

**Strategies for Integrating  
Substance Use Disorder Treatment for  
\_\_\_\_\_ Formerly Incarcerated People \_\_\_\_\_  
Re-entering their Communities**

**Wednesday, October 7, 2020**

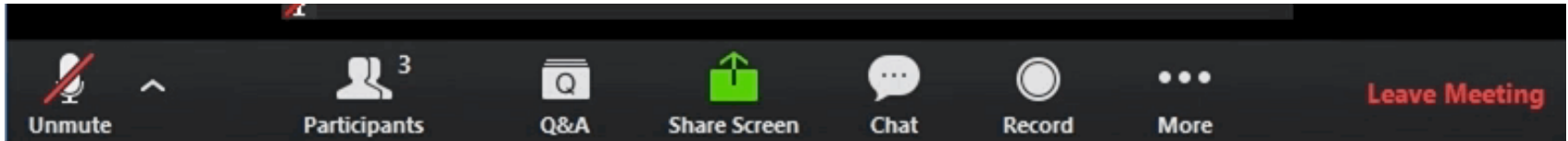
**3:00 – 4:00 pm ET**



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# How to Ask a Question/Make a Comment



Type in a **question** in the **Q&A box**  
Type in a **comment** in the **chat box**

Both are located at the bottom of your screen.  
We'll answer as many questions as we can at the end of  
the presentation.

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# Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)



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## Poll #2: What best describes your organization? (check all that apply)

- Behavioral Health Provider
- Primary Care Provider
- Mental Health Provider
- Substance Use Provider
- Correctional Facility or Organization
- Other (specify in chat box)



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# Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)



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We are a leading independent, national healthcare research and consulting firm providing technical and analytical services.

We specialize in publicly-funded health programs, system reform and public policy.

We work with purchasers, providers, policy-makers, program evaluators, investors, community-based organizations, and others.

We have extensive experience advising on and supporting the use of medications for opioid use disorder (MOUD) in jails and communities across the country.

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# Today's Presenters



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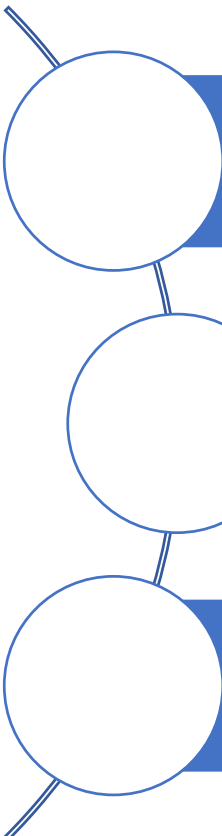
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# Learning Objectives



Review and reinforce the fundamentals of re-entry planning for formerly incarcerated individuals with a Substance Use Disorder returning to the community

Understand the current community provider regulatory and service realities for accessing community services for those with Substance Use Disorder and access to MAT and related services

Understand that corrections systems are a part of the community safety net and the need for connection and collaboration with the broader community system of care

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# A Moment of Reflection

We are living in times of largely unprecedented challenge – **traumatic times**

Corrections staff are responsible for the safety of our fellow citizens: **of the public and of their inmates**

**This is also true of Community Providers**

**We take a moment to honor and celebrate your courage and dedication – it is appreciated!**



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# Fundamentals of Re-entry Planning – Corrections Standards of Care

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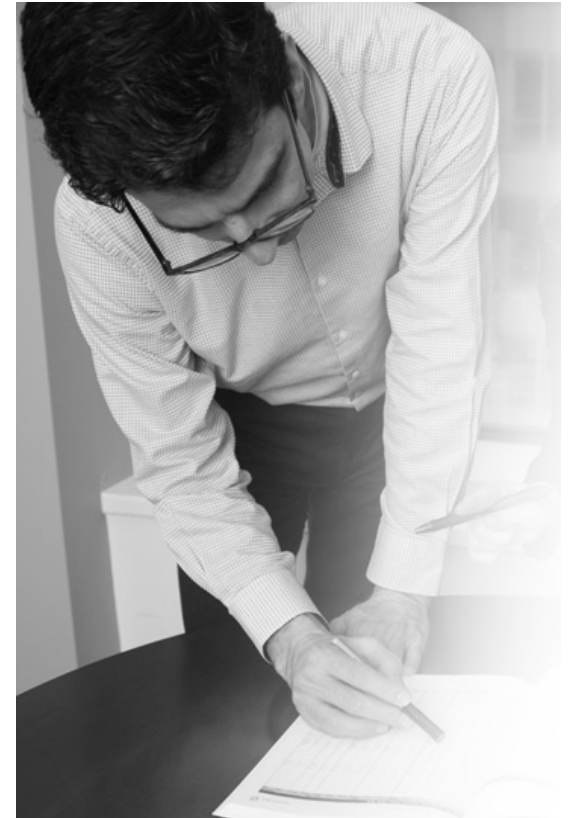
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# Fundamentals of Re-Entry Planning – U.S. Department of Justice

- **Re-entry planning begins at admission**
- Programming (while incarcerated) occurs based upon individual need while incarcerated
- **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*



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# 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**
- + 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



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# 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

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# Scale of the Problem Today

**Two-thirds of people  
in jail meet the  
criteria for drug  
dependence  
or abuse.**

—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

+ Of these, at least 25% have an Opioid Use Disorder.

+ So at least 16-17% jail detainees have Opioid Use Disorder.

**Many more have alcohol,  
methamphetamine  
and/or other addictions**

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# 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, of inmates.**
- + 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**.

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# Community System of Care

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# 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 Providers
  - 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

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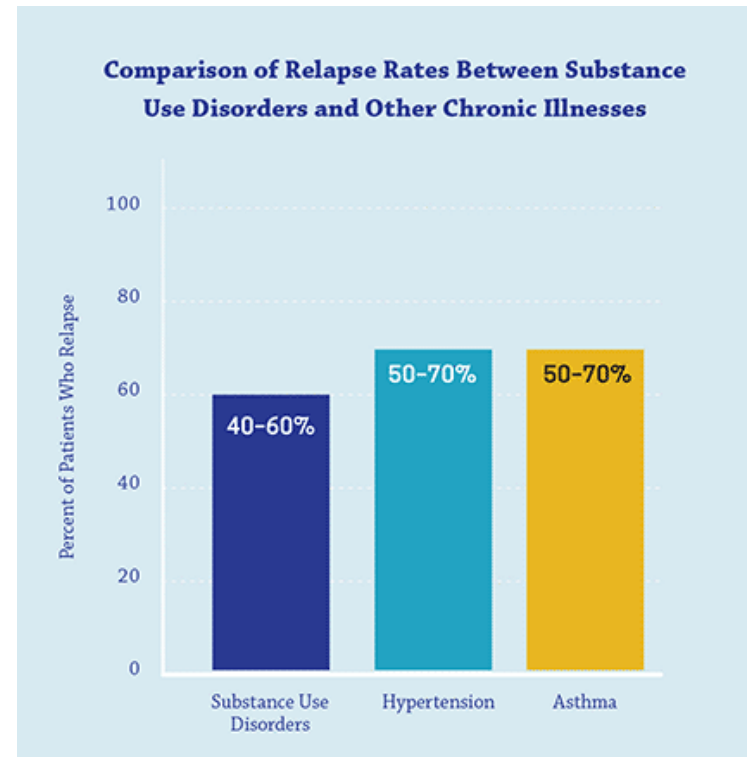
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# Addiction Treatment as a System of Care

- Addiction treatment, whether for the corrections involved, or everyone else, is not typically linear. Relapse happens – it is a chronic disease.
- Relapse is common for chronic diseases.
- And, the population in treatment has changed (2009-2019):
  - Treatment for drug and alcohol both decreased from 46% - 33%
  - **Treatment for drug abuse only increased from 39% - 51%**
  - Treatment for alcohol abuse only has decreased from 19% - 14%



Source: NIH, National Institute on Drug Abuse – Drugs, Brains, and Behavior: The Science of Addiction Treatment and Recovery

Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS): 2019 (Data on Substance Abuse Treatment Facilities)



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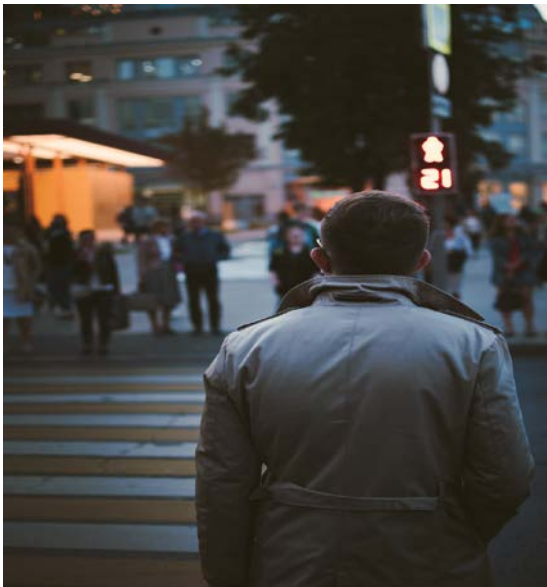
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# Addiction Treatment as a System of Care

- 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.**
- Corrections.....

# 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.

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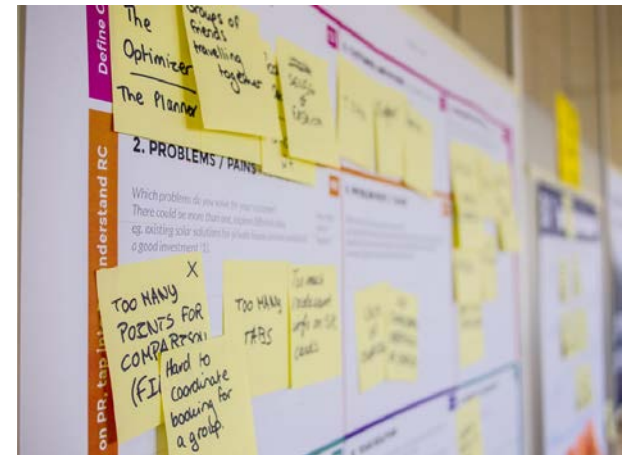
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# What is an Addictions System of Care?

- 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.



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# 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 the way you think?
  - Can people truly access your services as easily as you think?
- 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

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# There Are Challenges AND There Are Opportunities

## COVID 19 Misunderstanding Funding Issues Telehealth

There are guidelines for treatment in COVID 19 world

Lack of understanding of MAT

Need for Sustained funding rather than Grants

STIGMA

Telehealth is essential in COVID 19 world.

Telehealth also makes transitions easier

You are here

Once you know where you are then you can determine how to get where you want to be.

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# CHANGES FOR SUD TREATMENT DURING COVID-19 AND BEYOND

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# Treatment During Pandemic

Social Distancing is contrary to what we naturally do with empathetic listening!

Now that we have moved past *initial* crisis response, what does COVID-informed care look like?

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# OTP/NTP Operations

## Stakeholders in Regulation & Operation with OTP/NTP

SAMHSA

DEA

State OTP  
Regulatory  
Agencies

Professional  
Licensing  
Boards

Reimbursement

Accreditation  
Agencies



# Treatment During Pandemic

**Social Distancing is contrary to what we naturally do with empathetic listening!**

+ Openly acknowledge situation isn't ideal

+ **Discuss patient's preferred method of communication**

# Telehealth Treatment – Telehealth Software

**HIPAA  
COMPLIANT  
TELEHEALTH  
SOFTWARE**

Updox

Zoom for  
Healthcare

Doxy.me

Skype for  
Business

VSee

Google G  
Suite  
Hangouts  
Meet

Vidyo

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# Treatment During Pandemic

**Social Distancing is contrary to what we naturally do with empathetic listening!**

- + Openly acknowledge situation isn't ideal
- + Discuss patient's preferred method of communication
- + Offer reassurance care will continue

# Treatment During Pandemic

**Social Distancing is contrary to what we naturally do with empathetic listening!**

- + Openly acknowledge situation isn't ideal
- + Discuss patient's preferred method of communication
- + Offer reassurance care will continue
- + **Encourage creative solutions to provide high quality 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

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# DEA Changes During Public Health Emergency

## Prior to COVID-19 Emergency

- + Restrictions on prescribing of controlled substances, most significantly with patients who had not previously been seen in person by the prescriber.
- + These were commonly known as the Ryan Haight Act.

## Current State

In light of the public health emergency the DEA has relaxed the requirements to prescribe controlled substances via Telehealth.

# Toxicology Considerations – American Society of Addiction Medicine

- + Consider pausing urine drug testing in clinical practice
  - + In areas or settings where community spread of COVID-19 virus is occurring, it may be appropriate to provide continued access to on-going medications for addiction treatment without attending their treatment facility or having drug testing done.
  - + Urine drug testing is only one piece of information in the comprehensive treatment of opioid use disorder.
  - + Requiring patients to present to a health care facility to provide urine samples for urine drug testing may be more harmful than beneficial.
  - + Patients may unnecessarily increase their risks of exposure to the COVID-19 virus through their travel to or presence in health care facilities. Providers and programs should carefully weigh the risks and benefits of urine drug testing, both for the patient and for community public health and particularly for patients who are stable.

# Treatment During Pandemic

**Social Distancing is contrary to what we naturally do with empathetic listening!**

- + Openly acknowledge situation isn't ideal
- + Discuss patient's preferred method of communication
- + Offer reassurance care will continue
- + Encourage creative solutions to provide high quality care
- + **Individuals might need more, not less, therapeutic interaction during this period**

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# INFORMATION SHARING AND CARE COORDINATION

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# Significant Rule Changes for Information Exchange

- 1. Changes related to Public Health Emergency** – Will continue until the current COVID related public health emergency ends
- 2. Changes from SAMHSA rulemaking**
  - Changes to 42 CFR Part 2 started by SAMHSA in August 2019
  - New rules published July 15, 2020
  - Effective August 14, 2020
- 3. Changes from CARES Act**
  - Signed March 27, 2020
  - Provided emergency funding AND modified 42 CFR Part 2
  - HHS will implement additional changes in 42 CFR Part 2 over the next year
  - These changes will take effect March 27, 2021

# Major Changes to 42 CFR Part 2

Portion of 42 CFR	Change	Impact
Applicability & Re-disclosure	Clarify non-Part 2 providers are not covered by Part 2 requirements even if they have records that were previously received from a Part 2 entity. (Can just keep in separate part of chart)	Allows greater coordination of care between treatment providers
Disposition of records	Incidental message sent to a Part 2 provider's electronic device can be "sanitized" by deleting message	Previously was required to possibly wipe entire device if, for example, a text was received
Consent	May disclose to an entity such as a SSA or a clinic rather than an individual	Much easier to allow application for benefits and coordinate care

# Major Changes to 42 CFR Part 2(cont'd)

Portion of 42 CFR	Change	Impact
Disclosures for permitted activities	Allows easier, less ambiguous disclosure for “Payment and operations” with written consent	Now specifically spelled out, and added “care coordination” and “Case management”
Disclosure to PDMP and Central Registries	Non-OTP providers can query central registry and OTP’s can report to PDMP	Reduced duplication of treatment and safer patient care as MAT can be in PDMP
Medical emergencies	Specifically adds natural disasters as medical emergency allowing disclosure without specific consent	Allow appropriate care under crisis situations
Research	Mirror language in HIPPA for disclosure for research	Resolve ambiguity and update language to allow appropriate research activities
Audit	Allows disclosure for audit and program evaluation	Removes ambiguity to allow quality evaluation



# NCCHC Standard for Discharge Planning

- “For planned discharges, health staff arrange for a *reasonable supply* of current medications.”
- **Reasonable supply:** “... a combination of medications and prescriptions to allow the patient time to arrange for follow-up in the community.”
- Patients with serious medical and mental health conditions “**are given more than a list of community resources. Referrals are made to specialized clinics or community health providers.**”

*NCCHC Standards for Health Services in Jails J-E-10*

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# 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 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 has seen **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**

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# Continuing MAT Upon Release



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# Options for Continuing MAT 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).
- Arrange warm handoff whenever possible.
- Consider using telehealth for first visit after release before individual leaves the facility.
- **Consider opportunity to create or serve as Bridge clinic in your community.**



# APPLIED SCIENCE FOR YOUR ORGANIZATIONS

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# Challenges Identified from Correctional Facilities: What They Say

- + **Access to inmate for planning:** Rapid and/or unexpected release of inmates; access for reentry planners to inmates 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, etc. – particularly during COVID.
  - + Corrections primary role is safety and supervision, they will need your assistance to efficiently access services.
- + **Access to Basic Needs:** HOUSING, Transportation, other services
- + **Access to Medical Care:** Enrollment/Medical assistance; providers taking patients, primary care, psychiatry and MAT.
- + **Compliance/requirements:** Confidentiality; Counseling requirements; Take-Home Dosing; BRIDGE PRESCRIPTIONS



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# Fundamental Strategies for Re-entry Collaboration Planning



**Routine:** “Review your habits and routines—what is the core pleasure/need that comes from those routines. How can they be achieved differently now?”

**Connection:** “What’s needed and from whom? Make the effort to connect (even – especially - when you least feel like doing it.)”

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# Best Practices from Around The Nation

## + Reducing Jail Population – Decarceration during COVID

### + 7 Questions from the Council of State Governments Justice Center

1. Are there procedures in place in advance of release to ensure that the person is free of COVID-19, and are they implemented in a timely manner to avoid delayed release?
2. Does the person have the basic supplies they need—food, hand sanitizer, etc.—to ensure they remain healthy once they're home?
3. Does the person have a safe home to return to that is also virus-free? If not, what alternative community-based housing options may be utilized?
4. What medical or behavioral health medications and services does the person require immediately and potentially during a two-week quarantine? Do arrangements need to be made for them to access some of those services virtually?
5. Have we prepared the person with the technological literacy and equipment to receive and benefit from virtual, rather than in-person, supports?
6. If the person is being released to parole or other supervision, how are we asking them to interact with their parole officer in a time of social distancing?
7. If the local economy has collapsed, are we providing the person with access to public benefits to support themselves and their loved ones?



# Best Practices – Council of State Governments

- + **“Answering no to any of these questions is not a reason to keep someone behind bars longer. But failing to ask them means that we will introduce vulnerable people into situations of even greater chaos and stress than we already do.”**
- + **“It’s imperative that we embrace this crisis as an opportunity to ensure better outcomes at release by planning ahead and cooperating across systems.”**
- + **“It will take cooperation across disciplines—like housing, health, and workforce development—and among local, state, and federal policymakers to get re-entry right.”**



# Best Practices – Council of State Governments

- +Begin re-entry and transition planning at admission
- +Continue treatment to the extent possible; explore telehealth options
- +Leverage existing relationships to assure continuity of care; re-entry planning is fundamentally local
- +Make time to plan, which can be difficult during crisis. But crisis can create opportunity to plan and partner with corrections.
- +Develop new resources and relationships
- +**Share expertise on community standards of care; these may differ in corrections because of necessity**

# Observations and Opportunities

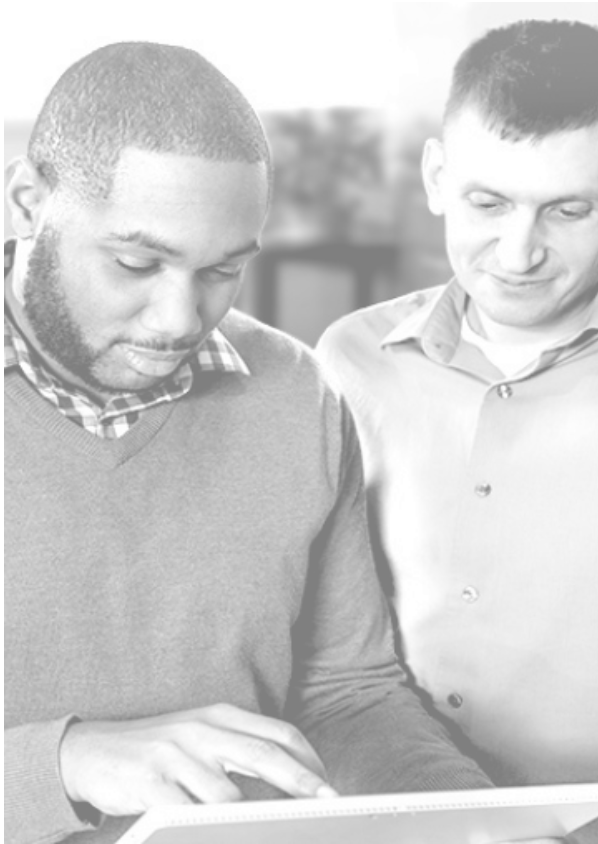
- + Re-entry best practices follow common principles of community behavioral healthcare
- + Corrections is simply an institutional placement for the individuals you serve; good re-entry planning is good transition planning.
- + Corrections operate differently, administratively and culturally, from community behavioral health by necessity (“Paramilitary organizations”) but have responsibility for healthcare of inmates.
  - + Most correctional leadership does not have a healthcare or behavioral health background
  - + Corrections can, and often do, mirror community practice siloes
  - + YOUR expertise is needed (integration, evidence-based practice, individualized planning).
- + **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.



# 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
- + Corrections to provider as well as payor/plan and state department
- + “Satellite” clinics (outpatient and MAT) in correctional facilities
- + Telehealth innovations – counseling, prescribing, consulting, Project ECHO

# All Reentry Strategies Require Local Involvement



## There is no substitute for local planning and local relationships

- + **Support from state administration is important**
- + Planning requires local providers and stakeholders
- + Success in one community is success in one community – they are all different
- + The goal is recovery and reintegration, not placement
- + Use technology
- + **Communication and partnerships**, warm hand off practices, discharge planning
- + **Be the community safety net**

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# “Don’t Waste a Crisis – Your Patient’s or Your Own”

## Traced to 1976 article by M. F. Weiner

- + Journal Medical Economics “Don’t Waste a Crisis — Your Patient’s or Your Own”
- + Weiner meant by this that a medical crisis can be used to improve aspects of:
  - + **Personality,**
  - + **Mental health**
  - + **Lifestyle**
- + Every intervention with an individual is an opportunity to help them achieve or maintain recovery
- + Sometimes, in times of greatest pressure, we can have the greatest impact



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# References

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- *“Best Practices for Successful Reentry for People Who Have Opioid Addictions”* The National Reentry Resource Center, November 2018.
- National Commission on Correctional Health Care Jail Discharge Standards for Inmates With Serious Health Needs Whose Discharge is Imminent
- Freakonomics Blog: *Quotes Uncovered: Who Said No Crisis Should Go to Waste?*  
<https://freakonomics.com/2009/08/13/quotes-uncovered-who-said-no-crisis-should-go-to-waste/>
- *“Substance Abuse and Mental Health Services Administration: Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide.”* HHS Publication No. SMA19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration, 2019.

# Next Steps

- Please look for a follow-up email with:
  - A link to a brief evaluation: Please complete – we appreciate your input!
  - A link to the recording of today’s webinar and slides for reference: feel free to forward to others on your team.
  
- For those of you with additional questions –
  - [dschneider@healthmanagement.com](mailto:dschneider@healthmanagement.com)
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*Thank you and stay safe!*

# Questions?

Email [integration@thenationalcouncil.org](mailto:integration@thenationalcouncil.org)

SAMHSA's Mission is to reduce the impact of substance abuse and mental illness on America's communities.

[www.samhsa.gov](http://www.samhsa.gov)

1-877-SAMHSA-7 (1-877-726-4727) 1-800-487-4889 (TDD)



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# Join us to Continue the Conversation!

**Join our Office Hour session on October 13, 3-4pm ET**

**[Register here](#)**

## **During this session we will discuss...**

- Unanswered questions from today's session
- Any other questions or comments you submit during registration
- Strategies to integrate substance use disorder treatment and collaborate with the broader community system of care to provide services



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# Upcoming CoE events:

**CoE Office Hours: Virtual Clinical Supervision During COVID-19; Strategies for Adjusting to Your Needs**

[Register here for the Office Hour](#) on Oct. 14, 3-4pm ET

**Addressing Implicit Bias in Organizational Structures**

[Register here for webinar](#) on Oct. 21, 2-3pm ET

[Register here for the Office Hour](#) on Oct. 29, 3-4pm ET

**Making the Case for High-functioning, Team-based Care in the Community Behavioral Health Care Setting**

[Register here for webinar](#) on Oct. 28, 1-2pm ET

**Interested in an individual consultation with the CoE experts on integrated care?**

[Contact us through this form here!](#)

**Looking for free trainings and credits?**

[Check out integrated health trainings from Relias here.](#)



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