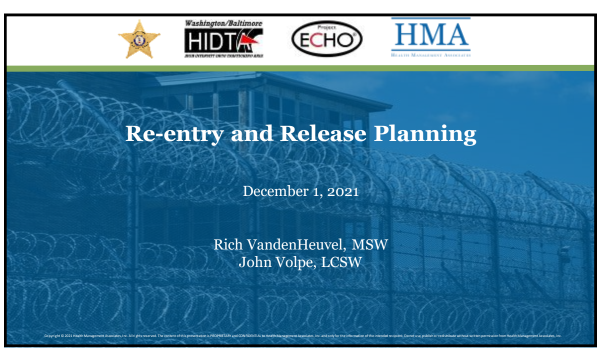
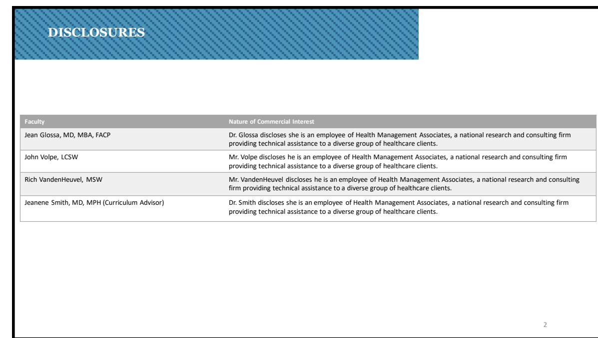




Faculty	Nature of Commercial Interest
Jean Glossa, MD, MBA, FACP	Dr. Glossa discloses she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
John Volpe, LCSW	Mr. Volpe discloses he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
Rich VandenHeuvel, MSW	Mr. VandenHeuvel discloses he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
Jeanene Smith, MD, MPH (Curriculum Advisor)	Dr. Smith discloses she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

LEARNING OBJECTIVES

- Recognize and reinforce the fundamentals of re-entry planning for incarcerated individuals with a substance use disorder returning to the community.
- Explain how correctional institutions, as part of the community safety net, can partner/collaborate with the community system of care to support continuity of care during reentry.
- Distinguish emerging trends impacting Reentry: precipitous release, bail reform, in-reach, telehealth, waivers, etc.

4

CME CREDIT

- If you are interested in receiving educational credit for this session, please indicate this on the evaluation form.
- You will receive a follow up email with an evaluation to complete.
- You will need to complete the evaluation in order to receive credit.
- 1.0 hour of CME is available through the American Academy of Family Practice, equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award – please complete the evaluation we will send at the conclusion of the session.

5

BUILD BACK BETTER AND REENTRY

- Reentry Act: On Thursday, November 18, 2021, the House passed the Build Back Better Act (BBB). The BBB contained language taken from the bipartisan Medicaid Reentry Act, which would allow for Medicaid services thirty days before release from a jail or prison
- Huge implications if passed:
  - States would need to pursue Medicaid Waivers
  - 30 days would cover a large percentage of inmates
  - Implications for jails, providers, health plans, state administrators
- Be aware – all of today's principles still fit, but major potential implications for county jails
- STAY TUNED

6

FUNDAMENTALS OF RE-ENTRY PLANNING – U.S. DEPARTMENT OF JUSTICE

- Reentry planning begins at admission
- Programming while incarcerated occurs based upon individual need
- Maintain community connections to the extent possible/desirable
- Comprehensive, individualized release planning
- Referral and access to services to assure continuity of needed care

Adapted from the US Department of Justice Roadmap to Reentry

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE STANDARDS FOR RE-ENTRY PLANNING

Re-entry planning includes the following:

- **Formal linkages between the facility and community-based organizations**
- Lists of community health professionals
- Discussions with the patient that emphasize **the importance of appropriate follow-up and aftercare**
  - **HMA Note:** Recommend at first dose of MOUD
- Appointments and **medications** that are **arranged for the patient at the time of release**
- Timely exchange of health information, such as problem lists, medications, allergies, procedures, and test results
  - **HMA Note:** Recommend tracking of both appts made and information shared and appts KEPT/Linkages made

FUNDAMENTALS OF RE-ENTRY FOR PEOPLE WITH OPIOID ADDICTIONS

Planning and coordination

- Screen, assess and test; manage withdrawal if needed
- Develop and maintain Collaborative Comprehensive Case Plans
- Facilitate in-reach by community-based treatment providers
- Create a relapse prevention plan (including naloxone upon release)

Behavioral health treatment and cognitive behavioral interventions

- Ensure treatment delivered in jail and community (including CBT)
- Connect to healthcare coverage

Probation and parole supervision

- Training and specialized caseloads where possible

Recovery support services, housing, and other support services in the community

- Immediately upon release

SCALE OF THE PROBLEM TODAY

What percentage of people in jail meet the criteria for drug dependence or abuse?

A. 35%
B. 50%
C. 66%
D. 83%

Please enter your answer in the chat box.

Source: Bureau of Justice Statistics 2014*

*Note: this is dated pre-opioid epidemic. Surveillance data tells us that rates of use and overdose are increasing during COVID-19 pandemic

WHAT PERCENTAGE HAVE AN OPIOID USE DISORDER?

A. 7%
B. 15%
C. 25%
D. 49%

Please enter your answer in the chat box.

CORRECTIONS IS PART OF THE COMMUNITY BEHAVIORAL HEALTH SAFETY NET

- **The Truth:** The state correctional system overall (prisons and jails) is the largest behavioral health treatment institution/organization in every state.
  - In 2018, the Bureau of Justice Statistics (BJS) reported **that 14% of prisoners in state and federal facilities** met the criteria for having **serious mental health conditions**.
  - In **local jails** the number was **26%**.
  - According to federal data, **40% of prisoners were diagnosed with a mental health disorder between 2011 and 2014.**
- **Corrections has a responsibility for healthcare, including behavioral healthcare (mental health and substance use disorder), of inmates.**
  - National Institute of Mental Health: "A substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use"
- In effect, correctional institutions operate as both:
  - Clinically Integrated Networks
  - Health Plans/Insurers
- For many individuals, especially those with a Substance Use Disorder, jail/prison is the entry point to treatment.
- The vast majority of those incarcerated; **95+% return to the community.**

COMMUNITY SYSTEM OF CARE

REMINDER WHERE MEDICATION ASSISTED TREATMENT (MAT) IS OCCURRING IN THE COMMUNITY

Opioid Treatment Provider & Narcotic Treatment Programs:

- ❑ "Methadone Clinic"
- ❑ Can prescribe methadone, buprenorphine and naltrexone
- ❑ Highly regulated
- ❑ No limit on number of patients

Office Based Opioid Treatment

- Prescriber completes 8-24 hours of training, obtains waiver*
- Can treat 30/100/275 patients with buprenorphine
- Can also use naltrexone

* Initial waiver for physicians only requires that an electronic notice be completed

14

WHAT IS AN ADDICTION SYSTEM OF CARE?

- Assessment
  - Screen, assess and test; manage withdrawal if needed
  - Develop and maintain Collaborative Comprehensive Case Plans
  - Facilitate in-reach by community-based treatment providers
  - Create a relapse prevention plan (including naloxone upon release)
- Level of Care Criteria
  - Ensure treatment delivered in jail and community (including CBT)
  - Connect to healthcare coverage
- Clear Referral Processes
  - Training and specialized caseloads where possible
- Referral Follow-up
  - Immediately upon release

Getting to this point – to being a system, may be tough. But when all players work together, with common goal, it is achievable.

15

COMMUNITY SYSTEM OF CARE – CRITICAL TO RECOVERY

- Addiction Treatment is not one thing!
  - In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social and psychological functioning.
- Behavioral Health Provider
  - Ensure treatment delivered in jail and community (including CBT)
  - Connect to healthcare coverage
- Corrections Systems
  - Ensure corrections systems are part of community-based system of care
- Primary Care Providers
  - Must integrate care
- Social Service Systems
  - Social Determinants of Health
  - Enrollment and Eligibility

16

ADDICTION TREATMENT AS A SYSTEM OF CARE

- Transition from one treatment setting to another is a critical factor in sustained recovery
- In clinical studies, rates of relapse (e.g., substance abuse, hospitalization, incarceration, readmission to residential treatment) following residential treatment range from 37% to 56% within the first year of discharge
- Although engagement in aftercare services has been shown to help maintain the gains achieved during residential treatment, only about half make initial contact with outpatient care and very few complete the recommended duration of aftercare services.
- Consider: How would re-entry look differently if Corrections were regarded as a Residential Treatment provider?

Source: HHS Public Access Barriers and Facilitators to Successful Transition from Long-Term Residential Substance Abuse Treatment, Mauel, Yuan, Herman, Svikis, Nichols, Palmer and Deren
(Brunette, Drake, Woods, & Hartnett, 2001; Ouimette et al., 1998; Sannibale, Hurkett, van den Bossche, O'Connor, Zador, Capus, Gregory, & McKenzie, 2003).

17

ADDICTION TREATMENT AS A SYSTEM OF CARE

Successful addiction treatment is not a single treatment episode or type. It is a continuum.

Successful transition between programs is critical.

- For those re-entering from corrections, Withdrawal Management and Residential are typically not involved
- But Medication Assisted Treatment (continuation), Intensive Outpatient Program, Outpatient Program, Recovery housing and Recovery Coach/Peer Support may all be needed
- "Formalized Agreements", including processes and outcome monitoring are recommended to assure connection is made

18

HOW DO YOU CREATE THAT?

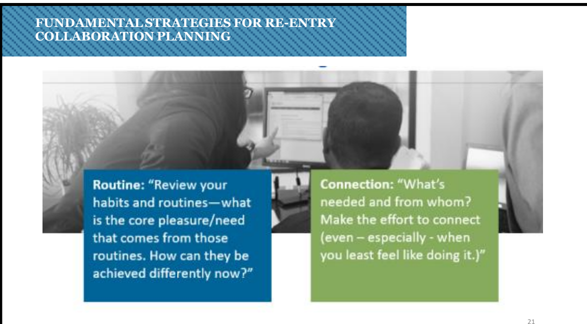
How "connected" is the SUD treatment system in your community? And how connected is it to other systems? This may feel like uncharted, primitive road, but……..

- Include the right people
  - Providers, referral sources, law enforcement, corrections, primary care, EDs, social services, community partners
- Understand the current reality
  - Does it work they way you think?
  - Can people truly access services as they should?
  - What will get you where you need to be
  - Timely access is critical for people transitioning back to the community on MAT. More than 2 days IS NOT Timely
  - Treatment is not the goal, it is the tool
  - Recovery is the goal
- What does that look like?
  - What has to happen differently to have better results?
- Make a plan; monitor the plan, modify the plan

19

CARE COORDINATION AND REENTRY BEST PRACTICES

FUNDAMENTAL STRATEGIES FOR RE-ENTRY COLLABORATION PLANNING



21

A REMINDER OF THE IMPORTANCE OF RE-ENTRY CONTINUITY FOR INDIVIDUALS WITH OPIOID USE DISORDER ON MAT

Providing MAT to inmates and continuity for re-entry improves healthcare outcomes

Release from prison or jail creates extremely high risk of overdose death

- Persons with history of heroin use released from prison have **129 times** the risk of overdose death than the general population **for those who go "cold turkey", leave incarceration, and return to their previous levels of drug use**
- Rhode Island Department of Corrections **saw 61% drop in opioid overdose deaths** after release within a year of MAT program launch, contributing to a **12% overall drop in overdose deaths across the state**
- Rikers Island saw **twice the rate of adherence in outpatient treatment** when methadone is continued
- **Treating pregnant women with OUD can profoundly impact the health of the fetus** and the recovery of the mother

22

CHALLENGES IDENTIFIED FROM CORRECTIONAL FACILITIES

- **Access to inmate for planning:** Rapid and/or unexpected release of inmates; access to reentry planners to develop plan.
  - Jails don't always have advanced notice of release; they need rapid access: "Hot Handoffs" vs. "Warm Handoffs"
- **Access to community treatment services:** Knowing what is available, who is accepting, wait times, etc.
- **Access to Basic Needs:** HOUSING, Transportation, other services
- **Access to Medical Care:** Enrollment/Medical assistance; providers taking patients, primary care, psychiatry and MOUD.
- **Compliance/requirements:** Confidentiality and HIE ; Counseling requirements; Take-Home Dosing; BRIDGE PRESCRIPTIONS

23

CHAT: WHAT CHALLENGES DO YOU ENCOUNTER W/ REENTRY PLANNING?

Please enter your answer in the chat box.

24

CONTINUING MOUD UPON RELEASE

Options for Continuing MOUD on Release

- Patient should be discharged with enough medication to last until they are able to fill prescription. Number of doses will depend on systems in place (availability of pharmacy, insurance, treatment providers in community)
  - Agreements for timely access can reduce amount needed
- Arrange "warm" handoff whenever possible
  - Define who is responsible for Care Coordination/Planning at each step
    - In jail
    - In community
    - Handoff is not successful until/unless responsibility for Care Coordination is given AND accepted from one Care Coordinator to the other
- Consider using telehealth for first visit after release before individual leaves the facility.
- Consider Bridge clinic opportunities in your community.

25

BEST PRACTICES – COUNCIL OF STATE GOVERNMENTS

- Begin re-entry and transition planning at admission
  - Engagement, information on first dose, re-entry "kit", relapse prevention planning
- Continue treatment to the extent possible; explore telehealth options
- Leverage existing relationships to assure continuity of care; re-entry planning is fundamentally local
  - Connect w/ community/existing provider, clear roles through transition
- Make time to plan, which can be difficult during crisis. But crisis can create opportunity to plan and partner with corrections.
  - Regular, ongoing schedule: Assess, Plan, Implement, Evaluate – repeat.
- Develop new resources and relationships
  - Community collaboration

26

OBSERVATIONS AND OPPORTUNITIES

- Re-entry best practices follow common principles of community behavioral healthcare
- Corrections is simply an institutional placement for the individuals served by community providers; good re-entry planning is good transition planning.
- Community practice siloes can, and often do, mirror corrections practice siloes:
  - "Dis-integrated" mental, SUD/OUD and physical healthcare
- **Tremendous need for behavioral health, SUD and MAT services in corrections**.
  - Optimal models in jails and prisons include community providers with correctional facility "Satellites" for seamless transitions, authorizations, and continuation of services
  - Doing "the right thing" may be a business opportunity for community providers
- **Jails:** Share expertise RE: Safety/Security/Supervision
- **Community Providers**: Share expertise RE: community standards of care

27

INNOVATIONS AND BEST PRACTICES

- "Embedded" (drug and alcohol) staff in jail and/or in-reach for assessment and continuity of care with appts set prior to release
- Formal agreements between jails and community providers; including behavioral health, SUD, and primary care (model of integrated practice)
- Regular collaborative meetings; involving treatment courts, law enforcement, and community corrections (probation/parole)
- Data use and information sharing agreements/releases – including Community wide ROIs
- Monitoring of outcomes: Appointments Kept/Treatment Continuation
- "Satellite" clinics (outpatient and MAT medication units) in correctional facilities
- Telehealth innovations – counseling, prescribing, consulting, peer groups

28

INNOVATIONS AND BEST PRACTICES

- Jail-In Reach
  - Federal CMS waivers (BBB/Re-entry Act)
  - Partnership with local/regional managed care health plans
- Follow up information (i.e. referral information, business cards for OTPs, etc) **at first dose in jail** to mitigate risk of precipitous release
- Navigation services upon release
- Peer Supports
  - In Reach
  - Community Groups
- Narcan upon discharge (for person reentering and families/support system)
- Release "backpacks": Information, Narcan, Bus Tokens, hygiene kit, etc.

29

ALL REENTRY STRATEGIES REQUIRE LOCAL INVOLVEMENT

There is no substitute for local planning and local relationships

- **Support from county and/or state administration is important**
- Planning requires local providers and stakeholders
- Success in one community is success in one community – communities have unique strengths and challenges
- The goal is recovery and reintegration, not placement
- Technology can be a powerful tool
- **Communication and partnerships**, warm hand off practices, discharge planning
- **Be the community safety net**

30

CHAT: WHAT INNOVATIONS TO SUPPORT REENTRY HAVE YOU IMPLEMENTED?

Please enter your answer in the chat box.

31

QUESTIONS AND DISCUSSION

REMINDER: CME CREDIT

- If you are interested in receiving educational credit for this session, please indicate this on the evaluation form.
- You will receive a follow up email with an evaluation to complete.
- You will need to complete the evaluation in order to receive credit.
- 1.0 hour of CME is available through the American Academy of Family Practice, equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award – please complete the evaluation we will send at the conclusion of the session.

33