Regionalization of Oregon's Medical Examiner System

- Dr. Gunson's 20+ year concept to decentralize the SMEO
- Driven by Geography
- Designed to support county M.E. systems & mitigate county costs
- Progress has been made
- MEIOW-generated alternatives?

Oregon's Medical Examiner System

- Oregon converted from a coroner system to an ME system in 1958
- Oregon is statutorily classified as a state medical examiner
- Governing statute: ORS 146
  - Establishes an ME system relying on county and state partnerships:
  - Each county must maintain a death investigation system
    - County medical examiner appointed by Chief Medical Examiner
    - Medicolegal death investigators appointed by county medical examiner
    - State Medical Examiner's Office (SMEO) provides training and oversight
    - Authority divided between Chief Medical Examiner, county medical examiners, and district attorneys

Medical Examiner Services

Postmortem Examinations and Data Collection:

- Potential to inform public health agencies by statistical reporting and tracking of trends
- Informs healthcare decisions of surviving family members

Death Certification:

- Timely and accurate death certification helps grieving families achieve closure by establishing specific cause of death
- Detailed death certificates aid public health data collection
- Death certificates are necessary for estate management and disposition planning

Administrative functions:

- Providing medical examiner reports to families
- Managing communication with external partners, including district attorneys, law enforcement officials, and public health agencies

Mass Fatality Planning

- Supports state disaster readiness by participating in workgroups and providing subject matter expertise

Oregon Death Investigation System

- County Responsibilities:
  - Scene response
  - Scene investigation
  - Scene photography
  - Scene report generation and publication
  - Case log data entry
  - Record procurement
  - Next of kin notification
  - Social contact interviews
  - External examination of the body
  - Coordination with local funeral homes
  - **Death Certification**
  - Best practice implementation

- State Responsibilities:
  - Autopsy performance
  - Autopsy photography
  - Autopsy report generation
  - Radiography
  - Toxicology and ancillary study interpretation
  - Medical record review
  - **Death certification**
  - Best practice recommendations

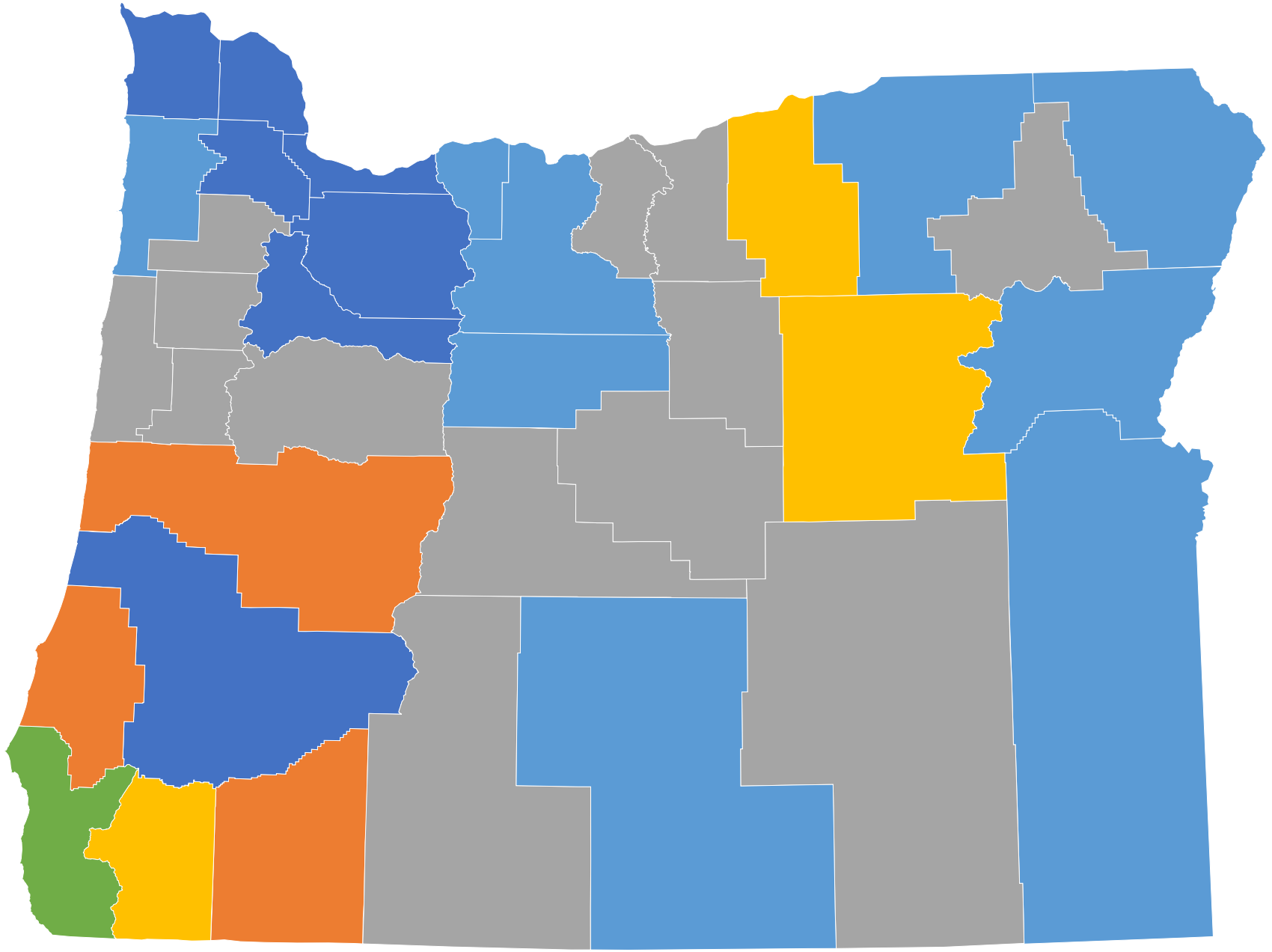
Oregon's Death Investigation System

Forensic Pathologist	• Board certified physician, responsible for forensic pathology services and subject matter expertise • Practices full-time
County Medical Examiner	• Locally appointed physician who administers county medical examiner program • Practices part-time
Medicolegal Death Investigator	• County-level employees, responsible for day-to-day activities of death investigation • Can be full-time or part-time

A State System in Name Only

- County capabilities vary widely due to funding and access to resources
- Lack of standardization
- Most county death investigation is performed on part-time basis
- Small size of SMEO limits oversight
- Reporting structure varies from county-to-county (DA? Other?)
- Law enforcement focus of system

Oregon County Medical Examiner Systems by Type



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County ME/Full Time MDI
No County ME/Full Time MDI
County ME/Part Time MDI
No County ME/Part time MDI
County ME/No MDI
No County ME/No MDI

System Gaps

- Neither state nor county agency can independently address all needs in each investigation
- Nature of county/state interactions vary from county to county
- Resources and expertise are concentrated in metro areas
- Access is limited in rural areas

Impacts to the Community

- Inequitable distribution of and access to medical examiner services
- Inconsistent documentation impairs data collection
- Medical background investigations are often incomplete
- Low autopsy rates relative to size of population
- Delayed death certification

Equity concerns

- Community impacts from impaired service delivery are most severe in rural jurisdictions
- Counties with underdeveloped death investigation services also contain vulnerable populations
- Most public health data is collected from well-funded, urban programs
- Insight into health impacts in vulnerable communities is limited

Current System Structure

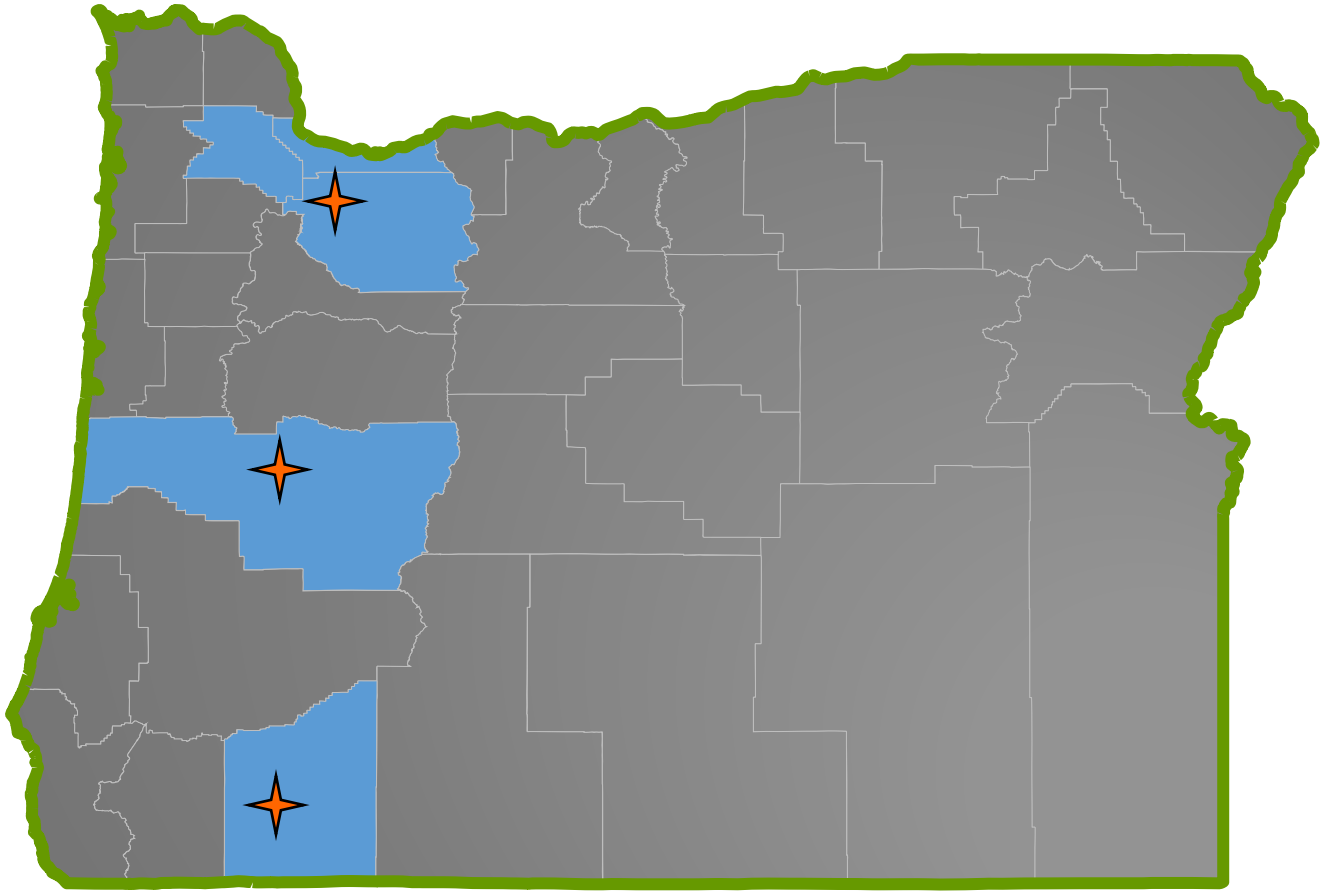
- Advantages:
  - Established medical examiner system (i.e. no need to convert from a coroner system)
  - Efficient organization of subject matter expertise
  - Employs forensic pathologists
  - Great potential for improvement within statutory structure

MEIOW

- Concerns solicited from constituent groups:
  - Resources
  - Communication
  - Training

Infrastructure Limitations

- Scientific Working Group for Medicolegal Death Investigation:
  - Transport distance should not exceed 100 miles in >10% of cases



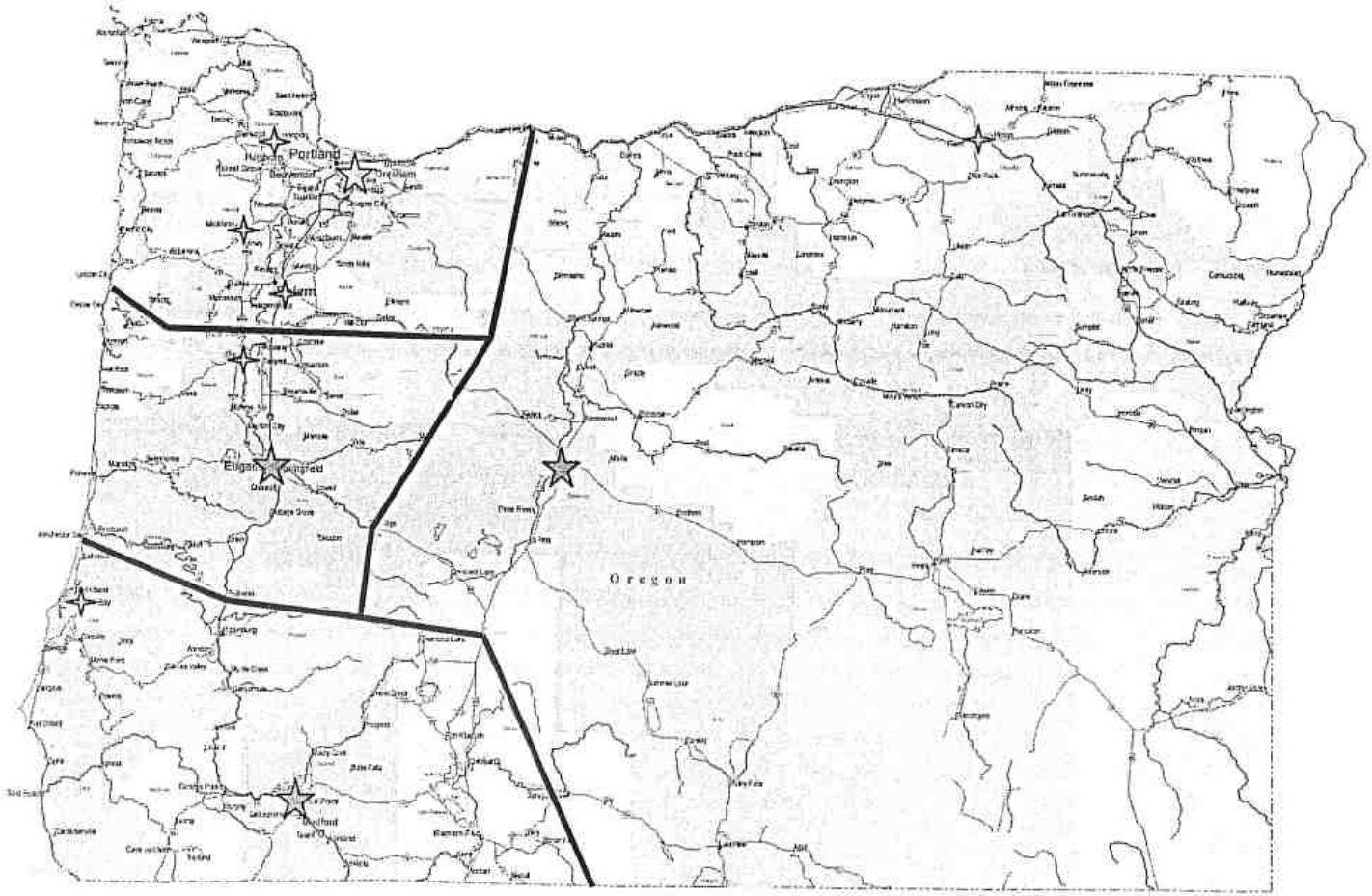
Resource considerations

- Facilities
- Recruitment
- Training

Long Term Solution?

Regionalization of State Medical Examiner’s Office

Regionalization



SMEO Regionalization

- Divide the state into four regions, each with:
  - Autopsy facility
  - Forensic pathologists
  - Medicolegal death investigator support
  - Forensic pathology support staff

What does this mean for counties?

- Goal: Fill in gaps in service delivery to produce a more equitable and consistent medical examiner system that better serves the community
- Supplement existing services, *not replace them*

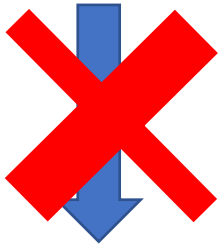
Oregon Health Authority

Direct assistance to county public health departments

Oregon Department of Justice

Attorneys designated to fill County DA vacancies

State Medical Examiner's Office



OSP Forensic Services Division

Crime scene investigation support for rural agencies

County/State Interaction

- Spirt of ORS 146: County/state cooperation
- SMEO assistance will be scaled to needs of county
- Expansion efforts lead by SMEO will be targeted and cost effective
- Established county MDIs and MEs will still have a role to play in the system

Regionalization Summary

- Proximate SMEO access/support to provide equitable service delivery
- Promote more consistent documentation and reporting of cases
- Promote better public health data
- Efficient allocation of limited subject matter expertise
- Avoid deepening of existing disparities