MOUD in Corrections: Moving to Implementation Notetaking Template – Breakout Rooms

Day:1/27/21
Room name: Limited Access / Staffing Availability

Questions asked:

HIPPA concerns, how to manage all of the policies and consents?

Discussion themes that arose:

- MOUD was rolled out but there was no new staff hired
    - Tried to combine with existing programs
    - Working with MOUD patients is very different than working in abstinence-based treatment
- System put the cart before the horse
    - No MOUD coordinator
    - Very little direction from the admin (they have never worked within the walls)
    - Need a point person at each facility to coordinate
- Top down hierarchical leadership doesn't work well in these kind of implementations
- Concern that the only treatment is MOUD
    - Patients are wanting 1:1, group sessions, and more education
    - Part of this is due to COVID – journals are given etc. there is a literacy issue with this
    - Potentially audio recordings back and forth can be done but there are a lot of security barriers and lack of access to technology

- COVID being a barrier to check in a provide behavioral therapies
    - Lots of people suffering from being put in isolation

- Lack of staff
    - Geographic barrier – in the middle of no where
- Accessibility to clinicians to prescribe
    - Funding barrier with paying these providers
    - Try to have them go to community provider outside of facility so they have some connection once they leave instead of just hoping they'll attend appointment before they leave

- Security might be at odds with the providers / program staff
    - Diversion rates are low but as soon as it happens once it "proves a point"
- A warden might be supportive of it so that can change behavior but you can't force and attitude change
    - There are 10% who you can probably never change their mind, so let that go

- Getting staff on board
    - Have a choice in which staff help and which don't
    - Need to create a buy in
    - Start with staff who believe in it (not the nay sayers) and they will talk to their peers are those people who are semi supportive will eventually become supportive so on and so forth
    - Some used to start with staff who were against it - this does not work they can really be obstructionist and throw in road blocks
- Some officers believe their job is safety not medicine administration and don't want to participate (even though they are against diversion)
    - There is a cycle between treatment and safety
    - You can't have treatment in an unsafe space
    - Treatment also provides a safe space

- One positive from COVID is telehealth
    - This is a great way to get access to providers who will prescribe
    - Have nurses on staff but use providers virtually
    - Use someone across the world (Spain) so that you can have someone available from midnight to 5am but it's the day for them

- HIPPA
    - Consents need to be renewed annually – this is difficult with pen and paper
    - Try to use an electronic system that reminds you (Brian had resources regarding this)
    - These are in place to protect the patients
    - CO don't need to know everything because there is a huge stigma with things like HIV and substance abuse
    - Hard to protect because there are often calls over the radio for MOUD med passes – this can be hard to navigate

Summary (a brief description summarizing key points that came out of interactive breakout session):

Programs launched without the proper planning or staff

Planning and research are key

Telehealth can be really important when it comes to access

Start with those employees are on board and support with grow