Meeting People Where They Are: Corrections, Telehealth and OUD

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Disclosures

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Learning Objectives

- Describe the critical nature of providing medication for opioid use disorder (MOUD) to persons with criminal justice (CJ) involvement
- Highlight barriers to treating individuals who are incarcerated
- Share a model for providing MOUD during and following incarceration
- Discuss the early data in support of our model

Present State

- ~1 in 3 people in custody with opioid use disorder (OUD)[1]
- Buprenorphine is 80.5% of MOUD offered[1]
- Substantial increase since 2018 in buprenorphine use[1,2]
- But MOUD reaching only 3.6% of people in custody[2]

Why provide MOUD in CJ?

1. Harms of severe withdrawal when beginning incarceration
2. Ongoing risks—institutional punishment, infection, physical harm, and overdose—from contraband opioids
3. Upon re-entry, people without MOUD treatment face mortality rates 50-100 times baseline[3]

Why provide MOUD in CJ

- Reduces risk of overdose death on re-entry[4]
- Reduces recidivism[5]
- Reduces harm from use when incarcerated
- Reduced future substance use and increases treatment[6,7]
- Reduces overall costs for the criminal justice system[8,9]

Barriers to MOUD in CJ

Barriers related to Criminal Justice

- Attitudes and misconceptions
- Concern for diversion
- Cost (e.g., time, staffing, medication)
- Probation Officer (PO) buy-in
- Loss of insurance

Barriers to MOUD in CJ

Barriers experienced by patients

- Lack of access to MOUD programs on release
- Anti-MOUD bias at some treatment agencies
- Fear of re-incarceration and consequent repeated forced withdrawal

Our Model: Overview

- Partner corrections and Boulder Care
- Collaborative relationships
- Champions for MOUD

1. Universal Screening

- All people incarcerated are screened and offered MOUD universally, so corrections did not play role of gatekeeper; medical staff were making the determination and normalized MOUD
- People who opted in were offered treatment with Boulder Care and a virtual appointment within 2 days (avg 0.8 days)

2. Easy, Private Access to Care

- Visits conducted on a shared computer in a private room; staff outside to discuss follow up
- Importance of a holistic approach including Peer Recovery Specialists and Care Advocates
- Telehealth enables persistent support, continuity and access, and reduces cost of in-sourcing jail providers

3. Medication Treatment

- Medications were e-prescribed to a local pharmacy; CJ staff picked up, ideally same-day
- Combination buprenorphine- naloxone films prescribed and administered by staff
- Set up for success post-discharge with combo product
- Reduction in diversion concerns for staff using the film
- Grant covered cost of medication

4. Follow Up Care

Regular follow-ups

- Weekly follow-up visits scheduled with staff, decreasing frequency as stability achieved

Release planning

- CJ case workers trained to reinstate insurance (Medicaid) to start on release
- Naloxone access upon release from Max's Mission, a local foundation (too expensive without insurance to prescribe)
- Gave 2+ weeks of medication on release because it takes 2-3 weeks to restart Medicaid pharmacy benefits; Boulder phone number and follow up appt printed on prescription label

Continuity of care

- Post-release appointments with Boulder are in-app

Contact Card Provided at Re-Entry

Ongoing Collaboration

- Collaborative relationship with JCCJ through ongoing communication and weekly meetings
- Build relationships with Parole Officers
- Relies on a central person/agency — identify champions

Peer Recovery Specialist (PRS) Role

- Importance of—and evidence for—PRS
- Cases
  - 36-year-old male with OUD. Began smoking heroin in his late 20s. Incarceration date late January 2021. Engaged with Boulder Care mid-March 2021 before his transfer to supportive housing.
  - 24-year-old male with OUD. Began smoking heroin in his teens. Incarceration date mid-June 2021. Engaged with Boulder Care in early July 2021.

Preliminary Outcomes

Outcomes

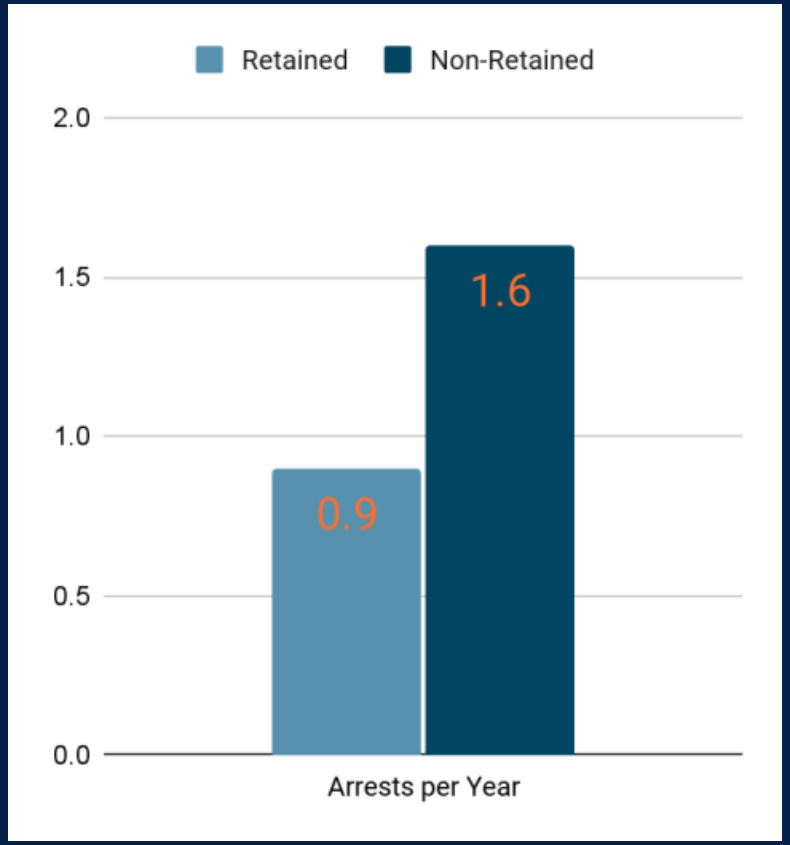
Time to Enrollment

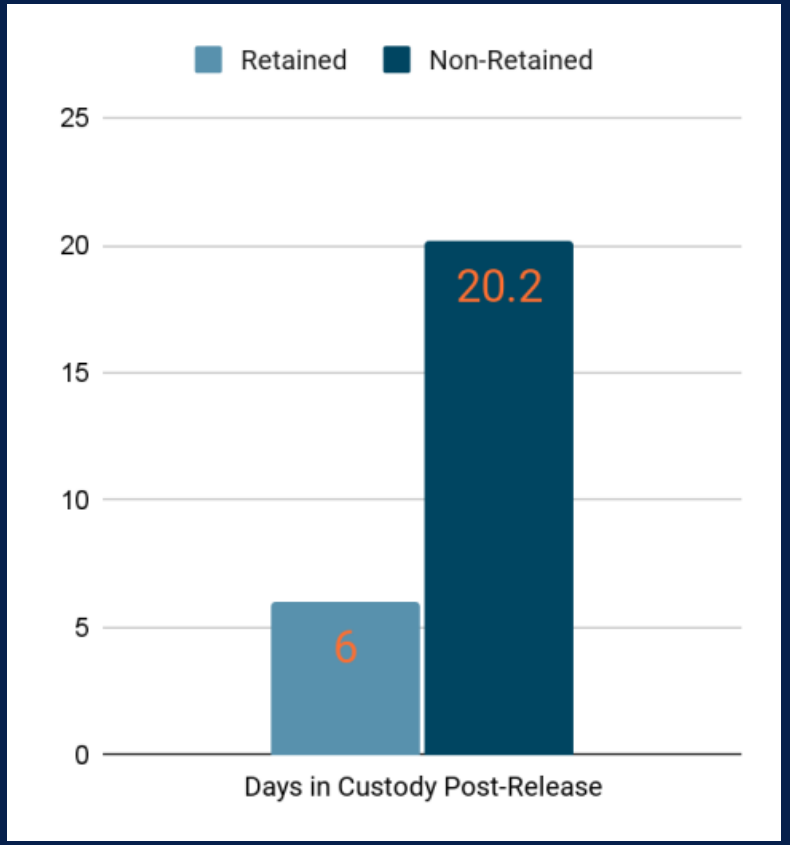
Time in days from reported interest in buprenorphine-naloxone to enrollment with Boulder Care: 0.8 days

Time to Buprenorphine-Naloxone Prescription

Time in days from reported interest in buprenorphine-naloxone to prescription provided by Boulder Care: 2.0 days

Return to Custody by MOUD Status





Strategy: PO Champions

- Easier to influence the CJ system from the inside
  - Identify a PO “champion”
- Listen to patients: which POs support MOUD
- Care coordination with PO

Strategy: CJ and CC Priorities

- MOUD supports CJ Priorities:
  - Increase available jail space for more serious offenses
  - Cost reductions—or better yet, possible grants/funding
  - Reduction in medical concerns
  - Quicker transition to facility's general population
- MOUD Care supports Community Correction Priorities:
  - Fewer probation violations and warrants
  - Reduced recidivism

Strategy: Helping with New Expectations

- Current legal exposure:
  - State and Federal suits centered on violations of the Americans with Disabilities Act (ADA)
  - Lawsuits from family members based on lack of community standard care and consequent harm
- State laws requiring MOUD
- Grant funding requirements

Call to Action & Next Steps

- Barriers to MOUD in custody have always been high
- This treatment is becoming more possible
- Eased telehealth restrictions allows patients treatment in context of limited CJ medical funding
- Partnership with correctional staff inside institutions and in the community continues to be crucial

Final Takeaways & Summary

- MOUD within CJ is achievable and imperative
- Telehealth is a scalable approach with fewer barriers
- Correctional champions in facilities and the community are key
- With help from these champions, treatment can follow already-established patterns of medical care

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Additional Resources

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