STARK COUNTY HEALTH DEPARTMENT

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

Overdose Fatality Review (OFR) Stark County 2022: Annual Report

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OFR Stark County 2022 Annual Report

OVERVIEW

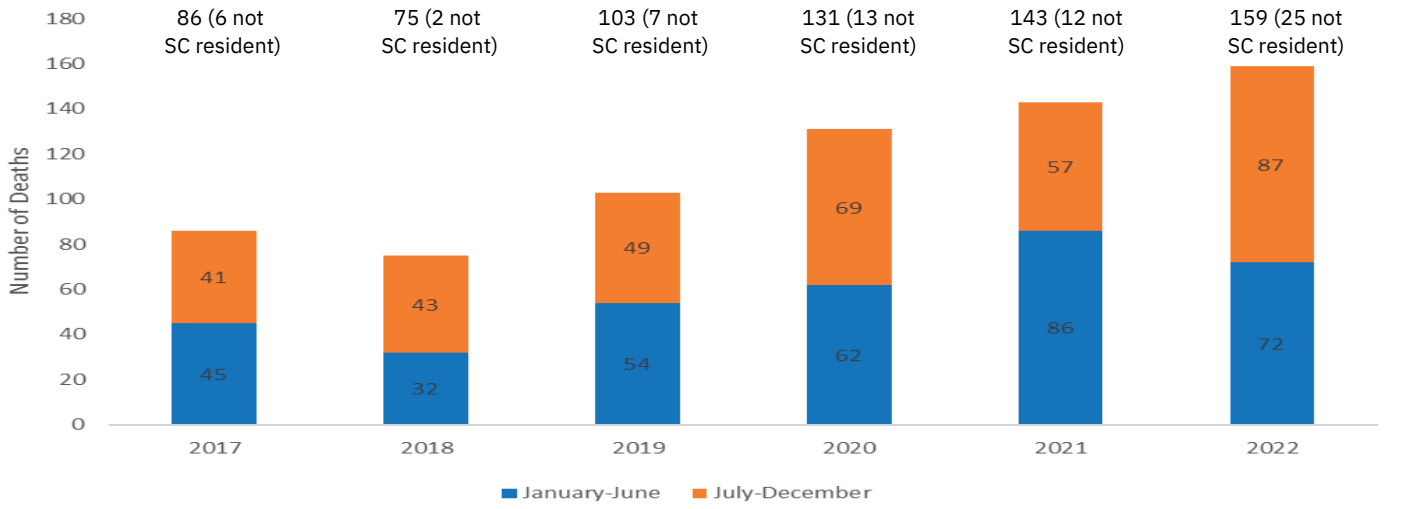
In 2022, the Overdose Fatality Review (OFR) committee met quarterly and reviewed data regarding unintentional overdose deaths that occurred in Stark County. Data was collected from coroner's reports, death certificates, Stark Criminal Justice Information Systems, Emergency Medical Services/Law Enforcement run reports, treatment information, and the Ohio Department of Health Secure Mortality Warehouse. There were 159 overdose deaths within Stark County in 2022 (25 were not Stark County residents). Stark County continues to see a rise in overdose deaths (Figure 1).

The committee is comprised of members from public health, mental health, addiction services, the coroner's office, physicians, hospitals, law enforcement, and StarkMHAR. The guiding principles of the OFR committee are:

- 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 to inform response strategies
- Continually improve the OFR process and prevention activities

Figure 1: Stark County 6 Year Comparison of Overdose Deaths

*Data from Ohio Department of Health Secure Mortality Warehouse



DRUG OVERDOSE PREVENTION (DR23) GRANT

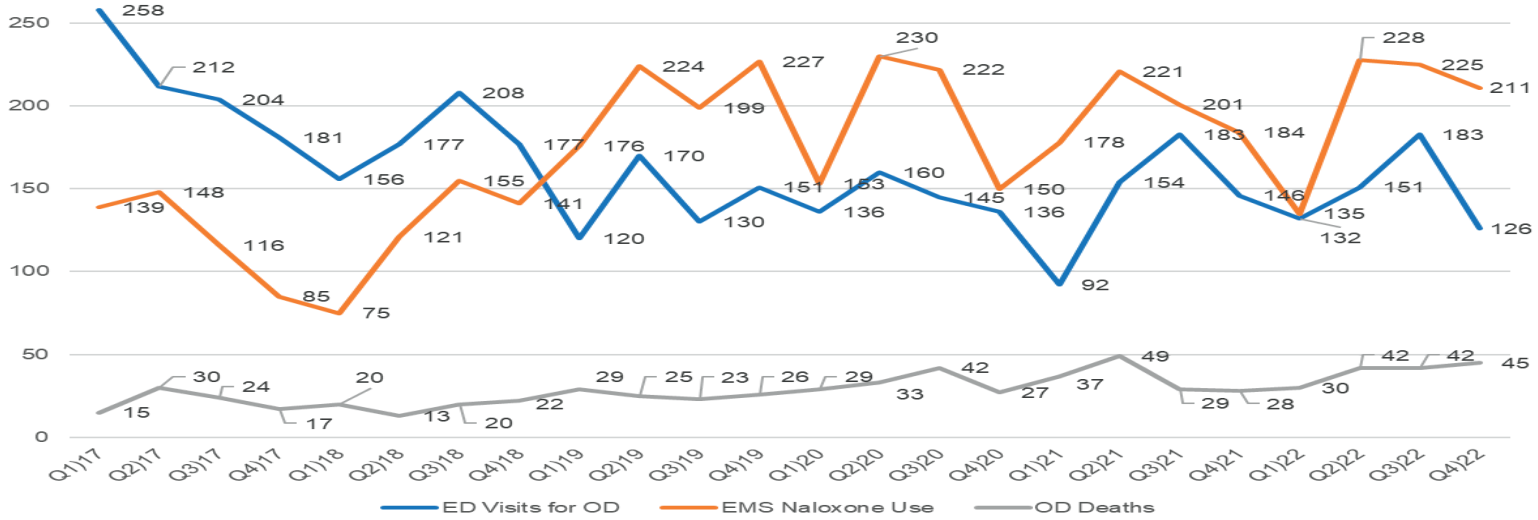
The DR23 grant began in September 2022. This grant was awarded to the Stark County Health Department (SCHD) from the Ohio Department of Health (ODH) in 2017. The main strategies of the grant are:

1. Participation in the Stark County Opiate and Addiction Task Force
2. Data and Information Gathering
3. Implementation of an Awareness Campaign

The grant helped to fund an awareness campaign. The ad to the right is an example of the education provided to the community which focuses on counterfeit pills and was designed for middle, high school, and college students. SCHD also utilized the OHAgainstOD campaign for targeted social media ads which provided education on the dangers of fentanyl. This grant will continue until August 31, 2023.

TRACKING NON-FATAL OVERDOSES

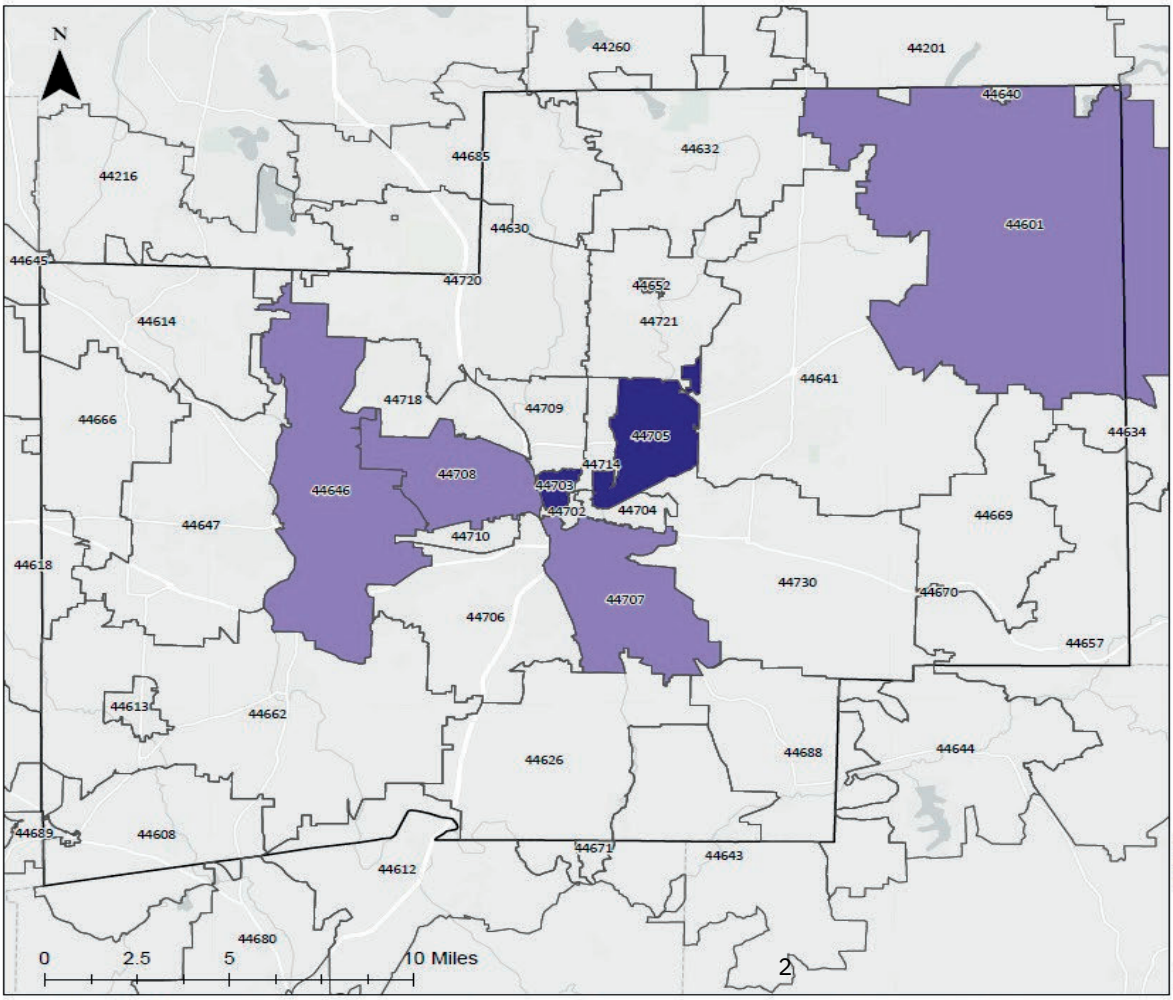
Figure 2 : Stark County Fatal vs. Non-Fatal Overdoses



Tracking non-fatal opioid overdoses has continued to be a focus of the OFR team. The data in Figure 2 was collected from the Stark County Coroner's Office, EMS Incident Reporting System, and Ohio's EpiCenter. This data provides a comparison of overdose deaths, EMS administration of naloxone, and emergency department visits. SCHD monitors EpiCenter emergency department visits on a weekly basis and these reports can be found using the link below. http://www.starkcountyohio.gov/public-health/nursing-services/overdose-prevention.

OD DEATHS BY ZIP CODE

Figure 3 : Bivariant map by Zip Code

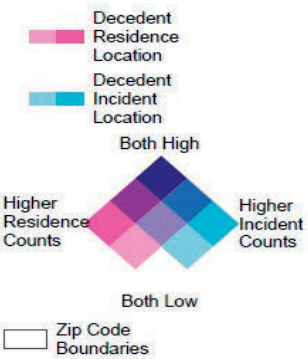


January - December 2022 Overdose Decedent Counts

This map uses a bivariate color scheme to represent the drug overdose deaths in Stark County from January to December 2022 by the decedents' residence and incident locations, mapped by zip code.

A bivariate color scheme displays two variables by using a grid of colors. For this map, the lighter colors mean fewer counts and darker colors mean more counts. Pink colors mean higher residence location counts, blue colors mean higher incident location counts, and purple colors mean a similar amount of both variables.

Areas shown with no color have less than 10 counts and have been suppressed for confidentiality.



Created 04/21/2023 | Projection: NAD 1983 (ft.) StatePlane Ohio North | Credits: Stark County Health Department, Ohio Department of Health

STARK COUNTY DEMOGRAPHICS

Of the overdose deaths that occurred in Stark County, the majority continue to be non-Hispanic white males. The age group with the highest rate in previous years has been 25-34. However, in 2019, this age group shifted to 35-44 and this continues to be the case for 2022. There continues to be an increase in the 55 and over age group when compared to previous years (see Figure 4). The county has seen an increase in non- Stark County residents who died within the county from an overdose.

Another area discussed and tracked is race/ethnicity data. Figure 5 shows the death rate by race. The highest percentage of deaths fall into the white category (85%). When looking at rate per 100,000 population, the black rates are significantly high. While the rates have increased since 2018, we did see a rate decrease in 2022. There were two decedents in 2022 whose race/ethnicity was in the other category.

The SCHD and partners continue to implement data-driven overdose prevention strategies.

Figure 4: Stark County Death Rate by Age Group

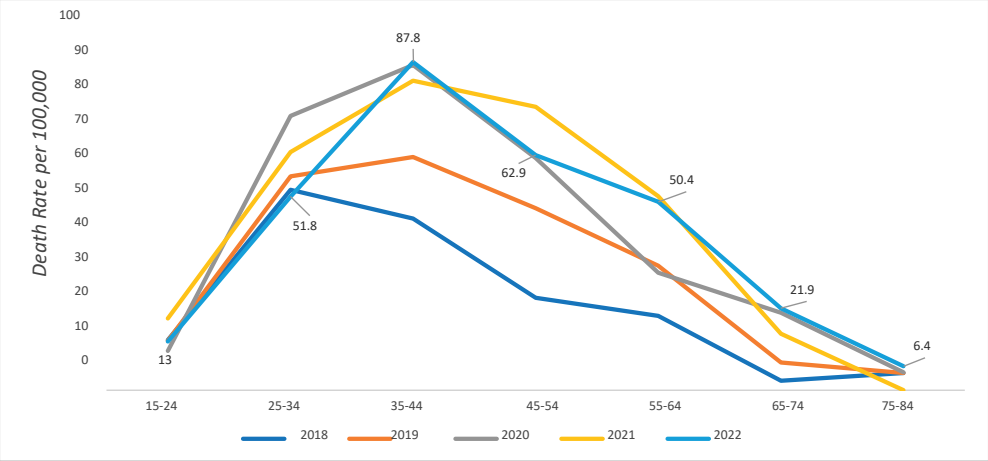
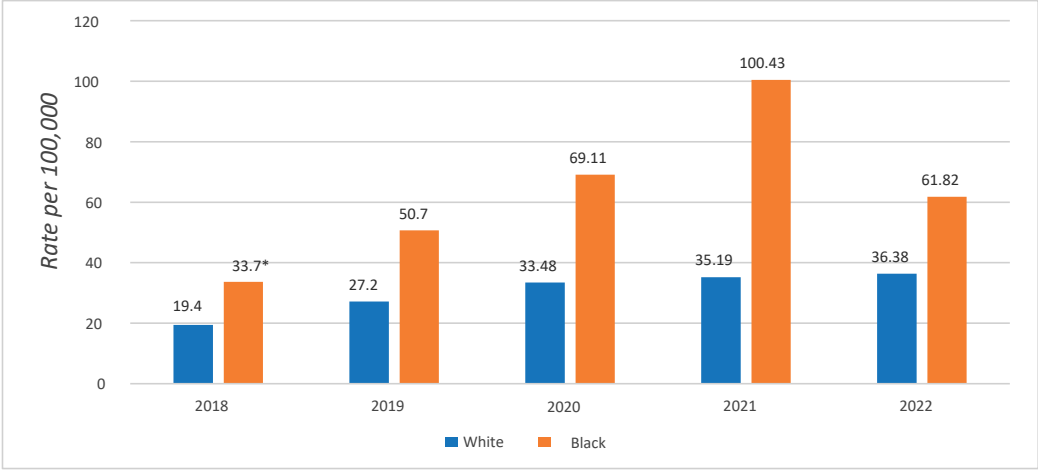


Figure 5: Stark County Death Rate by Race per 100,000



*2022 Rates calculated only include decedents that were Stark County residents
- Prior to 2022 rates based on total count and included non-Stark residents

*Rates with a numerator less than 10 may be unstable

COUNTYWIDE COLLABORATION

StarkMHAR, SCHD, Canton City Public Health, Massillon City Health Department, and Alliance City Health Department partnered to install NaloxBoxes around the county. These boxes, filled with naloxone (also known as Narcan), are an effort to decrease fatal overdoses. Naloxone is a medication that can reverse the effects of an opiate overdose. The boxes provide access to this life saving medication.

The boxes are placed in local restaurants, homeless shelters, hotels, and other high-traffic areas. Modeled after AED defibrillators, each NaloxBox contains two doses of Naloxone and directions how to deliver the opioid-reversal drug through a nasal spray. Figure 6 shows a picture of a NaloxBox. In addition, a NaloxBox locator has been created and can be found on the SCHD website at starkhealth.org.

Figure 6: NaloxBox Picture

Figure 7: Percent of Decedents Positive for Opiates Drug Combinations

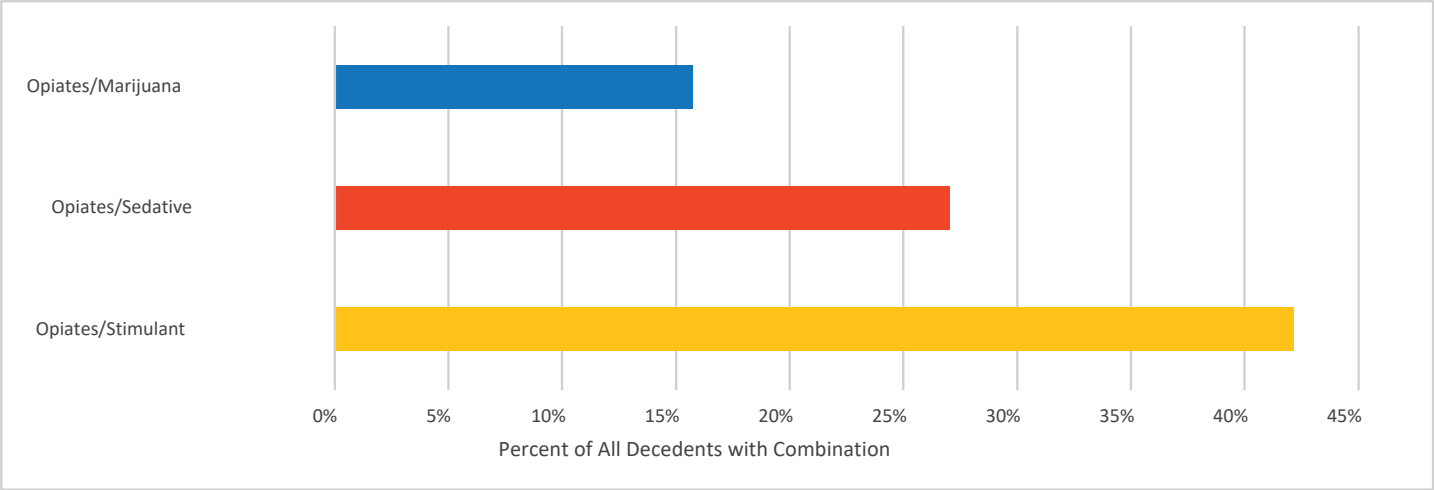


Figure 7 shows positive toxicology results for drug combinations of Stark County overdose decedents. An opiate could represent prescription or illicit drugs. Drug combinations continue to be a high risk factor for overdose.

Figure 8: Toxicology for the year 2022

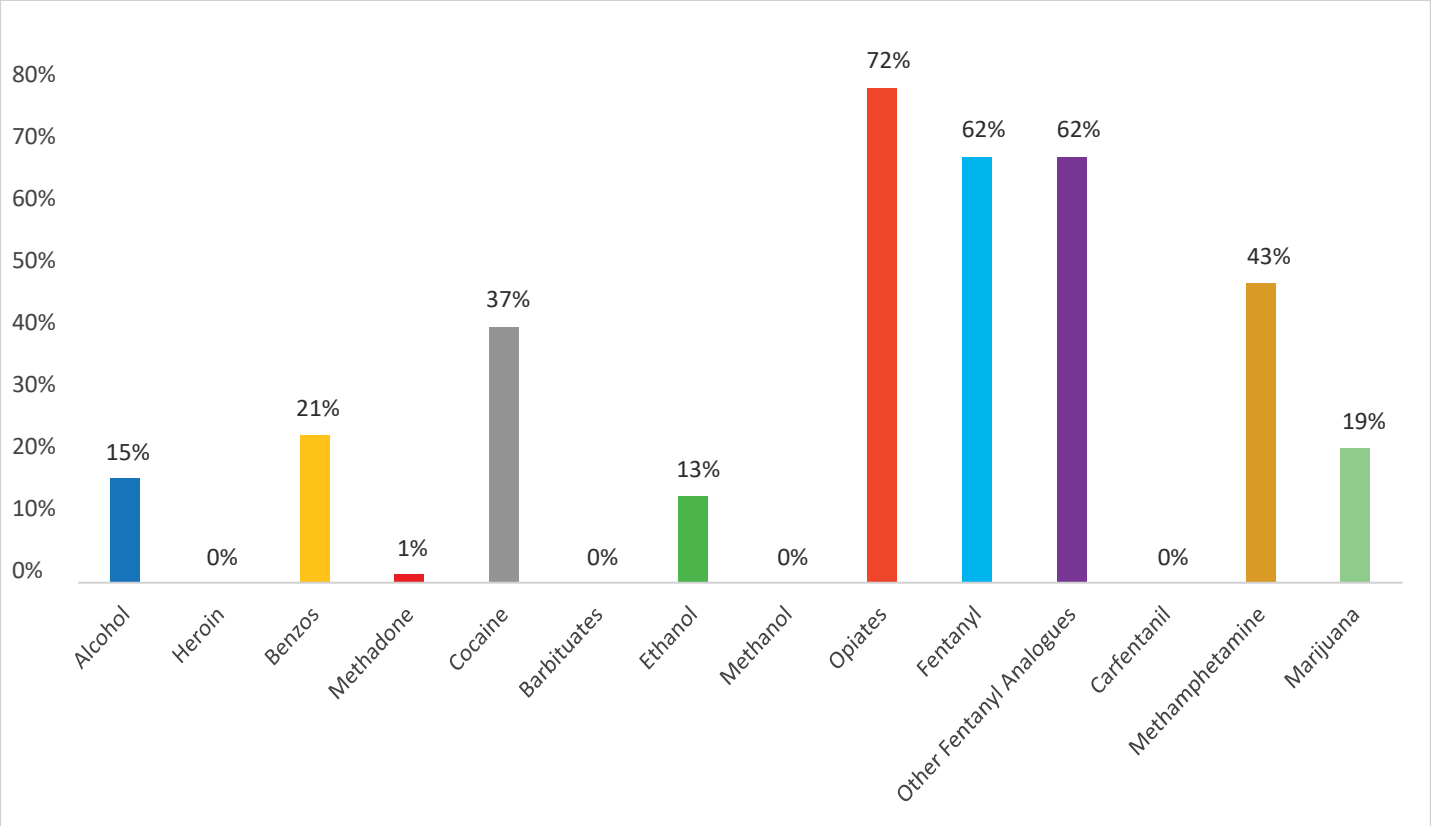


Figure 8 illustrates the percentage of illicit substances and alcohol listed in the cause of death for the 2022 unintentional overdose decedents. The following trends have been noted over the past several years: marijuana and cocaine has steadily decreased, while methamphetamine has steadily increased and has doubled since 2019. While fentanyl has steadily decreased over the past several years, it continues to be the driving force of the overdose deaths coupled with polysubstance of potent synthetic drugs and counterfeit pills. Alcohol has slightly fluctuated overall but has consistently been decreasing. Heroin and carfentanil positive toxicology results have not been seen in several years but have been replaced by newer and unknown fentanyl analogs and metabolites.

RECOMMENDATIONS

Figure 9: OFR Recommendations

Systemic:

1. Create a comprehensive case management system throughout the lifespan (patient advocate, emergency room navigators) with wrap around services to ensure all needs are met and to help connect primary care, criminal justice and mental health systems
2. Increase more accessible resources for community meetings and crisis resources

Agency Specific:

3. Improve patient assessment tools which involve all services patient is being treated for to help eliminate siloed care and improve coordination of care
4. Provide additional support for linkages to care after discharge from in-patient hospital stays and ER visits
5. Add Screening, Brief Intervention and Referral to Treatment (SBIRT) to all in-patient admit procedures in the ER. Any positive screenings are added to problem list
6. Education in ERs for medical professionals on addiction and signs and symptoms of hypertension combined with stimulant use
7. Provide linkages to care to primary care for ER patients without current primary care providers who have significant chronic medical conditions
8. Increase peer supporters or community health workers in the criminal justice system

Population Specific

9. Improve existing court programs to address substance use and mental distress in order to provide more comprehensive services to chronic patients and vulnerable populations
10. Increase awareness of concussion protocols for youth
11. Implement additional youth prevention programs

OFR Process Improvement

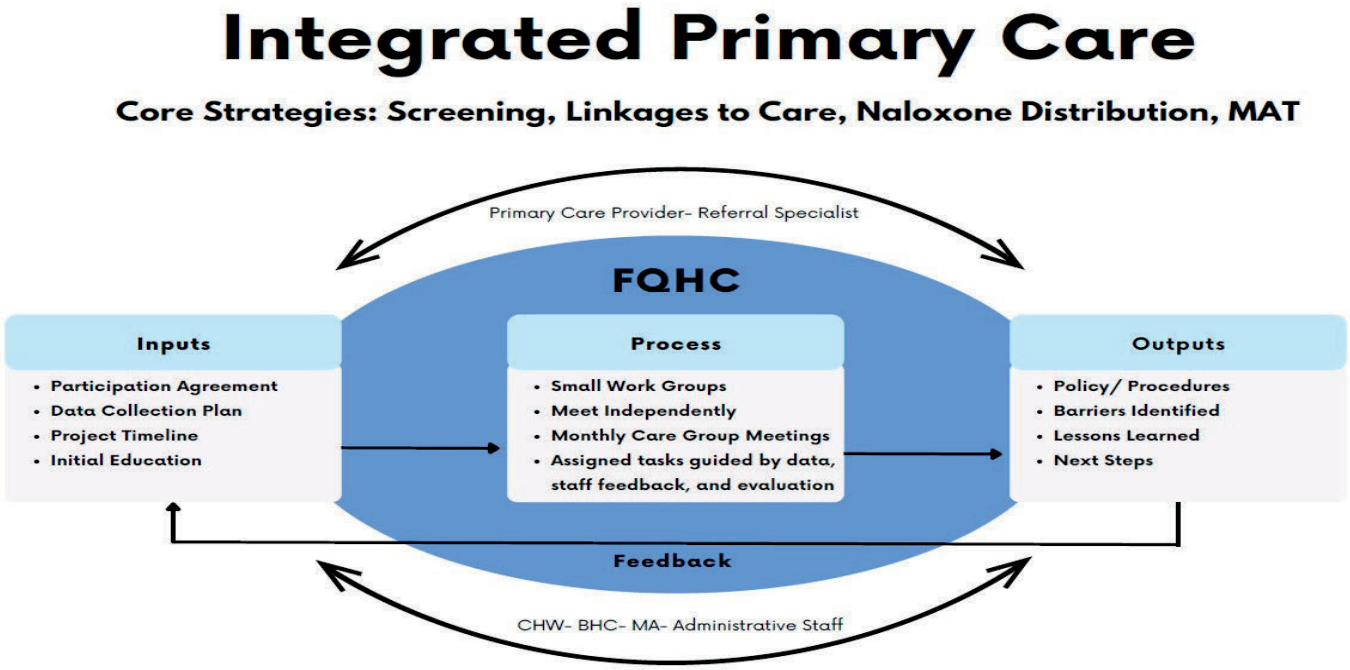
12. Coroner's office will provide OARSS report on individual case reviews at the OFR meetings when available

Figure 9: Recommendations were developed by reviewing 10 cases during quarterly OFR meetings during 2022.

COMPREHENSIVE SUSTAINABLE SYSTEM (CSS) —FQHC

During September 2022 to August 2023, SCHD worked with an area federally qualified health center (FQHC) to research and plan a new component of the CSS, Medically Assisted Treatment (MAT) and strengthen newly developed strategies from the previous year. In two years, the agency was able to screen for substance use issues, make referrals internally or externally through linkages of care and provide naloxone distribution.

Figure 10: Infographic—Implementation of Overdose Prevention Strategies



TARGETED EVALUATION

The primary purpose of the program evaluation is to document the progress and efficacy of the DR grant program, as implemented by SCHD. The full evaluation can be obtained by requesting it. The focus of the program was to decrease overdose deaths within Stark County by implementing and improving overdose prevention strategies with key partners/stakeholders and to engage community members by decreasing stigma. Some of the other strategies that were developed and improved throughout the county since 2019 include: developing a countywide NaloxBox policy and placing them in over 40 agencies, increasing the number of Project DAWN sites and the number of kits distributed, updating the community response plan annually, providing awareness campaigns through education on fentanyl and stimulants, adulterated drug supply, counterfeit pills, and the importance of carrying naloxone with a focus on vulnerable populations. Lastly, a plan for a mobile unit is being developed and will soon be implemented.

For the purposes of this OFR Annual Report, the successes of the Overdose Fatalities Review Committee and its policies have been highlighted below, but this is not inclusive of the many successes obtained throughout the county. The graph below shows the areas in which the committee made significant improvements and are explained underneath.

By-Law Updates	Developing Recommendations	Addressing Vulnerable Populations
•Data collection processes •Individual case review •Next of kin interview	•Population based case selection •Improving membership •Implementation of recommendations	•African American •Female •LGBTQ •Older Adults

SCHD developed an Overdose Fatality Review Committee in 2017 with the focus on aggregated data and identifying trends. At first, the aggregated data was collected by reviewing the coroner's investigation and death certificates. This information was put into Epi Info and analyzed. With the passing of Ohio Revised Code 307.631 in October of 2021, the committee updated the by-laws to include individual case reviews. Along with these updates, the internal process of data collection changed by accessing the ODH Secure Mortality Warehouse for aggregated data. This allowed for easier analysis and provided staff the time to focus on the new process of individual case reviews.

The focus of the individual case reviews has been on vulnerable populations which includes African American, females and LGBTQ populations. At first the recommendations developed for the OFR annual reports focused on already existing data sources such as the CDC-Evidence Based Strategies for Preventing overdose in Communities, along with trends that were identified within the aggregated data analysis.

The OFR process is continuously being evaluated through qualitative and quantitative measures. Some of the data sources include monitoring of sectors represented at the meetings, quality of the data being presented and developing innovative ways on how to display it, and number of recommendations that are developed from the individual case reviews. Lessons learned include providing better visualization of data related to case summaries/timelines, providing information to the committee ahead of the meeting and providing more formalized surveys to the committee to evaluate the process.

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References:
1. Death Statistics were from the Stark County Coroners Office, data was pulled from the Ohio Department of Heath's EpiCenter database Gender and Population data (death rates) was taken from the 2018 5-year estimate from Census Bureau website- subject to change https://www.census.gov/programs-surveys/acs 2021 numbers based on 2019 5-year estimate
2. Ohio Department of Public Safety, Division of Emergency Medical Services, EMS Incident Reporting System
3. Ohio Automated Prescription Reporting System (OARRS) Ohio Board of Pharmacy

THE RISKS OF MIXING DRUGS

- Severe side effects like brain damage, heart problems, seizures or stomach bleeding.
- Mental health issues like anxiety and depression.
- Health care, including addiction treatment, when using multiple drugs can be challenging.
- Increased risk of overdose.

Mixing drugs raises your risk for life-threatening side effects and overdose. **Understand the risks and protect yourself.**

COMMON DANGEROUS COMBINATIONS

- Alcohol and other drugs including pills.
- Benzodiazepines "benzos," and opioids (such as pills).
- Cocaine, amphetamines "meth," or other stimulants and opioids.
- Street drugs with fentanyl.

OH AGAINST OD

For 24/7 crisis support, call or text 988.
For 24/7 treatment referral, call 1-800-662-HELP (4357). Call 1-800-484-3731 if you plan on using alone.

Ohio Department of Health | Recovery Ohio | Mental Health & Addiction Services Ohio

LEARN MORE AT OHAGAINSTOD.OHIO.GOV

LOCAL RESOURCES FROM SAVE STARK

CARRY NALOXONE **DON'T USE ALONE** **CALL 911**

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