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GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES

Maryland Learning Collaborative To Support Opioid Use Disorder Examinations and Treatment Act and Medication Assisted Treatment (MAT) Implementation for Justice-Involved Populations

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EXECUTIVE SUMMARY

Implementation of comprehensive programs to treat individuals with substance use disorders is often a significant challenge for state and local correctional facilities. Historically, in correctional institutions across the country, medications assisted treatment (MAT) have not been offered to inmates, and medications for inmates on community-prescribed MAT have been tapered off or abruptly discontinued upon entry into the facility. According to the National Sheriff's Association and the National Commission on Correctional Health, using FDA-approved forms of MAT is now considered the standard of care for individuals with opioid use disorder (OUD) and use of MAT should be determined by the provider and patient (detainee). Routine processes of not providing or withdrawing from MAT is not the standard of care.[1].

Maryland is a leader among states choosing to tackle this tough issue where ingrained stigma, funding challenges, and inertia need to be overcome for successful implementation of these programs. In Maryland, the Opioid Use Disorder Examinations and Treatment Act (H. B. 116, the Act), passed during in the 2019 legislative session, requires local correctional facilities to offer comprehensive MAT programs including linkages to reentry services for ongoing MAT in the community.

Many of Maryland's local correctional leadership teams have reported challenges in meeting the forward-thinking requirements enumerated in the Act. To help facilities address these roadblocks, the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS) funded a technical assistance program. HealthCare Access Maryland (HCAM) and Health Management Associates (HMA) were charged with developing the program. During this high-intensity program, all local correctional facilities, their community partners, and other key stakeholders were able to access technical assistance (TA), also referred to as coaching, via virtual, in-person, or on-site venues.

The technical assistance program consisted of three core concepts:

- Weekly virtual learning sessions open to all participants
- Individualized site-specific coaching offered virtually and on site to each participating facility
- An all-day in-person learning collaborative

[1] National Sheriffs' Association. Promising Practice Guidelines for Jail-Based Medication-Assisted Treatment. October 2018. Available at: https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf. Accessed September 24, 2023.

HMA subject matter experts led the virtual sessions and coaching sessions, based on a curriculum aligned to the requirements of the Act. The HMA team integrated evidence-based practices for MAT and treatment for opioid use disorder (OUD) in justice-involved populations and individualized coaching to address the unique challenges of each site. Additionally, during an in-person learning collaborative, correctional facilities had the opportunity to learn from each other and share best practices.

Virtual Learning Sessions: **14**

Participants: **28**

Site Visits: **21**

Correctional Facilities: **18**

All-day Learning Collaborative: **1**

Participants: **133**

HMA facilitated 14 virtual learning sessions with an average of 28 participants per session and an average post-attendance evaluation rating of 4.63 on a five-point scale. HMA subject matter experts conducted a total of 21 site visits to 18 correctional facilities; several facilities had more than one site visit. HMA planned and facilitated a daylong learning collaborative as a capstone to the three-month TA program. National, state, and local subject matter experts presented plenary sessions, joined panel discussions, and led multiple interactive sessions. A total of 133 people with a variety of roles, ranging from correctional administrators to medical doctors participated in the event and rated their overall satisfaction of the session with 4.69 out of 5.00.

Overall attendance for all TA components was higher for all activities than initially anticipated and continued to grow throughout the program. More sites requested and engaged in individualized coaching and the feedback was overwhelmingly positive. The most common concern or suggestion was that the three-month coaching program was insufficient to address all the needs HMA and the leadership teams at the local correctional facilities identified. A few facilities opted out of the program for unclear reasons. Anecdotally, two sites considered themselves too advanced and indicated individualized coaching would be of little benefit to their facilities, though they did send representatives to all-day session. Two other institutions were unresponsive to outreach despite multiple attempts.

The HMA team assigned to each participating site administered a detailed survey of the current state of MAT services in the facility. This assessment was inclusive of all the Act's requirements. During the course of the technical assistance, the HMA coaches and correctional staff reviewed and recorded the progress in the implementation of the key components of the Act. Additionally, site-specific information was deidentified and then aggregated to provide information on how the overall cohort was performing.

Note that this was not an audit and responses from site teams were not verified.

Overall, most local correctional facilities that participated in the coaching aspect of the TA program reported the provision of at least two of the three FDA-approved forms of MAT; however, teams noted several non-evidence-based practices such as arbitrarily limiting the number of inmates in MAT programs and using stigmatizing language and practices. In other words, although many sites technically offer MAT, further analysis revealed barriers to full and equitable access for all inmates who could medically qualify for treatment. These additional limitations are significant because they will contribute to the barriers of meeting the intended impact of the legislation.

Based on the HMA team's observations, comments from participants, and the standard review of implementation progress, HMA identified the following key opportunities for future progress in expanding access to MAT for justice-involved individuals:

- Address the ongoing challenges local correctional facilities are having in meeting the community standard of care for treatment of individuals with substance use disorders so that individuals throughout the Maryland justice system have consistent, low-barrier access to evidence-based MAT.
- Connect facilities to sustainable funding opportunities to support their MAT programs.
    - Lack of funding was a consistently cited challenge for the local correctional facilities. Center for Medicare and Medicaid's (CMS) Section 1115 of the Social Security Act (42 U.S.C. § 1315) can provide funding for MAT and reentry services. HealthCare Access Maryland (HCAM) estimates that more than 75 percent of justice-involved individuals leaving the local correctional facilities in Maryland are eligible for Medicaid.
- Engage the Maryland Department of Corrections (DOC) regarding MAT services.
    - Individuals with SUD/OUD on MAT who are awaiting transfer to DOC should remain on their medication while in the local correctional facility, per the Act. It also is recommended that inmates continue to receive MAT after transfer to a DOC facility, in accordance with community and evidence-based standards. Knowing an inmate will need to be tapered off MAT before going to DOC is a rationale for many local correctional facilities to withhold MAT and puts the facility at risk of not following evidence-based guidelines or the Act's requirements. Maryland's efforts to address OUD for justice-involved individuals need to include the DOC as well as local correctional facilities for two reasons: 1) access to MAT in DOC would represent the evidence-based standard of care and save lives, and 2) it removes another barrier to offering MAT. Both DOC and local correctional facilities play a critical role in the safety net for substance use disorder treatment. In HMA's experience leading MAT implementation for justice-involved individuals, DOC and local detention centers are a mutual reinforcing feedback loop for change.

- Refine the Act's data-reporting requirements for local correctional facilities.
    - Almost all facilities voiced challenges with collecting, reporting, and sharing data as specified in the Act. Despite collaborative technical assistance sessions with 23 facilities, many of them still reported difficulties understanding and adhering to the current reporting definitions. The reporting process can be clarified with consistent definitions so that data can be collected and optimally shared across jurisdictions to track individuals who move across the state. HMA recommends aligning the data definitions with Medicaid (or Medicare) terminology for billable services which also creates a glide path for implementation of Medicaid payment under the 1115 waiver.
- Address stigma.
    - Stigma related to substance use still permeates every facet of our society, especially in the correctional community that has historically fought against illicit drug use and is responsible for upholding the laws prohibiting the sale, purchase, and possession of narcotics. Thinking of substance use disorder as a chronic disease requires a radical paradigm shift. Ongoing stigma hinders progress, which puts individuals and programs at risk. The HMA coaching team noted many bright spots and individual best practices, but much work remains to be done in this area.

In summary, progress was observed despite the short duration of technical assistance. Several local correctional facilities that were initially resistant to technical assistance welcomed the support by the end of the engagement. Going forward, higher-performing correctional facilities could serve as mentors to their neighboring jurisdictions. Several facilities made positive changes in reporting, administration of MAT, SUD treatment options, and reentry connections. The local correctional facilities would benefit from continued TA and engagement to strengthen their critical role in the safety-net SUD continuum and ultimately reduce OUD and overdose deaths.

TECHNICAL ASSISTANCE PROGRAM INTRODUCTION

HMA conducted the learning collaborative to support all elements of the Act including a focus on medication assisted treatment (MAT) implementation for justice-involved populations. Robust technical assistance (TA) was offered to local correctional facilities interested in receiving support for implementing and/or improving their MAT programs and reentry services to support continued recovery support in the community post-release.

The program was available April 1–June 30, 2023.

The technical assistance program was available to any local correctional facilities interested in developing and/or expanding access to MAT for opioid use disorder in their facilities. The TA program revolved around three key components: weekly virtual learning sessions, individualized site-specific coaching, and an all-day, in-person learning collaborative. Representatives from the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS) and HealthCare Access Maryland (HCAM) joined the sessions and led several presentations and discussions.

At the statewide level, participants were encouraged to engage in regular, interactive virtual sessions on a defined topic as well as open-ended "office hours" hosted by HMA subject matter experts (SMEs) where participants could ask questions and receive guidance. HMA also organized an all-day, in person learning collaborative. At the local level, HMA provided tailored 1:1 coaching to the correctional and healthcare teams to problem solve and support program development.[2]

Virtual Sessions

A key component of the technical assistance program was the weekly virtual sessions. These one-hour lunchtime sessions focused on key components of MAT programs delineated in the Act, as noted below. The facilitators and subject matter experts encouraged participation, questions, and feedback in an engaging, interactive format. Whenever possible, the virtual sessions incorporated presenters from the local correctional facilities who shared best practices. Even facilities with limited MAT implementation often had bright spots or learning experiences that they could share with other sites.

Learning theory recognizes that adults frequently learn best from other peers who have tackled the problem in a similar setting. Session materials such as slide decks and resources were shared via email after each session. These materials are available on the GOCPYVS's website.[3] Initial topics were proposed at the project's inception but were refined based on feedback gathered from the ongoing individualized coaching calls and site visits. One hour of professional educational credit (Continuing Medical Education [CME] and continuing education [CE]) was available for each session. A combined total of 34 hours of CME and CE credit were awarded.

The session topics are listed on the following page:

[2]In the Opioid Use Disorder Examinations and Treatment Act, MAT is defined as medication assisted treatment. In other instances, MAT may be defined as medications for addiction treatment or the term MOUD (medications for opioid use disorder is used to be more specific to OUD. The term and acronym MAT for medication assisted treatment is used throughout this report in line with H.B. 116.

[3]Opioid Use Disorder and Examinations - Governor's Office of Crime Prevention, Youth, and Victim Services (maryland.gov)

Date	Facilitators/Presenters	Session Topic/Title
March 28, 2023	*Traci Kodeck*, CEO, HCAM *Jean Glossa*, MD, MBA, Managing Director, HMA	General Project Information and Recruitment; Overview of Technical Assistance Opportunity
April 5, 2023	*Rich VandenHeuvel*, MSW, Principal, HMA	Moving Forward: Coaching for Jurisdiction Success
April 12, 2023	*Keegan Warren*, JD, LLM, Principal, HMA	The Current Legal Landscape for MAT in Jails: What Do Jail and County Leaders Need to Know to Manage Risk?
April 19, 2023	*John Volpe,* LCSW, Principal, HMA *Joseph Poindexter*, Senior Director, Health Insurance Programs, HCAM	Health Insurance Programs and Medicaid Enrollment for Returning Citizens
April 26, 2023	*Christopher Klein*, Superintendent, Anne Arundel County, Department of Detention Facilities *Marc Richman*, PhD, Principal, HMA *Rich VandenHeuvel*, MSW, Principal, HMA	The Case for MAT for Custody Leaders and Staff: Why MAT in My Jurisdiction?
May 3, 2023	*Shannon Robinson*, MD, Principal, HMA *Margaret Kirkegaard*, MD, MPH, Principal, HMA	Screening and Assessment- Applying Evidence Based Practices in Correctional Settings
May 10, 2023	*Marc Richman*, PhD, Principal, HMA *Shannon Robinson*, MD, Principal, HMA	Administration Integrity: Managing Diversion Risk with MAT
May 17, 2023	*Rachel Kesselman-Leonberger*, Senior Editor & Data Analyst, GOCPYVS *Jean Glossa*, MD, MBA, Managing Director, HMA	Data Collection and HB 116 Reporting Requirements

May 24, 2023	*Emily Keller*, Special Secretary of Opioid Response, Maryland Opioid Operational Command Center *Jennifer Custer*, Certified Peer Recovery Specialist, Washington County Sheriff's Office *Rich VandenHeuvel*, MSW, Principal, HMA	Secretary's Update on Maryland's OOCC Peer Recovery Supports
May 31, 2023	*Keegan Warren*, JD, LLM, Principal, HMA	The Current Legal Landscape for MAT in Jails: What Do Jail and County Leaders Need to Know to Manage Risk? Part 2
June 7, 2023	*Erick Weintraub*, MD, Associate Professor of Psychiatry, Director Division of Alcohol and Drug Abuse, Co-Director of Adult Psychiatry, University of Maryland, School of Medicine *Shannon Robinson*, MD, Principal, HMA	MAT Best Practices including Best Practices from Jail-Based Telehealth MAT Programs
June 14, 2023	*Nathan Kemper*, Director, Maryland Statistical Analysis Center, GOCPYVS *Marc Richman*, PhD, Principal, HMA	HB116 Data Workshop & Office Hour-Review Data Entry Requirements and Processes; Interactive Group Discussion
June 21, 2023	*Julie White*, MSW, Principal, HMA *Shannon Robinson*, MD, Principal, HMA	MAT and Withdrawal Management-Four Cases for Discussion
June 28, 2023	*Marc Richman*, PhD, Principal, HMA *Michael DuBose*, Principal, HMA	Best in Show: Highlights of Successes-Six Examples of Best Practices in MAT Programs from Participating Teams

Participation for Virtual Sessions

Participants were invited from various agencies, organizations, counties and correctional facilities in Maryland. Most of the participants were affiliated with a specific team or jurisdiction and frequently offered feedback and personal experience. The average attendance was 28 participants per session. This number does not include HMA facilitators.

- Allegany County Detention Center
- Anne Arundel County Department of Detention Facilities
- Baltimore City
- Baltimore County Department of Health
- Baltimore County Detention Center
- BayMark Health Services
- Behavioral Health Administration (BHA)
- Calvert County Behavioral Health
- Caroline County Detention Center
- Carroll County Detention Center
- Carroll County Sheriff's Office
- Cecil County Correctional Facility
- Chesapeake Detention Facility
- Department of Correction and Rehabilitation (DOCR)
- Department of Detention Facilities
- Division of Pretrial Detention and Services
- Dorchester County Corrections
- Maryland Department of Public Safety and Correctional Services (DPSCS)
- Governor's Office of Crime Prevention, Youth, and Victim Services
- Harford County Sheriff's Office
- HealthCare Access Maryland
- Howard County Department of Corrections
- Institute of Human Virology, University of Maryland School of Medicine
- Jennifer Road Detention Center
- Johns Hopkins University
- Kent County Detention Center
- Kolmac and Powell Recovery Maryland Division of Parole and Probation
- Maryland Treatment Centers
- MATClinics
- MedMark Treatment Centers
- Montgomery County Department of Corrections & Rehabilitation
- NaphCare
- Opioid Operational Command Center (OOCC)
- PrimeCare Medical, Inc.
- Pyramid Healthcare
- Queen Anne's County Department of Health
- St. Mary's County Detention and Rehabilitation Center
- Talbot County Department of Corrections
- University of Maryland, Baltimore
- Unity Health Care, DC
- University of Maryland, School of Medicine
- Washington County Sheriff's Office
- Wellpath
- Wicomico County Department of Corrections
- Wicomico County Detention Center
- Wicomico County Health Department
- Wicomico County Jail
- Worcester County Detention Center
- YesCare

Participants had the following positions and titles representing the transdisciplinary engagement required to effect change in carceral environments:

- ACFA
- Addiction Counselor
- Administrative Captain
- Administrative Commander
- Administrative Nurse Manager
- Administrative Services Commander
- Assistant Director of Nursing
- Alcohol and Drug Counselor II
- Assistant Director
- Assistant Regional Manager
- Assistant Warden
- Assistant. Commissioner
- Captain
- Case Manager
- CEO
- Certified Peer Recovery Specialist
- Charge Nurse
- Clinical Nurse Manager
- Clinical Supervisor
- Clinician
- Commissioner
- Communications Director
- Consultant (non HMA)
- Correctional Corporal Audit Unit
- Correctional Facility Administrator
- Correctional Treatment Services Coordinator
- Corrections Analyst
- CPRS/SBIRT Peer Screening Brief Intervention Referral Treatment
- Day Reporting Center Director
- Deputy Director
- Deputy Director for Administration - Custody
- Deputy Director of Services/Inmate Health (Physician)
- Deputy Health Officer
- Deputy Warden
- Director of Access Services
- Director of Data
- Director of Development
- Director of Outreach
- Director, Quality Assurance/State Opioid Treatment Authority
- Director, Criminal Justice Services
- Division Chief, Medical & Behavioral Health
- Executive Associate
- Executive Director
- Facility Administrator
- Health Service Administrator
- Human Service Program Manager
- Justice Reinvestment Coordinator
- Lieutenant
- MAT Coordinator
- MAT Discharge Planner
- MAT Program Manager
- Physician
- Medical Director -Opioid Treatment Program (OTP)
- Medical Liaison
- MOUD Counselor
- MOUD Nurse
- Nurse Practitioner
- Peer Recovery
- Physician
- Program Director
- Program Manager
- Re-Entry Coordinator
- Regional Director of Operations - MAT
- Regional Manager
- Registered Nurse
- Registered Peer Supervisor
- Resident Physician
- Security Captain
- Senior Director, Health Insurance Programs
- Senior Editor & Data Analyst
- Special Secretary of Opioid Response
- Statewide Medical Director
- Superintendent
- Supervisory Therapist
- Support Division Commander
- Urgent Care Nurse
- Vice President
- Warden

Following each session, participants were asked to complete an evaluation. The following results reflect an aggregate for all 14 virtual sessions.

Average Rating Across All 14 Sessions	
Quality of Presentation	4.63
Value of Topic	4.63
Time Allotted	4.42
Training Met Expectations	4.60
Overall Rating	4.63

Response Scale	
Excellent	5
Good	4
Average	3
Fair	2
Poor	1

Participant Feedback:

"Love the interactions and collaboration with other jails."

"The interactive component that allowed sites to share specific experiences, challenges and successes."

"The participation of very experienced people and inclusion of all of their understanding of words and questions of reporting. It sounds as if a lot of them should have been involved or consulted when the reporting criteria was developed."

"Real examples and the live speaker; She was so genuine and inspirational to listen to."

"As a physician, I am not certain sessions like this are entirely worth my time when the rest of the team from the jurisdiction/facility where I work are not specifically participating."

"The professional presenting, had items organized and shown/described in manner that made it easy to learn and understand."

"Nothing I didn't like - these are always educational - I wish we did these more often."

"Loved the freedom to share opportunities and experiences!"

"This is the last one [session]. Hopefully, we can continue receiving support."

Individualized Coaching and Site Visits

Individualized academic detailing, or coaching, is a highly effective strategy for adult learning and change management. Each correctional facility was matched with two HMA coaches with interdisciplinary experience significant for work with justice-involved individuals and carceral facilities and their care teams. The coaches sought to establish a relationship with each jurisdiction team and position themselves as trusted resources and not as compliance auditors or academic pedagogues. The coaches paid one to six visits (both virtual and in person) to each participating correctional facility. The most important function of coaching is active listening followed by actionable problem-solving strategies. Coaches also provided specific technical assistance resources, such as articles and sample policies, promoted connections between teams with similar issues or solutions, and reviewed processes. Coaches were available via phone, text, and email for continuous advice during the duration of coaching.

Though much of the coaching took place via video-conference calls, HMA coaches visited each site at least once. A total of 18 local correctional facilities received 21 site visits. The Appendix lists all site visits per jurisdiction by date.

While all correctional institutions serve the same function, individual facilities may differ in their appearance, physical layout, staffing, morale, and conditions of incarceration.

Site visits allowed the HMA team to observe on-the-ground procedures and better understand the specific facilities' barriers for MAT implementation.

During the coaching visits, the HMA team followed the site's lead, respectfully asking to see various areas and processes but never pushing or requiring. Many site visits also included interactions with inmates and observations of medication administration, often referred to as "med pass." Most site visits ended with an interactive team meeting and an educational session on the neurobiology of OUD as a chronic brain disease or other topics related to evidence-based MAT programs.

PARTICIPATING TEAMS THAT HAD ONE OR MORE SITE VISITS:

- Allegany Co. Sheriff's Office Detention Center
- Anne Arundel County Dept of Health - Jennifer Road
- Anne Arundel County Dept of Health - Ordnance Road
- Baltimore City Pretrial Facility
- Calvert County Detention Center
- Caroline County Health Department
- Carroll County Sheriff's Office/Detention Center
- Frederick County Adult Detention Center
- Garrett County Detention Center
- Harford County Detention Center
- Howard County Detention Center
- Montgomery County Detention Center
- Queen Anne's County Detention Center
- Saint Mary's County Detention and Rehabilitation Center.
- Talbot County Dept of Corrections
- Washington County Detention Center
- Wicomico County Corrections Center
- Worcester County Detention Center

In addition to providing a snapshot of the actual environment, the site visit fosters trust between the local team and the HMA coaches. Correctional facilities are inherently isolated from the community, a challenge that the COVID-19 pandemic exacerbated.

A site visit conveys interest and respect and sets the tone for subsequent coaching. With similar, but longer-term technical assistance programs in other states, HMA strives to return to each site at least once a year to meet new team members, reinforce best practices, introduce new concepts in person, and maintain trust and engagement.

Learning Collaborative

Summary of the Day:

A daylong, in-person session took place Tuesday, June 13, 8:30 am−4:00 pm, at the BWI (Baltimore-Washington International) Airport Marriott in Linthicum Heights. This event was open to all stakeholder interested in learning more about implementing or expanding MAT programs in Maryland's local correctional facilities and county justice systems. The project team invited and encouraged the attendance of representatives of correctional centers and jurisdiction teams, including members of clinical, custody, and administration teams who support MAT program design and implementation.

Topics included implementation planning, facilitation across jurisdictions, sharing best practices and lessons learned, and discussions about improving access to OUD treatment for justice-involved people. Attendees were asked to rate each session component on the quality of the presentation/facilitation, value of the topic, and an overall rating on a scale from one to five.

The day began with welcoming remarks from Brandi Cahn, Assistant Director of Justice Reinvestment, the Governor's Office of Crime Prevention, Youth, and Victim Services' (GOCPYVS). Ms. Cahn's remarks were followed by additional welcoming remarks from Traci Kodeck, CEO, HealthCare Access Maryland (HCAM).

The keynote address was presented by Karran Phillips, MD, MSc, Deputy Director of the Center for Substance Abuse Treatment, a division of the Substance Abuse and Mental Health Services Administration (SAMHSA), who shared details on SAMHSA's Support of Substance Use Disorder Treatment in the Criminal Justice Setting. Participants rated the keynote address as follows:

Quality of Presentation	Value of Topic	Overall Rating
4.63	4.59	4.59

Next, the participants participated in one of four breakout sessions organized to match their roles and responsibilities in their MAT programs (i.e., affinity groups). HMA coaches facilitated these peer-to-peer sessions to share challenges, best practices, and encourage connections for future support. Participants were organized as follows:

- Custody and sworn staff
- MAT prescribers and medical teams
- Behavioral health, SUD, community-based organizations, and certified peer recovery specialists
- Administrators and wardens

Group 1. Custody and Sworn Staff

Quality of Facilitation	Value of Topic	Overall Rating
4.67	4.67	4.67

Group 2. MOUD Prescribers and Medical Teams

Quality of Facilitation	Value of Topic	Overall Rating
4.92	4.92	4.92

Group 3. Behavioral Health, SUD, Community-Based Organizations, and Certified Peer Recovery Specialists

Quality of Facilitation	Value of Topic	Overall Rating
4.74	4.68	4.68

Group 4. Administrators and Wardens

Quality of Facilitation	Value of Topic	Overall Rating
4.79	4.79	4.79

After a networking lunch, attendees reconvened for a plenary panel focused on approaches to methadone programs titled *Local and State Perspectives on Methadone Access.* This interactive panel discussion featured representatives from different locations and programs within Maryland. Panelists shared their approach to ensure access to methadone, including their successes, challenges, and lessons learned while developing and implementing their models.

Panelists:

Franklin Dyson, Director, Quality Assurance/Maryland State Opioid Treatment Authority

Megan Singh, Regional Director of Operations, District of Columbia, Maryland, and West Virginia; MedMark

Christopher Klein, Superintendent, Department of Detention Facilities. Anne Arundel County

Renard Brooks[4], Assistant Secretary, Programs, Treatment and Reentry Services; Maryland Department of Public Safety and Correctional Services

Carolyn Thangawng, MD, MPH, FASAM, Medical Director, Opioid Treatment Programs – Baltimore Central Booking and Intake Center (BCBIC), MTC, MCIW; YesCare

Quality of Facilitation or Presentation	Value of Topic	Overall Rating
4.67	4.65	4.65

Participants then moved to the second breakout session of the day. HMA coaches and HCAM facilitated peer-to-peer sessions to share challenges, best practices, and encourage connections for future support. Participants chose one of four sessions:

Breakout #1: H.B. 116 Data Workshop

- During this breakout session, participants worked directly with Nathan Kemper, Director, Maryland Statistical Analysis Center, to review the Act's data requirements. The group discussed a representative case to practice data collection and shared practical approaches to reporting. Based on the high level of engagement and questions, additional time was dedicated to this topic at the following Wednesday's virtual session.

Breakout #2: Guidelines for Managing Substance Withdrawal in Jails

- This breakout session featured a high-level review of the new withdrawal guidelines from the Bureau of Justice Assistance (BJA). BJA, in conjunction with the National Institute of Corrections and other national organizations, convened an expert advisory panel to review the literature and create the first Guidelines for Managing Substance Withdrawal in Jails. The guidelines are a tool for local government officials, administrators, correctional officers, and healthcare professionals.

[4]At the time of the panel, Mr. Brooks was representing the Baltimore County Department of Corrections as Deputy Director, Programs and Services.

Breakout #3: Community Connections—Supporting Reentry Planning, Continuity of Care, and Collaboration with Community Providers

- Participants in this interactive discussion reviewed national and observed best practices in reentry coordination and continuity of care. Participants explored strategies that promote reentry including linkages to Medicaid enrollment, harm reduction models, in-reach peer recovery supports, warm handoffs, and mechanisms to address health-related social needs (HRSNs). HMA coaches, alongside Traci Kodeck, CEO, HealthCare Access Maryland, led the session.

Breakout #4: Measuring Success—Looking at the Big Picture

- This breakout session addressed approaches to measuring the impact of MAT programs, including metrics and key performance indicators that demonstrate success in MAT, and implementation of rapid cycle improvement processes in specific areas. Attendees discussed the impact and return on investment they would like to see in their programs and communities and received feedback on selecting measures that demonstrate their accomplishments.

Breakout #1: H.B. 116 Data Workshop

Quality of Facilitation	Value of Topic	Overall Rating
4.11	4.44	4.22

Breakout #2: Guidelines for Managing Substance Withdrawal in Jails

Quality of Facilitation	Value of Topic	Overall Rating
4.73	4.82	4.73

Breakout #3: Community Connections

Quality of Facilitation	Value of Topic	Overall Rating
4.00	4.00	3.90

Breakout #4: Measuring Success

Quality of Facilitation	Value of Topic	Overall Rating
4.73	4.80	4.80

Summary of the In-Person Learning Collaborative Evaluations

Following the completion of the learning collaborative event, participants were asked to complete an evaluation on the quality of the program. The following comments and ratings reflect an aggregate of all submitted evaluations.

Quality of Facilitation and Presentations	Value of Topic	Overall Rating
4.67	4.67	4.69

Participant Feedback

"All the information and education provided. All presenters being well knowledgeable in their topics, and in return, improving my education."

"Lots of time for networking with peers who have same mindset of reducing stigma of MAT."

"The openness of the breakout sessions and being free to ask questions without judgment."

"Loved the actual/real time experience sharing."

"Helpful to hear what other detention centers/providers are doing."

SURVEY OF MAT PROGRAMS

HMA collected information on the sites' progress in offering a comprehensive MAT program, including reentry services using a standardized tool based on the requirements of the Act. This survey allowed HMA to tailor technical assistance to the needs of the cohort and to the individual correctional facilities if the site participated in subsequent coaching sessions. The survey questions examined each domain of a full-scale MAT program and responses were assessed along a continuum of implementation, with the highest values representing the most robust programs. Coaches collected this information based on conversations (during site visits and coaching sessions) and observations, but responses were not independently validated or audited. HMA recommends that these results should not be generalized over all 24 local correctional facilities, as facilities that opted out cited a variety of reasons; two facilities self-reported they had all MAT program elements in place and two other facilities were unresponsive to all inquiries.

SURVEY INFORMATION WAS COLLECTED FROM THE MAT PROGRAMS AT THE FOLLOWING LOCATIONS:

- Allegany Co. Sheriff's Office Detention Center
- Anne Arundel County Dept of Health - Jennifer Road
- Anne Arundel County Dept of Health - Ordnance Road
- Baltimore City Pretrial Facility
- Baltimore County Department of Corrections
- Calvert County Detention Center
- Caroline County Health Department
- Carroll County Sheriff's Office/Detention Center
- Frederick County Adult Detention Center
- Garrett County Detention Center
- Harford County Detention Center
- Howard County Detention Center
- Montgomery County Detention Center
- Queen Anne's County Detention Center
- Saint Mary's County Detention and Rehabilitation Center.
- Talbot County Dept of Corrections
- Washington County Detention Center
- Wicomico County Corrections Center
- Worcester County Detention Center

Question 1: Perception of Leadership Support

Leadership support for MAT implementation is a key component of a successful program. HMA's experience with similar TA programs across the country shows that buy-in from leadership is critical to effective implementation. Obviously, support is necessary to garner appropriate resources, and it is even more important to model the value of MAT. Correctional facilities are inherently hierarchical environments. Authentic leadership for MAT implementation is necessary to promote engagement among the custody staff.

Participating sites were asked (or HMA observed) whether they had leadership buy-in from their sheriff or warden in support of the implementation of MAT programs in their facilities. More than one-quarter of the sites reported that they did not have the necessary leadership support. Additional TA could begin with the engagement of the sheriff or warden in the facilities or jurisdictions which reported less leadership engagement or support.

ANNE ARUNDEL COUNTY STOOD OUT TO HMA AS THEY DESCRIBED THEIR SUPERINTENDENT'S SUPPORT IN GETTING THE MOBILE UNIT SET UP FOR THE SITE THAT DOESN'T HAVE AN OTP.

Question 2: Use of Evidence-Based Screening and Assessment Processes and Tools

Evidence-based screening and assessment are the necessary initial steps in an MAT program and they help to minimize stigma and avoid missing individuals who may want or require treatment. The standard is to screen all individuals using an evidence-based tool and for individuals who screen positive to complete an appropriate assessment. Facilities were asked about (or HMA observed) their approach to screening and assessment along this continuum beginning with the minimal screening and assessment as the least advanced. Full advanced screening and assessment would include the use of a validated tool and pathways to treatment. Most correctional facilities were only doing minimal screening or assessment and are inconsistent in their use of evidence-based, validated tools and follow-through to develop individualized treatment plans. HMA coaches noted many facilities were working to improve their processes and were open to the use of better tools and workflows.

WORCESTER COUNTY DETENTION CENTER STOOD OUT TO HMA COACHES AS THEY DESCRIBED AND ROLE-PLAYED REMARKABLY PERSON-CENTERED AND RESPECTFUL INTERVIEW APPROACHES THAT LEADERSHIP MODELED AND CORRECTION OFFICERS DISPLAYED.

Question 2: Use of Evidence-Based Screening & Assessment Processes and Tools *(Choose One Option)*	
1 - Minimal SUD Screening/Assessment (non-validated tool)	6
2 - Screening tool "based upon validated instrument"	4
3 - Validated Screening Tool	5
4 - Validated Screening Tool; Positive Screening to Assessment Pathway	1
5 - Validated Screening Tool; Positive Screening to Assessment Pathway; Positive screening leads to a validated assessment by an appropriate clinician	1
6 - Validated Screening Tool; Positive Screening to Assessment Pathway; Positive screening leads to a validated assessment by an appropriate clinician; Completed assessment leads to individualized treatment planning	1
7 - Validated Screening Tool; Positive Screening to Assessment Pathway; Positive screening leads to a validated assessment by an appropriate clinician; Completed assessment leads to individualized treatment planning; Timely access to screening, assessment, and to individualized planning with timeliness monitored	1

Questions 3, 4, and 5: Use of FDA-Approved Medications for Addiction Treatment (MAT)

A comprehensive MAT program includes prescribing all three Food and Drug Administration (FDA)-approved forms of medication[5] offered for both continuation and initiation of treatment as clinically appropriate. In this report, "initiation" refers to an inmate receiving MAT after having never received MAT or not receiving MAT for a significant time period prior to incarceration. (Note: this differs from the current interpretation of initiation in H.B. 116). Correctional facilities will often begin an MAT program first by continuing MAT and then by adding serving as the initiator of MAT. This element of the survey is intended to assess the continuum of services where the most advanced response would indicate that the program offers both continuation and initiation of MAT.

As part of this survey, facilities also were asked about their approach to managing substance withdrawal (often referred to as detox). Though many correctional facilities offer comfort medications to address the symptoms of withdrawal such as diarrhea, this treatment is no longer the clinical or carceral standard for management of withdrawal[6] because buprenorphine or methadone addresses the actual opioid receptors in the brain and short circuits the withdrawal process. Management of opioid withdrawal with only comfort medications increases the risk of dehydration, electrolyte imbalance, and death and, therefore, a correctional facility's liability.

[5]FDA-approved forms of MAT are naltrexone (Vivitrol), buprenorphine (Suboxone or Subutex), and methadone.

[6] BJA guidelines.

Responses to these questions do not reflect whether the facility has a self-imposed limit on how many inmates can be on a type of MAT at once. Sites may have responded that they identify inmates who qualify for MAT, and they do prescribe the medications, but they limit the number of inmates in the MAT program at one time because of staffing or other operational considerations that the facility or medical team has imposed.

Question 3: Methadone *(Choose One Option)*	
1 - No methadone is provided in the correctional facility	3
2 - Only pregnant women with OUD are continued on methadone via formalized relationship with certified OTP	0
3 - Methadone is continued for all detainees in treatment with community OTP(s) via formalized relationship	9
4 - Initiation and continuation of methadone is offered for those clinically indicated while incarcerated	7

Question 4: Buprenorphine *(Choose One Option)*	
1 - No buprenorphine is prescribed for continuation or initiation	0
2 – Site offers buprenorphine continuation with valid, verified community prescription provided for pregnant women only	0
3 – Site offers buprenorphine continuation with valid, verified community prescription	5
4 – Site offers buprenorphine continuation with valid, verified community prescription and buprenorphine “taper” for evidence-based withdrawal management	4
5 – Site offers buprenorphine continuation including for those initiated to treat withdrawal as part of an individualized treatment plan	2
6 – Site offers initiation and continuation of buprenorphine for anyone clinically indicated as part of an individualized treatment plan	8

Question 5: Naltrexone *(Choose One Option)*	
1 - No naltrexone is provided in the correctional facility	1
2 – Site offers naltrexone continuation with valid, verified community prescription	5
3 - Site offers initiation of naltrexone for those clinically indicated while incarcerated	6
4 – Site offers initiation and continuation of naltrexone for anyone clinically indicated as part of an individualized treatment plan	7

Questions 6 and 7: Reentry Support for Continuation of Medication, Behavioral Health Support, and Medicaid Enrollment

The Act requires that correctional facilities facilitate reentry coordination for individuals receiving MAT. Release from carceral settings is an extremely high-risk period of overdose and deaths for individuals with SUD. Correctional facilities with strong relationships with community providers or county health departments (HD) including co-location or HD staff embedded in the facility can offer especially strong referral relationships for reentry.

ONE EXAMPLE OF THIS IS CALVERT COUNTY DETENTION CENTER, WHERE INMATES ARE REFERRED DIRECTLY TO THE COUNTY DEPARTMENT OF HEALTH WHO PROVIDES UNINTERRUPTED MAT IN THE COMMUNITY UPON RELEASE.

Question 6: Status of Reentry Coordination – Medication and Behavioral Health *(Choose One Option)*	
1 - No reentry/referral relationships ("good luck" discharge)	0
2 – Site provides information only upon release	1
3 – Site provides Information and one-way referral upon release	8
4 – Site performs a scheduled "warm handoff" – transition of Care Management responsibility (individualized planning, linking, monitoring, and coordinating) from facility to community – intentional and accepted transition of responsibility	2
5 – Site performs a scheduled warm handoff with a Memorandum of Agreement with community providers	6
6 – Site has "hot hand off" procedures – routine, urgent, and emergent processes for transitions and sudden/unplanned releases	2
7 – Site offers timely access to/continuity of care and successful linkage defined as: individual has access to agonist medication (filled prescription) prior to release as a "bridge" prescription from the facility	0

Question 7: Status of Reentry Coordination – Medicaid Enrollment *(Choose One Option)*	
1 - No reentry/referral relationships exist to support enrollment	0
2 – Site provides information only	1
3 – Site provides information and assistance with enrollment (onsite and/or offsite)	10
4 – Site ensures that enrollment is completed prior to reentry	8

Assisting with enrollment and reenrollment into Medicaid at release is essential for continuity of care. Returning citizens have a high rate of uninsurance in addition to having unmet social needs before release from custody. Data provided by a recent study in Maryland indicate that the top social needs and risks for soon-to-be-released inmates are employment, inadequate or unstable housing, food insecurity, lack of health insurance, education, and lack of transportation.

HealthCare Access Maryland's (HCAM) Returning Citizens HealthLink program currently addresses one of the social determinants of health needs (health insurance) and provides information and referrals for other programs as needed. HCAM facilitated a virtual learning session and breakout session at the in-person event to share information and resources regarding Medicaid enrollment for returning individuals.

HCAM's Returning Citizens HealthLink Program has made significant strides in enrolling Maryland's justice-involved population into health coverage. From January to July 2022, HCAM enrolled a total of 2,101 individuals, with 2,017 being new enrollments. During the same period in 2023, HCAM achieved an impressive growth of approximately 28 percent, enrolling 2,684 individuals. This growth is particularly significant considering that 2,563 of these were newly enrolled individuals gaining vital first-time access to healthcare services. This marks an approximate 27 percent increase in new enrollments from the previous year, demonstrating the expanding reach of their program. The increase in total enrollments, coupled with a consistent focus on redeterminations, underscores HCAM's sustained commitment to ensuring the health needs of the justice-involved population are adequately addressed. This continuous effort significantly aids reintegration into the community, signifying the powerful role of HCAM's work. Additional HCAM data on Medicaid enrollment are available in the Appendix.

Question 8: Integration of Peer Recovery Specialists to Support Individuals on MAT

Individuals with lived experience (i.e., peers may be individuals in SUD/OUD recovery or with previous justice involvement, or both) have been proven to have a significant impact on inmate engagement and retention in MAT programs.[7,8] As the survey information shows, HMA observed wide variation on how peers are hired and integrated into site teams. The Act defines peer recovery specialists as individuals who have been certified by an entity approved by the Maryland Department of Health to provide peer support services. No correctional facilities indicated peer training programs on site.

Whereas each detention center appears to have their unique approaches to hiring, training, and retaining peer staff, those facilities who have been successful with low-barrier, anti-stigma, and flexible solutions should be leveraged as an example for other jurisdictions.

[7]Marshall L, Molinksi A, Fleege J, Ramniceanu A. Peer Integration Into the Medication-Assisted Treatment (MAT) and Other Jail-Based Treatment Programs. BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program. June 23, 2020. Available at: https://www.cossapresources.org/Content/Documents/Events/Presentation_Slides-COSSAP_Webinar_PRSS_and_MAT-June_23.pdf?f=true.

[8] Substance Abuse and Mental Health Services Administration. Peer Support Workers for Those in Recovery. September 27. 2022. Available at: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

THE TEAM AT WASHINGTON COUNTY DETENTION CENTER DESCRIBED VERY CLEAR ACCEPTANCE OF, AND CHALLENGES WITH, HIRING INDIVIDUALS WITH SUD, OUD, AND/OR JUSTICE-INVOLVED BACKGROUNDS AND HAVE MADE ACCOMMODATIONS IN THE POLICIES TO RECRUIT AND RETAIN THESE TEAM MEMBERS.

Question 8: Integration of Peer Recovery Specialists to Support Individuals on MAT *(May Choose More Than One Answer)*	
No peer-support services are offered	5
Peer support is available inside the facility	8
Peer support is available on transition and discharge	7
Peer support is available upon reentry	4

Question 9: Internal Referrals to Behavioral Health Therapy and Counseling During Incarceration

Referral to behavioral health therapy support and counseling is key to engaging and sustaining individuals in treatment and recovery. While MAT addresses the neurochemical pathways, individuals with SUD need behavioral health counseling and support to develop new skills, address trauma, and develop healthy coping mechanisms.

Receiving MAT should not be contingent on participation in talk therapy.

Often individuals will be unreceptive to counseling until they are stabilized on MAT, so withholding MAT would be counterproductive. HMA heard this misconception during coaching calls and site visits. The state has an opportunity to clarify in the FAQs, potential future legislation, or versions of the Act so that sites do not use lack of participation in behavioral health therapy as a rationale for withholding MAT.

Question 9: Referrals to Behavioral Health Therapy and Counseling *(May choose more than one answer)*	
No programming for SUD treatment or recovery support is available	0
Self-help/12-step groups are available	10
Group and/or individual peer/mutual support services are available based upon an individualized treatment plan	7
Evidence-based group and/or individual counseling is available from licensed clinicians for those needing this level of care based upon individualized treatment plan	9
Evidence-based group, individual and cohorted/residential level of care (RSAT/Therapeutic Community/Recovery Pod model) are available	1

Question 10: Harm Reduction Strategies

Harm reduction strategies are not named explicitly in the Act, but they are part of a comprehensive program and can reduce morbidity and mortality from untreated SUD and OUD. HMA inquired about the availability or distribution of naloxone (Narcan) and fentanyl test strips. HMA discerned a variety of naloxone practices—from wide access and availability for staff and inmates, to provision upon reentry to the community, to visiting family members and friends, to an unacceptable lack of access. Though most facilities make naloxone available to individuals upon release (58%, or 11 of the 19 facilities surveyed), HMA observed only two sites where most staff carried naloxone on their person. Significant room for improvement exists so that all staff, and all returning citizens have quick access to this lifesaving medication.

No facilities reported providing fentanyl test strips. Training on the use of naloxone, fentanyl strips, and xylazine strips should be considered for future harm reduction education for both staff and inmates.

FOR EXAMPLE, HMA OBSERVED A SPECIFIC FACILITY PRACTICE WHERE ALL CUSTODY STAFF CARRIED NALOXONE IN THE FRONT POCKET OF THEIR SECURITY VEST. ANOTHER FACILITY ONLY HAD NALOXONE IN THE LOCKED MEDICATION CART IN ONE DISTANT AREA OF THE BUILDING.

Question 11: Data Reporting Processes

The Act requires local correctional facilities to report individual-level details about their MAT programs. As with other questions in this survey, HMA inquired about the status of data reporting but did not independently validate data. HMA heard anecdotal reports that some correctional facilities may be collecting partial data that could be reported, but these sites interpret the Act (per FAQs) as not requiring data reporting until the facility is compliant with all portions of the bill or prescribing all three forms of MAT. Therefore, reported data may not fully reflect the amount of MAT prescribed for facilities in process of fully expanding their program.

Two virtual sessions and a breakout session at the in-person learning collaborative were held to review and address questions regarding the Act's data requirements and reporting processes. Most local jurisdictions expressed confusion and frustration with the reporting mechanism, citing redundancies and several conflicting definitions of terms. Representatives from the GOCPYVS provided additional clarity and updates to the FAQs. Additional work remains if the data are to accurately portray MAT access and have any impact on recidivism or community overdose rates.

Question 11: HB116 Data Reporting Processes *(Note: More than one answer permitted)*	
No data is tracked	2
Some data is tracked, such as number of people treated	11
All data requirements are collected and the site is able to accurately and comprehensively report to state	6

FINDINGS AND RECOMMENDATIONS:

Leveraging the Progress and Addressing the Opportunities

Maryland is a leader among states choosing to tackle this tough issue where ingrained stigma, funding challenges, and inertia need to be overcome and implementation of comprehensive, evidence-based MAT programs is to be overcome. This technical assistance program highlighted the progress the state has made to date. Strengths include:

- Interest and engagement in technical assistance support. Correctional facilities can be understandably resistant to engage in technical assistance opportunities, especially site visits, which may bring attention to areas of noncompliance. In this program, participation exceeded the initial estimate and increased throughout the program. Several facilities requested to engage in individual TA following the in-person learning collaborative which left limited time to complete all site visits and coaching calls. One detention center team, an early attendee, requested nearly weekly coaching sessions, additional site visits, as well as ongoing TA if it becomes available.
- Correctional facilities progress when participating in technical assistance. Correctional facilities participating in technical assistance were all making progress in one or more areas. There was not sufficient time to capture a meaningful "pre" and "post" survey of progress during this three-month coaching program, but coaches reported on facilities implementing or expanding medication access, addressing stigma, training staff, and other MAT program improvements.

Despite the progress, several hurdles remain. These challenges must be addressed to meet the state's goals of compliance with the Act and, more importantly, create an ecosystem of SUD care in which the justice-involved population is treated with evidenced-based standards of care. These challenges are presented as the following opportunities for improvement.

Opportunity to Comply with Evidence-Based Standards of Care and BJA Treatment Guidelines

Although many correctional facilities reported that they are continuing or initiating MAT, the data should be interpreted with caution. For example, many facilities reported widely prescribing various forms of MAT; however, when the actual or even estimated numbers of inmates on MAT were shared, the numbers were below expectations. Nationally, up to 60 percent[9] of incarcerated individuals are thought to have substance use disorder. Several sites put arbitrary or self-imposed limitations on the number of inmates who could be prescribed MAT at a given time based on resources or other non-clinical factors. Many correctional centers wait for confirmation from a community provider before continuing MAT. This unnecessary barrier is unsupported by best practice guidelines.

[9] Bronson J, Stroop J, Zimmer S, and Berzofsky M. Drug Use, Dependence, and Abuse Among State Prisoners and Jail Confined Persons, 2007–2009. Washington, DC: US Department of Justice, Bureau of Justice Statistics: 3. Available at: https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf. Accessed February 23, 2022.

Opportunity to Connect Correctional Facilities to Funding: Section 1115 Medicaid Demonstration Support

Local correctional facilities are struggling with what they consider to be an unfunded mandate. Feedback included an appreciation of grant opportunities, but a recognition of the challenges and administrative burdens associated with grant funding. At least one correctional facility voiced their internal policy on their restrictions to use grant funding for new positions or programs that require sustainability beyond the grant period. The consensus was that facilities need a reliable and ongoing funding source to implement and maintain the MAT program.

A potential opportunity to address these concerns and provide a significant funding source to support the Act's requirement for local correctional facilities to establish and offer MAT programs is the new Section 1115 demonstration opportunity that the Centers for Medicare & Medicaid Services (CMS) announced April 17, 2023, in a State Medicaid Director Letter titled Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated. Through this Section 1115 reentry demonstration opportunity, correctional facilities could receive funding through a federal match of expenditures incurred by providing a targeted package of reentry services to Medicaid (or Children's Health Insurance Program [CHIP])-eligible justice-involved individuals (adults and youth) who are transitioning back into the community within 90 days.

The Section 1115 reentry demonstration is an opportunity to obtain federal Medicaid funding for MAT services provided to certain incarcerated individuals and is subject to the specific requirements of the CMS initiative as outlined in the April 2023 guidance. The federal requirements for states that implement the reentry demonstration initiative are comprehensive for both the state Medicaid program and participating carceral providers. Many program provider requirements may be new for MCD correctional facilities, which must be able to illustrate readiness to meet all applicable Medicaid requirements, in collaboration with Maryland Medicaid, before being eligible to obtain federal Medicaid reimbursement for MAT services provided to eligible justice-involved individuals. However, it should be noted that the CMS demonstration initiative is only available for Medicaid- or CHIP-eligible individuals transitioning out of incarceration within 90 days. This Section 1115 initiative would not be available to individuals who do not meet Medicaid or CHIP eligibility; and the state and/or carceral providers would have to find other possible funding opportunities to provide MAT to those non-eligible individuals.

Focusing on the Section 1115 reentry initiative, during this engagement, HMA developed an application framework for the Maryland Medicaid agency to guide stakeholder engagement and the development of a reentry program in alignment with CMS's guidance, as well as with federal transparency requirements for state Section 1115 proposals. The 18-page application framework provided to the GOCPYVS and the Maryland Medicaid Administration office staff on June 27, 2023, outlined the program and operational requirements that Maryland must consider when developing a robust Section 1115 program application for a new state reentry initiative. It also described operational considerations that are required to support the post-approval Section 1115 deliverables that must be approved by CMS as a condition to receive federal financial participation for the reentry program. The application framework serves as a comprehensive road map for Maryland to navigate the specifics of this complex federal demonstration initiative in a streamlined manner with applicable stakeholders.

For the next phase of support provided to Maryland, HMA will assist GOCPYVS, the Medicaid Administration, and other key stakeholders to develop the pilot design and parameters for the reentry program, using the road map outlined in the HMA-prepared application framework. HMA will provide project management support and facilitate stakeholder engagement, with perspective of federal regulatory and on the ground reentry implementation experts (from early work with California on their approved reentry demonstration), that will support Maryland in building out the application framework into a complete Section 1115 demonstration proposal in alignment with federal program requirements for submission to CMS.

Opportunity to Improve SUD Treatment for Individuals Transferring to DOC

A consistent theme across all of the participating correctional facilities throughout this technical assistance project centered on the fact that Maryland DOC does not continue or provide MAT for inmates. Before transferring to DOC custody, several facilities reported that they were required to taper individuals off of their MAT prior to transfer. Similarly, inmates on MAT needing withdrawal management are sent to designated DOC facilities, which may or may not be where they will serve their sentence. This situation presents significant barriers:

- Individuals diagnosed with OUD who are in local correctional facilities, sentenced to Maryland (MD) DOC, and awaiting transfer may choose not to begin clinically appropriate MAT knowing that they cannot continue this treatment in a DOC facility. Although this approach may be considered patient choice or patient-centered decision-making, it is not rooted in evidence-based care.
- Many correctional staff voiced uncertainty about the clinical indications or utility of starting a medication that will need to be tapered in near term.
- Individuals in the correctional facilities who are continued on MAT or initiated on MAT require withdrawal from their medication before entering an MD DOC facility, such as Baltimore City Detention Facility. This center has limited capacity has a waitlist for transfer. As a result, individuals often their pre-trial site for extended periods. As such, HMA coaches were told the local correctional facilities have been encouraged to begin the withdrawal process in their facilities prior to transfer. The recently released Bureau of Justice Assistance Withdrawal Management Guidelines[10] are clear with the guidance to continue MAT if the patient requests and at the discretion and supervision of the individual's prescribing clinician. Requiring local correctional facilities to discontinue MAT places them at risk of being out of compliance with the Act and at risk for managing OUD in a manner not adherent to best practices or the community standard of care.
- Local correctional facilities report this is particularly challenging when they have been maintaining individuals on doses of methadone (as clinically indicated) that require a longer medically supervised withdrawal process to avoid acute withdrawal symptoms. Facilities have expressed concern for the health of the individuals who will receive an abbreviated withdrawal process.

[10]US Department of Justice. Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals. June 6, 2023. Available at: https://www.cossapresources.org/Content/Documents/JailResources/Guidelines_for_Managing_Substance_Withdrawal_in_Jails_6-6-23_508.pdf.

Recent consultation with the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS) and Maryland Department of Corrections (MD DOC) regarding this issue was positive. MD DOC expressed willingness for additional consultation and technical assistance in working through these significant challenges.

Shifting policy and, ultimately, clinical practice is a significant change management initiative. It will require system-wide training on the disease model and biological basis for opioid use disorder and subsequent treatment and management of OUD. There is legal precedent and potential liability to the Department in not providing MAT for individuals in their custody[11]. Planning will also require resource discussions regarding custody, medical staffing, and medication costs. The legal imperative to provide MAT was covered during two of the virtual sessions. Those materials, along with an HMA-authored brief on this topic is included as an addendum to this report.

Opportunity to Improve Data Reporting and Sharing

Correctional facilities voiced challenges with collecting, reporting, and data-sharing requirements outlined in the Opioid Use Disorder Examinations and Treatment Act. Incomplete, inaccurate, or inconsistent data reporting will limit the state's intention to understand the impact of the MAT programs. The Act and the associated FAQs need more clear and consistent definitions so that data can be collected and optimally shared across jurisdictions in order to track individuals who move across the state.

Consider the following updates to the bill or FAQs:

- Clarify that facilities must report all forms of MAT even before full compliance. The FAQs suggest otherwise.
- Consider use of a health information exchange (HIE) or other shared database for sites to enter information specific to an individual with a unique identifier regardless of their location. Data should be tied to the individual rather than the detention center.
- Update FAQs for clearer definitions. For example, in the SUD treatment community, initiation is commonly considered the first dose or when an MAT-naïve patient is started on a new form of MAT. Conversely, facilities received guidance that initiation was considered the first dose of MAT given inside the site, regardless of whether the detainee received the same medication before incarceration. The medical community would consider this administration of medication to be continuation, not initiation.
- Align definitions to Medicaid billable service (i.e., completion of an initial screening and assessment, or a periodic evaluation). These terms are conflated in the Act and are a significant source of confusion. Using Medicaid terms and definitions will support a potential future transition to Medicaid billable services.

[11] Bureau of Justice Assistance. Managing Substance Withdrawal in Jails: A Legal Brief. February 2022. Available at: https://bja.ojp.gov/library/publications/managing-substance-withdrawal-jails-legal-brief.

Consider the following specific definitions:

Screening: A medical test or procedure performed on an individual to assess the likelihood of having a particular disease or condition and performed in accordance with an evidence-based tool. Screening usually occurs during the initial interaction with the individual and can be completed by a non-clinician.

Assessment: A more in-depth procedure meant to solidify the presence and severity of a disease and is performed in accordance with an evidence-based tool, usually performed soon after a positive screening test and usually completed by a clinician.

Screening and assessment tools: An industry standard, evidence-based tool identified and accepted by the medical, behavioral health, and SUD treatment community. Examples are listed at NIDA.NIH.gov and linked here.

Evaluation: Initial or periodic evaluation that a clinician conducts to identify or treat a disease, to further evaluate a clinical condition or symptom, to measure clinical progress, to consider medication adjustments, to discuss the pros and cons of treatment, to review or alter a treatment plan, to measure progress, or to determine needs for additional treatment. An evaluation may conclude with no recommended changes in treatment.

Additional details for the FAQs are listed in Table 1 of the Appendix.

Opportunity to Address Stigma

This is a long-term paradigm shift to an institution steeped in misperceptions about SUD. Previous ideas about OUD recovery were based on the notion that abstinence was the best treatment, and individuals needed to make better choices. Current theories are based on more extensive research and newer techniques of brain imaging. They recognize that addiction is a chronic brain disease and successful treatment includes medications to address neurochemical processing in the brain. Like most other chronic diseases, such as diabetes and heart disease, the best treatment approach involves the use of medications and healthy behavior changes. Ongoing, unresolved, or unaddressed stigma hinders progress, putting individuals and programs at risk.

Overcoming stigma about individuals with SUD and OUD will be an ongoing issue for years to come, but progress is possible, especially when leadership is highly engaged in the process. Education for staff, inmates, and their families also is key to overcoming these barriers. HMA included a comprehensive brief on “Overcoming Objectives” in the appendix of this report that can be shared widely. Using preferred and destigmatizing language is an important step in the process. Use of person-first language and preferred terminology, reduces stigma, negative bias, and the perpetuation of stereotypes when speaking about or to individuals experiencing withdrawal or with SUD.[12]

ENDNOTES

[12] Bureau of Justice Assistance, 2022, Bureau of Justice Assistance Style Guide, retrieved April 13, 2023, from https://bja.ojp.gov/doc/bja-style-guide.pdf; National Institute on Drug Abuse, 2021, Words Matter: Preferred Language for Talking About Addiction, retrieved April 13, 2023 from https://nida.nih.gov/research-topics/addiction-science/words-matterpreferred-language-talking-about-addiction#:~:text=Use%20person%2Dfirst%20language%2C%20which; National Institute on Drug Abuse, 2022, Your Words Matter – Language Showing Compassion and Care for Women, Infants, Families, and Communities Impacted by Substance Use Disorder, retrieved April 13, 2023 from https://nida.nih.gov/ nidamed-medical-health-professionals/health-professions-education/words-matter-language-showing-compassion-carewomen-infants-families-communities-impacted-substance-use-disorder; Justice Community Opioid Innovation Network, 2019, Advancing the Use of Person-first and Non-stigmatizing Language, retrieved April 2023 from https://www. jcoinctc.org/wp-content/uploads/10252019_JCOIN-First-Person-Language.pdf; National Council for Mental Wellbeing, n.d., Language Matters When Discussing Substance Use, retrieved April 13, 2023, from https://www.thenationalcouncil. org/wp-content/uploads/2021/11/Language-Matters-When-Discussing-Substance-Use-1.pdf.

https://www.cossapresources.org/Content/Documents/JailResources/Guidelines_for_Managing_Substance_Withdrawal_in_Jails_6-6-23_508.pdf

APPENDIX
HCAM Data on Medicaid Enrollment

Additional Data

Total Number of Enrollments from July 1, 2022, to June 30, 2023 (FY 23)

Row Labels	Count of Enrollment type:
Arrestee	860
In-Patient	188
Re-entry	3112
Grand Total	**4160**

Row Labels	Count of Application Type:
New	3993
Redetermination	167
Grand Total	**4160**

Total Number of Enrollments from January 2022 to December 2022

Row Labels	Count of Enrollment type:
Arrestee	965
In-Patient	35
Re-entry	2597
Grand Total	**3597**

Row Labels	Count of Application Type:
New	3432
Redetermination	165
Grand Total	**3597**

Total Number of Enrollments from January 2023 to July 2023

Row Labels	Count of Enrollment type:
Arrestee	588
In-Patient	195
Re-entry	1901
Grand Total	**3597**

Row Labels	Count of Application Type:
New	2563
Redetermination	121
Grand Total	**2684**

Site Visit Calendar

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
17	18	19	20	21 Harford County – April 21, 2023
	MAY 2	3	4 Anne Arundel County Department of Health (2 sites)	5 Talbot County Department of Corrections
8 Carroll County Sheriff's Office - Detention Center St. Mary's County Health Department	9 Washington County Detention Center	10	11 Harford County Detention Center	12 Baltimore City Pretrial Facility Montgomery County Department of Corrections & Rehabilitation
15	16	17	18	19
22	23	24	25	26
29	30	31 Anne Arundel County Department of Health (2 sites)	JUNE 1	2
5	6	7 Calvert County Detention Center	8 Worchester County	9
12 Baltimore City Pretrial Facility Montgomery County Department of Corrections & Rehabilitation	13	14 Frederick County Adult Detention Center	15 Allegany County Sheriff's Office - Detention Center Harford County Detention Center Queen Anne's County Detention Center Wicomico County Detention Center	16 Howard County Detention Center
19	20	21	22	23 Garrett County Detention Center
26	27 Caroline County Health Department	28	29	30

Data Definitions, Additional Information

	Definition	Example Intervention	Staff	Notes on billing
Screening- (assuming every inmate is screened during booking)	Screening is the act of identifying whether someone is **at risk** for an illness. Screen all patients to determine who should have an assessment. Usually conducted upon presentation and periodically such as annually.	NIDA Quick Screen; TAPS, TCU 5, AUDIT, CAGE	Clinical and nonclinical staff, may be custody officer; instruments are available either by paper, electronic or both; staff should be trained to perform screening tests.	When screening is conducted with an assessment and brief intervention it can be billed 99408 (Commercial insurance)/G0396 (Medicare)/H0049 (Medicaid) 15 to 30 min.
Assessment	A more in-depth evaluation meant to solidify the presence and severity of a disease.	TAPS, CRAFFT, DAST, NIDA Modified ASSIST	Prescriber, nurse, or BH provider.	May be conducted as part of screening before referral is made or can be conducted as part of an evaluation by a prescriber or BH provider.
Evaluation	Initially or periodically	Most common examples will be periodic medical management for MAT with prescribers; nursing evaluations related to MAT (not just med administration) and individual BH provider sessions for psychotherapy	Physician, nurse practitioner, physician assistant, licensed BH provider or therapist	Codes may include E&M 99201-99215 (clinical/medical). 90834, 90791, 90847, 90846, 90832, 90837- BH evaluation-psychotherapy session; additional codes may include: **Procedure Codes** H0001; H0010 modifier HA; H0011 modifier HA; H0018 modifier HA; H0019 modifier HA; H2036 modifier HA; H0049; H0050; H0002 **Diagnosis Codes** F10 – F19

Preferred Terminology[12]

Use…	Instead of…	Because…
• Individuals who are detained in jail • Individuals who enter jail • Person who has criminal justice system involvement • Person who was formerly incarcerated	• Inmate • Criminal • Offender • Justice-involved person • Felon	• Recognizes that people are not their crimes or criminal history. • Advances language that is accurate and not prejudicial.
• Substance use disorder • Substance use	• Substance abuse • Drug habit	• Avoids negative connotations and the undermining of SUD as a serious health condition.
• Person with a substance (opioid, alcohol, stimulant) use disorder • Individuals who exhibit signs of withdrawal or withdrawal symptoms • Individuals who report using substances (alcohol, opioids, stimulants) • Pregnant person with an opioid use disorder	• Addict • Drug or substance user • User • Dope addict • Alcoholic • Drug addict • Pregnant opiate addict	• Reflects an accurate, science-based understanding that the person has a medical condition. • Recognizes that the person has a disorder, rather than “is the disorder.” • Avoids negative associations, punitive attitudes, individual blame, judgment, and misinformation about SUD. • Reinforces use of the same terminology as with other medical conditions. • Encompasses the recovery process of improved health versus the implication that the person was “dirty” before recovery.
• Individuals who screen negative/positive (e.g., withdrawal, suicide risk) • Positive/negative screen result	• Dirty/clean screen • Dirty results • Failing drug screen/test	
• Person in recovery • Person in long-term recovery • Person who has maintained recovery	• Former addict • Former drug user • Former alcoholic • Person who “stayed clean”	
• Return to use • Experienced a recurrence • Resumed drinking or using drugs	• Relapsed • Slipped • Chronic relapse	• Advances language that is medically accurate and non- stigmatizing.

JULY 2019

CHCF Issue Brief

MAT for Opioid Use Disorder:
Overcoming Objections

Californians struggling with substance use, including opioid use disorder (OUD), should be screened for these illnesses *wherever* they seek help; those with OUD can be treated immediately and referred for ongoing care. California is building a "no wrong door" health care system, ensuring that medications for addiction treatment are widely available in emergency departments and hospitals, primary care and mental health clinics, jails and prisons, residential treatment programs, and other care settings.

The need is urgent, since fentanyl (an extremely potent street drug) is increasingly responsible for overdose deaths for users of opioids and stimulants; fentanyl overdose deaths have more than quadrupled in California between 2014 and 2017.

Medication-assisted treatment (MAT) uses FDA-approved medicines such as buprenorphine (Suboxone), methadone, and naltrexone (Vivitrol), often supplemented by behavioral treatment and social supports. Harm-reduction services are employed to keep patients safe until they are ready to seek treatment — services such as dispensing naloxone, an opioid antidote that prevents death from overdose, and providing clean syringes to prevent HIV and hepatitis C. A medication-first approach allows patients to first be stabilized on medication, and then be brought into the right level of care to fit their needs — thereby decreasing the risk of overdose and relapse.

Despite data showing the success of MAT in treating drug addiction, objections are still common. Following are some frequent objections and evidence-based responses.

Why treat a drug addiction with a drug?

- Buprenorphine and methadone are proven to cut overdose death rates in half while decreasing illicit drug use and HIV[1] and hepatitis C[2] transmission, and improving patient retention in treatment.[3]
- Injectable extended-release naltrexone is shown to reduce illicit drug use and to increase retention in treatment in three- to six-month trials.[4]
- Twelve-step and other abstinence-based approaches may be helpful for many substance use disorders, but they only succeed in 10% to 15% of people with opioid addiction when used alone, compared to a 50% to 80% rate for MAT.[5]
- Patients on MAT have lower health care costs compared to those on drug-free treatment.[6]
- Prison system data show that MAT reduces deaths. Without treatment, the risk of opioid overdose death for people shortly after leaving prison is 129 times that of the general population.[7]
- After Rhode Island implemented the use of all three medications for opioid addiction in its jail and prison system, overdose death rates after release dropped by 61%.[8]

About the Author

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Isn't drug-free, abstinence-based treatment better?

- Drug-free treatment is not as effective as MAT in preventing deaths. See "Dying to Be Free" about the high overdose rates in a state where only abstinence-based residential treatment was available. Relapses and deaths are common as patients struggle to maintain abstinence, since strong cravings persist for years after last use.[9]
- Prison system data point to the benefit of MAT in reducing deaths. The risk of opioid overdose death for people shortly after leaving prison is 129 times that of the general population.[10] After Rhode Island broadly implemented the use of MAT in its jail and prison system, overdose death rates after release dropped by 61%.[11]

Can people stop taking the medications?

- The American Society of Addiction Medicine recommends maintaining buprenorphine for at least one to two years, after which voluntary slow tapers can be attempted. People early in their disease can successfully taper off. If cravings come back, it is a sign that the taper was too soon.
- People with long-term opioid use may have permanent brain chemistry changes (see the free video "Addiction Neuroscience 101" for a simple and compelling explanation)[12] and require long-term treatment with MAT.
- Lifelong treatment is acceptable for other chronic diseases such as diabetes, HIV, or high blood pressure. Addiction is a chronic brain disease that often requires a similar approach.

Medications should only be used short-term.

- Using medications for a brief period only, during the detoxification period, results in high relapse rates (82% relapsing after methadone taper[13] and 92% relapsing after buprenorphine taper).[14] Death rates double after buprenorphine tapers and triple after methadone tapers.[15]
- Ongoing treatment with buprenorphine or methadone significantly reduces drug craving, which can last years after the initial detox period.[16] Cravings increase the chance of relapse and decrease people's ability to participate in recovery and rebuild their lives.

Buprenorphine is sold as a street drug. Isn't it just another way to get high?

- Buprenorphine diversion can be a sign of insufficient treatment access.[17] Areas with high diversion tend to have low availability of legitimate treatment. Easy treatment access tends to decrease the amount of buprenorphine diverted to the illegal market.
- Most people who take illicit buprenorphine are taking it for its intended purposes (withdrawal management, detoxification, or relapse prevention) and not to get "high." In fact, buprenorphine's chemical qualities (as a long-acting partial agonist medication) make it much more difficult to feel euphoria from buprenorphine compared to other drugs.[18]
- Patients who have experienced illicit buprenorphine are more likely to stay in treatment once they start treatment.[19]
- In correctional justice settings, certain interventions can prevent diversion: doing mouth checks, requiring crackers to be chewed and swallowed before and after administration, and using liquid formulations.

Naloxone, the "rescue drug," encourages risky drug use.

- Naloxone is an antidote, given by nasal spray or injection, that restarts breathing when someone is unconscious due to an overdose.
- Increased access to naloxone reduces mortality and has not been shown to increase drug use.[20]
- Communities with increased access to overdose prevention education and naloxone have seen greater reductions in opioid-related overdose deaths.[21]
- Naloxone distribution is cost-effective, particularly when distributed to people using heroin.[22]

People with addiction need to hit rock bottom — maybe go to jail — before they will change.

- This is a dangerous misconception of the nature of opioid addiction. Long-term opioid use alters brain chemistry in a way that produces uncontrollable cravings and intense despair that can persist years after last use. Hitting rock bottom frequently means overdose death from lethal street drugs or from mixing drugs.
- Incarceration does not protect people from drug use or overdose. California's opioid overdose rate inside prison is four times the national prison average.[23]
- Incarceration itself causes harm. People often lose jobs and housing, and emerge with felony records, making it much more difficult for them to get and stay in treatment after release, and more likely to resort to criminal activity to survive.
- More correctional justice institutions are moving to treatment over jail, to avoid the risk of felony convictions leading to unemployment, homelessness, and recidivism.

Primary care clinicians aren't equipped for addiction treatment. Same for clinicians who work in correctional justice settings.

- Buprenorphine management is more straightforward than other medications used routinely in primary care, such as insulin.
- Many resources have been developed to help primary care physicians and clinic staff learn how to treat patients with addiction:
  - Through Project Echo, UC Davis offers mentoring and instruction for providers via teleconferencing.
  - California's Substance Use Line, 844.326.2626, is open 24/7 for free consultation with addiction specialists.
  - The Providers Clinical Support System offers training and mentorship, as well as 24 hours of free online addiction learning.
- Buprenorphine is available on Medi-Cal and most insurance plans without prior authorization requirements and is dispensed at pharmacies. Buprenorphine is a Schedule III controlled substance, which means it can be prescribed over the phone without a special prescription pad.
- Patients can start buprenorphine at home, which decreases the burden on the office practice.[24] See links for patient-centered home induction instruction sheets in English and Spanish, and this buprenorphine quick-start one-page reference.
- There are also several telemedicine providers that prescribe buprenorphine to those in jail, in collaboration with the jail's health care providers.

People with addiction who are in correctional justice settings use "free" buprenorphine as a heroin substitute and then go back on heroin when they get out of jail. That's a bad use of taxpayer money.

- As above, patients who have experienced buprenorphine are more likely to stay in treatment or to seek treatment in the future. People with opioid addiction report that it was several experiences with buprenorphine — prescribed or illicit — that led to their eventual understanding of what "being clean" could feel like and to subsequently seek treatment.

Buprenorphine shouldn't be offered in practices that don't have robust treatment programs.

- Patients who can't afford counseling or can't afford the time off work can still benefit from MAT. Practices that do not have behavioral health services can still offer buprenorphine treatment alone.[25] Access to medications alone is better than no access at all.
- Some practices deploy trained medical assistants, social workers, or nurses to help with patient support and monitoring.

- A medication-first model allows people to access MAT without requiring lengthy assessments and participation in counseling. See "Treatment for Opioid Addiction, with No Strings Attached."[26]

Jails can't afford to add a new medication or program.

- Jail health systems have a powerful business case for streamlining access to MAT to avoid the high costs of overdose treatment. MAT has been shown to lower emergency department and hospitalization costs, lower hepatitis C and HIV rates, and decrease overdose deaths.[27]
- Compared to common medications for some chronic diseases, generic forms of MAT drugs (buprenorphine, methadone, and oral naltrexone) are relatively inexpensive.
- Jails are obligated to care for all inmate health needs; they do not seek outside funding to cover the cost of, for example, a new blood pressure medication when added to the formulary.
- Individuals using opioids who receive MAT have lower health care costs compared to those receiving opioid addiction treatment without medication.[28]

Opioid addiction is not treatable. People just keep relapsing.

- Addiction is a chronic illness, and relapse is part of the disease. It takes smokers an average of 30 or more attempts before they stop for good.[29]
- MAT has about the same success rate as that for other chronic diseases requiring difficult behavioral changes, and outcomes are as good as those for diabetes and COPD.[30] Many people go on to reestablish productive, satisfying lives.
- The tragic impact of opioid addiction on individuals, families, and whole communities cannot be ignored when viable treatment is available and shown to have high success rates.

Methadone clinics are more about making money than getting people off drugs.

- Like most of the US health care system, the majority of opioid treatment programs (previously known as methadone clinics) are commercial or for-profit. Many of these clinics were founded as a mission to help people with addiction.
- Methadone providers are closely regulated by the federal government and state governments and must adhere to strict clinical practices. All patients on methadone receive counseling and close supervision. Medi-Cal reimbursement rates for methadone services are set by the state and strictly controlled.
- California launched the Hub and Spoke System in 2017, which links methadone clinics with primary care clinics and other health care settings, enabling patients who are stable to be managed in less-intensive settings.

Summary

MAT is effective and is not difficult for providers to manage. However, integrating addiction treatment into health care settings requires culture change. Decades of misinformation has created a culture of blame and the false belief that will power alone enables recovery.

Learning to treat opioid addiction can be an organization's first step toward building skills to help patients with alcohol use disorder (which also benefits from medications) and other addictions that require intense behavioral therapy (like methamphetamine use disorder).

Understanding the science behind addiction and treatment can help change perspectives from blame to compassion and a reduction in stigma. Addiction is a chronic disease and not a character flaw. Training in the concepts of trauma-informed care can help staff overcome bias and change practices. These talking points can help inform conversations to change hearts and minds.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

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*This Issue Brief IS **NOT A LEGAL OPINION** but represents the product of policy and regulatory research and discussions with experts in the field.*

Issue in Brief: Avoiding Legal Liability for Discontinuing Medication for Opioid Use Disorder (MOUD)

By: Keegan D. Warren, J.D., LL.M.[1]

In September 2018, the Maine Department of Corrections settled a ground-breaking lawsuit by agreeing to not discontinue the plaintiff's buprenorphine, which had been prescribed by her physician, when she reported for incarceration.[i] In the intervening four years, there have been dozens of successful lawsuits against individual officials, individual staff, local jails, and state and federal prisons who have denied or limited access to medication for opioid use disorder (MOUD) to inmates. While most of these lawsuits have been filed by individual plaintiffs, there have been at least two successful class actions.[ii]

Courts have found constitutional violations under the Eighth and Fourteenth Amendments on grounds of deliberate indifference, and under Rehabilitation Act Section 504 and the Americans with Disabilities Act (ADA) Title II on grounds of discrimination against persons with OUD. Many other courts have addressed individual staff violations under state tort law, such as for wrongful death.[iii] Most recently, New Mexico's protection-and-advocacy organization sued the state's Corrections Department and two officials on behalf of all their constituents with OUD.[iv] That case alleges discrimination in violation of Patient Protection and Affordable Act Section 1557 in addition to the constitutional, Section 504, and ADA claims.

A wide range of carceral policies have generated legal liability or resulted in settlement, including those that require "cold turkey" withdrawal,[v] authorize only comfort medications for withdrawal,[vi] mandate tapered withdrawal from MOUD,[vii] offer only an alternative to MOUD,[viii] permit only a single MOUD,[ix] or limit MOUD to only certain populations, such as those pending release or pregnant persons.[x] Notably, the absence of an affirmative policy regarding MOUD has resulted in judicial oversight,[xi] as has denial of MOUD to someone who did not even have a prescription.[xii]

The federal executive branch has taken action consistent with these court findings: the Department of Justice' Civil Rights Division[xiii] and Office of Justice Programs Bureau of Justice Assistance[xiv] both issued guidance in 2022 that jails and prisons that do not provide continuing access to MOUD may be liable for discrimination under the ADA. The Justice Department has also investigated and sometimes sued entities—including a jail,[xv] a parole board,[xvi] two court systems,[xvii] and many others across sectors[xviii]—that have a one-size-fits-all approach to SUD-related medical needs.

The current state of case law suggests that denying MOUD as a blanket policy is legally impermissible. Rather, courts typically determine liability based on whether a jail or prison has taken reasonable measures to address the risk of the serious harm presented by withdrawal.[xix] Liability generally turns on whether the carceral institution has (1) conducted an individualized assessment—including for safety or

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diversion concerns—and (2) adhered to the standard of care, particularly where the proper care has been previously established by the detainee's provider in the community.

In sum, jails and prisons that by policy do not provide, minimally, continuing access to the appropriate MOUD at the appropriate dosage face significant risk of legal liability under both federal and state laws—and adverse health outcomes for those in their care.

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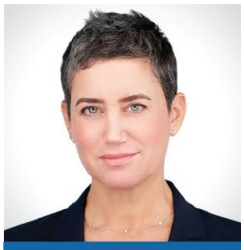

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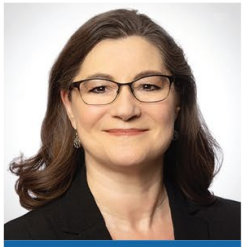

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Jean Glossa, MD, MBA, Managing Director Jean Glossa, MD, is an experienced physician and business leader whose career focused on improving access to healthcare for underserved and low-income populations. She has a background of clinical and leadership roles in a variety of practice settings throughout the safety net, including primary care, public health department and community clinics, migrant clinics, Medicaid-managed care, graduate medical education, and private practice. Having worked as a primary care physician for many years in remote areas and underserved communities, Dr. Glossa understands the challenges to delivering quality healthcare for all and seeks solutions to address these needs.

Her work at HMA has included projects regarding bidirectional integration of primary care and behavioral health, implementation of technology solutions such as telehealth and digital solutions and strengthening the best practices of team-based care and care management. Dr. Glossa appreciates the opportunities to collaborate directly with clinicians at the practice level to assess and improve systems of care through customized technical assistance unique to each client. Dr. Glossa uses her clinical and leadership practice transformation experience to work with HMA colleagues on projects focused on the response to the opioid epidemic. This complex crisis requires multidimensional solutions, so the approach includes education and collaboration of stakeholders across the system: primary care and behavioral health, hospitals and emergency departments, first responders,

corrections, payers, health departments, and state and local governments working together to combat the epidemic in their communities.

Dr. Glossa earned her medical degree and completed her internal medicine residency at the University of South Florida. Her business leadership and experience has been augmented with an executive master's degree in business administration from Auburn University in Alabama. Dr. Glossa has been continuously certified through the American Board of Internal Medicine.

Mary Kate Brousseau, MPH, CPHQ, Principal With frontline experience in health promotion and the delivery of human services, Mary Kate Brousseau is passionate about quality improvement and serving vulnerable populations. Ms. Brousseau has experience developing, implementing, and evaluating state and regional programs focused on preventive and primary care. Most recently, she created and directed the National Capital Area Breast Health Quality Consortium, a project funded by Susan G. Komen for the Cure. The consortium fosters a regional learning community and engages in data collection and on-site process improvement to drive systems change throughout the entire system of care to reduce disparities and improve outcomes for low-income women. She managed a Medicaid project to assist safety-net primary care providers through the transition to serve and bill for Medicaid patients. During her time at the Oregon Breast and Cervical Cancer Program, Ms. Brousseau refined health promotion, data collection, and patient navigation services as the program transitioned to a state-administered program. For four years, she coordinated community development, technical assistance, and clinical workforce development programs at the Oregon Primary Care Association while collaborating with other state and federal agencies to enhance healthcare services in Oregon. She gained direct experience and knowledge of the health system, grants, and the importance of the community health center model to ensure access to care. Ms. Brousseau earned her master's degree from Oregon State University and her bachelor's degree from the University of Virginia.

Keegan Warren, JD, LLM, Senior Consultant Keegan Warren brings a civil justice lens to health care design and strategic planning and specializes in access to care, health equity, and non-medical cost drivers.

A federally qualified health center (FQHC) director and attorney with two decades of senior management experience spanning both health and human services, Ms. Warren is a national subject matter expert on medical-legal partnership, a care delivery model that leverages legal services and expertise to advance individual and population health. These partnerships integrate the unique expertise of lawyers into health care settings to help clinicians, case managers, and social workers address structural problems at the root of many health inequities.

Ms. Warren's expertise is in the connections between health, health care, law, and how it impacts patient outcomes. She has worked with clinics to refine their approach to non-medical drivers of health and identify institutional policies that may be inadvertently catalyzing health disparities and driving up costs. She has extensive experience helping various stakeholders navigate professional values around confidentiality and privacy law to facilitate patient-centered data-sharing across sectors. She is certified in guardianship law and alternatives and collaborated with providers to integrate these decision-making tools into care for patient populations across the lifespan, such as neurotypical adolescents, parents with terminal diagnoses, and elders facing the end of life.

Ms. Warren's work includes sentinel and policy surveillance with client-specific practical application on targeted access issues ranging from medications for opioid use disorder (MOUD) in carceral settings, behavioral health data-sharing, 340B prescription drug access, and regional professional competitive dynamics.

She was appointed lecturer at The University of Texas' School of Design and Creative Technologies and adjunct professor at the School of Law and McCombs School of Business. Her courses have focused on health justice, particularly the ways that law incidentally impacts health and patient outcomes, as well as health care law and policy. Ms. Warren's pending publications take an epidemiological perspective to legal interventions as a concrete means for addressing social determinants of health and reducing health disparities for target populations, including pregnant persons and new parents, and for adults seeking musculoskeletal specialty care. Ms. Warren is currently finishing her third and final year of fellowship as a National Academy of Medicine Emerging Leader in Health and Medicine Scholar.

Ms. Warren earned a doctor of juris prudence from The University of Texas; a master of laws degree in health law and policy as the inaugural Southern Illinois Healthcare and Southern Illinois University MLP LLM Fellow; and a bachelor of arts degree in Spanish, international relations, and Latin American studies from the University of Arkansas. She is a veteran of the Army National Guard and is a member of the Order of St. Joan of Arc, the highest civilian award given by the Army Armor and Cavalry Associations.

Julie White, MSW, Principal With more than 25 years of experience in comprehensive healthcare and justice-related service delivery, Julie White has developed policy, strategic plans, and utilized implementation science to improve complex care operations, behavioral health programs, and streamline processes to improve quality and overall care delivery. She has worked alongside managed care organizations, large healthcare systems, community advocacy groups, and academic medical centers, most recently serving as chief operating officer for Rutgers University Correctional Health Care (UCHC) in New Jersey. In that role she was responsible for statewide correctional healthcare contracts, annual budget management, and oversight of staff and faculty. While at UCHC, she led the response to the onset of the COVID-19 pandemic across the system's multiple congregate settings. The multi-pronged response included implementing ongoing weekly universal testing and vaccination, as well as safety protocols, supply chain management, and workforce infrastructure plans to ensure continuity of care and adjustment throughout the pandemic. During her career, Ms. White has focused on building and improving cross-functional relationships and developing collaborative programs.

She served in various leadership positions at the University of Massachusetts Medical School where she directed health and criminal justice programs and served as the central point of contact for all client interactions with the Federal Bureau of Prisons. Additionally, she served as president of Veritas Correctional Services where she founded and led operations of the consulting business which provided client management and expertise across the correctional healthcare spectrum. Ms. White served as adjunct faculty at multiple universities and colleges where she developed and taught curriculum centered around sociology and criminal justice.

She is a mental health clinician who has also provided direct oversight of offender services operations at the Suffolk County House of Correction. Ms. White earned a master's degree in social work from Syracuse University and a bachelor's degree in psychology and criminal justice from the State University of New York, Geneseo.

Marc Richman, PhD, Principal Marc Richman is a licensed and practicing psychologist with more than 30 years of experience. He is a strong clinical, systems, and policy leader who believes merging his clinical and policy knowledge have made him stronger in both areas. Prior to joining HMA, Dr. Richman held executive leadership positions throughout the State of Delaware before retiring after 27 years of state service. He began his career in the child mental health division, spending his last five years as the division deputy director. While there, his primary focus was incorporating mental health and substance use into an integrated and holistic system. Dr. Richman also served as the chief liaison between the health division and Delaware's Family Court. He served on the adult side of the behavioral health system as an assistant director of community mental health and substance abuse services. Among other initiatives, he co-led expansion of the Substance Use Disorder Continuum to address the rising opioid epidemic ravaging the community, public, and private behavioral health systems. He also oversaw the statewide case management and assessment system for individuals with behavioral health challenges who were involved in the adult judicial system. He was appointed bureau chief of healthcare services for the Delaware Department of Correction and administered all the medical, behavioral health, and pharmacy contracts for the statewide prison system. In that role and until his retirement from the state, he proudly led his team on several key strategic initiatives throughout the system. Dr. Richman led the bureau and department through several class action lawsuits to improve healthcare, resulting in a reduction in restrictive housing for the seriously mentally ill, as well as significantly increasing services for this vulnerable population.

His bureau also successfully tackled the management and expansion of clinical services for the transgender population. In addition, he and his team oversaw the increase in assessment and treatment of offenders with hepatitis C, while managing the significant fiscal impact on the system. Dr. Richman's proudest and most notable contribution was leading the design and implementation of a full continuum of medications for addiction treatment throughout the entire Delaware prison system. He earned a doctorate in clinical and school psychology and a master's degree in psychology, both from Hofstra University, and a bachelor's degree in psychology from Gettysburg College.

Emma Martino, Research Associate Emma Martino is a public healthcare professional with a passion for effectively maintaining and exceeding healthcare standards. She has experience in public health communication, health record maintenance, and clinical operations. Before joining HMA, she gained valuable experience in the emergency registrar and admissions office at Doylestown Hospital, where she processed incoming patients; used, and maintained electronic health records; monitored patient progress, processed insurance information; and ensured HIPAA compliance. Ms. Martino also has experience in clinical operations and has worked in specialist offices where she processed incoming patients, scheduled procedures, monitored finances, and served as a liaison between departments. She completed an internship that included grant writing, proposal preparation, community outreach, and dissemination of public health educational materials. Ms. Martino earned a bachelor's degree in public health from East Stroudsburg University.

Nehath Sheriff, MPH, Consultant Nehath Sheriff has more than nine years of experience in public health with a proven record of identifying solutions to drive health equity initiatives, promote community health, and build sustainable long-term change in collaborative and team-based environments. Her experience includes working with large health systems, Medicaid-managed care organizations, and safety-net, community health programs. Before joining HMA, Ms. Sheriff was a senior policy analyst at the Brookings Institution's Center for Economic Studies where she led a team working with federal, state, and local level agencies to find sustainable solutions to pertinent health issues. She focused on finding innovative solutions to address mental health, refugee, and immigrant health outcomes. Ms. Sheriff identifies methods for improving health communication through cultural competency and the role of federally qualified health centers to advance the United States healthcare system. Prior to Brookings, she was a Medicaid business development consultant and strategically responded to state Medicaid requests for proposals.

She wrote plan responses focused on provider network and population health, which took into consideration each state's unique community strengths and resources. Ms. Sheriff founded and directed a safety-net medical clinic in Redmond, Washington. She served as an expert in community health initiatives, including addressing the COVID-19 pandemic and vaccine distribution, developing pop-up health clinics to advance health equity for vulnerable populations, and addressing mental and physical health by leveraging telehealth solutions and intermediaries. She is experienced in communicating with diverse stakeholders and external partners for advancing mutual goals. Ms. Sheriff earned a master's degree in public health with a focus on community oriented primary care from George Washington University. She earned bachelor's degrees in public health and biology from the University of Washington and a certificate in neurobiology and behavior from Columbia University.

Margaret Kirkegaard, MD, MPH, Principal Margaret Kirkegaard, MD, provides client consulting focused on physician engagement in healthcare reform, rural healthcare, medical education, community health and medical care integration, primary care development and transformation, population-based healthcare delivery, and underserved and vulnerable populations. Key projects with HMA include development of Medicaid policy and state innovation models in both Iowa and Illinois, development of a rural telehealth network in rural Illinois, and accountable care design for safety-net providers. Dr. Kirkegaard worked with special needs populations, including consumers who require long-term services and supports (LTSS) at the policy, health plan, and provider levels. She served as the interim medical director for a health plan with integrated LTSS services including home and community-based waiver services and advised provider organizations on the development of integrated medical and LTSS services. Dr. Kirkegaard's expertise is in the implementation of the patient-centered medical home model and the adoption of quality improvement tools for improved population health. For over six years, she served as the medical director of a state-wide, start-up primary care case management program for 1.8 million Medicaid clients. She was responsible for network development, practice engagement, and practice transformation to the medical home model for 5,700 primary care providers and 2,300 specialist providers. During her tenure, the program developed multiple clinical quality improvement tools, a pay-for-performance program, and achieved provider approval and client satisfaction ratings over 90 percent. Dr. Kirkegaard earned her medical degree from the University of Minnesota, and her master's degree in public health with a concentration in health policy and focus on quality improvement. She completed her family medicine residency at

Hinsdale Family Practice Residency. She is a board-certified family physician. Dr. Kirkegaard instructs medical students and residents and provides clinical care to patients at the Hinsdale Family Medicine Residency.

Deborah Rose, PsyD, Associate Principal Deborah Rose is an experienced executive with a demonstrated history of designing and scaling new initiatives in the healthcare industry. She has extensive experience working with managed Medicaid, procurement and grant writing, nonprofit management, integrated care, care coordination, program development, supported housing and homeless service models, stakeholder engagement, and social determinants of health. Before joining HMA, Dr. Rose served as deputy chief operating officer at the Institute for Community Living, where she provided administrative leadership to a team of 1,200 employees across 65 sites throughout New York City. Her prior work includes serving as the behavioral health home and community-based services director for Healthfirst under the Medicaid Health and Recovery Plan. In that role, she contributed to New York State's only behavioral value-based payment pilot program, resulting in more than $1 million in Medicaid savings. Previously, Dr. Rose was director of health homes at the New York City Health and Hospitals Corporation.

Dr. Rose has broad clinical experience with a variety of underserved populations in human services and has held executive leadership positions in nonprofit and community-based agencies. She has strived to improve access to and delivery of person-centered services for adults with intellectual and developmental disabilities, mental illness, and substance use disorders. Earlier appointments in her career include deputy director of behavioral health at Rikers Island, director of assisted outpatient treatment at the Bellevue Hospital Medical Center, and director of ambulatory behavioral health for Saint Vincent's Catholic Medical Centers.

Dr. Rose is a New York State-licensed psychologist. She earned a doctorate in clinical psychology and a master's degree in applied psychology, both from Long Island University. She also earned a bachelor's degree from Adelphi University in New York. Dr. Rose maintains certification in diversity, equity, and inclusion in the workplace.

Shannon Robinson, MD, Principal Shannon Robinson is board certified in psychiatry and addiction medicine and has delivered addiction and psychiatric care in emergency departments, med/surg hospitals, HIV and hepatitis C clinics, inpatient and outpatient mental health and addiction programs, and criminal justice settings. She joined HMA after serving as director of the alcohol and drug treatment program at the Veterans Affairs (VA) San Diego Healthcare System, where she initiated the medication-assisted treatment program, expanded access to evidence-based psychotherapies, and helped develop the VA's national educational materials for alcohol use disorders, opioid use disorders, pain management, and the treatment of insomnia. She served as the chief of addiction services for California Correctional Healthcare Services, where she was the champion change management agent for administration and line staff while initiating medication-assisted treatment within primary care. She also helped develop enhanced evidence-based SUD treatment and person-centered care throughout the California Department of Corrections and Rehabilitation. Dr. Robinson provided and supervised telehealth in the VA and California Correctional Healthcare Services, where she was part of a team that expanded telepsychiatry, and she started the tele-addiction service. Her research, clinical work,

training experience, and publications cover psychopharmacology, cognitive behavior therapies, hepatitis C, addictions, telehealth, correctional healthcare, primary and behavioral health integration, and related topics. She also has two decades of teaching experience with mental health, primary and specialty care, pharmacy, and nursing staff, which includes curriculum development, in-person presentations, interactive webinars, and virtual trainings for all healthcare disciplines, non-healthcare staff, patients, family, and lay persons. As part of her prior work, she has experience with designing, implementing, and overseeing operations for SUD treatment programs and staff, including alcohol drug counselors, psychologists, social workers, nurses, prescribers, and pharmacy staff. This work included the creation of workflows, policies and procedures, standardized practices/protocols, data reporting, and quality and performance improvement.

At HMA, Dr. Robinson has led and supported local and statewide efforts to improve access to evaluation and treatment for SUDs in all healthcare settings, starting with the assessment of services currently available, the review of evidence-based practices, and coaching on the implementation of evaluation and treatment for behavioral health issues. Dr. Robinson earned her medical degree from the University of Louisville School of Medicine and her bachelor's degree in psychology from the University of Kentucky. She completed her residency and psychosomatic psychiatry fellowship at the University of California, San Diego, where she remained a faculty member for more than 15 years.

Rich VandenHeuvel, MSW, Principal Rich VandenHeuvel is a former behavioral health executive with more than 20 years' experience working with and designing services, programs, and policies for adults and children living with intellectual/developmental disabilities, mental illness, and/or substance use disorders. Prior to joining HMA, Mr. VandenHeuvel served as the CEO for a newly formed public behavioral health managed care organization responsible for community-based services to adults and children with developmental and behavioral health needs. In addition to managing multiple funding streams, he led integration and management of substance abuse services (Medicaid and block grant), collaboration with Medicaid managed care health plans, and governing board and leadership development. Mr. VandenHeuvel led the creation of regional service standards, cost comparison standards, and provider network management and development including home- and community-based outpatient and inpatient services. Mr. VandenHeuvel also served as spokesperson and lead contract negotiator with the State of Michigan for the 10 Prepaid Inpatient Health Plans responsible for the Specialty Behavioral Health Services Benefit throughout Michigan, including the first integration of substance use disorder services into the Prepaid Inpatient Health Plans contract.

Previously, Mr. VandenHeuvel served in multiple roles for a regional, public community mental health organization, serving adults and children living with mental illness, developmental disabilities, and/or substance use disorders including direct service, performance improvement, and clinical director roles and a decade as executive director. Since coming to HMA, Mr. VandenHeuvel has specialized in the areas of home- and community-based services for persons with intellectual/developmental disabilities, behavioral health, and corrections health including best practices research, market analysis, and services integration. He earned his master's degree in social work from Grand Valley State University and his bachelor's degree from Michigan State University.

Bren Manaugh, MSW, LCSW-S, CCTS, Principal Bren Manaugh is a seasoned healthcare leader and specialist in organizational and systems transformation. Ms. Manaugh has expertise in innovative strategies for serving the safety-net and complex-care populations, with extensive experience with and expertise in persons with justice system involvement. She effectively engages stakeholders across systems to develop and drive person-centered, culturally responsive, and trauma-informed care to optimize outcomes and reduce costs. Ms. Manaugh currently directs HMA's projects in California and Illinois, supporting the implementation of evidence-based addiction treatment in more than 50 county jails. She has provided consultation support to jails, counties, providers, and health systems in multiple counties and states on implementing evidence-based clinical treatment and services for persons with behavioral health conditions. Her work has included providing practice transformation technical assistance and coaching to behavioral health and primary care providers as a clinical subject matter expert and coach on expanding access to substance use disorder treatment, including medication-assisted treatment for opioid use disorder. She brings together community providers, hospitals, peer supports, and the criminal justice system to improve service delivery, coordination, and quality.

Ms. Manaugh is at the leading edge of community innovations to improve law enforcement and emergency response for people challenged by these issues. She conducted an analysis and created a report and community guide for Arnold Ventures for communities developing behavioral health crisis solutions and law enforcement diversion solutions. Her work with community systems of care includes engaging stakeholders, formulating common aims and implementation plans, and developing data-sharing and evaluation structures.

Prior to joining HMA, Ms. Manaugh served as vice president of adult services at a large public behavioral health agency in San Antonio, Texas, where she developed and administered programs in the nationally recognized Bexar County Restoration Center and Diversion Program, partnering with multiple hospitals, city and county leadership, and the criminal justice system. She oversaw operations across a continuum of mental health and substance use disorder services and in partnership with the sheriff, police department, county, and courts across the entire sequential intercept map. Ms. Manaugh's approach engages multiple stakeholders and decision-makers to generate innovative strategies that produce results.

She earned her master's degree in social work from the University of Kansas and her bachelor's degree from the University of Minnesota. She is a licensed clinical social worker, a certified clinical supervisor, and a certified clinical trauma specialist.

John Volpe, LCSW, Principal John Volpe is an experienced senior health official with a demonstrated record of success at the intersection of health, social service, public safety, and the criminal justice system. Prior to joining HMA, Mr. Volpe served as special advisor on criminal justice for the New York City (NYC) Department of Health and Mental Hygiene, founding the Office of Criminal Justice. The office was designed to lead in the areas of policy, system design, cross-sector collaboration, and service delivery development and improvement where health and social services intersect with crisis systems, law enforcement, the courts, probation and parole, as well as jails and prisons. Mr. Volpe's key accomplishments in support of a strong public safety and public health paradigm include

work with the New York Police Department (NYPD) intervention training program, police/mental health co-response teams, crisis centers for NYPD drop off, Academy for Justice Informed Practice, NYC Crisis System Task Force, and probation and health homes.

Prior to joining city government, Mr. Volpe served at the NYC Legal Aid Society as a founding member of an interdisciplinary criminal defense project. Later, in an administrative role, he designed and secured grant funding to spearhead new efforts for at-risk populations, including frontline clinical court services to divert people from jail, immigrants facing deportation, and victims of human trafficking. Before entering the criminal justice field, Mr. Volpe served as a team leader for an innovative holistic nutrition program for a highly marginalized NYC HIV+ population and previously served as director of NYC's only group residence for gay and transgender young people in NYC's foster care system. His earliest social service roles were in the areas of case management, training, and program development in one of NYC's premier foster care agencies. A skilled public speaker and writer, Mr. Volpe's passion for innovation, transformation, and social justice fuel his commitment to improve opportunities for people most often left behind.

Mr. Volpe earned a master's degree in social work from Hunter College School of Social Work and his bachelor's degree from Georgetown University.