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

Why provide MOUD in CJ?

- Nearly 1 in 3 people in custody has been diagnosed with opioid use disorder (OUD)[1]
- Buprenorphine is the major type of of MOUD offered, comprising 80.5% of MOUD in CJ; methadone is at 4% [1]
- Data show a substantial increase since 2018 in buprenorphine treatment in CJ [1,2]
- Tragically, this increase in MOUD overall is still reaching only 3.6% of people with OUD in custody [2]

Why provide MOUD in CJ?

Lack of treatment with MOUD during incarceration markedly increases the harms people face, specifically:

1. Predictable harms of severe opioid withdrawal when beginning incarceration
2. Ongoing risks—including institutional punishment, infection, harm from other incarcerated persons, and overdose—from use of contraband opioids
3. Upon re-entry, without MOUD treatment, people face mortality rates that can be 50-100 times their community-matched cohort [3]

Why provide MOUD in CJ

In addition to being humane and the standard of care, MOUD treatment for people in custody and after release:

- Reduces the risk of overdose death on re-entry [4]
- Reduces recidivism [5]
- Reduces harm from ongoing use when incarcerated (ref)
- Is associated with reduced future substance use and increased treatment (ref Jeremy)
- Is associated with reduced overall costs for the criminal justice system (ref Jeremy)

Barriers to MOUD in CJ

Barriers related to Criminal Justice

- Attitudes/misconceptions (e.g., MOUD a crutch, only short-term, not needed in custody, etc.)
- Concern for version in jails/prisons and then community
- Cost (e.g., time, staffing, medication)
- Range of Probation Officer (PO) buy-in
- Insurance loss during incarceration; challenges restarting 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 deters patients from pursuing MOUD

Our Model: Overview

- Partnership with county corrections department, probation officers, and Boulder Care
- Foster a collaborative relationship with weekly meetings
- Champions for MOUD are crucial to have in jails/prisons and probation post-release

Our Model [1]

- Universal screening for all people who are incarcerated
  - Medical staff make determination for MOUD
  - Creates a normalizing effect regarding MOUD treatment
- People who choose treatment with buprenorphine are offered a virtual appointment with Boulder Care in 2 days or less
- Visits are conducted on a shared computer in a private room; staff outside to discuss follow up
  - Team Clinician, Peer Recovery Specialist, and Care Advocate
  - Telehealth readily allows ongoing support, continuity, and access
  - Model does not have cost of in-sourcing jail clinicians

Our Model [2]

- Medications are e-prescribed to a local pharmacy; CJ staff pick up the same day
- Combination buprenorphine-naloxone films prescribed and administered by staff
  - Allows for re-entry continuity with dual product
  - Staff have fewer diversion concerns with film
- Grant covers cost of medication
- Weekly follow-ups are scheduled by staff; increased stability leads to less frequent telehealth visits

Our Model [3]

- Release planning:
  - CJ case workers reinstate Medicaid to be active on release
  - Naloxone is provided on release
  - 2+ weeks of medication is provided on release to allow time for Medicaid pharmacy benefits to begin
  - Boulder Care phone and appointment printed on prescription label
- Next appointment occurs in-app with Boulder Care after release

Contact Card Provided at Re-Entry

Peer Recovery Specialist Role

- Importance of—and evidence for—Peer Recovery Specialists
- Cases
  - 36-year-old male with opioid use disorder. Started 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 opioid use disorder. Started smoking heroin in his teens. Incarceration date mid-June 2021. Engaged with Boulder Care in early July 2021.

Initial Demographics & Outcomes

Time to a) Enrollment & b) Bup-Nx Rx

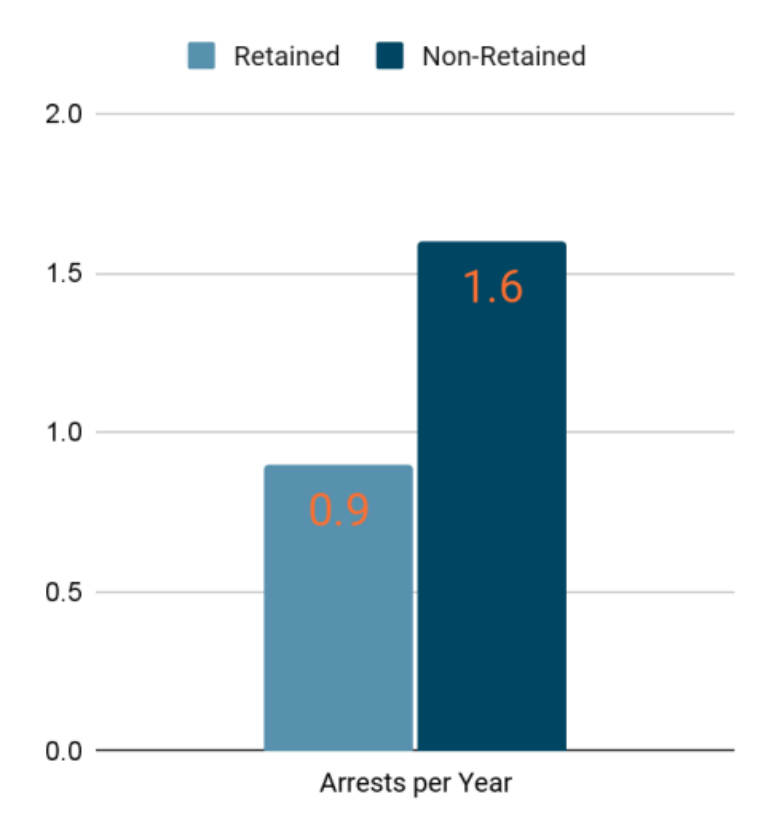
Time to Enrollment

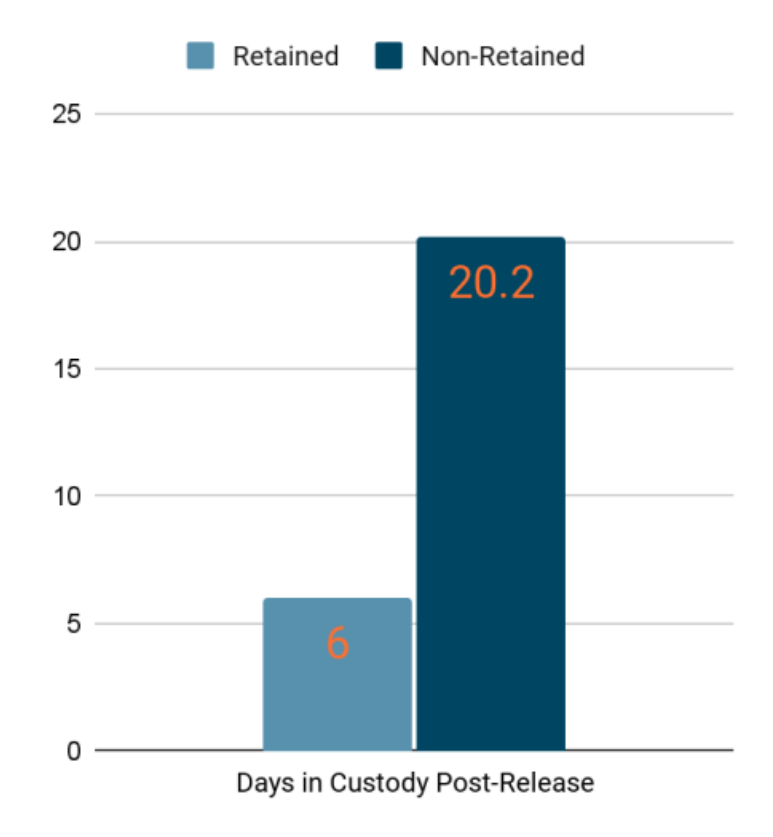
Time in days from reported interest in buprenorphine-naloxone to enrollment with Boulder Care: 0.8 days

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
- Listen to patients to find out what POs may be open to and supportive of MOUD treatment
- Reach out to the PO
- Be open to ongoing conversations with PO
- Find “expert” who can speak their language and, when possible, done their job

Strategy: CJ and CC Priorities

- How MOUD Care Helps CJ Priorities:
  - Increase available jail space for more serious offenses
  - Cost reductions—or better yet, possible grants/funding
  - Fewer sick people and sick calls
  - Quicker transition to facility's general population
- How MOUD Care Helps Community Correction Priorities:
  - Fewer probation violations and warrants
  - Decreased return to incarceration
  - Increased success for people on the outside

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 care with MOUD
- There are emerging requirements for CJ to provide MOUD care in order to receive grant funding (National Drug Court)
- Receipt of other grant and block funding increasingly requires MOUD care

Call to Action/Next steps

- The barriers to MOUD treatment for people in custody have always been high in the US
- However, a number of circumstances is making this treatment more possible
- Easing of telehealth restrictions due the pandemic allows a novel and effective way to meet the needs of patients in the context of limited CJ medical funding
- Nonetheless, partnership with correctional staff inside institutions and in the community continues to be crucial

Final Takeaways & Summary

- Treatment models providing buprenorphine for people in the correctional system have generally been limited by the idiosyncratic profile of each institution and jurisdiction
- Telehealth offers a scalable approach that places much less burden on the correctional system
- Core needs of this model are champions in correctional institutions as well as community corrections
- With help from these champions , treatment with buprenorphine can then follow already-established structures of medical care in CJ settings

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Additional Resources

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