CRISP DC

Use Case Policy: Health Department Fatality Reviews

Overview

Public Health Officials are tasked with a series of fatality review responsibilities across Maryland and the District of Columbia. Drug overdoses are a serious public health challenge in Maryland, DC, and the United States. The passage of HB 1282 established Local Overdose Fatality Review Teams (LOFRTs) under Maryland law to allow any jurisdiction to establish a team. The bill creates team structures and processes; including provisions governing data collection, maintenance and reporting, including confidentiality and agency disclosure requirements; and provides immunity from civil liability to team members participating in good faith and to persons providing information to LOFRTs. The goal is to better understand the epidemic and engage in comprehensive, cross-agency efforts to reduce opioid overdose deaths. These efforts include educating the public and implementing new medical practices. Teams established under the bill may advise the State about changes to law, policy, or practice on preventing overdose death. The more detailed and timely review of data allows the Department and local jurisdictions to identify patterns of overdose activity, which enhances public health responses and planned interventions at the state and local levels.

Maryland also has a State Child Fatality Review (CFR) Team intended to prevent child deaths by developing an understanding of the causes and incidence of child deaths. The team was established by the Maryland General Assembly in 1999 through the Md. Health Gen. Article 5-702-704. The law requires State CFR Team membership to include a range of departmental and child abuse and neglect experts. Data is currently collected from Vital Statistics, Injury Prevention, Highway Safety and local reviews is used to guide the State CFR Team in making significant and purposeful recommendations to the legislature and to community action groups aimed at preventing child deaths.

Maternal Mortality Review (MMR) was also authorized under Md. Health Gen. Article 13-1201 to support review team access to medical information to support the maternal death review process. In addition, Health Gen. Article 4-212 as amended by legislation (HB 1400) passed in 2018 grants a physician designated by the State Anatomy Board to complete a death certificate.

The District of Columbia Office of Chief Medical Examiner (OCME) has three fatality review boards authorized under separate statutes. The Domestic Violence Review Board, the Child Fatality Review Committee, and the Developmental Disabilities Fatality Review Committee are separately authorized to examine past events and circumstances surrounding specific fatalities by reviewing records and other pertinent documents of public and private agencies responsible for investigating deaths or treating patients. In addition, the State or the District may establish additional fatality review teams through statue, regulation, or executive order as needed.

Allowing CRISP query portal and specific report access for OCME physicians, State Anatomy Board physicians, fatality review teams, boards, and committees would provide members a more efficient

and effective way to access information pertinent to the work they are performing under existing regulations to help understand and mitigate these fatalities.

Permitted Purpose Category

For a Public Purpose, as permitted or required by Applicable Law and consistent with the mission of the HIE to advance the health and wellness of patients in the CRISP service area (Permitted Purpose #2).

Use Case Description

A member of the fatality review team identifies a fatality to be reviewed, prompting them to investigate and gather information on the fatality in an attempt to identify patterns and improve upon public health responses and interventions. Once the fatality to be investigated is identified appropriate members of the team shall have access to CRISP query portal to access information about the patient whose fatality is being investigated. In addition, CRISP DC may make specific information available in the form of a panel-based report upon request of the DC OCME or fatality review teams.

Membership of the team or boards are widely varied and may include Emergency Medical Service, law enforcement, community members, social workers, representation from local pharmacies, representation from the education department, and outreach. The OCME or the Departments of Health provides oversight to the teams. The agencies will ensure team compliance with expectations set out by CRISP in the Use Case.

Opt-Out Applicability

Any patients that opts out of CRISP will be opted out from the ability for the OCME physicians, fatality review teams, boards, and committees to access their health information via query or report.

Eligible Participants

The CRISP portal and requested reports would be available for use by OCME physicians and members of the Review Teams designated by the State or District or Local Health Departments. All users must be verified by a departmental point of contact and must complete the required steps to gain access to the system.

Approval

This Use Case Policy was originally approved by the Clinical Advisory Board on February 9, 2016. The updated use case has been approved by the Clinical Advisory Board.

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Chairperson	10/1/2021 Dated