GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
Opioid Fatality Review Board
October 14th, 2025, Open Meeting Minutes

There were (22) attendees:

Opioid Fatality Review Board (OFRB) Members: 12

Kenan Zamore (DC Health)	Dr. Jewell Reddick (Vice Chair)
Dr. Chimene Liburd (DHCF)	Dr. Barbara Wynter (CSOSA)
Dr. Priya Punnoose (DBH)	Snehal Parikh (DFS)
Dr. Kunil Raval (OCME)	Sgt. Robert Buck (MPD)
Rhonda Johnson (DC resident)	Dr. David Vitberg (DC FEMS)
Joseph Lippi (DHS)	Sharon Cauley (PSA)

Participants: 6

Eden Cunningham (DCHA)	Dr. Crystal Waters (CSOSA)
Laci Barrow (Samaritan Inns)	Dr. Sonal Batra, MST (GW Hospital)
Betty Smith (DC FEMS)	Dr. Sharon Hunt (DBH)

Fatality Review Staff: 4

Enisa Boardwine (OCME)	Woyni Teklay (OCME)
Kimberli Hall (OCME)	Scott Wetzel (OCME)

Open Meeting

I. Greetings:

- The Opioid Fatality Review Board (OFRB) meeting began at 3:02 p.m. and was opened by Kenan Zamore (Chair), who greeted board members and guests.

II. Roll Call

- The OCME staff conducted roll call of board members, participants, and staff.

III. Review and Majority vote to approve the agenda.

- There was a majority vote to approve the agenda.

IV. Review the open portion of the meeting minutes from September 9th , 2025, were reviewed.

- The open portion of September 9th, 2025, meeting minutes were reviewed and approved.

V. Guest presentation by Dr. Sonal Batra – Emergency Medicine Physician and Associate Professor of Health Policy & Management

- The meeting focused on the intersection of homelessness and opioid use disorder in healthcare, highlighting perceptions, systemic barriers, and the critical role of peer recovery specialists.
- The first article, titled "Perceptions of homelessness: Is there variation across medical careers and specialties?" addresses two research questions: Medical students' perceptions of People Experiencing Homelessness (PEH) and how that changes across training, as well as how perceptions of residents and faculty differ across specialties.
- According to data from the Community Partnership for the Prevention of Homelessness, the Point-in-Time (PIT) [1] Count Total Persons by Year for 2024 and 2025 are 3,960 and 3,782, respectively.
- Dual Diagnosis of adults who reside in DC was reported at 18% with 57% experiencing only mental health, and the remaining 24% experiencing only substance abuse.
- According to OCME data, there is a direct correlation between the percentage of homeless deaths from opioid overdose, wherein 57% of homeless deaths were from opioid overdoses in 2023.
- The study design employed a cross-sectional survey using the Health Professionals' Attitudes Towards the Homeless Inventory (HPATHI) among faculty and residents in Emergency, Internal, OB/GYN, and General Surgery specialties.
- Research has shown that there is a high overlap between homelessness and Opioid Use Disorder (OUD) in the DC, in which PEH face health inequalities and shorter life expectancy. As such, it is crucial to investigate the perceptions of healthcare professionals who are known to hold implicit biases that influence care.

Key Findings:

Positive attitudes were observed across all groups, characterized by a general favorable perception toward PEH, with most respondents agreeing that homeless people have the right to basic healthcare. Among medical students, third-year medical students showed more positive attitudes across all measures, with less resentment about the time spent with homeless patients.

[1] Annual census which features the sum of all individuals experiencing homelessness on a single night, including those in emergency shelters and those unsheltered.

General surgery and Ob/GYN had negative perceptions across all subscales compared to the other specialties. Emergency medicine had the most positive perceptions.

Interpretations and Limitations

Surgical fields attract different personalities and have less PEH exposure, and reimbursement models from payers are more directly tied to procedures.

Social desirability bias, in which individuals answer questions in a manner that is viewed favorably by others, may have contributed to the findings.

In general, increased clinical exposure to underserved populations during training has been shown to have positive impacts on how people perceive those vulnerable populations and their desire to care; however, these experiences need to be tailored by specialty.

- The second article, titled "Buprenorphine/naloxone initiation in the emergency department: A series of vignettes," was targeted towards emergency physicians, where it has been shown to improve engagement with outpatient treatment programs and reduce overall costs.
- The Number Needed to Treat (NNT), or the number of patients needed to treat and prevent one death in the first year for buprenorphine/naloxone, is 52.6.
- The Consolidated Appropriations Act of 2023 eliminated the X-waiver requirement, the need for special DEA numbers, patient limitation, and required training for clinical providers – hence any provider with a DEA Schedule III authority can prescribe.

ED Implementation Considerations

- Care team education is essential. Providers, nurses, and pharmacists need to be comfortable with buprenorphine/naloxone.
- System issues include the availability of buprenorphine/naloxone in automated dispensing systems, lack of pharmacy coordination, and billing restrictions.
- Administration should be protocolized and partnered with community-based providers, especially social workers and peer support specialists. Links to outpatient treatment programs are also needed. This one area is often lacking in clinical settings.
- Patient education on how to take medication (sublingual), what to expect, warning signs, and home initiation instructions, if applicable, is required if administering in an ED setting.

- Follow-up arrangements include a warm handoff to the MOUD clinic, involvement of a peer recovery specialist, social work support, and written appointment information to establish continuity of care.

Common Pitfalls & Solutions

In theory, all EDs in DC can administer buprenorphine/naloxone, but it is provider-dependent. Pitfalls include:

- Time concerns
  Solution: established protocols minimize ED length of stay (Median 2.4 hours with efficient workflow)
- Fear of precipitated withdrawal
  Solution: Start with test dose if uncertain and have treatment plan ready for precipitated withdrawal
- Stigma
  Solution: Increase exposure and integration to those with lived experience (PRCs)
- No Follow-up Resources
  Solution: Clear protocols to connect the right patient to the right place and prescribe enough medication to bridge gap in care. Increased presence of peer recovery specialists on a consistent basis.
- Pharmacy issues
  Solution: Call ahead to verify medication availability and provide list of pharmacies that stock buprenorphine/naloxone as it changes periodically.

Discussion points

- The Mobile Integrated Health Team (MIH Team) can benefit from training on best practices to engage patients in the field and initiate buprenorphine/naloxone from ED providers. Training from ED providers who have successfully engaged patients in the ED will help DC FEMS pre-hospital buprenorphine/naloxone concordance and adherence. DC FEMS pilot protocol for MOUD [2]
- DCHA should investigate opportunities for peer recovery specialists to engage with new residents and medical students to share their experiences and insights.
- Continue working on addressing stigma related to peer recovery specialists and advocate for their recognition in leadership roles within healthcare teams.
- Increase support for the integrated peer recovery specialist program to enhance connections to outpatient services. It is essential to have peer recovery specialists consistently incorporated into care teams in emergency departments (EDs) because

[2]https://fems.dc.gov/sites/default/files/dc/sites/fems/page_content/attachments/DC_Fire_%26_EMS_Protocols_August_2024.pdf

they play a crucial role in supporting patients. These specialists need to be integrated into both the field and clinical settings. Consistent and integrated availability of peer recovery specialists is necessary in both emergency departments and inpatient settings.

- Consider creating cross-hospital protocols for MOUD that can be easily referenced by providers. GW now has an algorithm posted and readily available for providers. According to DCHA, there is a focus group of DC ED clinicians who are working on this.
- Clearly define the role of a peer recovery specialist within a care team.
- Consider making policy recommendations based on the discussion of homelessness and induction services.
- Educating patients with SUD about the chronic nature of their condition that requires management. Timely resources for employment and addiction treatment should be made available.

Q & A

Q1. What best practices can new providers utilize to engage patients in the EDs across DC? Medical students have stated lack of resources in learning about buprenorphine/naloxone initiation in EDs.
A1. That concern is shifting rapidly. Residents are now becoming more comfortable. Continuous education across faculty and residents has proven to be more effective than mandated education for licensure.

VI. Program Updates

- Members were reminded to vote for the suggested meeting times using the poll.
- Members were encouraged to return their confidentiality form.

VII. Adjournment

- The next OFRB meeting is scheduled for November 18th, 2025, at 3:00 p.m.

Thank you for your participation!