PROJECT ECHO: OD-FIT

Overdose Fatality Investigation Techniques

Overdose Fatality Reviews (OFRs)

Tuesday, July 26 at 3-5 p.m. ET / 12-2 p.m. PT

Introduce Yourself In The Chat

Your Name, State, and Title!

Please rename yourself on Zoom with your first and last name so we can accurately take attendance for CEUs!

CEUS certificates will be sent out soon, please keep an eye on your inbox!

Agenda

- Chat with Christine Mattson and Kelly Quinn around SUDORS
- Conversation around overdose fatality reviews with Mallory O’Brien and Tom Gilson
- BREAK
- OFR practice case

Please annotate the Millie-and friends-Meter!

Tired, burnt out

Need more caffeine!

Ready to learn

Enjoying summer/warm weather

What's your Favorite Summer Activity? Annotate!

Spending time with family

Swimming

Reading

Traveling

Doing nothing/Relaxing

BBQs/Picnics

SUDORS data dashboard

- Includes data from 28 States and DC based on the following criteria
  - Reported all overdose deaths in jurisdiction in 2020
  - CME reports for at least 75% of deaths

- The dashboard is located here: https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

- Released an accompanying data brief here: Drug Overdose Deaths in 28 States and the District of Columbia: 2020 Data from the State Unintentional Drug Overdose Reporting System | Drug Overdose | CDC Injury Center

SUDORS Data Brief

Christine Mattson and Kelly Quinn, CDC

Drug Overdose Deaths in 28 States and the District of Columbia:

2020 data from the State Unintentional Drug Overdose Reporting System

SUDORS Data Brief, Number 1, June 2022

Christine L. Mattson, PhD, Sagar Kumar, MPH, Lauren J. Tanz, ScD, Priyam Patel, MSPH, Qingwei Luo, MS, and Nicole Davis, PhD

Accessible version: https://www.cdc.gov/drugoverdose/databriefs/sudors-1.html

KEY FINDINGS

1. **In 2020, 38,048 drug overdose deaths** were reported from **28 states and DC** for an age-adjusted rate of 30.6 per 100,000 people
2. **70%** of drug overdose deaths involved **illicitly manufactured fentanyls** (IMFs)
3. **The rate of drug overdose deaths** was **highest** among **American Indian/Alaska Native, non-Hispanic** and **Black, non-Hispanic persons**
4. **Two-thirds** of decedents had at least **one potential opportunity for linkage to care or implementation of a life-saving action** prior to death

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Introduction

In the United States, 91,799 drug overdose deaths occurred in 2020, a 30% increase from 2019, and provisional estimates suggest continued increases in 2021.[1,2] Recent increases in drug overdose deaths have been largely driven by illicitly manufactured fentanyl (IMF),[3,4,5] but deaths involving stimulants, such as cocaine and methamphetamine, are also on the rise.[3,4,6] This report uses data from the State Unintentional Drug Overdose Reporting System (SUDORS), which complements information available from other systems, to describe the drugs involved in and circumstances surrounding drug overdose deaths of unintentional or undetermined intent to help inform overdose prevention and response efforts.

Data Source and Methods

CDC funds 47 states and the District of Columbia to abstract information from death certificates and medical examiner and coroner reports, including toxicology results, on drug overdose deaths of unintentional or undetermined intent through SUDORS. Detailed information is abstracted and entered into a web-based system to describe decedent demographics, circumstances that preceded the fatal overdose (e.g., prior history of overdose, recent release from an institutional setting), circumstances occurring during or immediately preceding the overdose (e.g., presence of potential bystanders), as well as some limited medical history (e.g., mental health diagnoses, treatment for substance use disorder), and response to the overdose (e.g., naloxone administration). In addition, SUDORS contains information on drugs detected during post-mortem toxicology testing as well as those determined by a medical examiner or coroner to have caused death.

This report includes data from 28 states and the District of Columbia that collected information on all drug overdose deaths of unintentional and undetermined intent that occurred during January to December 2020 and had medical examiner/coroner reports for at least 75% of deaths (see map).

Key takeaways:

1. **Highly potent IMFs were involved in 70.0% of drug overdose deaths**
   - 27.9% of all drug overdose deaths involved IMFs with no other opioids or stimulants
   - IMFs were also frequently co-involved with other drugs
     - 12.8% of all drug overdose deaths involved IMFs and Cocaine
     - 7.2% of all drug overdose deaths involved IMFs and Methamphetamine
     - 5.8% of all drug overdose deaths involved IMFs and Heroin

   Recommended actions:
   - Ensure treatment for substance use disorder(s) addresses polysubstance use
   - Encourage people who use drugs not to use alone
   - Encourage friends and families of people who use drugs to recognize the signs and symptoms of overdose and ensure they know how to use naloxone
   - Expand naloxone distribution to people who use drugs, families, friends, and communities regardless of known opioid use because naloxone can be administered without concern for adverse reaction if opioids were not involved
   - Expand fentanyl test strip distribution and training on use and correct interpretation
2. **The overall rate of drug overdose deaths was highest among American Indian/Alaska Native, non-Hispanic and Black, non-Hispanic persons**

   Recommended actions:
   - Ensure substance use prevention and treatment interventions, including expanded linkage and retention in care, equitable access to treatment and behavioral interventions and harm reduction services (e.g., naloxone, comprehensive syringe services programs, and fentanyl test strips), are designed and implemented to reach American Indian/Alaska Native and Black persons
   - Integrate evidence-based substance use treatment with culturally appropriate traditional practices, such as spirituality and religion, which could improve treatment uptake.
3. **Drug overdose deaths involving opioids with stimulants accounted for one third of all drug overdose deaths, and rates differed by race/ethnicity**
   - Deaths rates involving opioids with stimulants were highest among American Indian/Alaska Native, non-Hispanic Black and White, non-Hispanic persons

   Recommended action:
   - Ensure increased access to medications for opioid use disorder, harm reduction services, cognitive behavioral therapy and evidence-based treatments for stimulant use disorders (e.g., contingency management) for all persons, including addressing access barriers (e.g., housing instability, transportation access, insurance status) for American Indian/Alaska Native and Black persons
4. **Two-thirds of drug overdose decedents had at least one potential opportunity for linkage to care prior to death or implementation of a life-saving action prior to death[a]**

   Recommended actions:
   - Initiate, link to, or continue evidence-based treatment services for substance use disorder(s), including medications for opioid use disorder, when people who use drugs interact with the health care and criminal justice systems
   - Integrate treatment for substance use disorder(s) and mental health when appropriate
   - Increase naloxone distribution and training for people who use drugs and their families and friends

Have a great rest of the summer, we will break for August and see you in the fall!

Overdose Fatality Review (OFR): ECHO

Mallory O'Brien, MS PhD
Tom Gilson, MD

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

OFR: Where to Start

Mallory O'Brien, M.S., Ph.D.
Consultant, IPA Overdose Fatality Reviews, CDC
Senior Policy Advisor, IPA, BJA COSSAP

Melissa Heinen, R.N., M.P.H.
Senior Research Associate, IIR

This event was supported by Grant No. 2017-AR-BX-K003 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the U.S. Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions in this presentation are those of the author(s) and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Learning Objectives

- After this ECHO session, participants will be able to:
  - Describe the purpose and value of an OFR
  - Understand how to begin an OFR
  - Connect with OFR experts and resources

Poll Questions

- Have you ever participated in a fatality review?
  - If you have, please type in the chat what kind (child, overdose, etc.)
- Have you ever participated in an overdose fatality review?

OFR Purpose and Value

- Overdoses are preventable
- Identify systems gaps: missed opportunities for prevention and intervention
- Design innovative community-specific prevention strategies

Public Health and Safety Team Leadership and Structure

Lead Agency: Oversees the OFR team coordination and provides administrative support

Governing Committee: Supports and provides resources to implement recommendations generated by case reviews

OFR Team: Multidisciplinary team that reviews a series of individual deaths to identify system-level missed opportunities for prevention and intervention

Subcommittee: Focuses attention on a recommendation or need such as case selection

OFR Team Members

- Local law enforcement officer
- Local public health official
- Emergency medical service provider
- Medical Examiner, Coroner, Death investigator, Toxocologist
- Probation and parole officer
- Behavioral health social worker
- School counselor
- Housing authority representative
- Prosecutor
- Substance abuse treatment provider
- Substance abuse prevention professional
- Harm-reduction outreach professional
- Community prevention coalition lead
- Drug treatment court representative
- Faith-based services or healing leader
- HIDTA (High Intensity Drug Trafficking Area) public health analyst
- County sheriff
- MAT (medication-assisted treatment) provider
- Tribal elder, community leader, or traditional healer

OFR Meeting: Agenda

- Opening remarks
- Goals and ground rules
- Confidentiality
- Summary, aggregate data
- Case presentation
- Agency report outs
- Case summarized and timeline drawn
- Formulate recommendations
- Summarize and adjourn

OFR Meeting: Facilitation

- Facilitator needs to be a neutral convener
  - Good listener
  - Develops trust with partners
  - Encourages group participation and engagement
  - Leads, but does not direct discussion
  - Guides the group towards collective problem-solving to craft recommendations

CUYAHOGA COUNTY POISON DEATH REVIEW COMMITTEE
CASE REVIEW FORM

BACKGROUND

Previous (legal) prescription pain medication use:
Medication(s):_____

_____

Previous illicit drug use? Yes ☐ No ☐
Intravenous drug use? Yes ☐ No ☐
Period of Abstinence? Yes ☐ No ☐ _____ time period (yrs./mo's – if known)
Veteran? Yes ☐ No ☐
Previous medical treatment? Yes ☐ No ☐ (last 2 years) Mental Health? Yes ☐ No ☐
Date/Location/Reason:_____

_____

_____

Previous detoxification/rehabilitation treatment: Yes ☐ No ☐ (last 2 years)
Date/Location/Reason:_____

_____

_____

Previous incarceration(s): Yes ☐ No ☐ (last 2 years)
Date/Location/Reason:_____

_____

Previous arrests: Yes ☐ No ☐ (last 2 years)
Date/Location/Reason:_____

_____

Previous law enforcement contact/parole: Yes ☐ No ☐ (last 2 years) : Drug Court: Yes ☐ No ☐
Date/Location/Reason :_____

_____

_____

RECOMMENDATIONS

Education: (Identify intervention points)_____

_____

_____

DAWN: (Identify intervention points)_____

_____

_____

Other: (Identify intervention points)_____

_____

_____

CUYAHOGA COUNTY
MEDICAL EXAMINER'S OFFICE
Thomas P. Gilson, M.D.
11001 Cedar Avenue
Cleveland, Ohio 44106
A National Association of Medical Examiner's (N.A.M.E.) accredited office.

CUYAHOGA COUNTY POISON DEATH REVIEW COMMITTEE
CASE REVIEW FORM

Case #: «Case»

DECEDENT INFORMATION

Decedent Name: «Namelast», «Name_First» «Name_Middle»

City of Residence: «City»

Gender: «Gender» Race: «Race» (Hispanic?: «Hispanic»)

Age: «Age»

Marital Status: «Marital_Status» Occupation: «Occupation»

CASE INFORMATION

Cause and Manner: «Cause_Of_Death»

Date of Death: «Death_Date_Month»/«Death_Date_Day»/«Death_Date_Year»

Injury Location (if known): «rc_Inj_Place», «rc_Inj_Cty_State»

Date of Injury (if known): «rc_Injury_Date»

INCIDENT INFORMATION

Using drugs with others: Yes ☐ No ☐

Others present in location but not using drugs: Yes ☐ No ☐

EMS response: Yes ☐ No ☐
Naloxone (Narcan) Administered: Yes ☐ No ☐

Paraphernalia Present: Yes ☐ No ☐

Type:_____

_____

_____

Data Collection: Confidentiality

- Confidentiality is essential
- Data sharing agreements
- Confidentiality agreements
- State legislation

Data Collection: OFR Data System

SECURE AND STORED AT A NEUTRAL AGENCY

STANDARD DATA ELEMENTS

OFR DATA SYSTEM VERSION 2.0

Data System Content

- OFR Meeting Administration
- Decedent Information
- Community Context
- Next of Kin Information
- Recommendation

Register to use OFR Data System Version 2.0

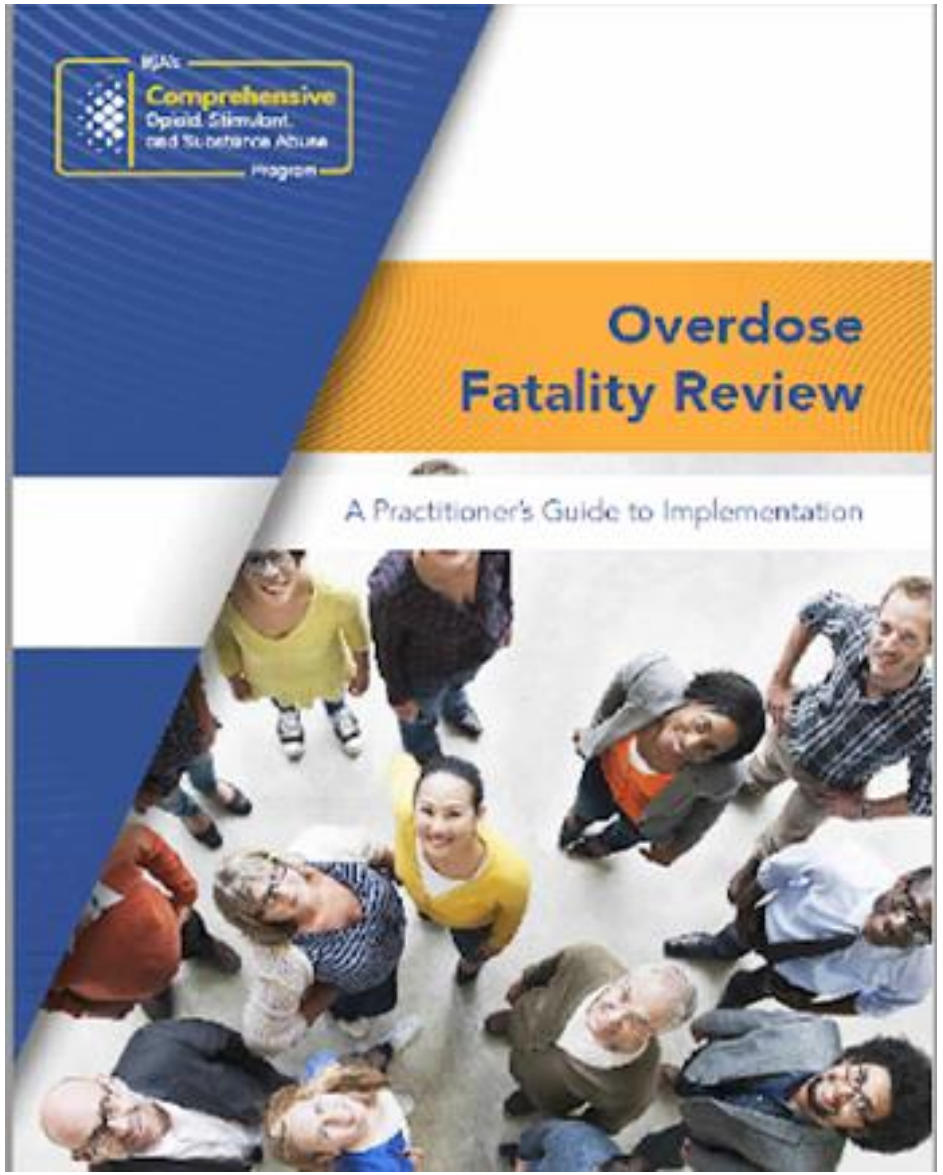
- On your server – REDCap
- On IIR server – Data Access Group

Recommendation: Significant Impact

Improve	Improve service delivery and investigation
Change	Change agency policies and practices
Revise	Revise local ordinance or state legislation
Initiate or modify	Initiate or modify community prevention strategies

Resources & Tools

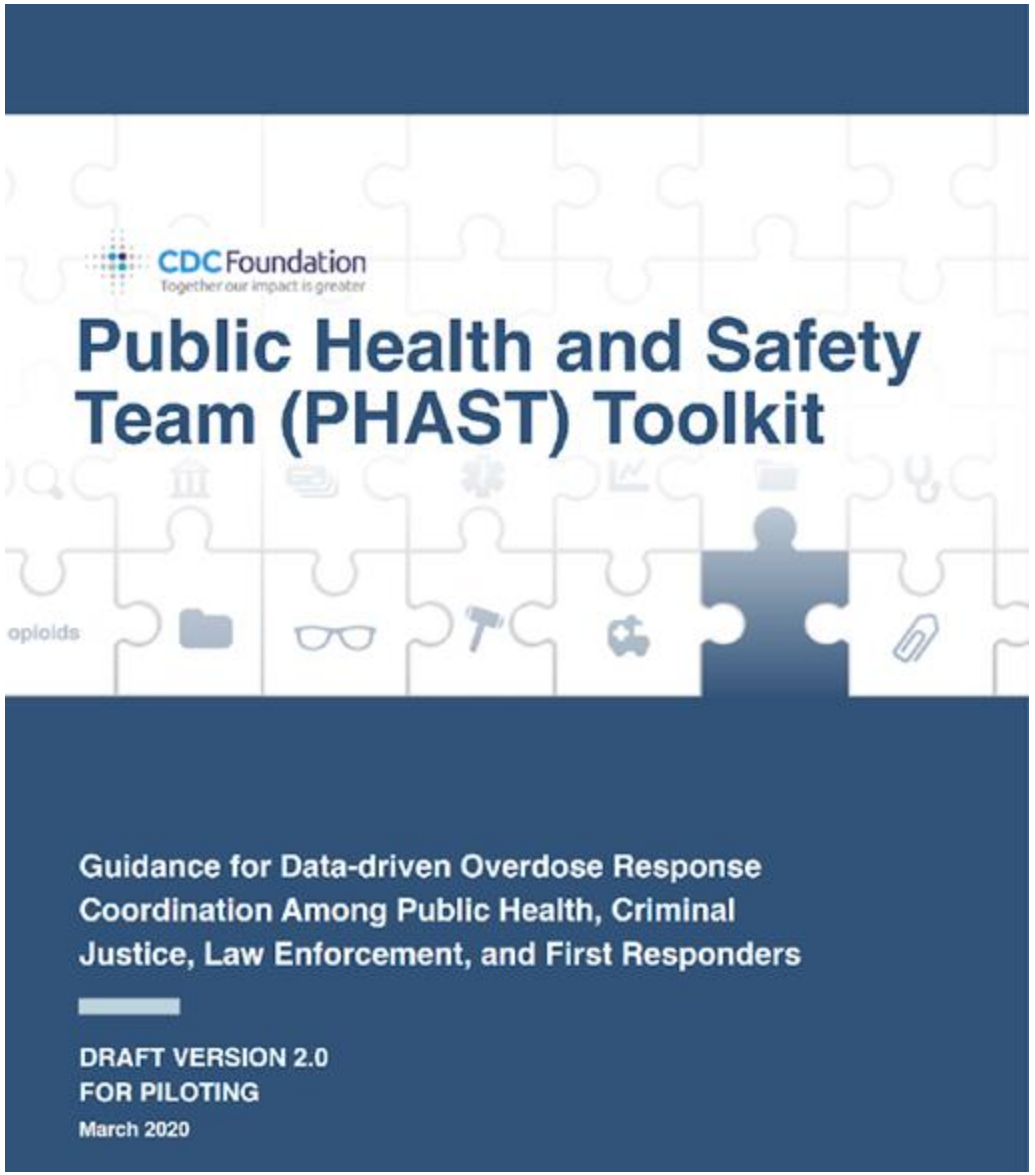
Overdose Fatality Review: A Practitioner's Guide to Implementation



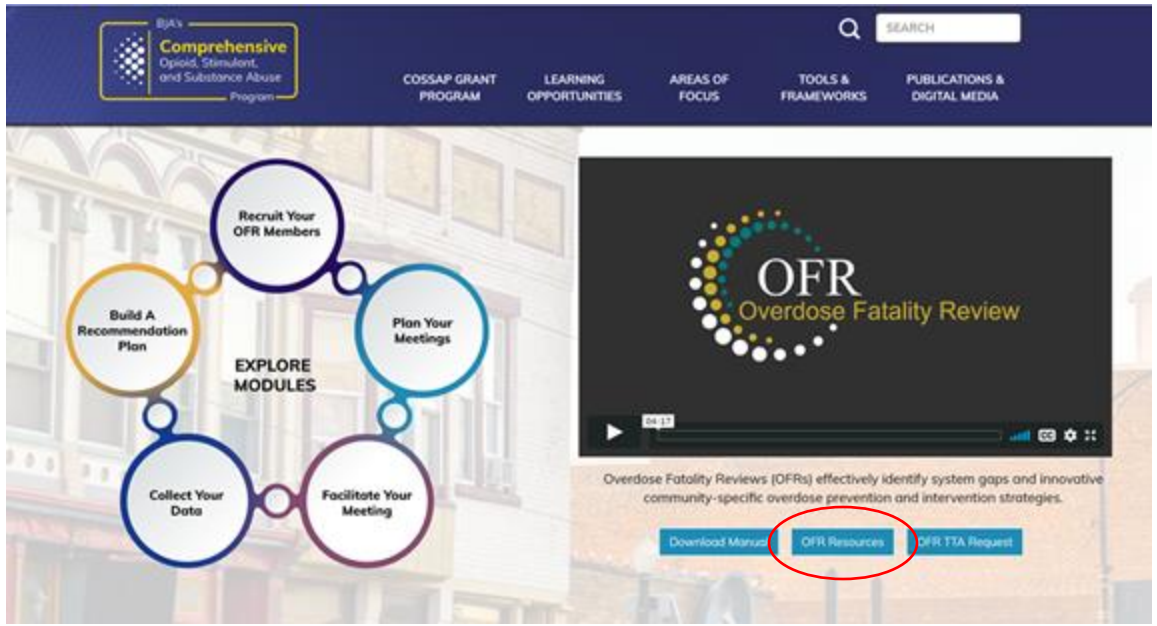
Modules

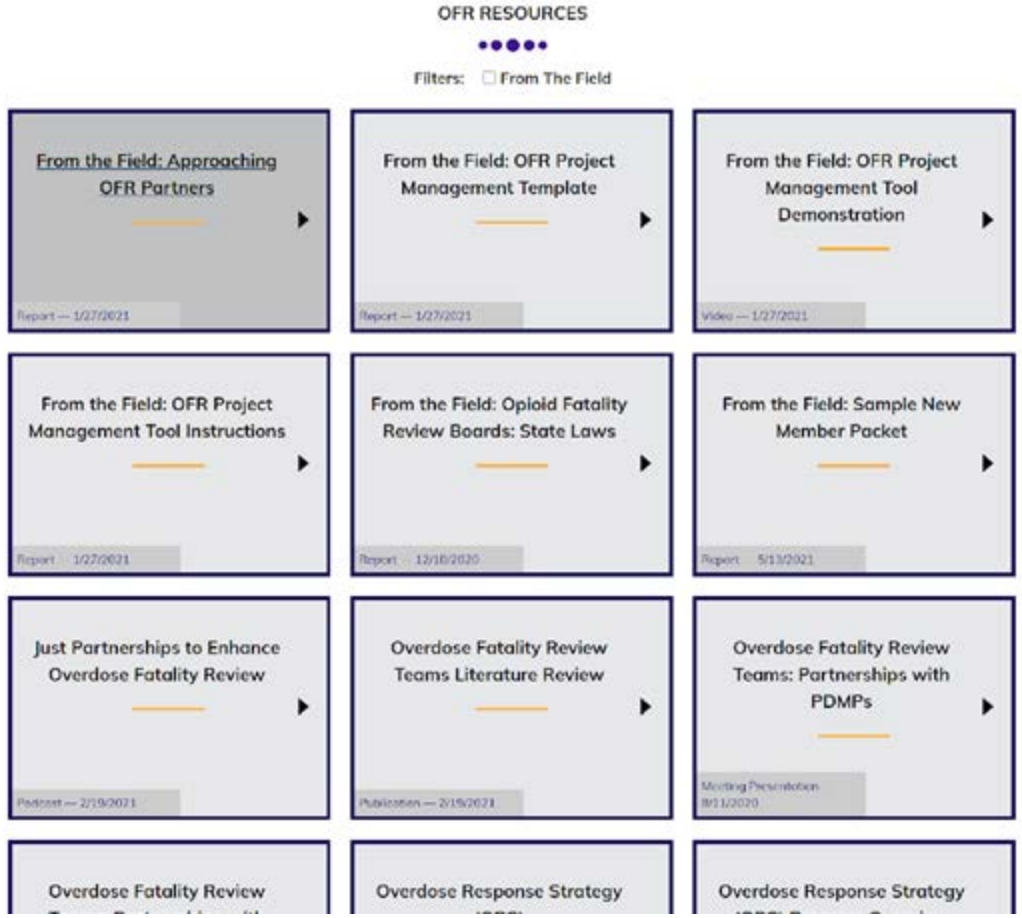

Recruit
Recruit Your OFR Members
Plan
Plan Your OFR Meeting
Facilitate
Facilitate Your OFR Meeting
Collect
Collect Your OFR Data
Build
Build a Recommendation Plan

PHAST Toolkit

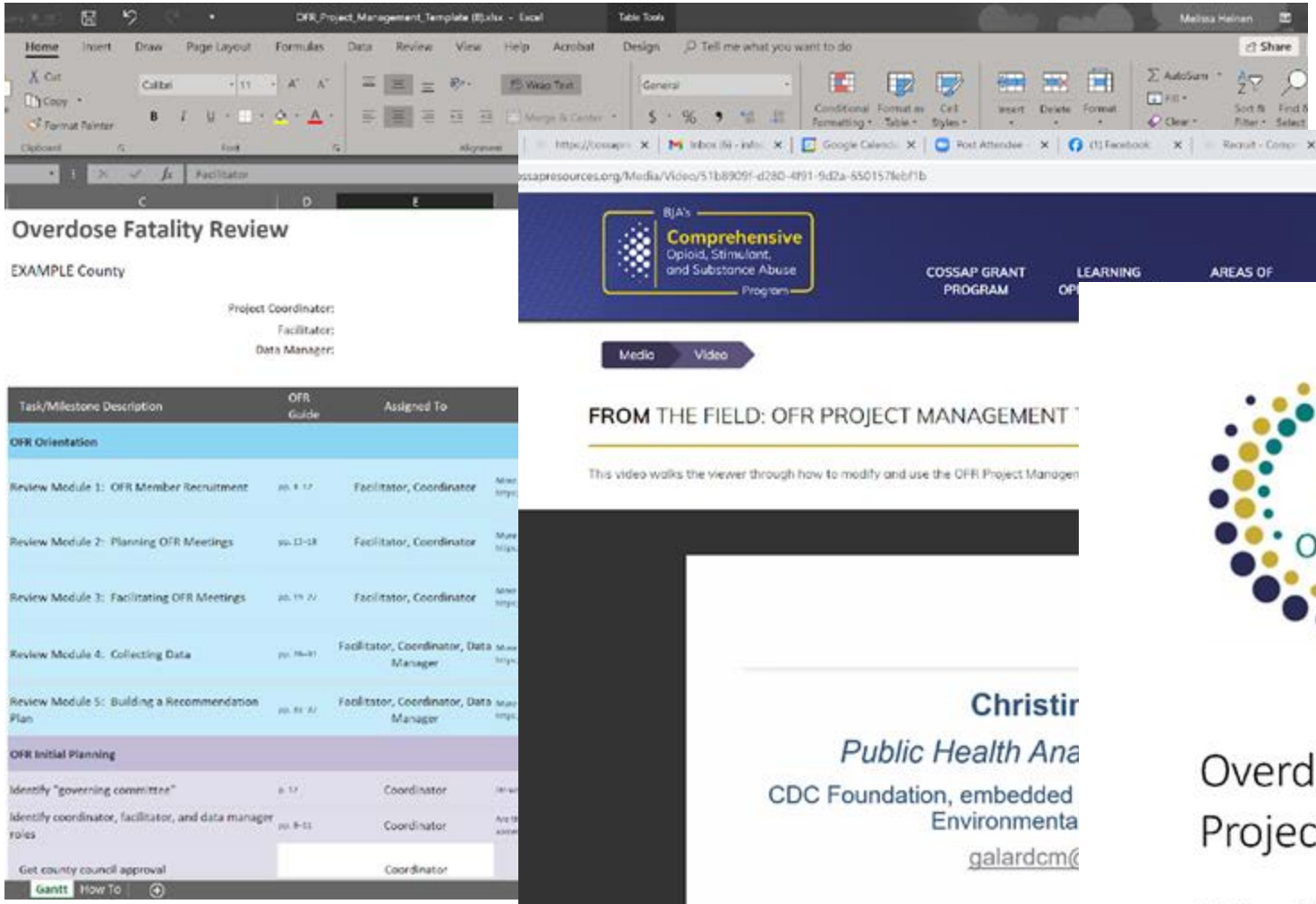


OFR Resources



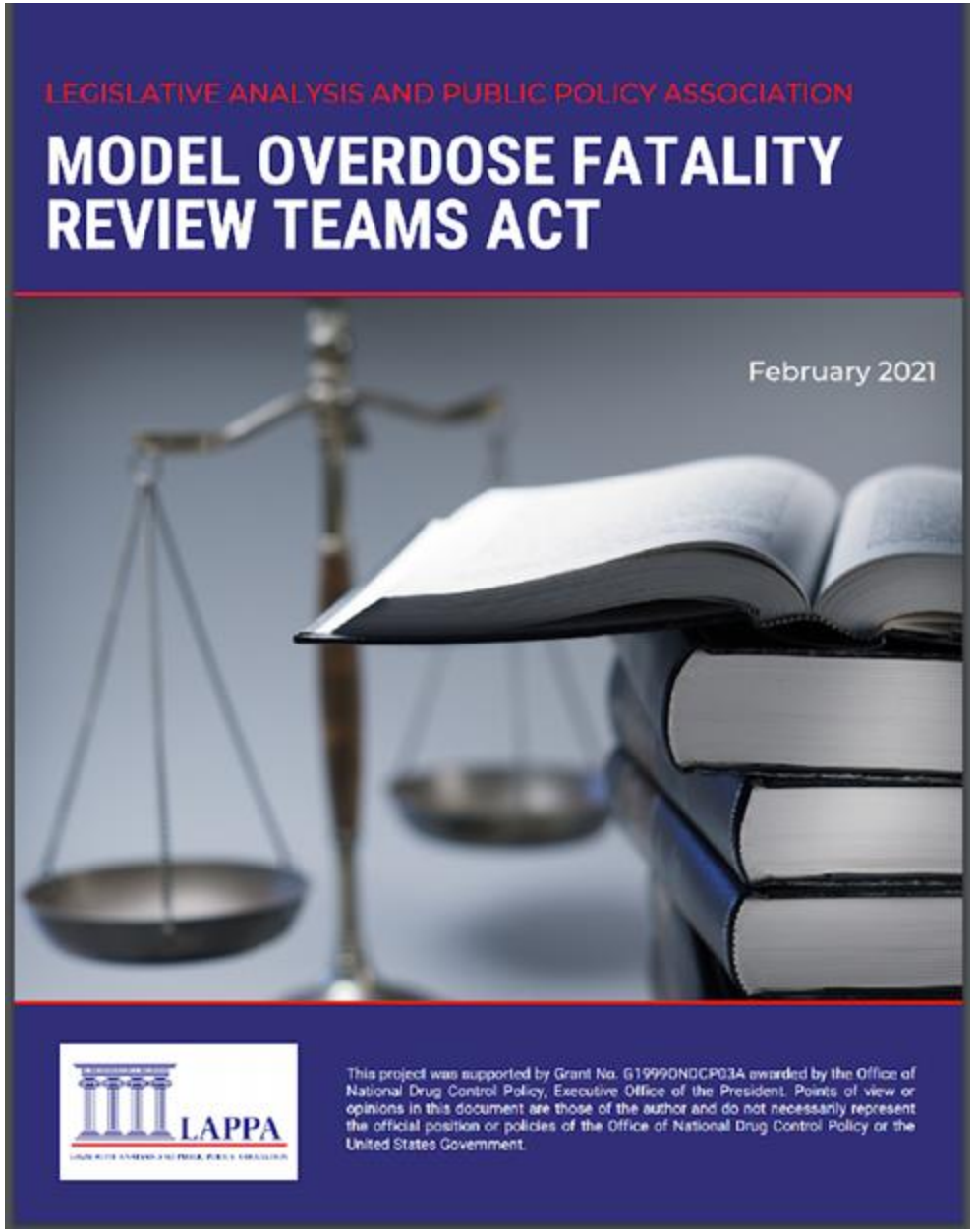


OFR Project Management Tools

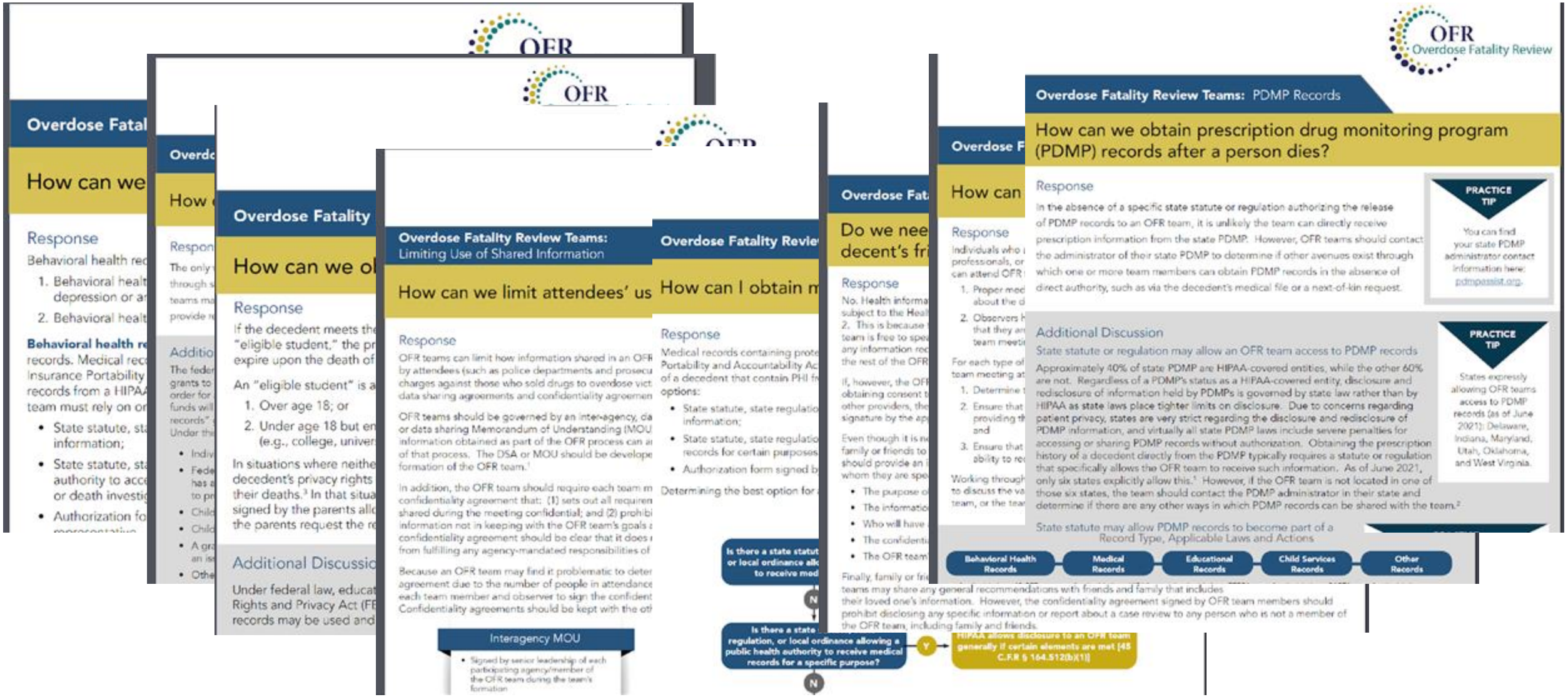


Overdose Fatality Review:
Project Management Tool Instructions

Author: Christina Galardi, MPH, MCRP with CDC Foundation

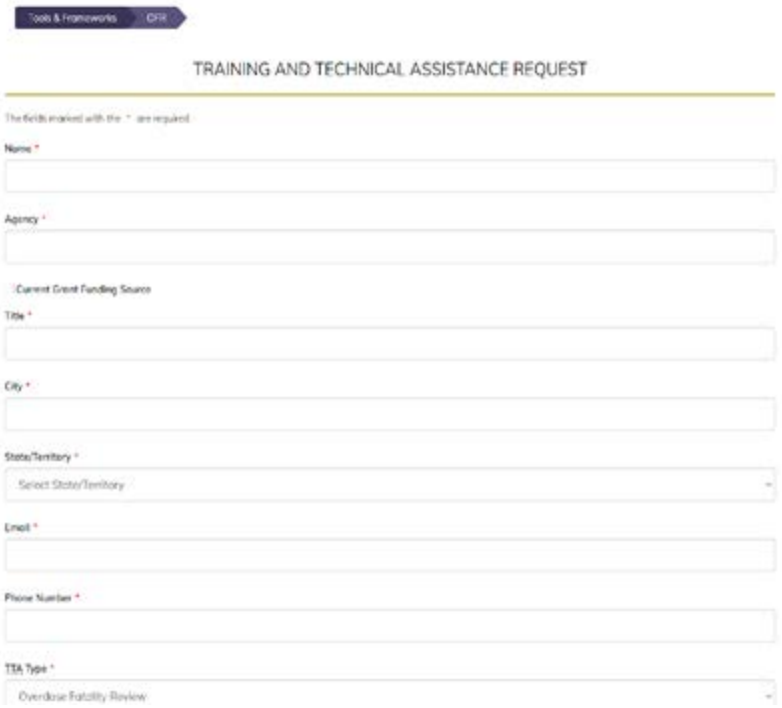

LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION
MODEL OVERDOSE FATALITY REVIEW TEAMS ACT
February 2021
LAPPA
This project was supported by Grant No. G19990NDCP03A awarded by the Office of National Drug Control Policy, Executive Office of the President. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government.

Information Sharing Guidance



LAPPA: Legislative Analysis and Public Policy Association

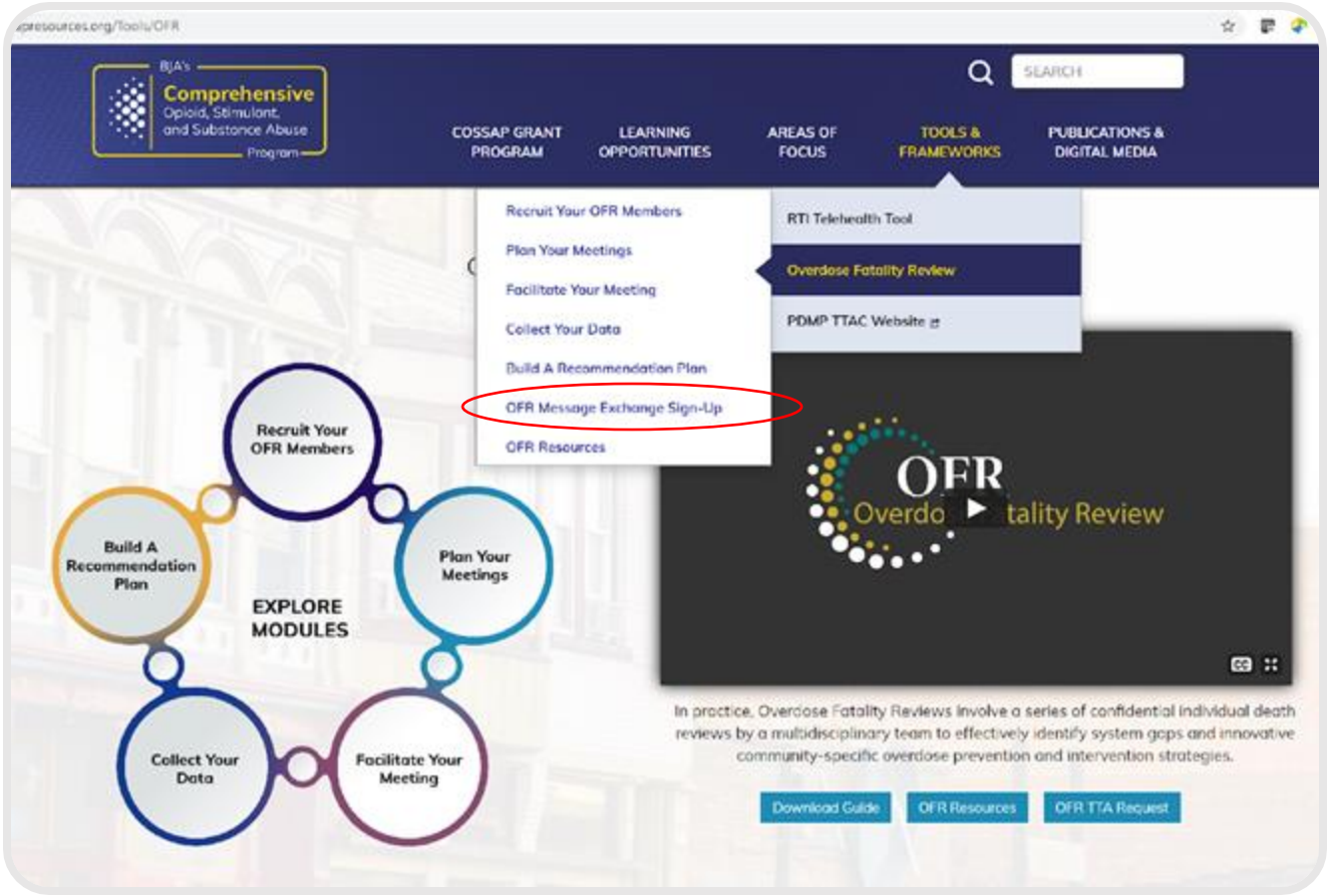
Training and Technical Assistance



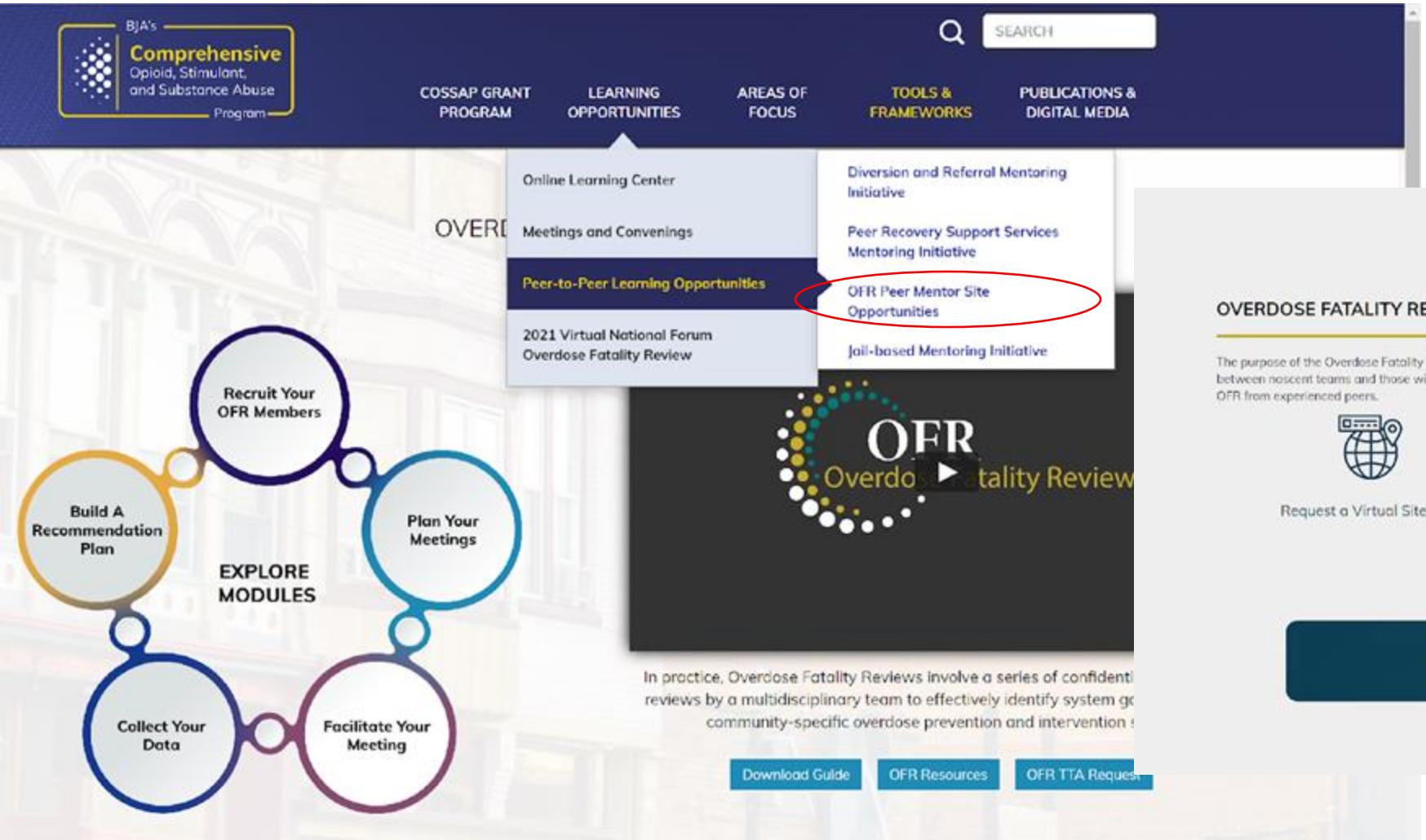
OFR Email Exchange

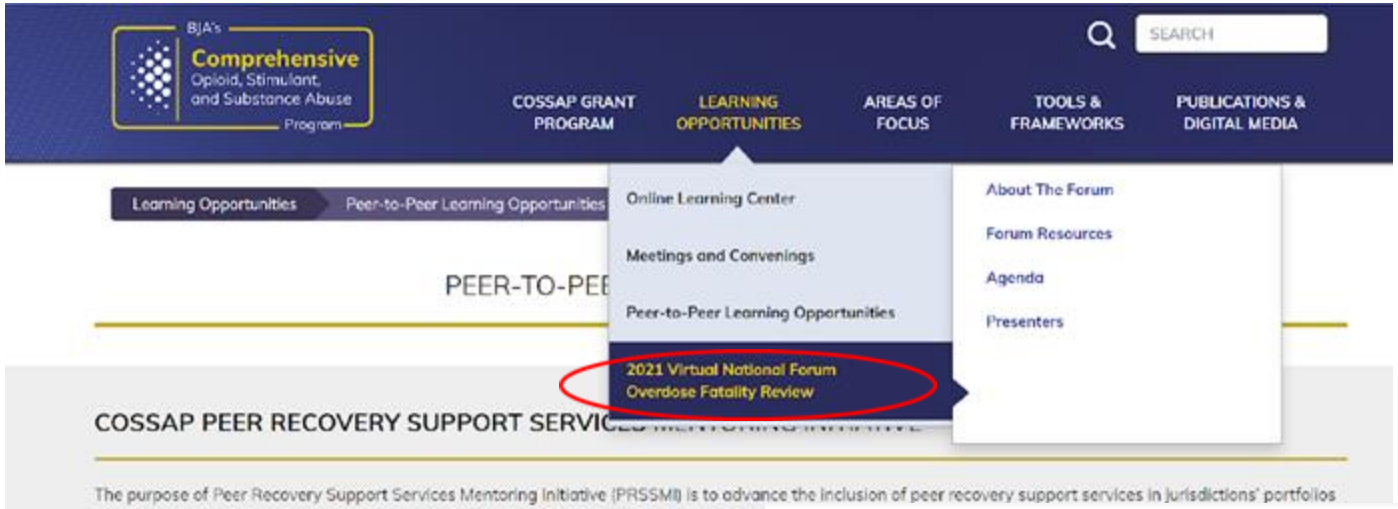
Great way to network with your peers

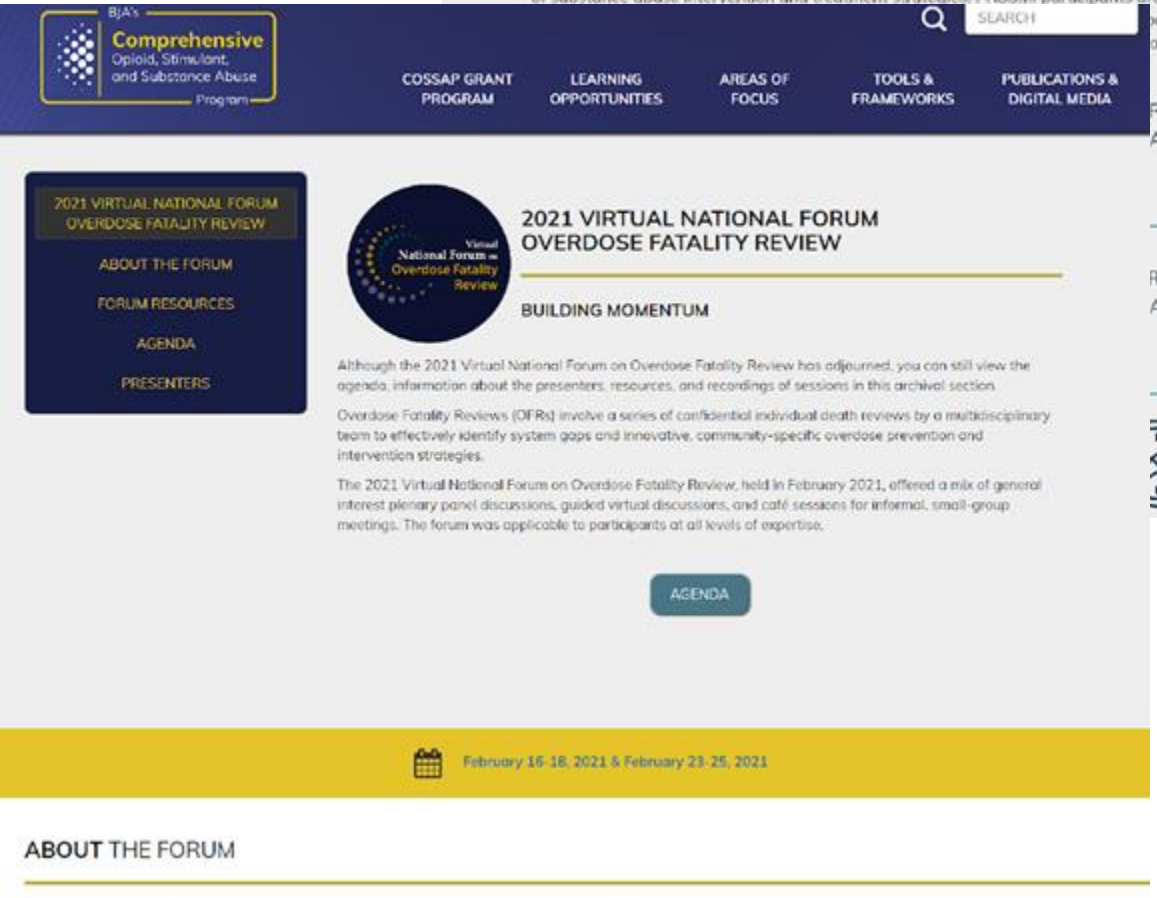
- Send an email to the group (OFR@cossapresources.org) and every member of the list will get the email. That is all there is to it.
- Sign up by emailing COSSAP@iir.com requesting to be added to the COSSAP OFR Email Exchange



OFR Peer Mentor Sites




BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program
SEARCH
COSSAP GRANT PROGRAM
LEARNING OPPORTUNITIES
AREAS OF FOCUS
TOOLS & FRAMEWORKS
PUBLICATIONS & DIGITAL MEDIA
Learning Opportunities
Peer-to-Peer Learning Opportunities
Online Learning Center
Meetings and Convenings
Peer-to-Peer Learning Opportunities
2021 Virtual National Forum Overdose Fatality Review
About The Forum
Forum Resources
Agenda
Presenters
PEER-TO-PEE
COSSAP PEER RECOVERY SUPPORT SERVICES
The purpose of Peer Recovery Support Services Mentoring Initiative (PRSSMI) is to advance the inclusion of peer recovery support services in jurisdictions' portfolios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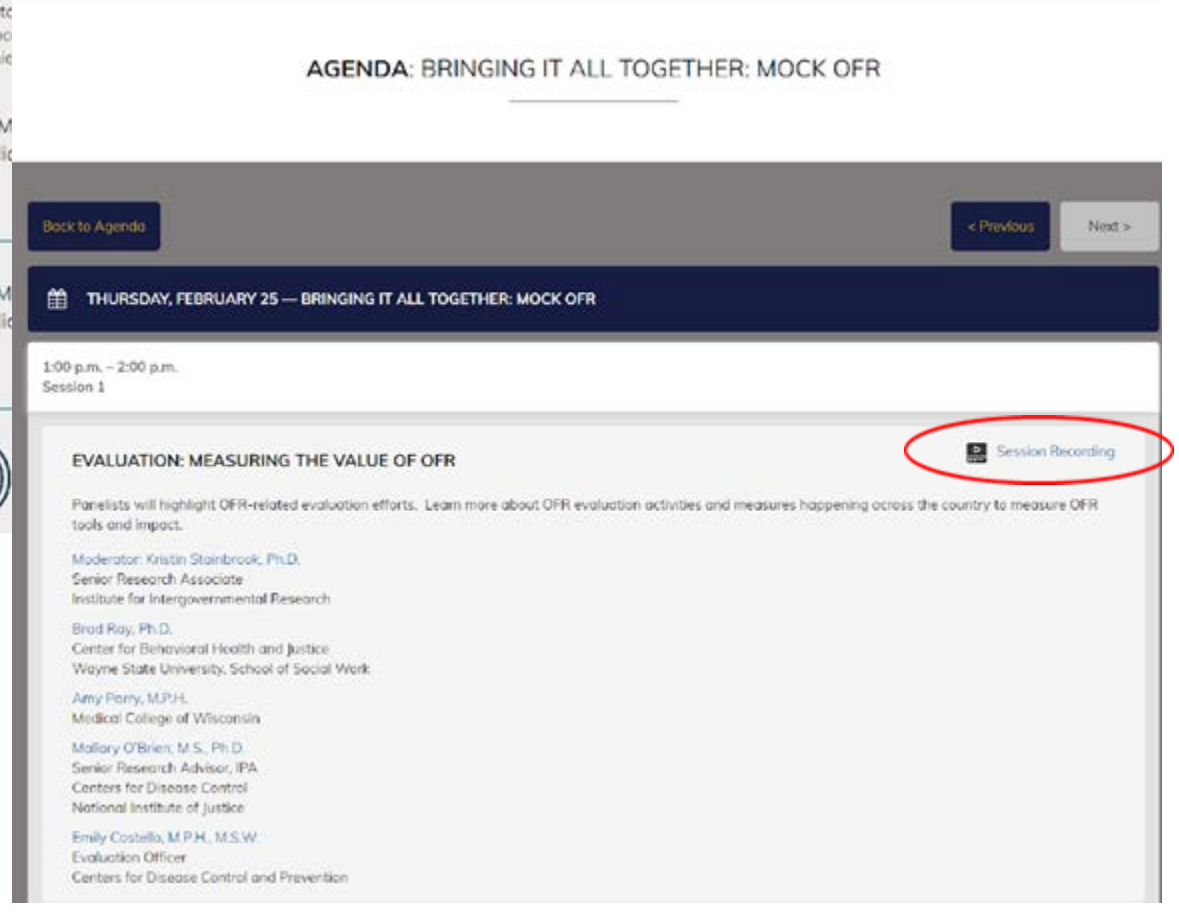
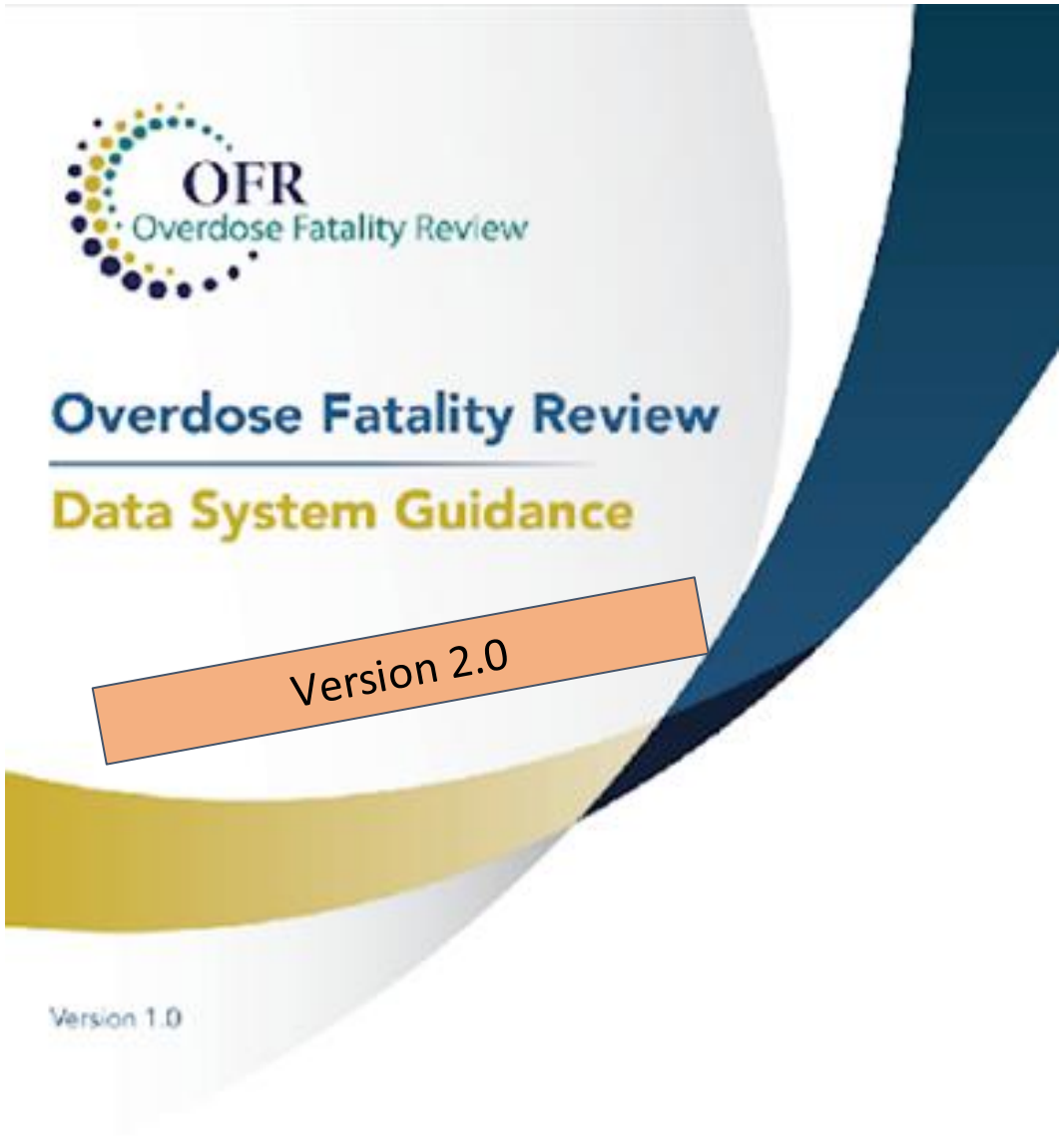
PUBLICATIONS & DIGITAL MEDIA
2021 VIRTUAL NATIONAL FORUM OVERDOSE FATALITY REVIEW
ABOUT THE FORUM
FORUM RESOURCES
AGENDA
PRESENTERS
2021 VIRTUAL NATIONAL FORUM OVERDOSE FATALITY REVIEW
BUILDING MOMENTUM
Although the 2021 Virtual National Forum on Overdose Fatality Review has adjourned, you can still view the agenda, information about the presenters, resources, and recordings of sessions in this archival section.
Overdose Fatality Reviews (OFRs) involve a series of confidential individual death reviews by a multidisciplinary team to effectively identify system gaps and innovative, community-specific overdose prevention and intervention strategies.
The 2021 Virtual National Forum on Overdose Fatality Review, held in February 2021, offered a mix of general interest plenary panel discussions, guided virtual discussions, and café sessions for informal, small-group meetings. The forum was applicable to participants at all levels of expertise.
AGENDA
February 16-18, 2021 & February 23-25, 2021
ABOUT THE FORUM


AGENDA: BRINGING IT ALL TOGETHER: MOCK OFR
Back to Agenda
< Previous
Next >
THURSDAY, FEBRUARY 25 — BRINGING IT ALL TOGETHER: MOCK OFR
1:00 p.m. – 2:00 p.m.
Session 1
EVALUATION: MEASURING THE VALUE OF OFR
Session Recording
Panelists will highlight OFR-related evaluation efforts. Learn more about OFR evaluation activities and measures happening across the country to measure OFR tools and impact.
Moderator: Kristin Stainbrook, Ph.D.
Senior Research Associate
Institute for Intergovernmental Research
Brad Ray, Ph.D.
Center for Behavioral Health and Justice
Wayne State University, School of Social Work
Amy Perry, M.P.H.
Medical College of Wisconsin
Mallory O'Brien, M.S., Ph.D.
Senior Research Advisor, IPA
Centers for Disease Control
National Institute of Justice
Emily Costello, M.P.H., M.S.W.
Evaluation Officer
Centers for Disease Control and Prevention

Webinars

- Partnerships for Prevention: Overdose Fatality Review 101
- Rural-focused OFR Webinar
- OFR Teams: Partnerships with PDMPs
- OFR and COVID-19 Response
- Uncovering the Connection Between a History of Problematic Substance Use and Brain Injury Matters in OFR

OFR Data System Version 2.0



OFR Community of Practice Calls

New-to-OFR CoP (January 2022)

Rural and Small Jurisdiction (October 2021)

Contact Information

Mallory O’Brien – Mallory.O'Brien@usdoj.gov

Tom Gilson – docgilson@msn.com

astho™

PROJECT ECHO: OD-FIT

Overdose Fatality Investigation Techniques

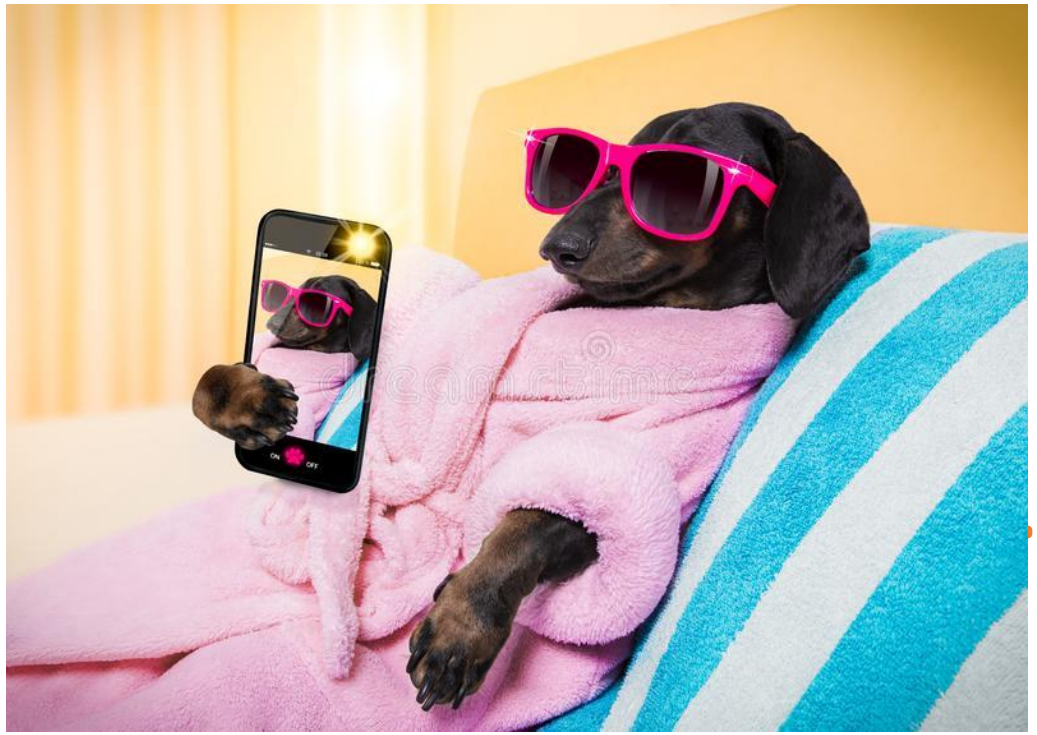
Questions? Unmute or type in the chat box!

astho™

PROJECT ECHO: OD-FIT

Overdose Fatality Investigation Techniques

10-Minute Break!



Overdose Fatality Review

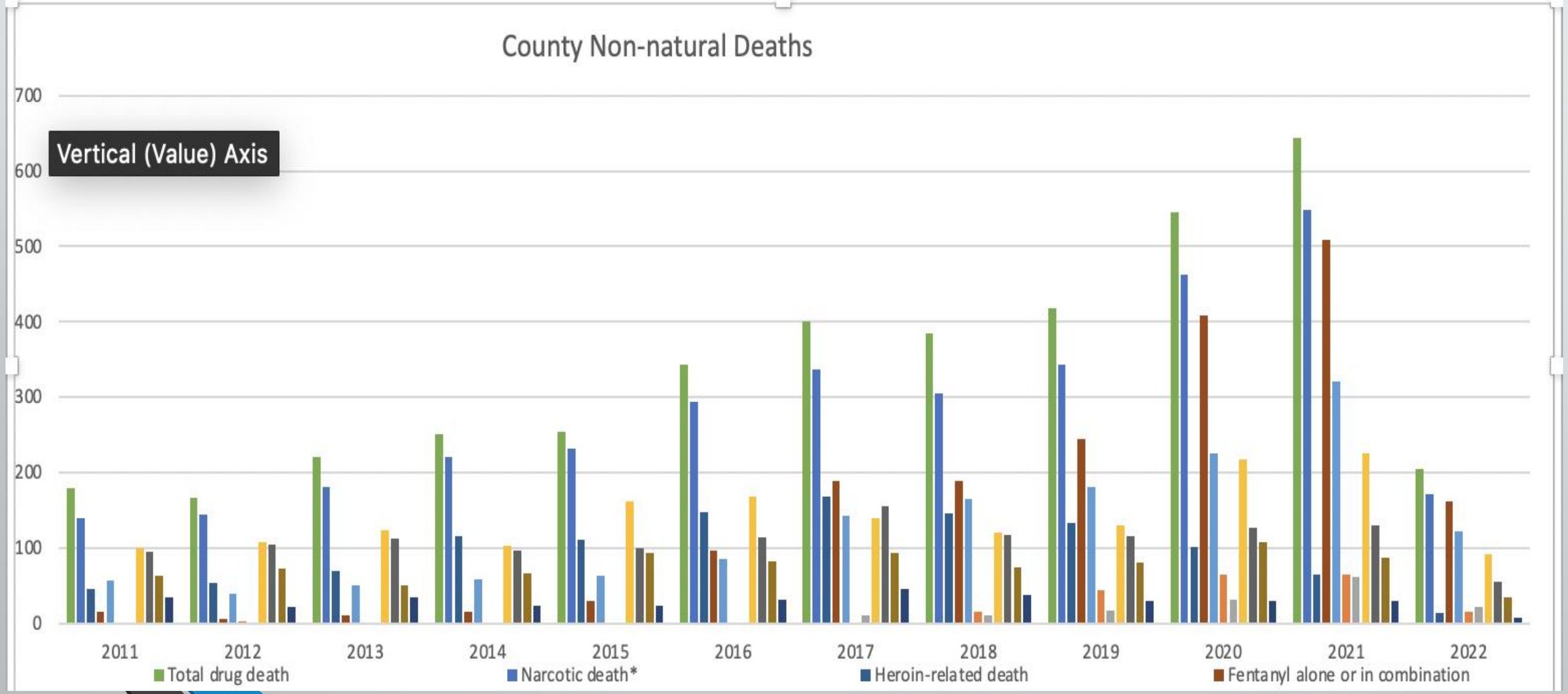
Suggested Aggregate Data Examples

Death type	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2022 est.
Total drug death	167	220	251	254	343	401	384	418	545	644	205	490
Narcotic death*	144	181	220	231	294	337	305	343	463	548	171	408
Heroin-related death	53	69	116	110	148	168	146	133	102	65	13	32
Fentanyl alone or in combination	5	11	16	30	97	188	188	244	409	508	162	387
Cocaine alone or in combination	39	51	58	63	85	142	165	181	225	321	122	292
Gabapentin/Pregabalin	3	0	0	0	0	0	15	44	65	64	16	39
Methamphetamine	1	0	0	1	1	11	11	17	31	62	21	51
Homicide	108	123	103	161	168	140	120	130	217	226	92	220
Suicide	104	113	96	99	114	156	117	115	126	130	55	132
Motor Vehicle Accident	72	51	67	93	82	94	74	80	107	87	35	84
Infant death	22	34	24	24	32	45	38	30	29	30	8	20
Autopsies (Milwaukee County)	967	971	951	988	1073	1086	1050	1181	1431	1452	591	1410
Autopsies (referral, private)	314	323	367	360	347	466	686	604	619	510	191	456
Autopsies (total)	1281	1294	1318	1348	1421	1558	1736	1786	2050	1962	782	1866

*Narcotic drug deaths are any in which opioids (morphine, heroin, etc.) or synthetic opioids (oxycodone, fentanyl, etc.) are involved

Updated 6/2/2022- drug-related totals lag by a few weeks.

Suggested Aggregate Data Examples



Additional Suggested Aggregate Data

- EMS
- ODMAP
- Naloxone Distribution

M. Smith

- Age: 32
- DOB: 3.26.1990
- DOD:7.02.2022
- Cause: Fentanyl, Norfentanyl, Adderall, Oxycodone, and Lorazepam intoxication
- Manner: Accident
- Employment: Factory Worker
- Educational Attainment: H.S. Graduate or GED
- Marital Status: Divorced
- Veteran Status: No
- Children: Yes
- Obituary: Yes

Coroner Report

- On July 2, 2022 responded to apartment complex
- Found by BF in bedroom after returning from work at car factory.
- Three children at home, ages 12, 10, 3
- Decedent upset evening before due to possible firing for time spent in jail
- Drug paraphernalia found at the scene, empty Rx bottles on floor

Coroner Report

- Mother arrived on scene, stated:
  - Noted decedent had a history of drug use
  - Began using drugs after first pregnancy
  - Former partner and father abusive, father of two older children
  - Current partner also abusive
  - Had period of sobriety
  - Recent arrest, concerned about losing job

Toxicology from state lab

- Fentanyl: Therapeutic Range: .1-.4 ng/mL Results: 4.0 ng/mL
- Norfentanyl: Therapeutic Range: 10-200 ng/mL Results: 250 ng/mL
- Adderall Therapeutic Range: Results: 5-400 ng/mL Results: 40 ng/mL
- Oxycodone Therapeutic Range: Results: 10-40 ng/mL Results: 100 ng/mL
- Lorazepam Therapeutic Range: 50-240 ng/mL Results: 400 ng/mL

PDMP Report

Date Prescibed	Date Filled	Doctor DEA Number	Provider Type	Prescription Length by Days	Number of Pills Dispensed	Prescription
7/1/2022	7/1/2022	1	General Practitioner	30	30	Lorazepam
7/1/2022	7/1/2022	1	General Practitioner	30	60	Oxycodone
6/30/2022	6/30/2022	2	Psychiatry	30	90	Adderall
6/15/2022	6/15/2022	1	General Practitioner	30	30	Lorazepam
6/15/2022	6/15/2022	1	General Practitioner	30	60	Oxycodone
6/1/2022	6/1/2022	2	Psychiatry	30	90	Adderall
5/15/2022	5/15/2022	1	General Practitioner	30	30	Lorazepam
5/15/2022	5/15/2022	1	General Practitioner	30	60	Oxycodone
5/1/2022	5/1/2022	2	Psychiatry	30	90	Adderall
4/5/2022	4/5/2022	3	Psychiatry	30	60	Suboxone
3/5/2022	3/5/2022	3	Psychiatry	30	60	Suboxone
2/15/2022	2/15/2022	3	Psychiatry	14	28	Suboxone
2/1/2022	2/1/2022	3	Psychiatry	14	28	Suboxone
1/1/2022	1/1/2022	4	Emergency Medicine	7	21	Oxycodone

Additional Information from Partners

- Public Health
- EMS
- LE
- Fire
- Prosecution
- Courts
- Probation/Parole
- Jail
- Child protective services
- Behavioral Health
- Harm reduction specialist
- School
- Housing
- Substance abuse prevention specialist
- MAT Provider

Timeline

- 2008- Graduated H.S.
- 2010- Daughter is Born
- 2011- Partner is arrested for domestic violence. DCS case substantiated
- 2012- Madeline marries partner
- 2013- Son is born
- 2014- Partner is arrested for domestic violence. DCS case substantiated
- 2015- Divorce finalized
- 2016- Madeline arrested for DUI
- 2016- Madeline arrested for theft. Successfully completed probation
- 2017- Madeline arrested for drug possession. Successfully completed drug court
- 2018- Continues treatment program started in drug court

Timeline

- 2020- Loses job and experiences periods of housing instability
- 2020- Discontinues treatment program due to lack of insurance coverage
- 2021- Begins job at factory
- 2021- Arrested for possession. DCS case initiated, and child placed into kinship care
- 2021- Released form incarceration after six month stay
- 1/1 2022- ER visit for broken arm and facial laceration
- 2/1/2022- 4/5/2022- MAT Prescriptions
- 5/1/2022- ER visit for nonfatal overdose
- 5/14/2022- ER visit for nonfatal overdose
- 6/16/2022- Arrested for possession of a syringe
- 6/30/2022- Released from incarceration
- 7/2/2022- died from Fentanyl, Norfentanyl, Adderall, Oxycodone and Lorazepam intoxication

Discussion

- Summary
- Recommendations
- Next Steps

PROJECT ECHO: OD-FIT

Overdose Fatality Investigation Techniques

Thank you so much for attending this year's, Project ECHO: OD-FIT! We will see you in the fall!

TELL US WHAT YOU THINK >>

Help ASTHO evaluate Project ECHO: OD-FIT

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also open this survey in a browser.