establish a single overdose fatality review team for those counties.

Any of the following individuals could be a member of an overdose fatality review team:

-- The following officials of the participating county: a) the county health officer, b) the prosecuting attorney, or the attorney's designee, c) the director of the community mental health agency, or the director's designee, or d) the county medical examiner, or the medical examiner's designee.
-- A law enforcement officer of the Department of State Police, the participating county, or a municipality within the participating county.
-- A representative of a jail or detention center in the participating county.
-- A health care provider who specialized in the prevention, diagnosis, and treatment of substance use disorders.
-- A mental health provider who specialized in the treatment of substance use disorders.
-- A substance use disorder treatment provider.
-- A representative of an emergency medical services provider in the participating county.
-- A representative from the Department of Corrections who had experience with parole, probation, or community corrections.

-- An epidemiologist from a local health department or an organization in the participating County.
-- A child protective services caseworker.
-- A representative from the DHHS who was involved with issues regarding adult protective services.
-- Any other individual whose membership was necessary for the overdose fatality review team to complete duties required under the bill.

At the first meeting of the overdose fatality review team, it would have to elect a member as a chairperson and could elect other officers that it considered necessary or appropriate.

The chairperson would have to do all the following for the overdose fatality review team:

-- Solicit and recruit additional individuals listed below to participate in individual overdose reviews and community overdose reviews.
-- Call the meetings and implement the protocols and procedures.
-- Oversee that confidentiality forms were signed as needed.
-- Request and collect the information needed to conduct individual overdose reviews and community overdose reviews.
-- If a vacancy occurred, appoint an individual from the same or equivalent position or discipline.
-- Make written requests for information that were necessary to carry out the duties of the overdose fatality review team.

Any of the following individuals could be invited to participate in an individual overdose review or community overdose review:

-- A prepaid inpatient health plan chief executive officer or the officer's designee, or the prepaid inpatient health plan substance use disorder director.
-- A superintendent of a school in the participating county, or his or her designee.
-- A representative of a hospital in the participating county.
-- A health care provider who specialized in emergency medicine.
-- A health care provider who specialized in pain management.
-- A pharmacist who had expertise in addressing prescription drug misuse and diversion.
-- A representative from a poison control center.
-- A mental health provider.
-- A prescription drug monitoring program administrator.
-- A representative from a harm reduction provider.
-- A recovery coach, peer support worker, or other representative of the recovery community.
-- A representative from a drug court in the participating county.
-- A substance use disorder prevention specialist or representative.
-- The director of the DHHS office in the participating county, or his or her designee.
-- Any other individual necessary to complete the duties of the overdose fatality review team.

Responsibilities

The bill would require an overdose fatality review team to do all the following:

-- Promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities.
-- Identify potential causes and incidence of drug overdose fatalities in the participating county.

-- Recommend and plan for changes within the agencies represented on the overdose fatality review team to prevent drug overdose fatalities.
-- Propose potential changes to law, policy, funding, or practices to prevent drug overdoses.
-- Recommend prevention and intervention strategies, focusing on evidence-based strategies and promising practices, to improve the coordination of services and investigations among agencies represented by members of the overdose fatality review team to reduce drug overdose fatalities.

Also, an overdose fatality review team would have to establish and implement, in consultation with the DHHS, protocols and procedures to do all the following:

-- Recruit individuals to participate in individual overdose reviews and community overdose reviews.
-- Plan and facilitate meetings.
-- Collect, analyze, interpret, and maintain data on drug overdose fatalities in the participating county.
-- Build a recommendation plan.

Meetings of an overdose fatality review team could be conducted remotely through a secure platform.

An overdose fatality review team would have to submit an annual report to the public, the local health department of the participating county, and the DHHS that contained all the following information:

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

The report could not contain identifying information.

Confidentiality

Under the bill, except as otherwise expressly prohibited by Federal or State law, overdose fatality review team members and individuals invited to participate in an individual overdose review or community overdose review could discuss confidential matters and share confidential information, as outlined in data sharing agreements, during an overdose fatality review team meeting. The bill would not authorize the disclosure of confidential information described above outside of the meeting.

If an individual had not signed a confidentiality form, he or she could not participate in or observe an overdose fatality review team meeting, individual overdose review, 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 as otherwise expressly prohibited by Federal or State law, on written request of the chairperson, a health care provider, substance use disorder treatment provider, hospital, or health system would have to provide, within five business days after receiving the request, the chairperson information and records regarding the physical health, mental health, or treatment for substance use disorder of an individual who was the subject of an individual overdose review of the overdose fatality review team.

Except as otherwise expressly prohibited by Federal or State law, on written request of the chairperson, a person would have to provide, within five business days after receiving the request, the chairperson the information and records regarding resources provided by a social services agency to a family member of the individual who is the subject of an individual overdose review and the following information or records regarding the 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.

A person that provided the chairperson records or information described above could charge the overdose fatality review team a fee in the same manner as a public body may charge a fee under FOIA.

If a family member or friend of the individual who was the subject of an individual overdose review submits a request 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.

Except as otherwise provided, information obtained or created by or for an overdose fatality review team would be confidential and would not be subject to discovery or FOIA. Documents created by or for the overdose fatality review team would not be subject to subpoena, except that documents and records otherwise available from other sources would not be exempt from subpoena, discovery, or introduction into evidence from other sources solely because they were presented to or reviewed by an overdose fatality review team.

An overdose fatality review team would have to comply with Federal and State laws pertaining to confidentiality and to the disclosure of substance use disorder treatment records, including 42 USC 290dd-2 and 42 CFR part 2 (both of which generally pertain to the confidentiality of records related to substance use disorder patients).

If an overdose fatality review team member knowingly disclosed confidential information in violation of the bill, a person aggrieved by that violation could bring a civil action for damages and any costs and reasonable attorney fees allowed by the court.

Department Annual Report

The bill would require the DHHS to submit an annual report to the Governor and to the Senate and House of Representatives committees responsible for issues concerning health or human services that aggregated the information provided by overdose fatality review teams in their annual reports.

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