YORK COUNTY OVERDOSE FATALITY REVIEW

Annual Report

BUREAU OF HEALTH

YORK OPIOID COLLABORATIVE

Overdoses Are Preventable.

York County established its Overdose Fatality Review Team in 2021, with key community members involved and organizations represented.

The York County Overdose Fatality Review (OFR) Team was established by a joint initiative between the City of York Bureau of Health, York Opioid Collaborative, and the County of York Offices of the Coroner and District Attorney. The City of York Bureau of Health received Overdose Data to Action (OD2A) funding in January 2020 and within the first two years of funding, York worked to build capacity with stakeholders interested in collaborating on the OFR Team. York County established its Overdose Fatality Review Team in 2021, with key community members involved and organizations represented.

The OFR Team affiliation agreement, confidentiality agreement, meeting confidentiality acknowledgment, roles and responsibilities, process and procedures, and other templates were finalized prior to the first case review on Tuesday, June 1, 2021. Stakeholders were recruited, processes and protocols were developed, confidentiality documents were developed, and 12 case review meetings were convened between June 2021 and May 2023. We reviewed two cases each bimonthly (one accidental and one suicide). During each case review, we identified improvement opportunities in our systems for helping people with substance use disorder and their families.

Our Purpose

The purpose of this Team is to prevent overdose deaths. We accomplish this purpose by examining individual, organizational, and systems level factors related to overdose deaths that occur in York County, Pennsylvania. The OFR purpose is to:

- Develop an understanding of the causes and incidence of overdose deaths in York County.
- Identify risk factors and missed opportunities for prevention and intervention to make policy and programmatic recommendations to prevent future overdose deaths.
- Promote cooperation and coordination among agencies involved in the investigations of overdose deaths and/or provide services to families.
- Define effective localized strategies for coordinating services related to overdose prevention.
- Development and implementation of data-driven prevention and intervention strategies.
- Identify system gaps and innovative community-specific overdose prevention and intervention strategies.
- Develop plans for and recommend changes within the agencies represented on the team to law, policy, and practice that relate to prevent overdose deaths.
- Inform public health and public safety of emerging trends in overdose events.

The purpose of the York County Overdose Fatality Review Team is to prevent overdose deaths.

Our Objectives

To fulfill the purposes of the York County Overdose Fatality Review Team, the Team objectives are to:

- Establish policies and procedures for sharing all available information on overdose decedents from local, county, and state government agencies and private entities (including medical examiner investigative records, behavioral health and somatic care treatment records, healthcare payer records, social service records, criminal justice history information, family and social history, etc.) that maintain confidentiality.
- Conduct multidisciplinary, multi-agency reviews of available information to determine the incidence and prevalence of fatal overdose and the factors that cause or are correlated with overdoses.
- Identify points of contact between deceased individuals and healthcare, social services, criminal justice, and other systems where prevention/intervention efforts could be implemented.
- Identify the specific factors that put individuals at high-risk for overdose.
- Improve coordination and collaboration between member agencies/entities.
- Inform the development of comprehensive local overdose prevention and response plans and identify changes to statue, regulation and policies that support plan implementation and overdose prevention efforts generally.
- Assist with implementation, impact and outcomes assessment of overdose prevention activities and the development of best practices.

Meetings

Meetings were held bi-monthly in 2021-2022 with 4 meetings in 2021, 6 meetings in 2022, and 2 meetings in 2023. Two cases were reviewed each bi-monthly meeting, including one accidental drug-confirmed death case and one suicide death by drug case. In 2023, we shifted to quarterly meetings and reviewed three cases, including two accidental drug-confirmed death cases and one suicide death by drug case. A typical meeting will be two hours in length. Given the sensitive nature of the information shared and the need to build trusted relationships, the meetings are closed and not open to the public.

Team Structure & Members

LEAD ORGANIZATION

STEERING COMMITTEE

GOVERNING COMMITTEE — YORK COUNTY OFR TEAM

Lead Organization - City of York Bureau of Health

Act 101 outlines categories of individuals who may be selected as a member of a death review team by its "lead organization." 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 Pennsylvania Department of Health. The City of York Bureau of Health received funding through the Overdose Data to Action (OD2A) from January 2020 - August 2023 to support this initiative.

Public Health and Safety Team (PHAST) - OFR Governance Committee

Steering Committee

The Steering Committee of the York County OFR Team includes the York County Coroner's Office, the York County District Attorney's Office, York Opioid Collaborative, and the City of York Bureau of Health.

CHAIR
Pam Gay
York County Coroner

CHAIR
Chuck Murphy
York County
District Attorney's Office

FACILITATOR
Dr. Matthew Howie
WellSpan Health

COORDINATOR/ DATA MANAGER
Samantha Zahm
City of York Bureau of Health

COORDINATOR
Brittany Shutz
York Opioid Collaborative

Membership - Primary Team Members

Casey Darling-Horan
York/Adams MH DD

Dr. Mitchell Crawford
WellSpan Health

Adam Ogle
York County Prison

Michael Stough
York County Probation Services

Audrey Gladfelter
York/Adams Drug and Alcohol Commission

Clair Doll
York County Human Services

Tanya Stauffer
York County Children, Youth and Families

Tia Neal
York County Department of Emergency Services, 911 Communications

Becky Lockner
Lived Experience/CRS

Theresa Sellers
UPMC in Central PA

Committee Members/Partner Agencies

As of January 2023, there were 15 primary team members representing 13 different organizations.

- City of York Bureau of Health
- Person with Lived / Living Experience
- UPMC in Central PA
- WellSpan Health
- WellSpan Philhaven, Behavioral Health
- York County Children, Youth and Families
- York County Coroner's Office
- York County Department of Emergency Services, 911 Communications
- York County District Attorney's Office
- York County Human Services
- York County Prison
- York County Probation Department of Adult Services
- York Opioid Collaborative
- York/Adams Drug & Alcohol Commission
- York/Adams Mental Health – Intellectual & Developmental Disabilities (MH-IDD)

An OFR is a systemic process used to examine the underlying causes of overdose fatalies in real time and problem solve.

The York County OFR team is multidisciplinary that includes team members who can share caselevel data about the decedent and/or contribute to the analysis of available data as a subject maer expert. Currently, it is not feasible to review every overdose death in our community. An OFR is a systemic process used to examine the underlying causes of overdose fatalies in real time and problem solve.

1 Case Selection and Data Gathering:

- ✔ Identify cases, gather records and examine the Coroner's Office report
- ✔ Identify 2-3 cases based on case selection criteria
- ✔ Recruit guest members based off the York County Coroner's Office Death Investigation Report
- ✔ Access records of the deceased via record request letter*
- ✔ Secure email sent to team members with Coroner's Office Death Investigation Reports (4-weeks prior)
  - o For virtual meetings: send out Zoom registration information
- ✔ Prepare PowerPoint presentation with compiled data into detailed case notes and other visuals
- ✔ 2-Week Meeting reminder email sent to members
- ✔ Prepared agendas and other meeting materials – printed/emailed to members

2 Review Cases:

- ✔ In-depth case reviews by multi-disciplinary partners to examine case information and identify contributing factors and key takeaways

3 Make Recommendations:

- ✔ Collectively identify changes within and across already existing programs and systems designed to prevent and reduce overdose

4 Change Systems:

- ✔ Actionable recommendations to strengthen these programs and systems. Every interaction with a part of the system is an opportunity for intervention

Case Selection Criteria

York County Coroner, Pam Gay, began performing autopsies on each individual who overdosed in 2014. The Coroner and District Attorney, David Sunday, spent months persuading York County's 23 police departments, many of which rarely handle major investigations, to treat every overdose like a crime scene. These efforts were aided in part by a 2011 change in Pennsylvania state law that demoted drug delivery resulting in death (DDRD) from a murder charge to a first-degree felony. DDRD charges increased 356% statewide in Pennsylvania from 2015 to 2019. York is one of the highest counties with the highest percentage of DDRD offenses. Under current law, prosecutors have five years to charge a person who provided a drug that led to a fatal overdose.

Case determination is decided by the following criteria:

INCLUDE:

Drug overdose deaths where the death certificate AND/OR the coroner or medical examiner report indicates that acute drug toxicity was directly the cause of death

- All drug overdose deaths of unintentional or undetermined intent should be included

Manner of death[1] — deaths where the manner of death is accident, suicide or undetermined related to drugs.

- The manner of death is the circumstance that led to the cause of death. The Commonwealth of Pennsylvania recognizes five manners of death—Homicide, Suicide, Accident, Natural, and Undetermined

EXCLUDE:

Age of decedent under 21 years old—excluded cases are being reviewed by local child death review team under Public Health Child Death Review Act[2]

Cases under active investigation and litigation—exclude cases that would hinder the progress of an active investigation or criminal proceeding

- Accidental cases currently being reviewed first by the York County District Attorney's Office to ensure these cases are excluded.

[1] PA Laws Empowering, Defining and Limiting the Power of the Coroner, http://www.pacoroners.org/Laws.php and Death Investigation: A Guide for the Scene Investigator https://www.ojp.gov/pdffiles/167568.pdf
[2] 11 Pa. Stat. § 2150.20

Every member of our community should have the chance to live a healthy life. Knowing who lives here helps us figure out how to best serve our community and what extra support might be needed. Factors like age, race and ethnicity, sex, languages spoken, immigrant population, veterans, and disabilities are all important to understand the unique needs of our community. York County, Pennsylvania is an urban county with a total population of 461,058 people according to the U.S. Census[3]. While York County is predominantly White (82%), the City of York is predominantly populations of people of color (62%).

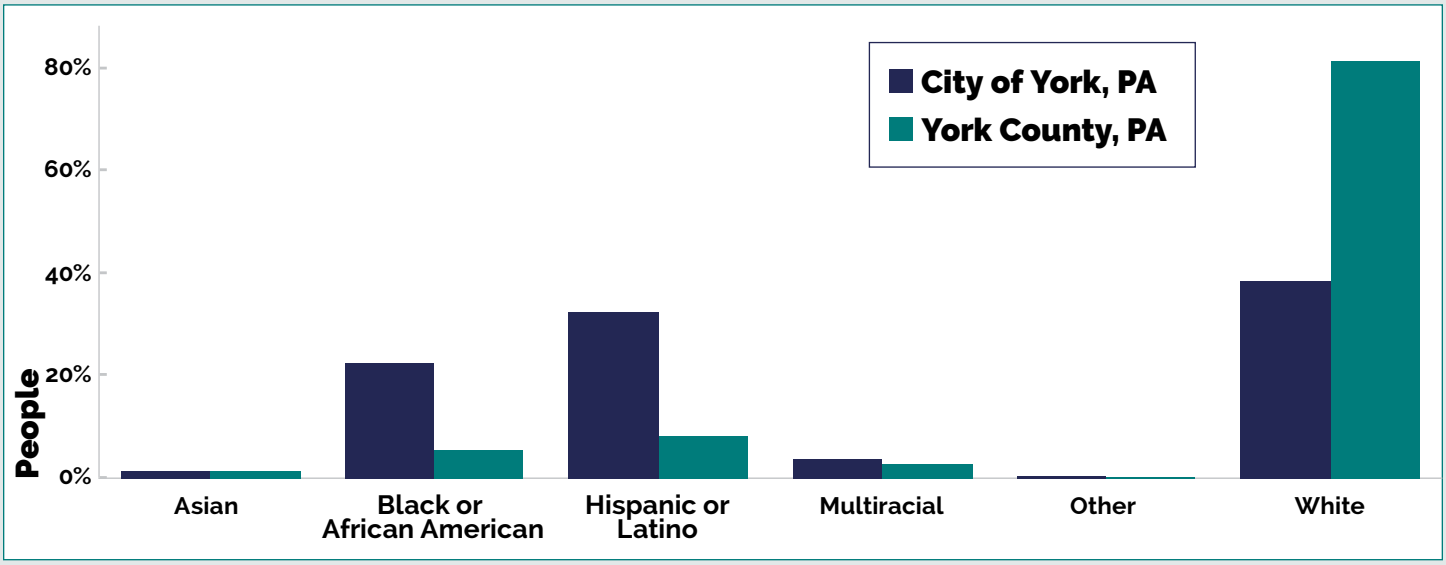
People of Color

62%
of People
City of York, PA

18%
of People
York County, PA

Source: US Census Bureau ACS 5-year 2017-2021

Race & Ethnicity



Source: US Census Bureau ACS 5-year 2017-2021
Note: Hispanic or Latino includes any race. All other races in this chart are not Hispanic or Latino.

The Opioid Epidemic and Addiction Crisis in York County, Pennsylvania

In recent years, more people have died in York County, Pennsylvania, by drug overdoses – primarily due to opioid and substance misuse – than by traffic incidents. Reports of opioid overdoses and other substance misuse-related deaths in York County are astonishing. According to annual reports issued by the York County Coroner, accidental drug overdoses are consistently one of the top causes of traumatic death in the county. On average, nearly 15 Pennsylvanians died from a drug overdose every day in 2021.

The overdose death rate in York County per 100,000 population increased 37.41% from 22.6 in 2013-2015 to 33.0 in 2017-2019. In addition, the overdose death rate in York County per 100,000 population was 43.09% higher in 2017-2019 than the overdose death rate nationwide.

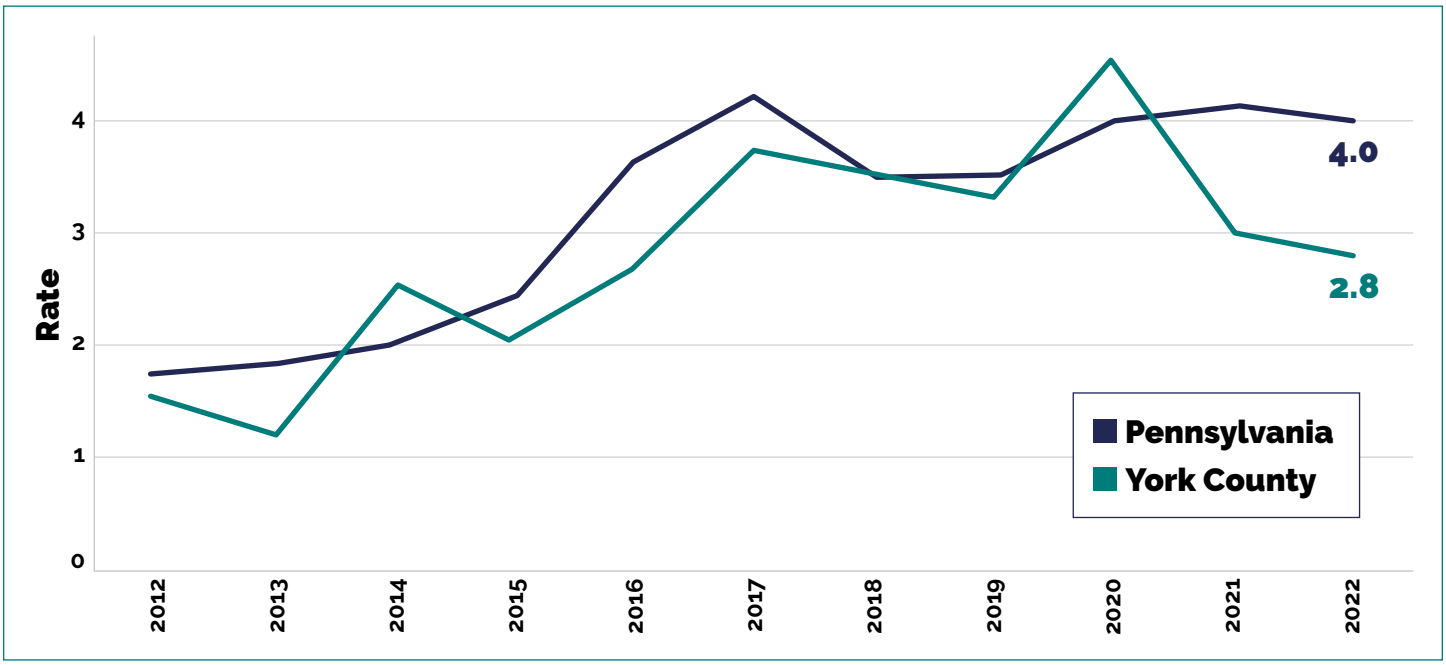
In recent years, more people have died in York County by drug overdoses than by traffic accidents.

Age-Adjusted Rate of Drug Overdose Deaths per 100,000[4]

	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
York County	22.6	26.4	23.9	28.9	33.0
Pennsylvania	20.4	23.8	31.7	40.7	40.1
United States	14.9	16.9	19.3	20.7	21.3

[4] https://www.health.pa.gov/topics/Documents/Programs/PDMP/Pennsylvania%20Overdose%20Data%20Brief%202021.pdf

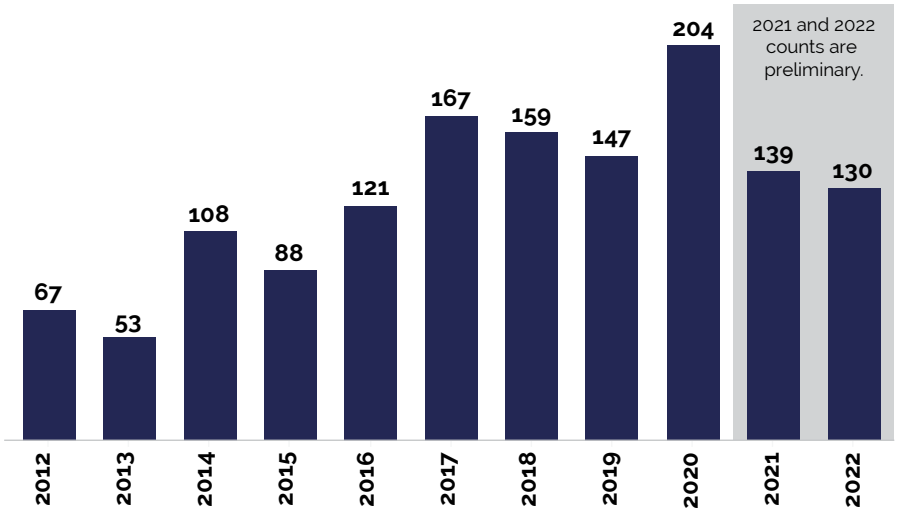
Rate of Any Drug Overdose Deaths Per 100,000 Population by Year



Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

In York County, drug overdose deaths were slowly on the decline from 2017 to 2019 (12.73%) in York County. However, the opioid epidemic has not gone away and in fact, has gotten worse because of the COIVD 19 pandemic in 2020. To prevent the spread of COIVD 19, prolonged mitigation efforts such as social distancing led to an increase in isolation and created barriers to care. Among the impacts was a sharp increase by 32.48% in overdose deaths in York County from 2019 to 2020, when the COVID epidemic swelled. Drug overdose deaths spiked to an all-time high in 2020 in York County. After the uptick in 2020, drug overdose deaths decreased by 37.90% from 2020 to 2021. The figure on the next page shows total drug overdose death counts in York County by year.

Any Drug Overdose Death Estimates by Year in York County, 2012-2022



2021 and 2022 death data is preliminary and subject to change, based on death record data reported to the Department of Health (DOH) as of July 2023. Death investigations and overdose death records are often delayed by 3-6 months and **2021/2022** counts will likely be higher than currently reported.

*** Any Drug** overdoses include overdoses from illicit, prescription or over-the-counter drugs, excluding alcohol-only related overdoses. Counts do not include suicides or homicides where someone intended to harm another person by poisoning.

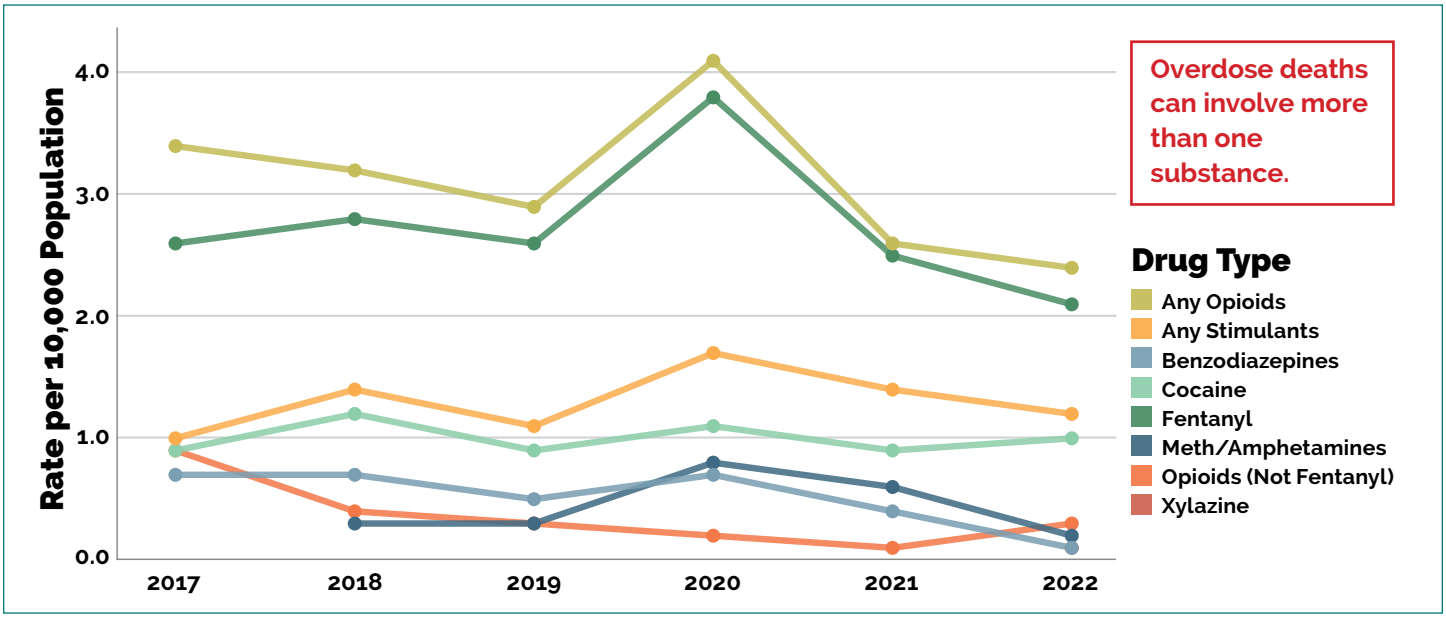
Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

[5] https://www.health.pa.gov/topics/HealthStatistics/HealthyPeople/Documents/current/county/su-03-drug-overdose-death-rate-lhi.aspx and NCHS Data Brief, Number 457, December 2022 (cdc.gov)

Opioids continue to be an important driver of drug overdose death in York County.

However, increases in other substances contributing to death validates we are dealing with a poly-substance use epidemic. Preliminary estimates show that of the 946 total drug overdose deaths identified between 2017 to 2022, 89.11% (843) were confirmed to involve an opioid in York County with an 8.85% increase from 2017 to 2022.

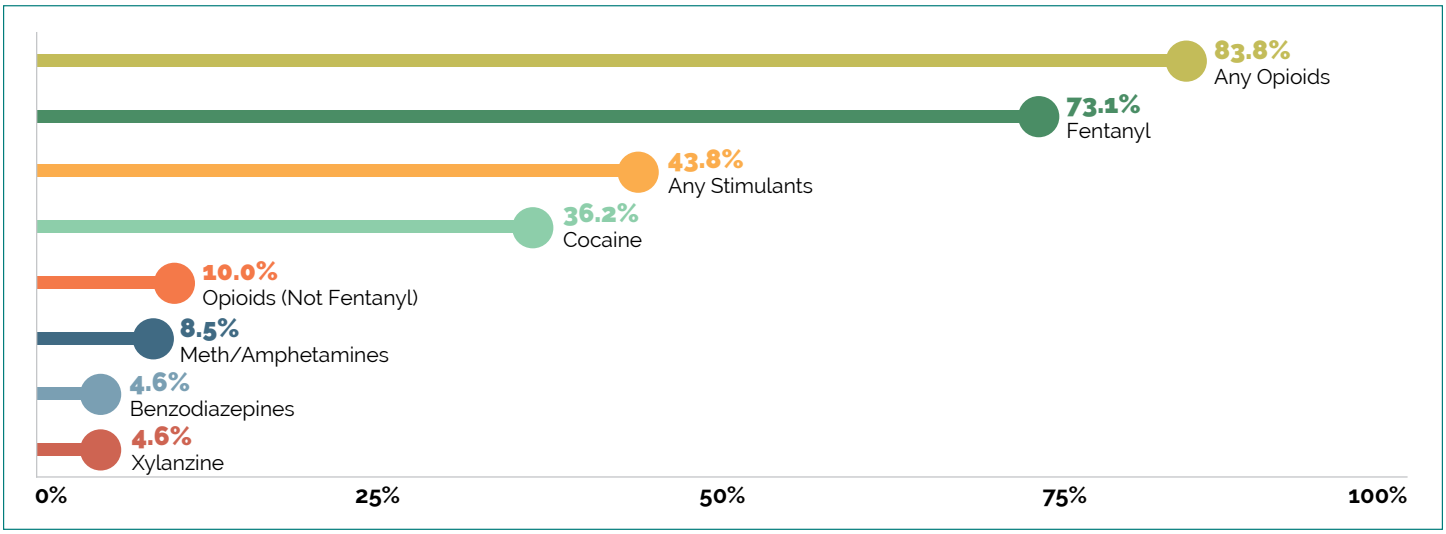
Trends in the Most Common Drugs Contributing to Cause of Death in York County from 2017 to 2022



Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

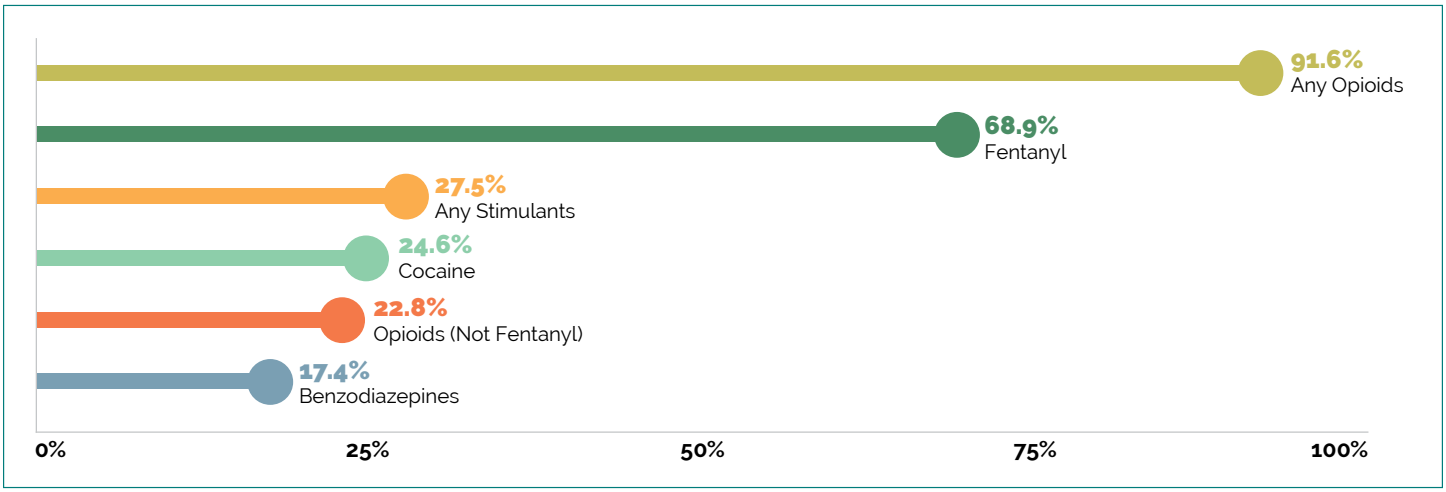
The most common combinations of drugs contributing to death remains fentanyl only with 46.11% in 2017 and 40.00% in 2022. Stimulant involvement includes overdoses of any prescription stimulant medication, such as methylphenidate, or illicit stimulants, such as cocaine and methamphetamine contributing to death and increased by 45.72% compared to 2017 to 2022. In 2017, 27.54% (46) involved any stimulant. For comparison, 43.85% (57) involved any stimulant in 2022.

Drug Classes Contributing to Cause of Death for the 130 Overdose Deaths in York County, 2022



Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

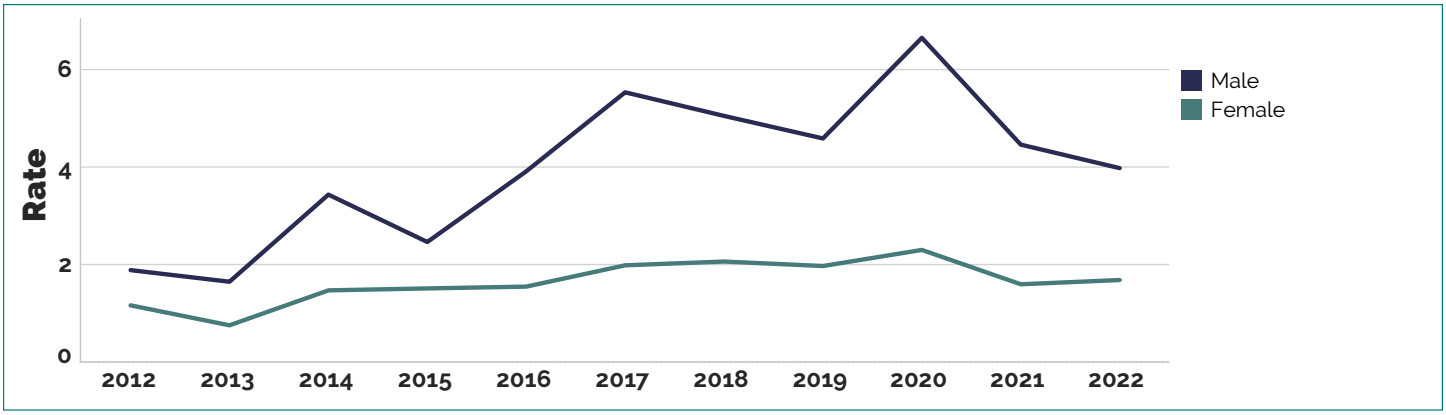
Drug Classes Contributing to Cause of Death for the 167 Overdose Deaths in York County, 2017



Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

Despite relatively equal populations of males (49.7%) to females (50.3%) in York County according to the U.S. Census Bureau, there was a disproportionately higher number of overdose deaths among males in York County. 70.00% of drug overdose deaths occurred among males.

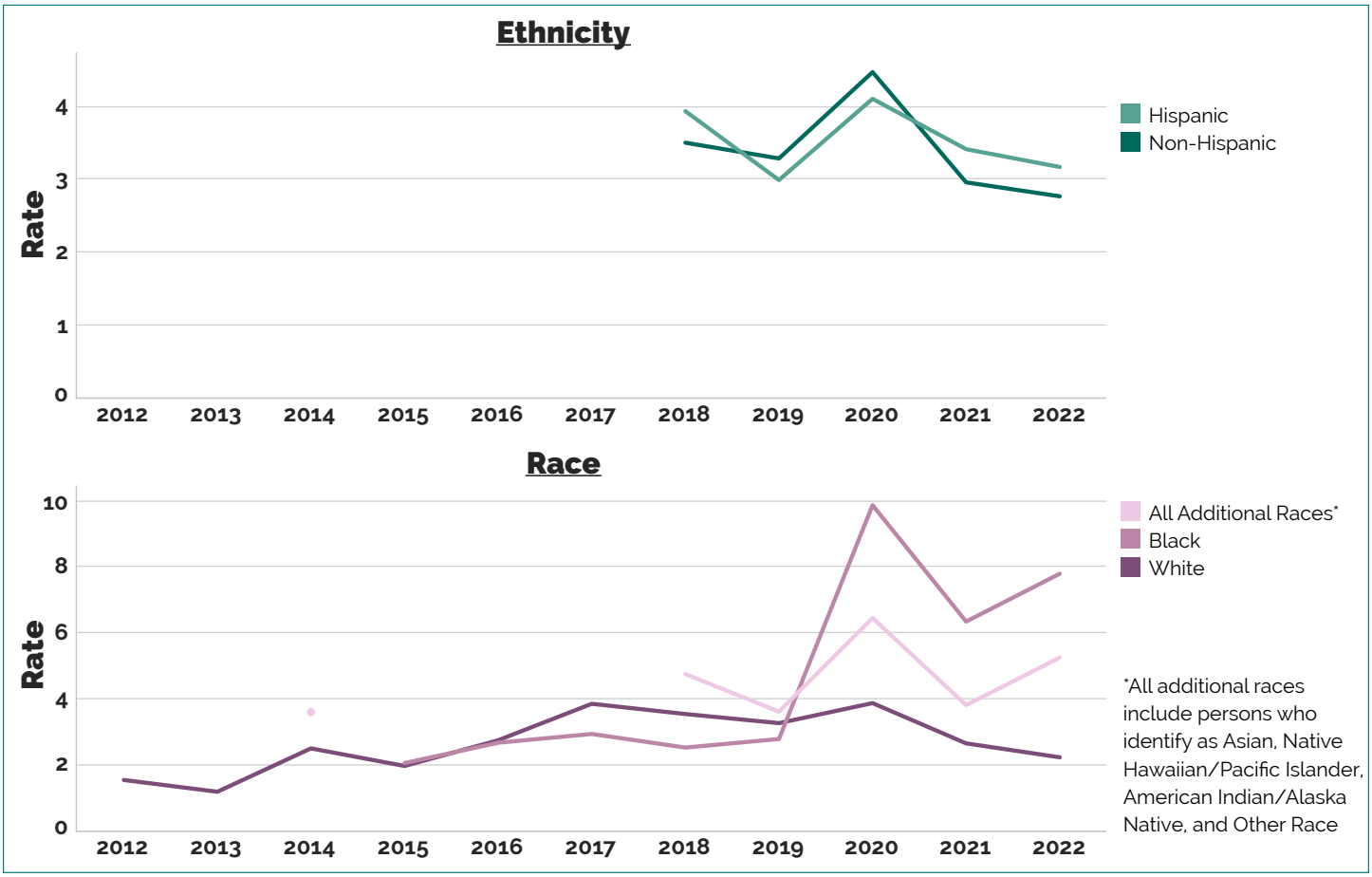
Demographic Trends for Sex by Rate of Death per 10,000 in York County 2012 – 2022



Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

YORK COUNTY
Overdose Fatality Review

Demographic Trends for Ethnicity and Race by Rate of Death per 10,000 in York County, 2012 – 2022

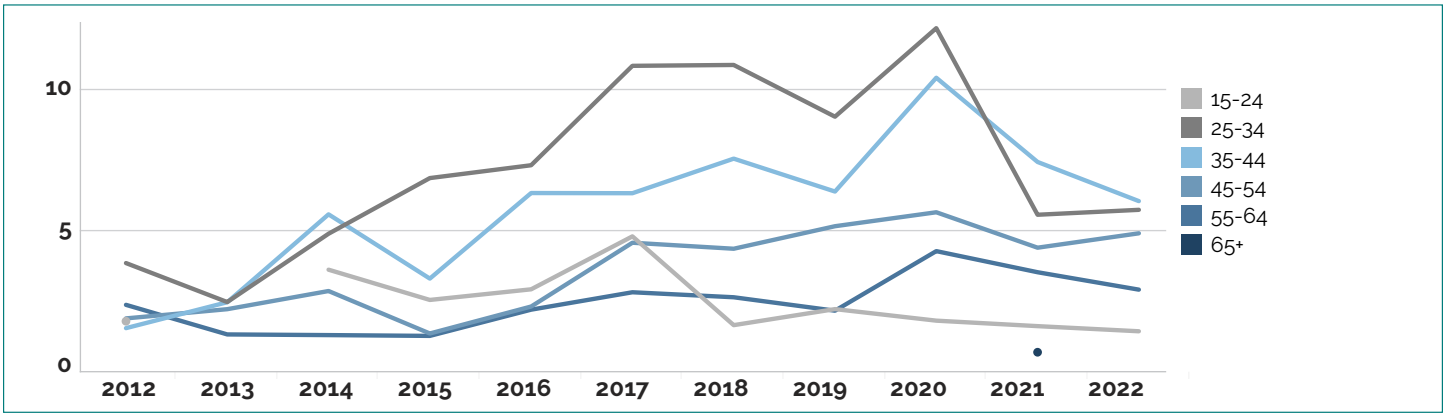


Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

The figures above show rate of overdose deaths per 10,000 population in York County by race and ethnicity. While York County is predominantly white, we have seen a significant increase of overdose deaths in populations of people of color over the past five years.

The figure below shows the majority of drug overdose deaths in 2022 occurred among those 35–44 years old (6.1 deaths per 10,000 population), followed by those 25–34 years old (5.8 deaths per 10,000 population).

Demographic Trends for Age by Rate of Death per 10,000 in York County, 2012 – 2022



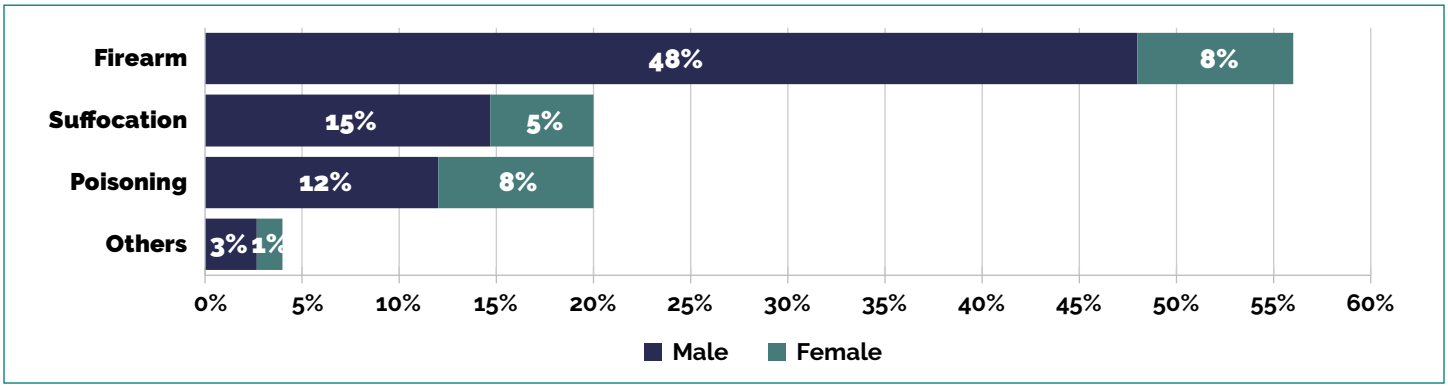
Source: Pennsylvania ODSMP – Drug Overdose Surveillance Interactive Data Report

Trends in Suicide Deaths in York County, Pennsylvania

The Pennsylvania Violent Death Reporting System[6] (PAVDRS) is a state-level surveillance system funded through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). The PAVDRS program collects data on all suicides, homicides, undetermined deaths, and accidental firearm deaths occurring in Pennsylvania.

Firearms were the most common method of death by suicide, accounting for 48% of all suicide deaths from 2016-2018[7] in York County. The next most common method of suicide was suffocation including hangings at 29% followed by poisoning at 21% including drug overdose.

Leading Causes of Suicide Deaths in York County by Sex, 2016-2018



Source: Pennsylvania Violent Death Reporting System York County Factsheet 2019

The suicide rates in York County per 100,000 population increased 18.41% from 14.3 in 2011-2015 to 17.2 in 2015-2019. This is 21.94% higher than nationwide suicide rates in 2015-2019.

Age-Adjusted Suicide Rate per 100,000[8]

	2011-2015	2012-2016	2013-2017	2014-2018	2015-2019
York County	14.3	15.3	16.9	17.8	17.2
Pennsylvania	13.1	13.4	14.0	14.3	14.5
United States	12.7	12.9	13.2	13.6	13.8

In York County, males were 3 times more likely to die by suicide than females. The rate of suicide is highest among middle-aged white men.

- ✔ In 2019, York County had 75 suicide deaths (58 males and 17 females) which occurred at a rate of 16.7 suicide deaths per 100,000 people. In 2019, York County averaged more than 1 suicide death every week.
- ✔ In 2018, York County had 92 suicide deaths (69 males and 23 females) at a rate of 20.5 suicide deaths per 100,000 people. Approximately 8 suicide deaths occurred every month in 2018 in York County.
- ✔ In 2017, York County had 90 suicide deaths (69 males and 21 females) at a rate of 19.2 suicide deaths per 100,000 people. Approximately 7 suicide deaths occurred every month in 2017 in York County.

[6] https://www.health.pa.gov/topics/programs/violence-prevention/Pages/VDRS.aspx
[7] https://www.health.pa.gov/topics/Documents/Programs/Violence%20and%20Injury%20Prevention/2016-2018%20PAVDRS%20York%20County%20Suicide%20Fact%20Sheet.pdf
[8] https://www.health.pa.gov/topics/HealthStatistics/HealthyPeople/Documents/current/county/mhmd-01-suicide-rate-lhi.aspx and https://www.cdc.gov/nchs/data/databriefs/db464-tables.pdf#1

Data & Findings from Case Reviews

25 **Total Cases:**
15 accidental and
10 suicide by drug
were reviewed June 2021 – May 2023

15 Accidental Drug Overdose Fatalities

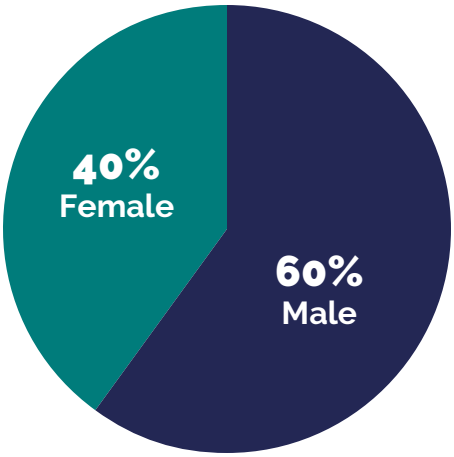
- ✔ **Sex**
  Males (9) and Females (6)
- ✔ **Race**
  White (13), Hispanic (1), and Bi-racial (1)
- ✔ **Average Age of Decedent at Time of Death**
  31 years

The majority of the people who died from an accidental drug overdoses were never married or single (79%). In addition, the majority of people who died from a drug overdose died in their own home. Of the 15 accidental overdose fatalities reviewed, 12 (80%) occurred at Residence, 2 (13%) at a Motel, and 1 (7%) at Friend's Residence.

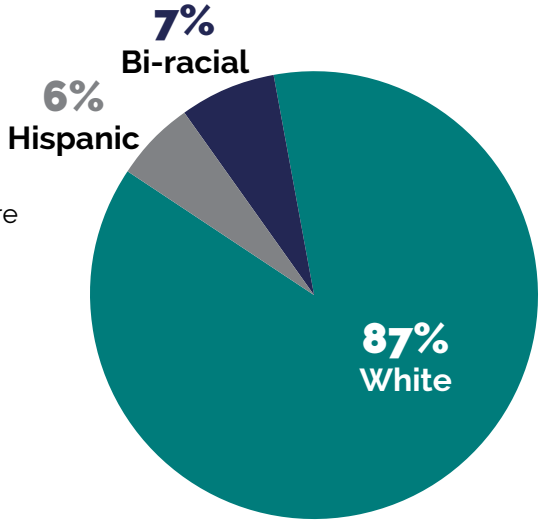
Over 50% (8) of the 15 accidental overdose fatalities reviewed, mixed substance toxicity was reported as the cause of death with fentanyl and/or morphine being present in all fatalities except one.

Over 90% of the people who died from a drug overdose were not born in Pennsylvania (N=11) with the majority birth state being Maryland followed by Florida and New York.

By Sex



By Race

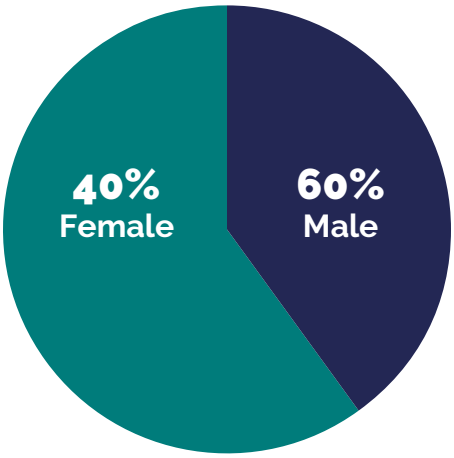


10 Accidental Drug Overdose Fatalities

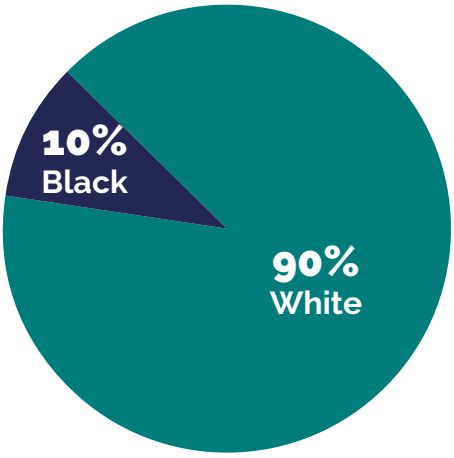
- ✔ **Sex**
  Males (4) and Females (6)
- ✔ **Race**
  White (9) and Black (1)
- ✔ **Average Age of Decedent at Time of Death**
  60 years

The majority of people who died from suicide by drug died in their own home. Of the 10 suicide fatalities reviewed, 9 (90%) occurred at Residence and 1 (10%) occurred at Parent's Residence.

By Sex



By Race



Additional Case Statistics

Among the 25 fatalities reviewed, the average age was 40 years old.

- **20-29 years old** = 8 cases
- **30-39 years old** = 6 cases
- **40-49 years old** = 5 cases
- **50-59 years old** = 2 cases
- **60+ years old** = 4 cases

Among the 25 fatalities reviewed, the year of death:

- **2014** = 1 case
- **2016** = 1 case
- **2017** = 6 cases
- **2018** = 9 cases
- **2019** = 1 case
- **2020** = 3 cases
- **2021** = 4 cases

Recommendations

After review of overdose related data, the OFR team develops recommendations to prevent future overdoses and overdose deaths. Recommendations are then shared to be implemented by OFR partners and community agencies. Recommendations to date have focused on communication, information and resource sharing, training, referrals to services, naloxone distribution and education opportunities. The recommendations generated during the case reviews meetings are taken to the following Public Health and Safety Team (PHAST) meetings for feedback and support. Below is a snapshot of some recommendations that have been or are currently in the process of being implemented along with updates on progress that has been made:

Recommendation	Timeline	October 2022	December 2022	January 2023
Create a referral-to-help card that partner agencies can share with at-risk individuals and their loved ones (based off Winnebago County We Heart You Initiative). [York County Probation Services, York Opioid Collaborative]	Ongoing	York Opioid Collaborative to assist sharing card county wide.	"We Care, York" cards are available. Request cards and/or request a PDF version to print at your convenience from York Opioid Collaborative.	Update version & print more in next few months • 988 change – Casey to assist
Crisis intervention should follow up after certain patient encounters. [MH-IDD]	Follow-up	Crisis intervention does have a follow-up and protocol.	N/A	Changed timeline from complete to follow-up.
Offer training and support to first responder agencies in York County. [York Opioid Collaborative]	On Hold	Need to explore further	Need to explore further	N/A
Naloxone distribution to Motels/ Hotels [York City Bureau of Health + Tamar, YADAC, York Opioid Collaborative]	In Progress	Identify motels to reach out to and process for having naloxone on site. Reaching out to corporate hotels.	Letters sent out to motels/hotels to set-up having naloxone on site. So far, no responses from hotels; we need to schedule some targeted outreach.	Working on some targeted outreach in-person and phone calls. Workgroup presented to Explore York in January 2023 and Brittany continuing outreach and engagement.
Naloxone distribution to patients via Healthcare System. [WellSpan Health]	In Progress	N/A	• WellSpan Health – Opioid Stewardship Steering Committee (best-practice alert for co-prescribing) • UPMC Memorial is giving out naloxone to some patients (knee replacement surgery), but may not be giving proper education around use • York Prison is distributing Narcan to all inmates being released into the community (~250 per month)	Expand activity to include Naloxone distribution to patients via Healthcare System and Other Community Partners
Grief support and resources: More grief support for surviving family members, especially children, especially something that goes beyond support groups. [York City Bureau of Health & York Opioid Collaborative & Coroner's Office & YADAC]	In Progress	Identify agency to assist with grief counseling, support and other services families need after an overdose of a loved one. Connection/ support/engagement. Need to explore further.	Connection/support/engagement. Need to explore further next steps in 2023 including resources to families. Need to explore further with workgroup in 2023..	Next Steps in 2023 create a workgroup to explore further.
Post Overdose Response Strategy: expanding linkages to care for those who don't go to the hospital post overdose. [YADAC/RASE Project and Co-Responder oversight]	In Progress	N/A	Addition of expanding linkages to care for those who don't go to the hospital post overdose, in the description. The agency YADAC/RASE Project and Co-Responder oversight was added. Timeline changed to in progress. Developing procedures for referral to CRS via co-responder program within police departments.	YOC is represented on the Co-Responder Steering Committee. The tasks of implementing a pilot PORT has been responsibility to the Co-responder oversight, as this will be embedded within the existing efforts of that program with the additional resource of a CRS.

Themes from Deaths Reviewed

- ✔ History of Trauma
- ✔ Mental Health and/or Substance Use Disorder (SUD) History
- ✔ Resource Navigation
- ✔ Naloxone Access
- ✔ Bereavement Support Services

February 2023	March 2023	April 2023	May 2023
Distribution ideas discussed • State Police at Loganville Barracks • Maternal Floor at hospitals. hospitals, maternity wards, etc. (Possible exploration in maternity wards in York and how we can support them)	York Opioid Collaborative and York City Bureau of Health working on updating version & print more since 2 numbers need updated	The card has been updated to reflect the following changes: • TrueNorth Crisis Line removed • 988 added	• York Opioid collaborative updated "We Care, York" cards. • Email from York Opioid Collaborative to request new cards • Distribute new cards: 3 boxes on 5/4 (~375 per box) to YOC; 5/9 YCBH distributed 1 box to MCH & 1 box to Sexual Wellness
Potential to come up with more data points that can be collected by crisis team related to substance use in light of new program developments.	N/A	N/A	MH-IDD to follow-up on the crisis intervention protocol. Waiting for updated from MH-IDD
On Hold	N/A	N/A	N/A
A small group met to discuss intentional hotel/motel outreach. A larger group meeting is being scheduled to discuss outreach strategies moving forward.	YADAC visited 10 hotels in person and shared information about the HHI, handed out some Narcan Kits and Deterra pouches. Plan to continue to meet with hotels throughout the year. Also plan to expand outreach to other hospitality businesses including restaurants, special event venues and tourism businesses such as breweries and brewery tours.	N/A	YADAC following up in-person. 10 ONEbox ordered and received. Working on distribution plan and data-informed placement
Communication sent to UPMC to see if progress can be made on access to naloxone inpatient, emergency room, etc. Dr. Howie to follow up with Mitch Crawford and Prison	Working on reviewing information and creating a workgroup. Ordered more Someone I Love Died from a Drug Overdose children's book	N/A	WellSpan continues to look into criteria for alerts and pharmacy has signage and working to have it in-hands in ED with discharge.
Next Steps in 2023 create a workgroup to explore further.	Identify agency to assist with grief counseling, support and other services families need after an overdose of a loved one. Connection/support/engagement. Need to explore further.	Working on reviewing information and creating a workgroup	Working on creating a workgroup to explore further
Developing procedures for referral to CRS via co-responder program within police departments.	N/A	N/A	Post Overdose Response Team Co-Responder, MOU being reviewed and approved at commissions joint board meeting.

BUREAU OF HEALTH

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