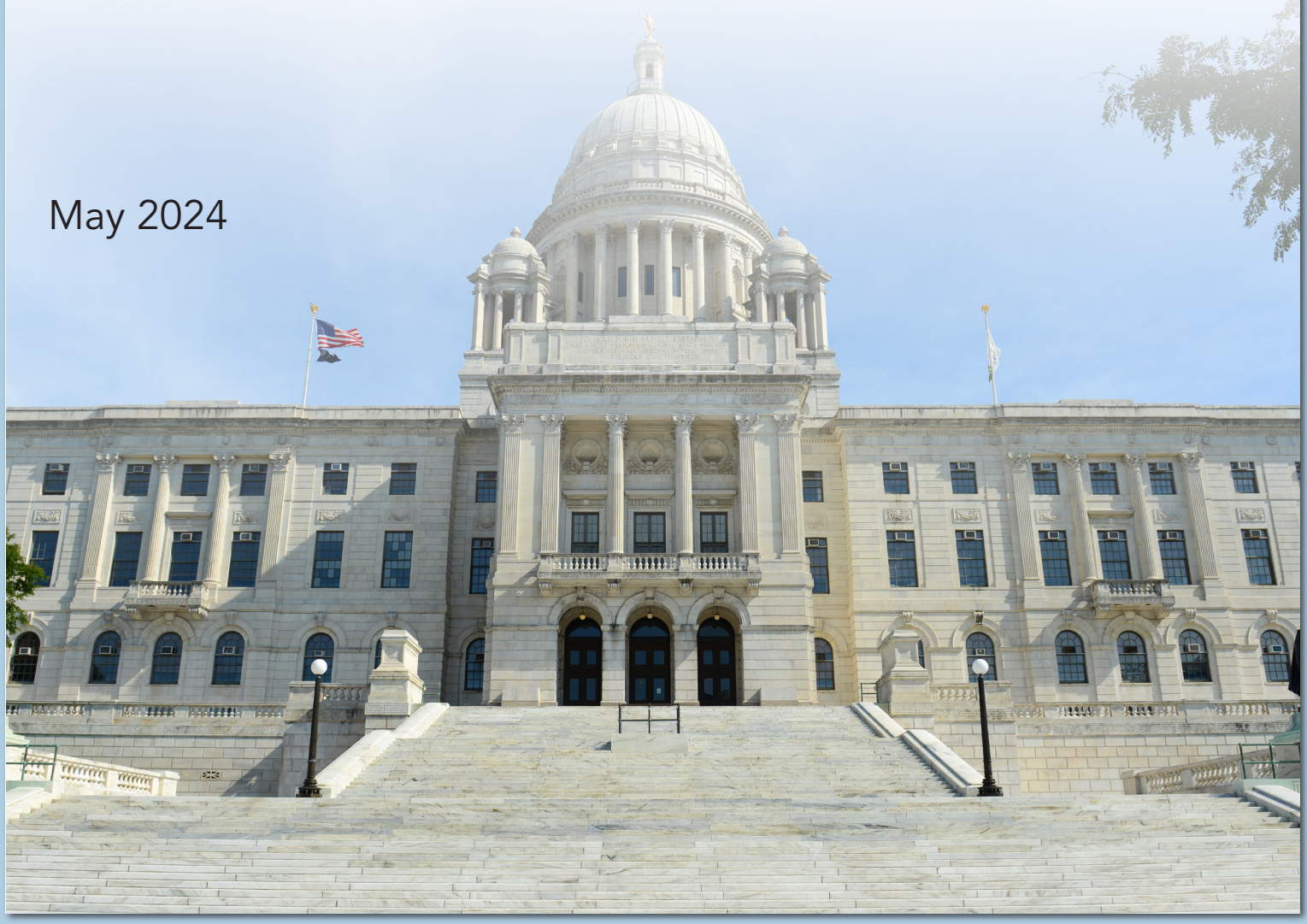
OFR
Overdose Fatality Review

# Overdose Fatality Review
# Summary of State Laws

May 2024



COSSUP
Comprehensive Opioid, Stimulant, and Substance Use Program

LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

# Contents



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# OVERVIEW

Beginning in 2020, the Legislative Analysis and Public Policy Association (LAPPA) undertook an ongoing research project to identify both currently-in-force statutes and recently proposed legislation related to overdose fatality review (OFR), throughout all 50 states, the District of Columbia, and U.S. territories, titled "Overdose Fatality Review Boards: State Laws" (previously updated February 2021). This document represents the latest iteration of that project, with information updated through December 2023.

OFRs are multidisciplinary teams established on the state, city, or county level "to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies."[1] These OFRs review fatal drug overdose cases within their jurisdictions to determine what factors and characteristics may lead to a possible overdose. By understanding what influences a fatal overdose, the OFR can recommend changes in law, policy, and agency response and coordination that will better allow the state, city, or county to prevent future overdose deaths.

As of December 2023, 18 states have laws authorizing the establishment of state-level and/or locality-level OFRs.[2] While the lack of a jurisdiction-wide (such as state or territory) law does not prevent an OFR from operating, such laws provide several benefits when compared to OFRs established without them. First, jurisdiction-wide laws can directly authorize OFRs to obtain many types of disclosure-protected information about the decedent. Without such laws, OFRs—and the individuals and entities from which it requests information—are bound to their own interpretations of the confidentiality provisions of the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 290dd-2, 42 Code of Federal Regulations (CFR) Part 2, and state or local confidentiality laws. This may result in an unwillingness to provide the requested information due to unduly restrictive interpretations and/or confusion caused by varying conclusions among jurisdictions. Second, OFR legislation helps enhance the legitimacy of OFRs, especially in areas where some community members may be reluctant to establish one. Finally, laws promote uniformity and consistency among the local teams within a state or territory.

In February 2021, through a cooperative agreement with the Office of National Drug Control Policy, LAPPA released the Model Overdose Fatality Review Teams Act (the "Model Act"), which creates a framework for establishing county-level, multidisciplinary OFRs in individual states.[3] The Model Act addresses the duties, responsibilities, and composition of OFRs in order for them to properly examine and understand the circumstances leading up to a fatal overdose.

At the time LAPPA introduced the Model Act, 12 states already had laws supporting OFRs:

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| 2013 | Pennsylvania (methadone death review) |
| 2013 | West Virginia |
| 2014 | Maryland |
| 2016 | Delaware |
| 2017 | Arizona |
| 2018 | Rhode Island |
| 2018 | Oklahoma |
| 2018 | Virginia |
| 2019 | North Dakota |
| 2020 | Utah[4] |
| 2020 | Indiana |
| 2020 | New Hampshire[5] |

Since the introduction of the Model Act, seven states have enacted laws to support OFRs. The Nebraska, New Jersey, Pennsylvania, and Washington laws are based, in whole or in part, on the Model Act.

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| 2021 | Maine |
| 2021 | Ohio |
| 2022 | Pennsylvania (suicide and overdose death review) |
| 2022 | Washington |
| 2022 | New Jersey |
| 2023 | Michigan |
| 2023 | Nebraska |

In addition, legislators in the four states listed below introduced bills during 2023 sessions that would authorize OFRs. The Kansas and Tennessee bills are clearly based on the Model Act.

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| 2023 | Kansas |
| 2023 | New York |
| 2023 | Tennessee |
| 2023 | Wisconsin |

The remainder of this publication is organized into four sections. The first two sections present jurisdiction-by-jurisdiction tables describing aspects of the OFR law currently in effect and how it compares to the Model Act. The tables cover the following aspects of the laws:

- Statutory or regulatory citation(s) and effective date(s) of OFR-related laws
- Drugs or substances of focus of OFR teams
- Operational level (i.e., state or local/county)
- Team members who must (or may) be part of OFR teams
- Team duties, tasks, and objectives
- Team members' ability to access health records and other information
- Confidentiality provisions
- Data reporting requirements

**Section 1** pertains to states whose OFR laws pre-date the Model Act.

**Section 2** covers states whose laws post-date the Model Act.

**Section 3** describes OFR legislation proposed during 2023 but not enacted as of the time of publication.

**Section 4** describes Colorado's law, which is the one state to date with an OFR-related law that focuses on something other than authorizing/implementing a state or local OFR.[6]

Those wanting to read a state's statute should do so directly on the state's website. This publication is designed to assist state and local governments in what is currently in place in their state and others to help guide their OFR efforts—specifically, as they relate to information sharing.

# SECTION 1:
## JURISDICTIONS WITH OFR LAWS PRE-DATING THE MODEL ACT

# ARIZONA

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| **Statute(s) and/or Regulation(s)** | Ariz. Rev. Stat. Ann. §§ 36-198 to 36-198.01 (West 2023) |
| **Effective Date** | The original effective date was August 9, 2017. A sunset provision automatically repealed the statutes, effective January 1, 2023. The legislature reenacted the statutes, effective April 17, 2023. |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | State and local review teams. Unlike the Model Act, Arizona established a state OFR team in addition to local OFR teams. The state review team reviews cases in counties without a local team or where the victim's county of residence is unknown. |
| **Team Members** | The Arizona Drug Overdose Fatality Review Team (DOFR Team) is composed of representatives from the following entities: (1) the Office of the Attorney General; (2) the Arizona Department of Health Services; (3) the Arizona Health Care Cost Containment System; (4) the Arizona Department of Economic Security; (5) the Governor's Office of Youth, Faith, and Family; (6) the Administrative Office of the Courts; (7) the Arizona Department of Corrections; (8) the Arizona Council of Human Services Providers; and (9) the Arizona Department of Public Safety.<br><br>The director of health services can appoint the following members to serve on the DOFR Team: (1) a medical examiner who is a rural forensic pathologist; (2) a medical examiner who is a metropolitan forensic pathologist; (3) a representative of a tribal government; (4) a public member; (5) a representative of a professional emergency management system association; (6) a health care professional from a statewide association representing nurses; (7) a health care professional from a statewide association representing physicians; (8) a representative of an association of county health officers; (9) a representative of an association representing hospitals; (10) a health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders (SUDs); and (11) a county sheriff, or the sheriff's designee, who represents a county with a population of less than 500,000 persons and a county sheriff, or the sheriff's designee, who represents a county with a population of more than 5,000 persons.<br><br>Arizona law has established a set of required team members and a set of appointed members. In comparison, the Model Act has established a set of required members and a set of suggested members. The team members listed in Arizona law are similar to those listed in the Model Act. |

# ARIZONA (continued)

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| **Duties, Tasks, and Objectives** | Arizona law requires the DOFR Team to develop a drug overdose fatalities data collection system and conduct an annual analysis on the incidence and causes of drug overdose deaths in the state that occurred the preceding year. In addition, the DOFR Team encourages and assists the development of local OFR teams by developing standards and protocols for these local teams, as well as providing training and technical assistance.<br><br>Moreover, the DOFR Team develops protocols for drug overdose investigations and studies the adequacy of statutes, ordinances, rules, training, and services to determine what changes are needed to decrease the incidence of preventable drug overdose fatalities. Finally, the DOFR Team educates the public about the incidence and causes of overdose deaths and what the public can do to prevent these deaths.<br><br>Because of the dual state and local team format, Arizona law focuses on the state-level team establishing and providing technical assistance to local teams, which is different from the Model Act. |
| **Access to Information** | The chairperson of the DOFR Team or a local team may request, as necessary to carry out the team's duties, information and records from (1) a provider of medical, dental, or mental health care; and (2) the state or a political subdivision of the state that might assist the DOFR Team or local team in reviewing the fatality. Access to the information requested is to be provided to the chairperson within 5 days. Law enforcement agencies shall provide unredacted department reports to the chairperson of a local DOFR team on request. A law enforcement agency, with the approval of the prosecuting attorney, may withhold from a review team investigative records that might interfere with a pending criminal investigation or prosecution. A member of the DOFR Team or local team may contact, interview, or obtain information, by request or subpoena, from a family member of a deceased person who overdosed on drugs. The director of the department of health services or the director's designee may apply to the superior court for a subpoena, as necessary, to compel the production of books, records, documents, and other evidence related to the person who overdosed on drugs.<br><br>The list of information that the team can request is not as specific as that in the Model Act. It also does not list the specific individuals or entities that must comply with a record request, as the Model Act does. |
| **Confidentiality** | All information and records acquired by the DOFR Team, or any local team, are confidential and are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding; except that information, documents, and records that are otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented to or reviewed by a team. Members of a team, individuals attending a team meeting, and individuals who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in, or opinions formed as a result of, a meeting. Meetings of the DOFR Team or a local team are closed to the public and not subject to state public meeting law, if the team is reviewing information about an overdose victim. A person who violates these requirements is guilty of a class 2 misdemeanor.<br><br>Arizona law does not require team members to sign a confidentiality form before participating, as the Model Act does. However, Arizona law does have a criminal liability. |
| **Reporting Requirement** | None. Arizona law is different from the Model Act, which requires each local team to submit an annual de-identified report to the county and state departments of health. |
| **Funding Source** | Not addressed in statute. Arizona law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# DELAWARE

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| **Statute(s) and/or Regulation(s)** | Del. Code Ann. tit. 16 §§ 4799A to 4799D (West 2023) |
| **Effective Date** | April 21, 2016 (amended June 15, 2021) |
| **Drugs or Substances of Focus** | No longer specified. Prior to the June 2021 amendment, the Delaware Drug Overdose Fatality Review Commission (Commission) only reviewed overdoses involving opiates, fentanyl, and/or heroin. Current law is the same as the Model Act. |
| **Operational Level** | State-level commission and three regional review teams. Delaware law differs from the Model Act in that there is a state-level commission and a limited number of regional review teams. |
| **Team Members** | The Commission is composed of the (1) attorney general, (2) the secretary of health and social services, (3) the director of the division of forensic science, (4) the secretary of safety and homeland security, (5) the director of the division of public health, and (6) the commissioner of the department of correction.<br><br>In addition, the governor appoints the following members to the Commission: (1) two representatives of the Medical Society of Delaware, (2) a representative of the Delaware Nurses Association, (3) a representative of the Police Chiefs Council of Delaware who is an active law enforcement officer, (4) a representative of the Delaware Fraternal Order of Police who is an active law enforcement officer, (5) two advocates from statewide nonprofit organizations, and (6) a representative of the Delaware Healthcare Association.<br><br>Delaware law has established a set of required team members and a set of members who need to be appointed. In comparison, the Model Act has established a set of required members and a set of suggested members. The list of team members in Delaware law is not as expansive as it is in the Model Act. |
| **Duties, Tasks, and Objectives** | The Commission investigates and reviews the facts and circumstances of all overdose deaths that occur in the state. This is not as specific as the Model Act. |
| **Access to Information** | The Commission may access the medical records of the deceased. In addition, the Commission can compel the production of any records related to the death or that are pertinent to the Commission's investigation.<br><br>Unlike the Model Act, Delaware law does not list the specific records the team can access or the individuals or entities who must comply with a records request. |

# DELAWARE (continued)

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| **Confidentiality** | Meetings of the Commission and the regional review teams are closed to the public. The records of the Commission and of all regional review teams, including original documents and documents produced in the review process regarding the facts and circumstances of each death, are confidential and not releasable to any person, except as expressly provided in state law.<br><br>Such records shall be used by the Commission and any regional review team only in the exercise of the proper function of the Commission or review team and are not public records nor available for court subpoena or subject to discovery. Members of the Commission and the regional review teams, and their agents and employees, are immune from claims, suits, liability, damages, or any other recourse, civil or criminal, arising from any act, proceeding, decision, or determination undertaken or performed, or recommendation made, provided such persons acted in good faith and without malice. No person in attendance at a meeting of the Commission or a regional review team shall be required to testify as to what transpired during the meeting. No organization, institution, or person furnishing information, data, reports, or records to the Commission or any regional review team with respect to any subject examined or treated by such organizations, institution, or person, by reason of furnishing such information, shall be liable in damages to any person or subject to any other recourse, civil or criminal.<br><br>Delaware law does not require team members to sign a confidentiality form before participating, as the Model Act does. Delaware law also does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | At least annually, the Commission must make recommendations to the governor and general assembly regarding practices or conditions that impact the frequency of overdose deaths and steps to take to reduce the number of those deaths.<br><br>Like the Model Act, Delaware law requires the Commission to submit an annual report. |
| **Funding Source** | Not addressed in statute. Delaware law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# INDIANA

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| **Statute(s) and/or Regulation(s)** | Ind. Code Ann. § 16-49.5 Chapters 1 and 2 (West 2023) |
| **Effective Date** | July 1, 2020 |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | Local/county level. This is the same as the Model Act. |
| **Team Members** | A suicide and OFR team may be established in a county or in multiple counties. Members of a team must be appointed by the county health officer or another entity approved by the Indiana Department of Health and may include local representatives from the following disciplines: (1) public health, (2) primary health care, (3) mental health, (4) law enforcement, (5) behavioral health, (6) parole or probation, (7) addiction medicine, (8) emergency medical services (EMS), and (9) social work. Members may also include (1) a coroner or deputy coroner, (2) an epidemiologist, and/or (3) a pathologist.<br><br>Indiana's team member list is not as expansive as the team members identified—as required or suggested—in the Model Act. |
| **Duties, Tasks, and Objectives** | Teams must meet at least quarterly and must (1) determine the factors contributing to suicides and overdose fatalities; (2) identify public health and clinical interventions to improve systems of care and enhance coordination; and (3) develop strategies for the prevention of suicides and overdose fatalities. During each review, the team should (1) identify the factors that contributed to the fatality; (2) determine whether similar fatalities may be prevented; (3) identify any agencies or resources that may be used to assist in the prevention of a similar fatality; and (4) identify any solution to improve practice and policy among the agencies, entities, and resources.<br><br>This is similar to the Model Act. |
| **Access to Information** | A team may review the following records if the records pertain to a person or incident within the scope of the team's review: (1) records held by the local or state health department, the Indiana scheduled prescription electronic collection and tracking program, and the department of child services; (2) medical records; (3) law enforcement records; (4) autopsy reports; (5) coroner records; (6) mental health reports; (7) EMS provider records; (8) fire department-run reports; (9) disciplinary or health records generated by a local school system; and (10) any other record concerning the assessment, care, fatality, diagnosis, near fatality, or treatment of the person subject to a team review.<br><br>Indiana law is similar to the Model Act in that it specifies the various types of records the team may review. However, it does not specify the individuals or entities that must comply with a records request, as the Model Act does. |
| **Confidentiality** | Before a team member may participate in the review of a suicide or overdose fatality, the member must sign a confidentiality form prepared by the Indiana Department of Health. Individuals who are invited by the team chairperson to attend a team meeting must also sign a confidentiality form before attending or participating in the team meeting. Except as otherwise provided, information and records acquired by a team during the execution of the team's duties are confidential and exempt from disclosure. Records, information, documents, and reports acquired or produced by a team are not subject to subpoena or discovery or admissible as evidence in any administrative or judicial proceeding.<br><br>Indiana law requires team members to sign a confidentiality form before participating, which is similar to the Model Act. Indiana law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |

# INDIANA (continued)

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| **Reporting Requirement** | Before July 1 of each year, a team must submit a report to the Indiana Department of Health that includes (1) a summary of the data collected concerning the reviews conducted by the team the previous calendar year, (2) actions recommended by the team to improve systems of care and community resources to reduce overdose fatalities in the area served by the team, and (3) solutions proposed for any system inadequacies.<br><br>Like the Model Act, Indiana law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. Indiana law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# MARYLAND

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| **Statute(s) and/or Regulation(s)** | Md. Code Ann., Health-Gen. §§ 5-901 to 5-906 (West 2023) |
| **Effective Date** | October 1, 2014 |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | Local/county level. This is the same as the Model Act. |
| **Team Members** | Maryland counties can establish local OFR teams. State law requires the teams to include the following members or their designees: (1) the county health officer; (2) the director of the local department of social services; (3) the state's attorney; (4) the superintendent of schools; (5) a state, county, or municipal law enforcement officer; (6) the director of behavioral health services in the county; (7) an EMS provider in the county; (8) a representative of a hospital; (9) a health care professional who specializes in the prevention, diagnosis, and treatment of SUDs; (10) a representative of a local jail or detention center; (11) a representative from parole, probation, and community corrections; (12) the secretary of juvenile services; (13) a member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the county health officer; and (14) any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer.<br><br>The list of required team members in Maryland's law is similar to that of the Model Act. Maryland law, however, does not provide a list of potential additional team members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The teams must meet at least quarterly to review drug overdose death cases and to recommend actions to improve coordination of services and investigations among the member agencies, as well as recommend actions to prevent drug overdose deaths.<br><br>This is similar to the Model Act. |
| **Access to Information** | The chairperson of the local team may request, as necessary, the following information:<br>1. Health care records, including information about physical health, mental health, and treatment for SUD for:<br>• An individual whose death or near fatality is being reviewed; or<br>• An individual convicted of a crime that caused a death or near fatality.<br>2. Records maintained by the state or local government agency, including death certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency for:<br>• An individual whose death or near fatality is being reviewed;<br>• An individual convicted of a crime that caused a death or near fatality; or<br>• The family of an individual described in a. or b.<br>Once a record is requested by the team, the providing entity should immediately provide it to the team.<br><br>This section of Maryland law is similar to the Model Act, but the Model Act does not address records related to "an individual convicted of a crime that caused a death or near fatality." In addition, Maryland law does not specifically list the individuals or entities that must comply with a records request, as the Model Act does. |

# MARYLAND (continued)

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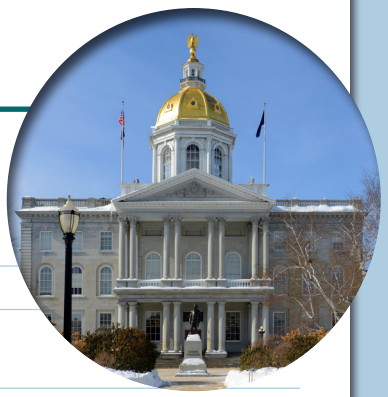
| **Confidentiality** | All information and records acquired by a local team in the exercise of its purpose and duties under the law are confidential, exempt from disclosure under Title 4 of the General Provisions Article ("Public Information Act"), and may be disclosed only as necessary to carry out the team's purpose and duties. Mental health records are subject to the additional limitations under Md. Code Ann., Health-Gen. § 4-307 (West 2022) for disclosure of a medical record developed primarily in connection with the provision of mental health services. SUD treatment records are subject to any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance use treatment services under state law or 42 U.S.C. § 290DD-2 and 42 CFR Part 2. Statistical compilations of data and reports of the local team that do not contain any information that would permit the identification of any person to be ascertained are public information. Except as necessary to carry out a local team's purpose and duties, members of a local team and persons attending a local team meeting may not disclose (1) what transpired at the meeting that is not public or (2) any information for which the law prevents disclosure.<br><br>Members of a local team, persons attending a local team meeting, and persons who present information to a local team may not be questioned in any civil or criminal proceeding about information presented in, or opinions formed as a result of, a meeting. Information, documents, or records of a local team are not subject to subpoena, discovery, or records of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding. A person who violates the confidentiality provisions is guilty of a misdemeanor and, on conviction, is subject to a fine not exceeding $500, imprisonment not exceeding 90 days, or both.<br><br>Unlike the Model Act, Maryland law does not require team members to sign a confidentiality form before participating in an overdose review. Maryland law does have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | Teams must provide requested reports to the Maryland Department of Hygiene and Mental Health, including: (1) discussion of individual cases, (2) steps taken to improve coordination of services and investigations, (3) steps taken to implement changes recommended by the local team within member agencies, and (4) recommendations on needed changes to state and local laws, policies, or practices to prevent drug overdose deaths.<br><br>Like the Model Act, Maryland has a reporting requirement for local teams, but it does not specify how often reports need to be submitted. |
| **Funding Source** | Not addressed in statute. Maryland law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# NEW HAMPSHIRE



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| **Statute(s) and/or Regulation(s)** | N.H. Rev. Stat. Ann. § 126-DD:1 (West 2023)<br><br>(Initially, a 2016 order established the Drug Overdose Fatality Review Commission [N.H. Exec. Order No. 2016-05].) |
| **Effective Date** | September 27, 2020 (statute); October 12, 2016 (executive order) |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | The New Hampshire Drug Overdose Fatality Review Commission (Commission) is composed of the following individuals or their designees: (1) one member of the senate, appointed by the president of the senate; (2) three members of the house of representatives, appointed by the speaker of the house of representatives; (3) the attorney general; (4) the chief medical examiner; (5) the commissioner of health and human services; (6) the commissioner of safety; (7) the chairperson of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery; (8) a representative of the New Hampshire Association of Chiefs of Police; (9) a representative of the New Hampshire Association of Fire Chiefs; (10) a health official from a city health department, appointed by the governor; (11) a victim/witness advocate, appointed by the attorney general; (12) a representative of the New Hampshire Hospital Association; (13) a representative of the recovery community, appointed by the governor; (14) a representative of the treatment community, appointed by the governor; (15) a representative of the prevention community, appointed by the governor; (16) a representative of New Futures; (17) a representative of American Medical Response; (18) a representative of the Drug Enforcement Administration; (19) the governor's advisor on addiction and behavioral health; (20) a suicide prevention specialist, appointed by the National Alliance on Mental Illness, New Hampshire chapter; and (21) a representative of the New Hampshire Medical Society.<br><br>The list of required team members in New Hampshire's law is similar to that of the Model Act, but it does include some members that are not included in the Model Act, such as members of the state legislature. The New Hampshire law contains one list of team members instead of a list of required members and a list of potential additional members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The Commission must (1) review trends and patterns of overdose-related fatalities in New Hampshire; (2) identify high-risk factors, current practices, and gaps in system responses; (3) recommend policies, practices, and services that will encourage collaboration and reduce overdose fatalities; (4) improve sources of data collection by developing a system to share information between agencies and offices that work with individuals struggling with addiction; (5) educate the public, policymakers, and funders about overdose-related fatalities and about strategies for intervention and effective prevention, treatment, and recovery; and (6) review laws and programs enacted in other states, counties, or municipalities.<br><br>This is similar to the Model Act. |

# NEW HAMPSHIRE (continued)

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| **Access to Information** | Upon the request of the chairperson of the Commission and as necessary to carry out the Commission's duties, the chairperson shall be provided, within 5 days, excluding weekends and holidays, with access to information and records regarding a drug overdose fatality that is being reviewed by the Commission or regarding the overdose victim. The Commission may request the information and records from any of the following: (1) a provider of medical, dental, or behavioral health care; and (2) any state, or a political subdivision of this state, that might assist the Commission in reviewing the fatality.<br><br>New Hampshire law is not as specific as the Model Act regarding what type of records the team can request and what individuals or entities must comply with a records request. |
| **Confidentiality** | Proceedings, records, and opinions of the Commission are confidential, not subject to N.H. Rev. Stat. Ann. 91-A (West 2022), and not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. Members of the Commission may not be questioned in any civil or criminal proceeding regarding information presented in, or opinions formed as a result of, a meeting of the team. The Commission shall maintain the confidentiality of all records pursuant to N.H. Rev. Stat. Ann. 169-C:25 (West 2022), N.H. Rev. Stat. Ann. 170-G:8-a (West 2022), and all other related confidentiality laws. The information and records obtained and created in execution of the Commission's official functions are exempt from disclosure pursuant to N.H. Rev. Stat. Ann. 91-A (West 2022) and are privileged and exempt from use or disclosure in any criminal or civil matter or administrative proceeding. Any person who knowingly discloses case records or other information obtained from Commission proceedings commits a misdemeanor.<br><br>Unlike the Model Act, New Hampshire law does not require team members to sign a confidentiality form before participating in an overdose review. New Hampshire law does have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | The Commission is required to complete an annual statistical report on the incidence and causes of overdose fatalities in the state during the past fiscal year and submit a copy of this report, including its recommendations for proposed legislation and actions, to the governor, the senate president, and the speaker of the house of representatives. The commission is to submit the report on or before December 15 of each year.<br><br>Like the Model Act, New Hampshire law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. New Hampshire law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# NORTH DAKOTA

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| **Statute(s) and/or Regulation(s)** | N.D. Cent. Code Ann. §§ 23-50-01 to 50-05 (West 2023) |
| **Effective Date** | August 1, 2019 |
| **Drugs or Substances of Focus** | Prescription drugs, illicit drugs, and alcohol. This is different from the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | The forensic pathology department of the University of North Dakota School of Medicine and Health Science appoints individuals to serve as members on the Drug Fatalities Review Panel (Panel). The Panel must include representation from multiple disciplines and services. Membership may include (1) a forensic pathologist, (2) a pharmacist with knowledge in pharmacogenomics, (3) representatives of rural and urban health care facilities, (4) a licensed addiction counselor, (5) a physician, and (6) representatives of nonregulatory divisions of the department of health and the department of human services.<br><br>Unlike the Model Act, North Dakota law only requires that a team include representation from multiple disciplines and services. It does not list any specifically required members, and it suggests very few potential team members in comparison to the Model Act. |
| **Duties, Tasks, and Objectives** | The Panel provides outcome data on drug-related fatalities in the state as a basis for policy, intervention, and other program effectiveness. In addition, the Panel promotes interagency communication and training for individuals and agencies that share a responsibility in responding to or preventing drug-related fatalities. Moreover, the Panel promotes the use of intervention and education programs to prevent drug-related fatalities. When conducting a review, the Panel should identify factors that may have contributed to a preventable fatality and make recommendations to identify whether a fatality was preventable.<br><br>This is similar to the Model Act. |
| **Access to Information** | Upon the written request of the presiding officer of the Panel, a health care facility and a health care provider shall disclose all patient records of the facility or provider that are requested by the Panel and pertain to an identified drug fatality. The presiding officer may request records from the most recent 36-month period.<br><br>Unlike the Model Act, North Dakota law only addresses access to medical records and only allows a team to have access to records within a 36-month period. |
| **Confidentiality** | Notwithstanding N.D. Cent. Code Ann. §§ 44-04-18 to 44-04-19 (West 2022) ("Access to public meetings" and "Access to public records—electronically stored information"), (1) all portions of a Panel's meeting that reviews drug fatalities are closed to the public; and (2) all Panel documentation and reports that are related to review of drug fatalities are confidential, except for the annual state report, which may not disclose personally identifiable information of decedents. The confidential records are not discoverable as evidence.<br><br>Unlike the Model Act, North Dakota law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, North Dakota law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |

# NORTH DAKOTA (continued)

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| **Reporting Requirement** | Annually, the Panel shall compile a state report of fatalities reviewed. The report must include identification of patterns, trends, and policy issues related to drug fatalities but may not disclose personally identifiable information.<br><br>Like the Model Act, North Dakota law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. North Dakota law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# OKLAHOMA

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| **Statute(s) and/or Regulation(s)** | Okla. Stat. Ann. tit. 63 §§ 2-1001 to 2-1003 (West 2023) |
| **Effective Date** | November 1, 2018 |
| **Drugs or Substances of Focus** | Opioids. This is different from the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | The Oklahoma Opioid Overdose Fatality Review Board (Board) is composed of the following individuals or their designees: (1) the attorney general, (2) the chief medical examiner, (3) the commissioner of health, (4) the chief of injury prevention services, (5) the president of the Oklahoma State Medical Association, (6) the director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control, (7) the commissioner of mental health and substance abuse services, (8) the president of the Oklahoma Osteopathic Association, (9) the director of human services; (10) the director of the Oklahoma State Bureau of Investigation, (11) the president of the Association of Oklahoma Narcotic Enforcers, and (12) the executive director of the State Board of Pharmacy.<br><br>In addition, the attorney general also appoints the following individuals to the Board: (1) a county sheriff selected from a list of three names submitted by the executive board of the Oklahoma Sheriffs' Association; (2) a chief of a municipal police department selected from a list of three names submitted by the Oklahoma Association of Chiefs of Police; (3) a licensed attorney who is in private practice selected from a list of three names submitted by the Board of Governors of the Oklahoma Bar Association; (4) a district attorney selected from a list of three names submitted by the Oklahoma District Attorneys Council; (5) a physician with emergency medical training selected from a list of three names submitted by the Oklahoma State Medical Association; (6) a physician with experience in SUD treatment and recovery selected from a list of three names submitted by the Oklahoma Osteopathic Association; (7) a nurse selected from a list of three names submitted by the Oklahoma Nurses Association; (8) two individuals, at least one of whom currently receives, or formerly has been a consumer of, recovery services related to opioid use, selected from a list of three names submitted by the Oklahoma Department of Mental Health and Substance Abuse Services; and (9) a member of the judiciary selected from a list of three names submitted by the Oklahoma Supreme Court.<br><br>Oklahoma has established a set of required team members and a set of members who need to be appointed. In comparison, the Model Act has established a set of required members and a set of suggested members. The team members listed in Oklahoma law are similar to those listed in the Model Act. |
| **Duties, Tasks, and Objectives** | The Board must coordinate and integrate state and local efforts to address overdose death. The Board conducts case reviews of opioid overdose deaths of persons 18 years or older in the state and collects, analyzes, and interprets state and local data on opioid overdose deaths. In addition, the Board makes recommendations on how to improve policies, procedures, and practices within the agencies to prevent fatal opioid overdoses.<br><br>This is similar to the Model Act. |

# OKLAHOMA (continued)

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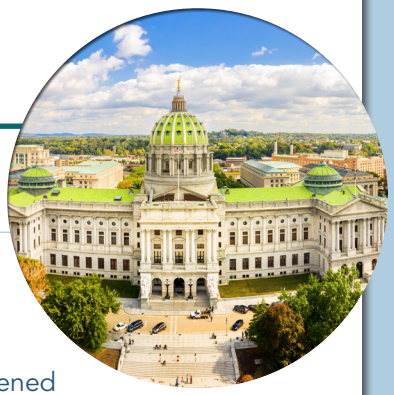
| **Access to Information** | The Board can request and obtain a copy of all records and reports pertaining to an adult whose case is under review, including (1) the medical examiner's report(s); (2) hospital records; (3) school records; (4) court records; (5) prosecutorial records; (6) local, state, and federal law enforcement records, including the Oklahoma State Bureau of Investigations and the Oklahoma Bureau of Narcotics and Dangerous Drug Control; (7) fire department records; (8) department of health records; (8) medical and dental records; (9) department of mental health and substance abuse services and other mental health records; (10) EMS records; (11) files of the department of human services; and (12) records in the possession of the child death review board when conducting a joint review.<br><br>Like the Model Act, Oklahoma law allows a team to request a variety of records. However, it does not specify which persons or entities must comply with a records request, as the Model Act does. |
| **Confidentiality** | Confidential information provided to the Board shall be maintained by the Board in a confidential manner as otherwise required by state and federal law. Any person damaged by the disclosure of such confidential information by the Board or its members that is not authorized by law may maintain an action for damages, costs, and attorney fees. Information, documents, and records in the possession of the Board are not subject to subpoena or discovery in any civil or criminal proceedings. All discussions of individual cases and any writings produced by or created for the Board while determining a recommended remedial measure, as the result of a review of an individual case of an opioid overdose death, shall be privileged and shall not be admissible as evidence in any proceeding.<br><br>Unlike the Model Act, Oklahoma law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Oklahoma law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | Each year, the Board is required to submit an annual statistical report on the incidence and causes of opioid overdose deaths in the state for which the Board has completed its review during the past calendar year. The Board shall also prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the Board relating to the review of opioid overdose deaths, the extent to which the state medical and law enforcement systems are coordinated, and an evaluation of whether the state is efficiently discharging its responsibilities to prevent opioid overdose deaths. The report shall be completed no later than February 1 of the subsequent year.<br><br>Like the Model Act, Oklahoma law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. Oklahoma law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# PENNSYLVANIA (2013 Law)



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| **Statute(s) and/or Regulation(s)** | 71 Pa. Stat. and Cons. Stat. Ann. §§ 1691.1 to 1691.9 (West 2023) |
| **Effective Date** | When initially established on January 22, 2013, the statute (titled the "Methadone Death and Incident Review Act") applied only to deaths caused primarily or secondarily by methadone. Effective February 23, 2021, the statute became the "Medication Death and Incident Review Act," and its focus broadened to deaths where a medication approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder is the primary or secondary cause of death or may be a contributing factor. |
| **Drugs or Substances of Focus** | Medications approved by the FDA for the treatment of opioid use disorder. This is different from the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | The Pennsylvania Medication Death and Incident Review Team (Team) is composed of the following individuals or their designees: (1) the secretary of drug and alcohol programs; (2) the director of drug and alcohol programs; (3) a representative from an opioid-assisted treatment program; (4) a representative from a licensed drug and alcohol treatment program that is not defined as an opioid-assisted treatment program; (5) a representative from law enforcement recommended by a statewide association representing members of law enforcement; (6) a representative from the medical community recommended by a statewide association representing physicians; (7) a district attorney recommended by a statewide association representing district attorneys; (8) a coroner or medical examiner recommended by a statewide association representing county coroners and medical examiners; (9) a member of the public; (10) a patient or family advocate; (11) a representative from a recovery organization; (12) an office-based agonist treatment provider who is assigned a waiver from the U.S. Drug Enforcement Administration (DEA), including a special identification number, commonly referred to as the "X" DEA number, to provide office-based prescribing of buprenorphine; (13) a representative of the department of health who is affiliated with the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP);7 and (14) a toxicologist.<br><br>Pennsylvania law contains one list of team members instead of a list of required members and a list of potential additional members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The Team reviews each death in which a medication approved by the FDA for the treatment of opioid use disorder is either the primary or secondary cause of death to determine what role that medication plays in each of those deaths. In addition, the Team communicates concerns to regulators and helps facilitate communication between the health care system and the legal system about health and public safety issues. Moreover, the Team develops best practices to prevent future medication-related deaths and medication-related incidents.<br><br>This is similar to the Model Act. |

# PENNSYLVANIA (2013 Law) (continued)

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| **Access to Information** | When necessary, the Team may review and inspect the following information: (1) coroner's reports or post-mortem examination records; (2) death certificates and birth certificates; (3) law enforcement records and interviews with law enforcement officials; (4) medical records from hospitals, other health care providers, and narcotic treatment programs; (5) information and reports made available by the county children and youth agency; (6) information made available by firefighters or emergency services personnel; (7) reports and records made available by the court; (8) EMS records; (9) traffic fatality reports; (10) opioid-assisted treatment program incident reports; (11) opioid-assisted treatment program licensure surveys from the program licensure division; and (12) any other records necessary to conduct the review.<br><br>Like the Model Act, Pennsylvania law allows a team to request a variety of records. However, it does not specify which persons or entities must comply with a records request, as the Model Act does. |
| **Confidentiality** | The Team shall maintain the confidentiality of any identifying information obtained relating to the death of an individual or adverse incidents regarding medication, including the name of the individual, guardians, family members, caretakers, or alleged or suspected perpetrators of abuse, neglect, or a criminal act. Each member of the Team and any person appearing before the Team shall sign a confidentiality agreement applicable to all proceedings and reviews conducted by the Team. The proceedings, deliberations, and records of the Team are privileged and confidential and shall not be subject to "right to know" laws, discovery, subpoena, or introduction into evidence in any civil or criminal action. Team meetings at which specific deaths are discussed are closed to the public. A person violating these provisions commits a third-degree misdemeanor.<br><br>Like the Model Act, Pennsylvania law requires team members to sign a confidentiality form before participating in an overdose review. In addition, Pennsylvania law has a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | The Team is required to prepare an annual report that is to be posted on the department's internet website and distributed to the chairperson and the minority chairperson of the judiciary committee of the senate, the chairperson and the minority chairperson of the health and human services committee of the senate, the chairperson and the minority chairperson of the judiciary committee of the house of representatives, and the chairperson and the minority chairperson of the human services committee of the house of representatives. Each report shall (1) provide public information regarding the number and causes of medication-related deaths and medication-related incidents; (2) provide aggregate data on 5-year trends on medication-related deaths and medication-related incidents, when such information is available; (3) make recommendations to prevent future medication-related deaths, medication-related incidents, and abuse and set forth the department's plan for implementing the recommendations; (4) recommend changes to statutes and regulations to decrease medication-related deaths and medication-related incidents; and (5) provide data on medication-related deaths and medication-related incidents and concerns regarding opioid-assisted treatment programs.<br><br>Like the Model Act, Pennsylvania law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. Pennsylvania law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# RHODE ISLAND

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| **Statute(s) and/or Regulation(s)** | 23 R.I. Gen. Laws Ann. § 23-4-3(11) (West 2023) |
| **Effective Date** | June 28, 2018. An amendment effective May 26, 2021, removed the sunset provision terminating the provision in 2020. |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | Rhode Island's multidisciplinary team review of drug-related overdose deaths may include, as determined by the director of health, the following individuals: (1) a representative from the department of health; (2) a representative from the office of the attorney general; (3) a representative from the Rhode Island State Police; (4) a representative from the department of corrections; (5) a representative from the department of behavioral healthcare, developmental disabilities, and hospitals; (6) a representative from the Rhode Island Police Chiefs Association; (7) a representative from the Hospital Association of Rhode Island; (8) an emergency department physician; (9) a primary care physician; (10) an SUD medicine/treatment provider; (11) a mental health clinician; (12) a toxicologist; (13) a recovery coach or other representative of the recovery community; and (14) others as may be determined by the director of health.<br><br>The Rhode Island law contains one list of team members instead of a list of required members and a list of potential additional members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The team's goal is to reduce the prevalence of overdose deaths by examining emerging trends in overdoses, identifying potential demographic, geographic, and structural points for prevention, as well as other factors.<br><br>Rhode Island law is not as specific as the Model Act. |
| **Access to Information** | Unlike the Model Act, Rhode Island law does not address details about what records and information the team can request or access. |
| **Confidentiality** | The team's work product is confidential and protected under all applicable laws, including HIPAA and the Rhode Island Confidentiality of Health Care Information Act. The information provided to the team is exempt from subpoena, discovery, or introduction into evidence in any civil or criminal proceeding and is not subject to disclosure beyond the team members.<br><br>The team is allowed to gather information from consenting relatives regarding the circumstances of the decedent's death as long as the information gathered remains confidential and is only publicly released as aggregate de-identified information. The information gathered shall not be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding and shall not be subject to disclosure beyond the team members, except to authorized employees of the department of health as necessary to perform its official duties.<br><br>Unlike the Model Act, Rhode Island law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Rhode Island law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |

# RHODE ISLAND (continued)

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| **Reporting Requirement** | The team is required to submit a report on or before December 1 of each year to the governor, the speaker of the house of representatives, and the president of the senate. The report should summarize the activities of the team as well as the team's findings, progress toward reaching its goals, and recommendations for any needed changes in legislation or otherwise.<br><br>Like the Model Act, Rhode Island law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. Rhode Island law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# UTAH

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| **Statute(s) and/or Regulation(s)** | Utah Code Ann. § 26B-1-403 (West 2023) |
| **Effective Date** | The Utah Opioid and Overdose Fatality Review Committee (Committee) was chartered in 2017 pursuant to implied authority under Utah's Injury Reporting Rule. The governor signed the authorizing statute (H.B. 295) on March 28, 2020. The statute was renumbered on May 3, 2023. |
| **Drugs or Substances of Focus** | Opioids and substances that closely resemble opioids. This is different from the Model Act. There are anecdotal reports that the Committee reviews cocaine-related deaths even though the statute only mentions opioids and substances that closely resemble opioids. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | The Utah Department of Health (Department) established the Committee, consisting of (1) the attorney general; (2) a state, county, or municipal law enforcement officer; (3) the manager of the Department's Violence Injury Program; (4) an EMS provider; (5) a representative from the office of the medical examiner; (6) a representative from the division of substance abuse and mental health; (7) a representative from the office of vital records; (8) a representative from the office of health care statistics; (9) a representative from the division of professional licensing; (10) a health care professional who specializes in the prevention, diagnosis, and treatment of SUDs; (11) a representative from a state or local jail or detention center; (12) a representative from the department of corrections; (13) a representative from juvenile justice services; (14) a representative from the department of public safety; (15) a representative from the commission on criminal and juvenile justice; (16) a physician from a Utah-based medical center; and (17) a physician from a nonprofit vertically integrated health care organization. The president of the senate may also appoint one member of the senate and the speaker of the house of representatives may appoint one member of the house of representatives to serve on the Committee.<br><br>The list of required team members in Utah's law is similar to that of the Model Act, but it does include some members who are not included in the Model Act, such as members of the state legislature. The Utah law contains one list of team members instead of a list of required members and a list of potential additional members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The Committee reviews available information regarding a decedent of an opioid overdose death and identifies specific factors that put the decedent at risk for an opioid overdose. The Committee also makes recommendations for changes to law or policy that may prevent opioid overdose deaths and informs public health and public safety entities of emerging trends in opioid overdose deaths. The Committee can meet up to eight times each year.<br><br>This is similar to the Model Act. |
| **Access to Information** | The Department must give the Committee access to all reports, records, and other documents that are relevant to the Committee's responsibilities, including reports, records, or documents that are private, controlled, or protected under the state's Government Records Access and Management Act. The Committee may interview or request information from a staff member, a provider, or any other person who may have knowledge or expertise that is relevant to the review of an opioid overdose death.<br><br>Utah law is not as specific as the Model Act regarding what records the team can access. In addition, it does not specify which persons or entities must comply with a records request, as the Model Act does. |

# UTAH (continued)

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| **Confidentiality** | In accordance with Utah Code Ann. 63G-2-206(6) (West 2022), the Committee faces the same restrictions on disclosure of a report, record, or other document as the Department. When an individual case is discussed in a committee meeting, the Committee is required to close the meeting to the public.<br><br>Unlike the Model Act, Utah law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Utah law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | Unlike the Model Act, Utah does not have a reporting requirement. |
| **Funding Source** | Not addressed in statute. Utah law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# VIRGINIA

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| **Statute(s) and/or Regulation(s)** | VA Code Ann. § 32.1-283.7 (West 2023) |
| **Effective Date** | July 1, 2018 |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | Local/county level. This is the same as the Model Act. |
| **Team Members** | Any county or city may establish a local or regional OFR team. The local teams may be composed of the following persons from the localities represented on a particular board or their designees: (1) a medical examiner, (2) a local social services official, (3) a director of the relevant local or district health department, (4) a chief law enforcement officer, (5) an attorney for the commonwealth, (6) an executive director of the local community services board or other local mental health agency, (7) a local judge, (8) the local school division superintendent, and (9) a representative of a local jail or detention center.<br><br>Additional members who can be appointed by the chairperson of the team may include (1) representatives of local human services agencies, (2) local health care professionals who specialize in the prevention and treatment of substance use disorders, (3) local EMS personnel, (4) a representative of a hospital, (5) experts in forensic medicine and pathology, (6) local funeral services providers, and (7) representatives of the local bar.<br><br>Virginia law has established a set of required team members and a set of members who can be appointed by the chair. In comparison, the Model Act has established a set of required members and a set of suggested members. The team members listed in Virginia's law are similar to those listed in the Model Act. |
| **Duties, Tasks, and Objectives** | Local teams review the death of any person who lives in the commonwealth and whose death was or is suspected to be due to overdose. In addition, the teams promote cooperation and coordination among agencies involved in investigations of overdose deaths or providing services to surviving family members. Moreover, the teams recommend changes within the agencies represented on the local team and advise state agencies on changes to law, policy, or practice to prevent overdose deaths.<br><br>This is similar to the Model Act. |
| **Access to Information** | Unlike the Model Act, Virginia law does not detail what records and information a team can request or access. |

# VIRGINIA (continued)

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| **Confidentiality** | All information and records obtained or created regarding a review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act. All such information and records shall be used by a team only in the exercise of its proper purpose and function and shall not be disclosed. Such information and records shall not be subject to subpoena, subpoena duces tecum, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during the fatality review. No person who participated in the review and no member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the victim's family shall be returned to the originating agency or destroyed. The portions of meetings in which individual cases are discussed by the team shall be closed to the public. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. A violation of these provisions is punishable as a class 3 misdemeanor.<br><br>Like the Model Act, Virginia law requires team members to sign a confidentiality form before participating in an overdose review. In addition, Virginia law has a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | Unlike the Model Act, Virginia law does not have a reporting requirement. |
| **Funding Source** | Not addressed in statute. Virginia law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# WEST VIRGINIA

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| **Statute(s) and/or Regulation(s)** | W. Va. Code Ann. § 61-12A-2 (West 2023) (authorizing statute)<br><br>W. Va. Code R. § 64-29-7 (2023) (membership and responsibilities)<br><br>W. Va. Code R. § 64-29-15 (2023) (confidentiality) |
| **Effective Date** | July 12, 2013 |
| **Drugs or Substances of Focus** | Prescription drugs. This is different from the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | West Virginia's Unintentional Pharmaceutical Drug Overdose Fatality Review Panel (Panel) consists of the following members or their designees: (1) the chief medical examiner for public health; (2) the director of the West Virginia State Board of Pharmacy; (3) the commissioner of public health; (4) the director of the division of vital statistics; (5) the superintendent of the West Virginia State Police; (6) one representative who is a physician nominated by the West Virginia State Medical Association; (7) one representative who is a registered nurse nominated by the West Virginia Nurses Association; (8) one representative who is a doctor of osteopathy nominated by the West Virginia Society of Osteopathic Medicine; (9) one licensed physician or doctor of osteopathy who practices pain management as a principal part of their practice; (10) one representative who is a doctor of pharmacy, with a background in prescription drug abuse and diversion, selected by the West Virginia Pharmacists Association; (11) one representative who is a licensed counselor selected by the West Virginia Association of Alcoholism and Drug Abuse Counselors; (12) one representative of the United States Drug Enforcement Administration; (13) one representative who is a prosecuting attorney selected by the West Virginia Prosecuting Attorneys Institute; (14) a person who is considered an expert in bioethics training; (15) one representative who is a licensed dentist recommended by the Board of Dental Examiners; and (16) any additional persons that the chairperson of the panel determines is needed in the review and consideration of a particular case.<br><br>West Virginia law contains one list of team members instead of a list of required members and a list of potential additional members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The Panel reviews and analyzes all deaths occurring within the state where the cause of death was determined to be due to an unintentional pharmaceutical drug overdose and determines what trends, patterns, and risk factors are related to unintentional pharmaceutical drug overdose fatalities. In addition, the Panel develops and implements standards for the uniform and consistent reporting of unintentional pharmaceutical drug overdose deaths by law enforcement or other emergency service responders and provides statistical information and analysis regarding the causes of unintentional pharmaceutical drug overdose fatalities.<br><br>This is similar to the Model Act. |
| **Access to Information** | The Panel may request the following information and records as necessary to carry out its responsibilities: (1) medical, dental, and mental health records; (2) substance use records; and (3) information and records maintained by any state, county, and local government agency.<br><br>West Virginia law is not as specific as the Model Act regarding what records the team can access. In addition, it does not specify which persons or entities must comply with a records request, as the Model Act does. |

# WEST VIRGINIA (continued)

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| **Confidentiality** | All information and records of the Panel, and opinions expressed by members, are confidential and not to be released or disclosed except as aggregate data in the Panel's annual report. The Panel's proceedings, records, and opinions are confidential and are not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. Panel members may not be questioned in any civil or criminal proceeding regarding information presented in, or opinions formed as a result of, a meeting of the Panel.<br><br>Unlike the Model Act, West Virginia law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, West Virginia law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | The West Virginia Fatality and Mortality Review Team, which oversees the Panel as well as the child fatality review panel, the domestic violence fatality review panel, and the infant and maternal mortality review panel, is required to submit an annual report to the governor and to the legislative oversight commission on health and human resources accountability concerning its activities within the state and the activities of the advisory panels. The report is due annually on December 1. The report is to include statistical information concerning cases reviewed during the year, trends and patterns concerning these cases, and the team's recommendations to reduce the number of fatalities and mortalities that occur in the state.<br><br>Like the Model Act, West Virginia law requires a team to submit an annual report. |
| **Funding Source** | Not addressed in statute. West Virginia law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# SECTION 2:
## JURISDICTIONS WITH OFR LAWS POST-DATING THE MODEL ACT

# MAINE

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| **Statute(s) and/or Regulation(s)** | Me. Rev. Stat. Ann. tit. 5, § 200-M (West 2023) |
| **Effective Date** | June 21, 2021 |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | State level. This is different from the Model Act. |
| **Team Members** | The Maine Accidental Drug Overdose Death Review Panel (Panel) consists of the following members: (1) the chief medical examiner; (2) the commissioner of public safety; (3) the director of behavioral health within the Maine Department of Health and Human Services; (4) the director of the Maine Center for Disease Control and Prevention; (5) the chief justice of the Maine Supreme Judicial Court; (6) a prosecutor nominated by a statewide association of prosecutors and appointed by the attorney general; (7) a police chief nominated by a statewide association of chiefs of police and appointed by the attorney general; (8) a sheriff nominated by a statewide association of sheriffs and appointed by the attorney general; (9) one or more physicians who treat SUD, appointed by the governor; (10) an EMS representative, appointed by the commissioner of public safety; (11) an expert in harm reduction strategies, appointed by the governor; (12) an academic research professor with experience in reviewing drug overdose deaths, appointed by the attorney general; (13) a representative of families affected by drug overdose deaths, appointed by the governor; (14) a person in recovery from SUD, appointed by the governor; and (15) the director of opioid response within the Governor's Office of Policy Innovation and the Future.<br><br>Maine law contains one list of team members instead of a list of required members and a list of potential additional members, as the Model Act does. |
| **Duties, Tasks, and Objectives** | The Panel shall examine a subset of the deaths associated with accidental drug overdoses, taking into consideration the racial and ethnic composition of the population of individuals whose deaths are associated with an accidental drug overdose. The deaths selected for review must be recommended by the chief medical examiner or the examiner's designee or by an individual with whom the office of the attorney general contracts for services.<br><br>Notwithstanding any provision of law to the contrary, the Panel may review information surrounding a nonfatal, accidental drug overdose, if review of such a case promotes the purpose of the Panel under this section. The Panel shall recommend to state, county, and local agencies methods of preventing deaths as the result of accidental drug overdoses, including modification or enactment of laws, rules, policies, and procedures.<br><br>This is similar to the Model Act. |

# MAINE (continued)

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| **Access to Information** | In any case subject to review by the Panel, upon oral or written request of the Panel, and notwithstanding any provision of law to the contrary, any person who possesses information or records that are necessary and relevant to a Panel review shall, as soon as practicable, provide the Panel with the information and records.<br><br>Maine law is not as specific as the Model Act regarding what records the team can access. In addition, it does not specify which persons or entities must comply with a records request, as the Model Act does. |
| **Confidentiality** | The proceedings and records of the Panel are confidential and are not subject to subpoena, discovery, or introduction into evidence in a civil or criminal action. The office of the attorney general shall disclose conclusions of the Panel, upon request, but may not disclose information, records, or data that are otherwise classified as confidential.<br><br>Unlike the Model Act, Maine law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Maine law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | Unlike the Model Act, Maine law does not have a reporting requirement. |
| **Funding Source** | Not addressed in statute. Maine law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# MICHIGAN

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| **Statute(s) and/or Regulation(s)** | 2023 Mich. Legis. Serv. P.A. 313 (S.B. 133) (West) |
| **Effective Date** | February 13, 2024 |
| **Drugs or Substances of Focus** | Not specified. Michigan's law establishes review teams using some structure and language from the Model Act. Unless noted below, the law's provisions are consistent with the Act. |
| **Operational Level** | Local/county level. |
| **Team Members** | Any of the following individuals may be a member of an OFR team: (1) the county health officer; (2) the prosecuting attorney for the county or the attorney's designee; (3) the director of the county's community mental health agency or the director's designee; (4) the county medical examiner or the medical examiner's designee; (5) a law enforcement officer of the department of state police, the participating county, or a municipality within the participating county; (6) a representative of a jail or detection center in the county; (7) a health care provider who specializes in the prevention, diagnosis, and treatment of SUDs; (8) a mental health provider who specializes in the treatment of SUDs; (9) an SUD treatment provider; (10) a representative of an EMS provider in the county; (11) a representative from the department of corrections who has experience with parole, probation, or community corrections; (12) an epidemiologist from a local health department or an organization in the county; (13) a child protective services caseworker; (14) a representative from the department of health and human services who is involved with issues regarding adult protective services; (15) a representative of a hospital with a service area within the county; and (16) any other individual whose membership is necessary for the OFR team to complete the duties required.<br><br>Any of the following individuals may be invited to participate in an individual overdose review: (1) a prepaid inpatient health plan chief executive officer or that officer's designee, or the prepaid inpatient health plan SUD director; (2) a superintendent of a school in the county, or the superintendent's designee; (3) a representative of a hospital in the participating county; (4) a health care provider who specializes in emergency medicine; (5) a health care provider who specializes in pain management; (6) a pharmacist who has expertise in addressing prescription drug misuse and diversion; (7) a representative from a poison control center; (8) a mental health provider; (9) a prescription drug monitoring program administrator; (10) a representative from a harm reduction provider; (11) a recovery coach, peer support worker, or other representative of the recovery community; (12) a representative from a drug court in the county; (13) an SUD prevention specialist or representative; (14) the director of the department of health and human services office in the county, or the director's designee; and (15) any other individual necessary to complete the duties of the OFR team. |
| **Duties, Tasks, and Objectives** | An OFR team shall do all of the following: (1) promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities; (2) identify potential causes and incidences of drug overdose fatalities in the county; (3) recommend and plan for changes within the agencies represented on the OFR team to prevent drug overdose fatalities; (4) propose potential changes to law, policy, funding, or practices to prevent drug overdoses; and (5) 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 OFR team to reduce drug overdose fatalities. |

# MICHIGAN (continued)

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| **Access to Information** | Except as otherwise expressly prohibited by federal or state law, on written request of the chairperson, a health care provider, SUD treatment provider, hospital, or health system shall, not more than 30 business days after receiving the request, provide the chairperson information and relevant records regarding the physical health, mental health, or treatment for the SUD of an individual who is the subject of an individual overdose review of the OFR team.<br><br>Except as otherwise expressly prohibited by federal or state law, on written request of the chairperson, a person shall, not more than 5 business days after receiving the request, provide the chairperson the following information and records: (1) death investigative information. (2) medical examiner investigative information; (3) law enforcement investigative information; (4) EMS reports; (5) fire department records; (6) prosecuting attorney records; (7) parole and probation information and records; (8) court records; (9) school records; (10) information and records regarding resources provided to the decedent by a social services agency; and (11) 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.<br><br>If a family member or friend of the individual who is the subject of an individual overdose review submits a request to submit information to an OFR team, a member of that team may contact, interview, or obtain the information about the individual from that family member or friend.<br><br>Unlike the Model Act, Michigan law does not identify any other persons or entities that must comply with a records request other than health care providers, SUD treatment providers, hospitals, or health systems. |
| **Confidentiality** | Except as otherwise expressly prohibited by federal or state law, OFR team members and invited individuals may discuss confidential matters and share confidential information during an OFR team meeting. This, however, does not authorize the disclosure of confidential information outside of the meeting. If an individual has not signed a confidentiality form, that individual must not participate in or observe an OFR team meeting, individual overdose review, or community overdose review. The confidentiality form must 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 failure to maintain confidentiality. Information obtained or created by or for an OFR team is confidential and not subject to discovery, subpoena, or the Freedom of Information Act (Mich. Comp. Laws Ann. § 15.231 et seq. [West 2023]). Documents and records otherwise available from other sources are not exempt from discovery, subpoena, or introduction into evidence from other sources solely because they were presented to or reviewed by an OFR team. An OFR team shall comply with federal and state laws pertaining to confidentiality and to the disclosure of SUD treatment records, including, but not limited to, 42 U.S.C. 290dd-2 and 42 CFR Part 2. If an OFR 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.<br><br>Michigan law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act like the Model Act does. |

# MICHIGAN (continued)

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| **Reporting Requirement** | The OFR team shall submit an annual report to the public, the local health department of the county, and the department of health and human services that contains all of the following information: (1) the total number of drug overdose fatalities that occurred within the participating county; (2) the number of individual overdose reviews conducted by the OFR team; and (3) any recommendations. The report must not contain any identifying information. |
| **Funding Source** | Not addressed in statute. Michigan law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# NEBRASKA

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| **Statute(s) and/or Regulation(s)** | Neb. Rev. Stat. Ann. §§ 71-3422 to 71-3437 (West 2023) |
| **Effective Date** | June 7, 2023. Nebraska's law establishes overdose review teams using structure and language from the Model Act. Unless noted below, the law's provisions are consistent with the Model Act. |
| **Drugs or Substances of Focus** | Not specified. |
| **Operational Level** | Local/county level. |
| **Team Members** | A local public health department may establish a local team for its jurisdiction or for a group of cities, counties, or districts, pursuant to an agreement among multiple local public health departments.<br><br>A local team must consist of core members who may include one or more members from the following backgrounds: (1) officials from the local public health department or from another local public health department, or such officials' designees; (2) behavioral health provisions or officials; (3) law enforcement personnel; (4) representatives of jails or detection centers; (5) the coroner or the coroner's designee; (6) health care providers who specialize in the prevention, diagnosis, and treatment of SUDs; (7) mental health providers who specialize in SUDs; (8) representatives of EMS providers in the county; (9) the director of children and family services of the department of health and human services' division of children and family services or the director's designee; and (10) representatives from the board of parole, the office of probation administration, the division of parole supervision, or the community corrections division of the Nebraska Commission on Law Enforcement and Criminal Justice.<br><br>A local team may also include, either as permanent or temporary members, the following: (1) a local school superintendent or the superintendent's designee; (2) a representative of a local hospital; (3) a health care provider who specializes in emergency medicine; (4) a health care provider who specializes in pain management; (5) a pharmacist with a background in prescription drug misuse and diversion; (6) an SUD treatment provider from a licensed SUD treatment program; (7) a poison control center representative; (8) a mental health provider who is a generalist; (9) a prescription drug monitoring program administrator or such administrator's designee; (10) a representative from a harm reduction provider; (11) a recovery coach, peer support worker, or other representative of the recovery community; (12) a representative from the local drug court; and (13) any other individual necessary for the work of the local team. |
| **Duties, Tasks, and Objectives** | A local team shall (1) promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities; (2) examine the incidence, causes, and contributing factors of drug overdose deaths in jurisdictions where the local team operates; (3) develop recommendations for changes within communities, public and private agencies, institutions, and systems, based on an analysis of the causes and contributing factors of drug overdose deaths; (4) advise local, regional, and state policymakers about potential changes to law, policy, funding, or practices to prevent drug overdoses; (5) establish and implement protocols and procedures for overdose investigations and to maintain confidentiality; (6) conduct a multidisciplinary review of information received regarding a person who died of a drug overdose; (7) recommend prevention and intervention strategies to improve coordination of services and investigations among member agencies and providers to reduce overdose deaths; and (8) collect, analyze, interpret, and maintain data on local overdose deaths. |

# NEBRASKA (continued)

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| **Access to Information** | Upon written request of the local public health department, and as necessary to carry out the purpose and duties of the local team, the lead organization shall be provided with the following information: (1) nonprivileged information and records regarding the physical health, mental health, and treatment for any SUD maintained by a health care provider, SUD treatment provider, hospital, or health system for an individual whose death is being reviewed by the local team; and (2) information and records maintained by a state or local government agency or entity, including, but not limited to, death investigative information, coroner investigative information, law enforcement investigative information, EMS reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records, and information and records of a social services agency, including the department, if the agency or entity provided services to an individual whose death is being reviewed by the local team.<br><br>The following persons or entities shall comply with a records request by the local public health department: (1) a coroner; (2) a fire department; (3) a health system; (4) a hospital; (5) a law enforcement agency; (6) a local or state governmental agency, including, but not limited to, the department, local public health authorities, the attorney general, county attorneys, public defenders, the commission on public advocacy, the department of correctional services, the office of probation administration, and the division of parole supervision; (7) a mental health provider; (8) a health care provider; (9) an SUD treatment provider; (10) a school, including a public or private elementary, secondary, or post-secondary institution; (11) an EMS provider; (12) a social services provider; and (13) any other person who is in possession of records pertinent to the local team's investigation of an overdose fatality. |
| **Confidentiality** | Members of a local team and other individuals in attendance at a local team meeting, including, but not limited to, experts, health care professionals, or other observers (1) shall sign a confidentiality agreement; (2) are bound by all applicable local, state, and federal laws concerning the confidentiality of matters reviewed by the local team but may discuss confidential matters and share confidential information during such meeting; and (3) except as otherwise permitted by law, shall not disclose confidential information outside of the meeting.<br><br>A member of a local team or an individual in attendance at a local team meeting shall not be subject to civil or criminal liability or any professional disciplinary action for the sharing or discussion of any confidential matter with the local team during a local team meeting. This immunity does not apply to a local team member or attendee who intentionally or knowingly discloses confidential information in violation of the Overdose Fatality Review Teams Act or any state or federal law.<br><br>A local team is not considered to be a public body for purposes of the Open Meetings Act. Except for reports, information and records acquired or created by a local team are not public records subject to disclosure, pursuant to Neb. Rev. Stat. Ann. §§ 84-712 to 84-712.09 (West 2023), and shall (1) be confidential; (2) not be subject to subpoena; (3) be privileged and inadmissible in evidence in any legal proceeding of any kind or character; and (4) not be disclosed to any other department or agency of the State of Nebraska, except the department of health and human services as specified in the Overdose Fatality Review Teams Act.<br><br>A person aggrieved by the intentional or knowing disclosure of confidential information in violation of the Overdose Fatality Review Teams Act by a local team, its members, or a person in attendance at a local team meeting may bring a civil action for appropriate relief against the person who committed such violation. A person who intentionally or knowingly violates the confidentiality requirements of the Overdose Fatality Review Teams Act is guilty of a class II misdemeanor. |

# NEBRASKA (continued)

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| **Reporting Requirement** | On or before June 1, 2024, and on or before June 1 thereafter, each local team shall submit a report to the department. The report shall include at least the following for the preceding year: (1) the total number of fatal drug overdoses that occurred within the jurisdiction of the local team; (2) the number of fatal drug overdoses investigated by the local team; (3) the causes, manner, and contributing factors of drug overdose deaths in the team's jurisdiction, including trends; (4) recommendations regarding the prevention of fatal and nonfatal drug overdoses for changes within communities, public and private agencies, institutions, and systems, based on an analysis of such causes and contributing factors—such recommendations shall include recommended changes to laws, rules and regulations, policies, training needs, or service gaps to prevent future drug overdose deaths; and (5) a follow-up analysis of the implementation of and results from any recommendations made by the local team, including, but not limited to, changes in local or state law, policy, or funding made as a result of the local team's recommendations. The report must include only de-identified information and must not identify any victim, living or dead, of a drug overdose. The report is not confidential and should be made available to the public. |
| **Funding Source** | Not addressed in statute. Nebraska law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# NEW JERSEY

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| **Statute(s) and/or Regulation(s)** | N.J. Stat. Ann. §§ 26:3A2-20.3 to 20.10 (West 2023) |
| **Effective Date** | April 18, 2022. New Jersey's law establishes overdose review teams using structure and language from the Model Act. Unless noted below, the law's provisions are consistent with the Model Act. |
| **Drugs or Substances of Focus** | Not specified. |
| **Operational Level** | Local/county level. |
| **Team Members** | At a minimum, each local OFR team shall include (1) the county health officer or a designee; (2) the regional or county medical examiner, or a designee; (3) a member of the local advisory committee on alcohol use disorder and substance use disorder, if one exists within the local team's jurisdiction; (4) a state, county, or municipal law enforcement officer or county prosecutor; (5) an SUD health care professional; and (6) the county or municipal director of behavioral health services or a designee.<br><br>A local OFR team may also include any of the following: (1) the superintendent of schools or a designee; (2) an EMS provider; (3) a representative of a health care facility, including a hospital, health system, or federally qualified health center; (4) a representative of a county jail, detention center, or corrections department; (5) a representative of a county social services agency; (6) an individual with access to the prescription monitoring program; (7) a representative of the local office of the division of child protection and permanency in the department of children and families; (8) a representative of a county health care facility; (9) a representative of a harm reduction center, if one is located in a municipality or county over which the local team exercises jurisdiction; (10) a representative of the office of county probation and parole services; and (11) any individual deemed necessary for the work of the local team, as recommended by the chairperson and approved by a majority vote of the team members and by the department of health. |
| **Duties, Tasks, and Objectives** | A local OFR team shall (1) collect, analyze, interpret, and maintain local data on overdose deaths, which information shall be maintained by the local team in accordance with all appropriate and industry-standard technical, administrative, and physical controls necessary to protect the privacy and security of the information; (2) conduct a multidisciplinary review of the information collected regarding a decedent of a confirmed fatal drug overdose, which shall include (a) consideration of the decedent's points of contact with health care systems, social services, educational institutions, child and family services, the criminal justice system, including law enforcement, and any other systems with which the decedent had contact prior to death; and (b) identification of the specific factors and social determinants of health that put the decedent at risk for an overdose; (3) recommend prevention and intervention strategies to improve the coordination of services and investigations among member agencies in effort to reduce overdose deaths; (4) produce confidential case reports based on information received; and (5) submit to the department of health an annual report containing only de-identified data associated with the jurisdiction served by the local team. |

# NEW JERSEY (continued)

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| **Access to Information** | The following individuals and entities may disclose, within a reasonable period of time following a request, medical records and information requested by the local team: (1) county medical examiners, (2) paid fire departments or volunteer fire companies, (3) hospitals and health systems, (4) law enforcement agencies, (5) state and local government agencies, (6) mental health providers, (7) health care practitioners, (8) SUD treatment programs and providers, (9) public and private schools and institutions of higher education, (10) EMS providers, (11) social services agencies and providers, and (12) the prescription monitoring program.<br><br>These individuals or entities may provide a local team with the following information: (1) any relevant information and records maintained by a health care provider related to an individual's physical health, mental health, and SUD treatment; and (2) any relevant information and records maintained by a state or local government agency, including criminal history records and records of probation and parole, if the transmission of such records does not imperil ongoing investigations; medical examiner records; social service records; and school records and educational histories.<br><br>New Jersey law differs from the Model Act in that state law identifies the individuals and entities that may disclose records, while the Model Act requires those listed to comply with a records request. |
| **Confidentiality** | A local OFR team shall establish policies and procedures to ensure that all records in its possession containing personally identifiable information are properly handled and retained and are securely and permanently destroyed within 1 year of, or within a reasonable period of time after, the conclusion of a local team's review of a decedent's case. A local team may only request, collect, analyze, and share information for public health purposes directly related to the review of confirmed fatal drug overdoses and, except as otherwise provided in this act, in compliance with all applicable state and federal laws or regulations. A local OFR team shall develop a confidentiality policy and form establishing: (1) the requirements for maintaining the confidentiality of any information disclosed during a meeting, during review, or any other time; (2) the responsibilities concerning those requirements; and (3) any penalties associated with failure to maintain such confidentiality. Meetings of a local team during which confidential information is discussed shall be closed to the public.<br><br>Unlike the Model Act, New Jersey law does not specifically require team members to sign a confidentiality form before participating in an overdose review. In addition, New Jersey law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act. |
| **Reporting Requirement** | The department of health shall analyze and compile reports from each local OFR team and submit one statewide annual overdose fatality report containing information from each local team. The report shall be submitted to the governor and the legislature. |
| **Funding Source** | The department of health, the office of the chief state medical examiner, applicable county and local health departments, applicable county medical examiner offices, and local OFR teams may pursue all sources of federal funding, matching funds, and foundation funding available to implement the provisions of this act. The department of health, the office of the chief state medical examiner, county medical examiner offices, and local OFR teams may accept such gifts, grants, and endowments, from public or private sources, as may be made, in trust or otherwise, or any income derived according to the terms of a gift, grant, or endowment, to implement the provisions of this act.<br><br>New Jersey law, like the Model Act, contains a funding provision. However, unlike the Model Act, New Jersey law does not establish an OFR teams grant program in the state treasury. |

# OHIO

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| **Statute(s) and/or Regulation(s)** | Ohio Rev. Code Ann. §§ 307.631 to 307.639 (West 2023) |
| **Effective Date** | September 30, 2021 |
| **Drugs or Substances of Focus** | Not specified. This is the same as the Model Act. |
| **Operational Level** | Local/county level. This is the same as the Model Act. |
| **Team Members** | A board of county commissioners may appoint a health commissioner of the board of health of a city or general health district that is entirely or partially located in the county in which the board of county commissioners is located to establish a local drug OFR committee to review drug overdose deaths and opioid-involved deaths occurring in the county. The health commissioner shall select four members to serve on the review committee. A local review committee shall consist of the following: (1) the chief of police of a police department in the county or the county sheriff, or a designee of the chief or sheriff; (2) a public health official or the official's designee; (3) the executive director of the board of alcohol, drug addiction, and mental health services for the county or the executive director's designee; and (4) a physician who is authorized to practice medicine and surgery or osteopathic medicine and surgery. If two or more counties join to form a joint drug OFR committee, then the members of the committee shall be representatives from the most populous county served by the committee. The review committee shall invite the county coroner or, in the case of a regional review committee, the county coroner from the most populous county to serve on the committee. The coroner is not required to accept the invitation.<br><br>The list of team members in Ohio law is not as expansive as the list of members—both required and suggested—in the Model Act. |
| **Duties, Tasks, and Objectives** | The purpose of a local OFR committee is to decrease the incidence of preventable overdose deaths by doing all of the following: (1) promoting cooperation, collaboration, and communication among all groups, professions, agencies, or entities engaged in SUD prevention, education, or treatment efforts; (2) maintaining a comprehensive database of all overdose deaths that occur in the county or region served by the review committee in order to develop an understanding of the causes and incidence of those deaths; (3) recommending and developing plans for implementing local service and program changes and changes to the groups, professions, agencies, or entities that serve local residents that might prevent overdose deaths; and (4) providing the department of health with aggregate data, trends, and patterns concerning overdose deaths.<br><br>This is similar to the Model Act. |
| **Access to Information** | For each drug overdose or opioid-involved death reviewed by a local committee, the committee shall collect all of the following: (1) demographic information of the deceased, including age, sex, race, and ethnicity; (2) the year in which the death occurred; (3) the geographic location of the death; (4) the cause of death; (5) any factors contributing to the death; and (6) any other information the committee considers relevant.<br><br>Ohio law is not as specific as the Model Act regarding what records the team can access. In addition, it does not specify which persons or entities must comply with a records request, as the Model Act does. |

# OHIO (continued)

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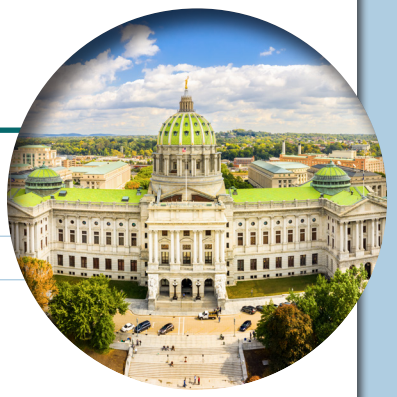
| **Confidentiality** | In an effort to ensure confidentiality, each local committee shall do all of the following: (1) maintain all records in a secure location; (2) develop security measures to prevent unauthorized access to records containing information that could reasonably identify any person; and (3) develop a system for storing, processing, indexing, retrieving, and destroying information obtained in the course of reviewing a drug overdose or opioid-involved death. Any information, document, or report presented to a drug OFR committee; all statements made by review committee members during meetings of the review committee; all work products of the review committee; and data submitted by the review committee to the department of health, other than the annual report, are confidential and shall be used by the review committee, its members, and the department of health only in the exercise of the proper functions of the review committee and the department of health.<br><br>Unlike the Model Act, Ohio law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Ohio law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | By April 1 of each year, the person convening a local committee is required to prepare and submit to the Ohio Department of Health a report that includes all of the following information for the previous calendar year: (1) the total number of drug overdose or opioid-involved deaths in the county or region; (2) the total number of drug overdose or opioid-involved deaths reviewed by the committee; (3) a summary of demographic information for the deaths reviewed, including age, sex, race, and ethnicity; and (4) a summary of any trends or patterns identified by the committee. The report must specify the number of drug overdose or opioid-involved deaths that were not reviewed during the previous calendar year. The report must include recommendations for actions that might prevent other deaths, as well as any other information the review board determines should be included.<br><br>Like the Model Act, Ohio law has an annual reporting requirement. |
| **Funding Source** | Not addressed in statute. Ohio law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# PENNSYLVANIA (2022 Law)



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| **Statute(s) and/or Regulation(s)** | 71 Pa. Stat. and Cons. Stat. Ann. §§ 557 to 557.7 (West 2023) |
| **Effective Date** | December 5, 2022 |
| **Drugs or Substances of Focus** | Not specified. Pennsylvania's law authorizes suicide and overdose death review teams using some structure and language from the Model Act. Unless noted below, the law's provisions are consistent with the Model Act. |
| **Operational Level** | Local/county level. In counties where there is a local health department, the local health department shall be the lead organization to oversee and coordinate the death review team in a form and manner as prescribed by the department of health for the commonwealth. In counties choosing to establish a death review team, if there is not a local health department, an organization interested in being selected as the lead organization shall submit an application, in a form and manner as prescribed by the department of health, for review and approval. The provisions about lead organizations are not in the Model Act. |
| **Team Members** | Members of the overdose death review team shall be selected from any of the following categories: (1) a coroner or medical examiner, (2) a pathologist, (3) a psychologist, (4) a psychiatrist, (5) a local behavioral health representative, (6) an individual who is a member of the education community with experience regarding existing and potential overdose prevention efforts for students in primary and secondary schools, (7) an individual who is a member of the law enforcement community with experience regarding existing and potential overdose prevention efforts for individuals who are involved with the law enforcement system, (8) a representative of an organization that advocates for individuals with behavioral health issues and their family members, (9) a representative of an organization that advocates for individuals with SUDs and their family members, (10) a representative from a single county authority, (11) the county health officer or the officer's designee, (12) the director of the local office responsible for human services or the director's designee, and (13) the local district attorney or the district attorney's designee.<br><br>In addition to the members selected above, the lead organization may select additional members for a death review team as deemed necessary by the lead organization to administer the death review team's duties, including individuals with experience and knowledge in the following areas: (1) physical health services, (2) social services, (3) law enforcement, (4) education, (5) emergency medicine, (6) behavioral health services, (7) juvenile delinquency, (8) adult or juvenile probation, and (9) drug and alcohol SUDs. |

# PENNSYLVANIA (2022 Law) (continued)

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| **Duties, Tasks, and Objectives** | Upon receipt of a report of an overdose death, a death review team may perform the following: (1) inquire into cause of death upon receipt of a report of a qualifying death; (2) conduct a multidisciplinary review of available information collected regarding a deceased individual; (3) establish policies and procedures for collecting and reviewing available information and records regarding the deceased individual from state, county, and local agencies, law enforcement, and private entities; (4) identify points of contact between the deceased individual and health care systems, social services systems, criminal justice systems, and other systems involved with the deceased individual; (5) identify the risk factors that put individuals at risk for an overdose or suicide within the death review team's jurisdiction; (6) promote cooperation and coordination across state, county, and local agencies involved in overdose or suicide investigations; (7) recommend improvements in sources of information relating to investigating reported overdose or suicide deaths, including standards for the uniform and consistent reporting of overdose or suicide deaths by law enforcement or other emergency service responders within the death review team's jurisdiction; and (8) recommend improvements to state laws and local partnerships, policies, and practices to prevent overdose and suicide deaths.<br><br>The department of health is given the following duties under the law: (1) provide technical assistance; (2) facilitate communication between death review teams; (3) transmit certain available information to the appropriate death review team regarding a fatal suicide or overdose in the death review team's jurisdiction; (4) promulgate regulations as necessary to implement the law; and (5) submit an annual report to the governor and the general assembly by September of each year that includes a summary of reports received from local death review teams and recommendations relating to the reduction of risk of death by suicide and overdose. Only provision 5 is contained in the Model Act. |
| **Access to Information** | To the extent permitted by federal law, a death review team may access records as follows:<br><br>If deemed necessary for its review, the death review team may petition the court for leave to review and inspect all files and records of the court relating to a deceased individual in accordance with 42 Pa. Stat. and Cons. Stat. Ann. § 6307 (West 2022) (relating to inspection of court files and records).<br><br>Persons or entities that provide SUD treatment services shall provide to an overdose death review team the records of a deceased individual under review without need for authorization of any person, including the executor, administrator, or personal representative of the deceased individual, for purposes of review.<br><br>The death review team may review and inspect mental health care service files and records of a deceased individual under review without the need for authorization of any person, including the executor, administrator or personal representative of the deceased individual, for purposes of review. Health care facilities and health care providers, pharmacies, and mental health care providers shall provide medical records of a deceased individual under review without the need for authorization of any person, including the executor, administrator or personal representative of the deceased individual, for purposes of review.<br><br>Other records pertaining to the deceased under review shall be open to inspection as permitted by law. |

# PENNSYLVANIA (2022 Law) (continued)

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| **Access to Information (continued)** | Notwithstanding any other provision of law, the following shall be provided to a death review team upon written request of the lead organization or chairperson of a death review team:<br><br>Records regarding the treatment for SUD, maintained by a federally assisted SUD treatment provider, for a deceased individual under review by a death review team, as permitted to be shared in accordance with federal law, including 42 CFR Part 2.<br><br>Records regarding the physical health and mental health—maintained by a health care provider, hospital, or health system—for a deceased individual under review by a death review team.<br><br>Records maintained by a state or local government agency or entity, including death investigative information, medical examiner investigative information, law enforcement investigative information, EMS reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records and information and records of a social services agency, including the department of human services, if the agency or entity previously provided services to the deceased individual under review by a death review team.<br><br>The following shall comply with a records request by a death review team: (1) a coroner or medical examiner; (2) a fire department; (3) a health system; (4) a hospital; (5) a law enforcement agency; (6) a state or local government agency, including the department of health, the department of human services, and the department of corrections; (7) a mental health provider; (8) a health care provider; (9) an SUD treatment provider; (10) a school; (11) an EMS provider; (12) a social services provider; (13) a prescription drug monitoring program representative; and (14) any other person or entity that is in possession of records pertinent to the death review team's investigation of an overdose death.<br><br>Pennsylvania's OFR law addresses access to records in two separate sections, § 557.4 and § 557.5. Section 557.4, summarized on page 41, includes language that is not found in the Model Act. Section 557.5, summarized on this page, is more reflective of the Model Act. |
| **Confidentiality** | A death review team meeting shall be closed to the public, and information discussed at the meeting shall be confidential. The proceedings, records, and information maintained by and shared with a death review team may not be (1) disclosed under the commonwealth's Right-to-Know Law or (2) subject to discovery, subpoena, or introduction into evidence in a criminal or civil proceeding. Information presented in, or opinions formed as a result of, a meeting of a death review team may not be subject to subpoena or discovery or admissible as evidence in a civil or criminal action. An individual who is not a member of a death review team may, in good faith, provide information to a death review team. A member of a death review team or an individual who, in good faith, provides information to a death review team may not be disciplined, criminally prosecuted, or held administratively or civilly liable for complying with the provisions of this statute.<br><br>Unlike the Model Act, Pennsylvania law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Pennsylvania law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |

# PENNSYLVANIA (2022 Law) (continued)

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| **Reporting Requirement** | A death review team shall prepare and submit to the department of health an annual report. The team shall publish the annual report on the local department of health's or local government's publicly accessible internet website for the purpose of evaluations, policy considerations, and health care program enhancements. The annual report must comply with all confidentiality requirements and should include all of the following information: (1) a summary of the aggregated, non-individually identifiable findings of the death review team for the previous year; (2) recommendations to improve systems of care and community resources to reduce suicides or fatal overdoses in the death review team's jurisdiction; (3) proposed solutions for inadequacies in the systems of care; (4) recommendations to improve sources of information regarding the investigation of reported suicides and overdose deaths, including standards for the uniform and consistent reporting of suicides and fatal overdoses by law enforcement or other emergency service responders within the death review team's jurisdiction; and (5) recommendations for improvements to state laws and local partnerships, policies, and practices to prevent suicide and overdose fatalities.<br><br>The department of health is required to submit an annual report to the governor and the general assembly by September of each year that includes a summary of reports received from local death review teams and recommendations relating to the reduction of risk of death by overdose. |
| **Funding Source** | Not addressed in statute. Pennsylvania law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# WASHINGTON

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| **Statute(s) and/or Regulation(s)** | Wash. Rev. Code Ann. § 70.05.210 (West 2023) |
| **Effective Date** | June 9, 2022 |
| **Drugs or Substances of Focus** | Not specified. Washington law establishes review teams using some structure and language from the Model Act. Unless noted below, the law's provisions are consistent with the Model Act. |
| **Operational Level** | Local/county level. |
| **Team Members** | Unlike the Model Act, Washington law does not specify who should be on the team other than that the team should be multidisciplinary. |
| **Duties, Tasks, and Objectives** | A multidisciplinary overdose, withdrawal, and suicide fatality review team is tasked with reviewing overdose, withdrawal, and suicide deaths and developing strategies for the prevention of overdose, withdrawal, and suicide fatalities. The review process may include (1) a systematic review of medical, clinical, and hospital records related to the overdose, withdrawal, and suicide; (2) confidential interviews conducted; and (3) analysis of individual case information and review of this information by a team of professionals to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.<br><br>Washington law allows the team to review withdrawal cases in addition to overdose cases, which is different from the Model Act. |
| **Access to Information** | A review team has the authority to request and receive (1) all medical records related to the overdose, withdrawal, and suicide; (2) autopsy reports; (3) medical examiner reports; (4) coroner reports; (5) school records; (6) criminal justice records; (7) law enforcement records; and (8) social service records.<br><br>Upon request by the local health department, (1) health care providers; (2) health care facilities; (3) clinics and schools; (4) the criminal justice department; (5) law enforcement; (6) laboratories; (7) medical examiners; (8) coroners; (9) professions and facilities licensed by the department of health; (10) local health jurisdictions; (11) the health care authority and its licensees and providers; (12) the department of health and its licensees; (13) the department of social and health services and its licensees and providers; and (14) the department of children, youth, and families and its licensees and providers must provide to the local health department all medical records related to the overdose, withdrawal, and suicide; autopsy reports; medical examiner reports; coroner reports; social services records; and other data requested for specific overdose, withdrawal, and suicide fatalities to perform an overdose, withdrawal, and suicide fatality review. |

# WASHINGTON (continued)

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| **Confidentiality** | All health information collected as part of an overdose, withdrawal, and suicide fatality review is confidential, subject to the restrictions on disclosure provided in Wash. Rev. Code Ann. § 70.02 (West 2022). Documents collected may be used solely by local health departments for the purposes of the review. Information, documents, proceedings, records, and opinions created, collected, or maintained by review teams or the local health department in support of the teams are confidential and are not subject to public inspection or copying nor discovery or introduction into evidence in civil or criminal actions. Any person who attended a meeting of the review team or who participated in the creation, collection, or maintenance of the review team's information, documents, proceedings, records, or opinions may not testify in any civil or criminal action as to the content of such proceedings or the review team's information, documents, records, or opinions. All meetings, proceedings, and deliberations of the review teams are confidential and may be conducted in executive session.<br><br>Unlike the Model Act, Washington law does not require team members to sign a confidentiality form before participating in an overdose review. In addition, Washington law does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act, as the Model Act does. |
| **Reporting Requirement** | Unlike the Model Act, Washington law does not have an annual reporting requirement. |
| **Funding Source** | Not addressed by statute. Washington law is different from the Model Act, which establishes an OFR teams program grant fund in the state treasury and allows the fund to be funded by legislative appropriation, federal grants, private grants, and gifts. |

# SECTION 3:
## LEGISLATION AUTHORIZING OFRS PROPOSED DURING 2023

| State/Bill Number/ Status | Description |
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| **Kansas**<br><br>H.B. 2390, 2023–2024 Leg., Reg. Sess. (Kan. 2023) (conference committee report issued April 6, 2023) | This bill proposes establishing the "Kansas Overdose Fatality Review Board Act," which amounts to the Model Act largely as written. As compared to the Model Act, the primary differences in this bill are (1) the team is established on the state level as opposed to the local level; (2) there is no requirement for team members to sign a confidentiality form before participating in an overdose review; and (3) there are no funding provisions. |
| **New York**<br><br>S.B. 5378, 2023–2024 Leg., Reg. Sess. (N.Y. 2023) (pending in committee) | This bill proposes to authorize an accidental fatality review team to be established at a local or regional level, with the approval of the New York Department of Health, for the purpose of investigating the unexpected or unexplained death of any person, including, but not limited to, deaths suspected to be caused by overdose or suicide. The bill provides a list of required team members not as extensive as the Model Act. The bill does not list the types of records the team can access, nor does it specify which individuals or entities must comply with a records request. Unlike the Model Act, the bill does not (1) require team members to sign a confidentiality form before participating in an overdose review; (2) have a criminal liability provision for individuals who violate the confidentiality requirements of the act; and (3) have an annual reporting requirement. No funding provisions were included in the bill. |
| **Tennessee**<br><br>H.B. 566, 113rd Gen. Assemb., Reg. Sess. (Tenn. 2023) (bill died upon legislature's adjournment); and S.B. 291, 113rd Gen. Assemb., Reg. Sess. (Tenn. 2023) (bill died upon legislature's adjournment) | These bills proposed establishing the "Overdose Fatality Review Act," which amounted to the Model Act largely as written. As compared to the Model Act, the primary difference in these bills was that there were no funding provisions. |

| State/Bill Number/ Status | Description |
|---|---|
| **Wisconsin**<br><br>S.B. 177, 2023–2024 Leg., Reg. Sess. (Wis. 2023) (pending in committee); and A. 188, 2023–2024 Leg., Reg. Sess. (Wis. 2023) (pending in committee) | Under this bill, the department of health services must establish a fatality review program composed of local fatality review teams established at the option of a county, a local health department, or a tribal health department, or a combination of these entities. The bill contains general provisions governing any type of fatality review team. The bill identifies examples of the types of deaths that may constitute a reviewable death, including those caused by unintentional injury, overdose, suicide, and homicide, among other causes. The bill provides a list of required team members not as extensive as the Model Act. The bill does not list the types of records the team can access, but it does specify which individuals or entities may comply with a records request. Like the Model Act, the bill does require team members to sign a confidentiality form before participating in an overdose review. Unlike the Model Act, the bill does not have a criminal liability provision for individuals who violate the confidentiality requirements of the act and does not have an annual reporting requirement. No funding provisions are included in the bill. |

# SECTION 4:
## JURISDICTIONS WITH OFR-RELATED LAWS THAT DO NOT ESTABLISH OR AUTHORIZE OFRS

# COLORADO

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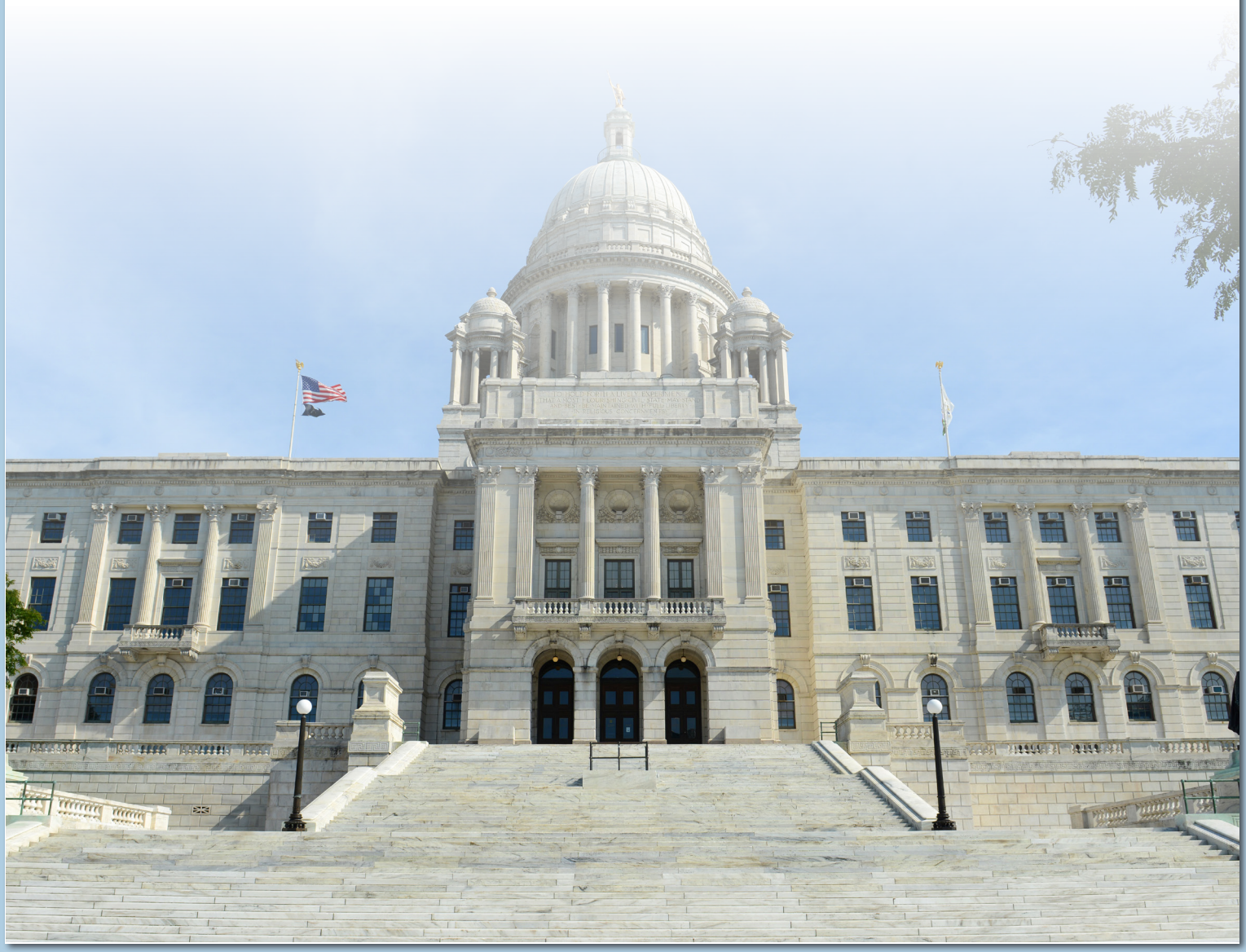
| **Statute(s) and/or Regulation(s)** | Colo. Rev. Stat. Ann. § 25-20.5-1701 (West 2022) |
| **Effective Date** | July 1, 2022 |
| **Description** | Unlike other state laws described in this document, Colorado's law does not focus on the establishment of state or local overdose review teams. Instead, it asks the Colorado Department of Public Health and Environment (Department) to develop recommendations about forming a state-level committee. As a result, the Colorado law is much different than the Model Act. The Department shall convene interested stakeholders for the purpose of developing recommendations for the establishment of an overdose trends review committee that would be responsible for (1) identifying and reviewing nonfatal and fatal drug-related overdoses that occur in Colorado; (2) identifying the causes of overdose-related deaths and conducting a review of other factors, including, but not limited to, housing status or criminal justice system involvement; (3) developing evidence-based recommendations to address preventable overdose-related deaths, including legislation, policies, areas for scientific research, rules, training, and best practices; (4) making annual policy-related and funding-related recommendations to the governor and the general assembly about drug trends, including synthetic drugs that present a high risk for causing overdose-related deaths; and (5) establishing a process for data sharing among state departments, counties, and other relevant entities in order to access necessary data concerning nonfatal and fatal drug-related overdoses in Colorado. On or before September 1, 2023, the Department must submit a report of its recommendations to the Joint Budget Committee and any substance use interim committee existing at that time. The Department shall establish the overdose trends review committee by September 1, 2024. |

# ENDNOTES

1. Melissa Heinen and Mallory O'Brien, July 2020, Overdose Fatality Review: A Practitioner's Guide to Implementation, https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf.
2. An 18th state, Colorado, has a law pertaining to OFRs. Unlike the other 17 states, however, Colorado's law does not focus on the establishment of state or local OFRs. Instead, it asks the state department of health to develop recommendations about forming a state-level committee.
3. Legislative Analysis and Public Policy Association, February 11, 2021, Model Overdose Fatality Review Teams Act, https://legislativeanalysis.org/model-overdose-fatality-review-teams-act/.
4. Initially established in 2017 via committee formation ("charter") pursuant to implied authority under Utah's Injury Reporting Rule.
5. Initially established in 2016 via an executive order.
6. The goal of this research document is to provide accurate and complete information that is free of omissions. If you believe that this document contains misinformation or errors, please email LAPPA at info@thelappa.org.
7. Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act, 35 Pa. Stat. and Cons. Stat. Ann. §§ 872.1–872.40 (enacted in 2015).



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