All-Team Quarterly Learning Collaborative

Jail MAT and Drug Court Teams

Tuesday, April 2, 2024

AGENDA

- Welcome and Learning Collaborative Updates
- Key State and National Policy & Guidance Updates
- Using Quality Improvement to Monitor and Improve SUD Treatment in Correctional Facilities
- Maximizing Partnerships to Identify and Support Those with SUD at the Jail "Front Door" and Reentry
- Making your MAT Program Sustainable: Best Practices Tips for Leadership and Implementation Planning
- Upcoming Opportunities and Wrap Up

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DATA REMINDER

- For counties receiving Jail MAT funding under this project, Q4 2023 data was due March 31, 2024.
- Your coach/the PM team will reach out if you have any missing data.
- 2023 data trends and findings will be presented at the June Learning Collaborative.

Questions? Please email MATinCountyCJ@healthmanagement.com.

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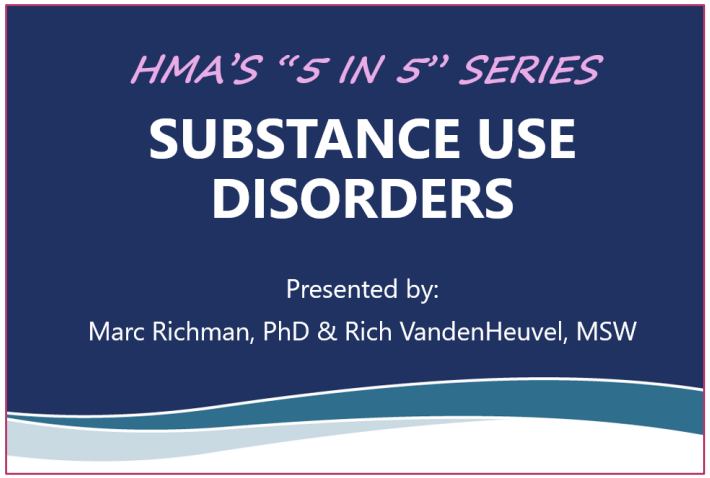
“5 IN 5” SERIES

5-minute videos with key takeaway points to share with your staff:

- Substance Use Disorders
- Opioid Use Disorders
- Medications for Opioid Use Disorder (MOUD)
- **Coming soon:** Substance Withdrawal



Note: These videos are downloadable as well to upload to tablets and computers.

WEBINAR RECORDINGS FROM PAST QUARTER

- Saving Lives and Reducing Other Risks in Your Jail Through Harm Reduction
- ASAM Clinical Considerations for High-Potency Synthetic Opioids

POLL – TRAUMA-INFORMED LEARNING COMMUNITY

- Would your county be interested in participating in a Trauma-Informed Learning Community?
  - Yes
  - No

Learning community will include:

- Monthly or bi-monthly meetings with your peers and subject matter experts (SMEs)
- One-on-one technical assistance with SMEs
- Access to tools and resources

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KEY STATE AND NATIONAL POLICY & GUIDANCE UPDATES

11:05 – 11:25 am PDT
Presenters: Bren Manaugh, Debbi Witham & Shannon Robinson, MD

42 CFR PART 8 FINAL RULE | MEDICATIONS FOR THE TREATMENT OF OPIOID USE DISORDER

- Part 8 of Title 42 of the Code of Federal Regulations (CFR) includes updated regulations for OTPs/NTPs.
- Final rule released in February 2024. The effective date of this final rule is April 2, 2024, and the compliance date is October 2, 2024.
- Removes obstacles that have previously prevented patients from accessing MOUD treatment.

Helpful Links

- Part 8 of Title 42 of the Code of Federal Regulations (CFR)
- Table of Changes
- Frequently Asked Questions
- What It Means for Patients

42 CFR PART 8 FINAL RULE | MAIN TAKEAWAYS FOR JAILS AND DRUG COURTS

1. Allows for more frequent take-homes earlier in treatment.
   - Can reduce barriers to obtaining methadone in jails.
2. Allows the initial medical exam to be completed via telehealth.
   - Can reduce barriers to initiation of methadone in jails.
3. Extends time interim maintenance can be provided and removes language the OTP must be public or non-profit.
   - Can reduce wait times for methadone when OTPs are at capacity.
4. Clarifies that medications for opioid use disorder should not be withheld for lack of access to counseling and therapy available though NTPs/OTPs should provide these services.
5. Clarifies definition of mobile unit for methadone.
   - Together with DEA lifting the moratorium on mobile methadone units, dispensing from a mobile unit can be an option for jails.

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42 CFR PART 2 FINAL RULE | CONFIDENTIALITY OF SUBSTANCE USE DISORDER (SUD) PATIENT RECORDS

- Part 2 of Title 42 of the Code of Federal Regulations (CFR) includes updated regulations for patient consent and disclosures for patients with a SUD.
- Final rule released in February 2024; will go into effect April 2024 (and compliance date of February 2026).
- Updates confidentiality rules for patients with SUD, including allowing a single consent for disclosures for treatment, payment and health care operations.

Helpful Links

- Part 2 of Title 42 of the Code of Federal Regulations (CFR)
- Fact Sheet 42 CFR Part 2 Final Rule
- HIPAA and Part 2

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42 CFR PART 2 FINAL RULE | MAIN TAKEAWAYS FOR JAILS AND DRUG COURTS

1. Requires a separate patient consent for the use and disclosure of SUD counseling notes.
2. Allows a single consent for all future uses and disclosures for treatment, payment, and health care operations.
3. Express statement that patient consent for segmentation of Part 2 Data is not required.
4. Prohibits combining patient consent for the use and disclosure of records for civil, criminal, administrative, or legislative proceedings with patient consent for any other use or disclosure.

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CASE LAW UPDATE | DOJ SECURES AGREEMENT WITH PA COURTS TO RESOLVE MOUD DENIAL CASE

- The DOJ reached a historic settlement to resolve a lawsuit for violating the Americans with Disabilities Act by denying individuals access to medications for opioid use disorder (MOUD).

For more information, please visit the following links: DOJ Press Release and Legal Action Center Summary.

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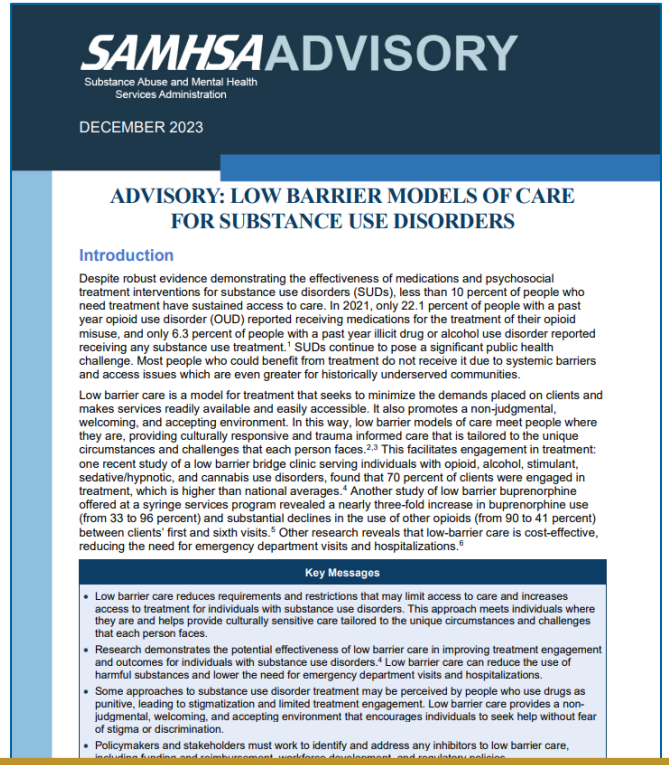
LOW-BARRIER CARE

- SAMHSA released Advisory: Low Barrier Models of Care for Substance Use Disorders in December 2023.



SAMHSA ADVISORY

Substance Abuse and Mental Health Services Administration

DECEMBER 2023

ADVISORY: LOW BARRIER MODELS OF CARE FOR SUBSTANCE USE DISORDERS

Introduction

Despite robust evidence demonstrating the effectiveness of medications and psychosocial treatment interventions for substance use disorders (SUDs), less than 10 percent of people who need treatment have sustained access to care. In 2021, only 22.1 percent of people with a past year opioid use disorder (OUD) reported receiving medications for the treatment of their opioid misuse, and only 6.3 percent of people with a past year illicit drug or alcohol use disorder reported receiving any substance use treatment.[1] SUDs continue to pose a significant public health challenge. Most people who could benefit from treatment do not receive it due to systemic barriers and access issues which are even greater for historically underserved communities.

Low barrier care is a model for treatment that seeks to minimize the demands placed on clients and makes services readily available and easily accessible. It also promotes a non-judgmental, welcoming, and accepting environment. In this way, low barrier models of care meet people where they are, providing culturally responsive and trauma informed care that is tailored to the unique circumstances and challenges that each person faces.[2,3] This facilitates engagement in treatment: one recent study of a low barrier bridge clinic serving individuals with opioid, alcohol, stimulant, sedative/hypnotic, and cannabis use disorders, found that 70 percent of clients were engaged in treatment, which is higher than national averages.[4] Another study of low barrier buprenorphine offered at a syringe services program revealed a nearly three-fold increase in buprenorphine use (from 33 to 96 percent) and substantial declines in the use of other opioids (from 90 to 41 percent) between clients' first and sixth visits.[5] Other research reveals that low-barrier care is cost-effective, reducing the need for emergency department visits and hospitalizations.[6]

Key Messages

- Low barrier care reduces requirements and restrictions that may limit access to care and increases access to treatment for individuals with substance use disorders. This approach meets individuals where they are and helps provide culturally sensitive care tailored to the unique circumstances and challenges that each person faces.
- Research demonstrates the potential effectiveness of low barrier care in improving treatment engagement and outcomes for individuals with substance use disorders.[4] Low barrier care can reduce the use of harmful substances and lower the need for emergency department visits and hospitalizations.
- Some approaches to substance use disorder treatment may be perceived by people who use drugs as punitive, leading to stigmatization and limited treatment engagement. Low barrier care provides a non-judgmental, welcoming, and accepting environment that encourages individuals to seek help without fear of stigma or discrimination.
- Policymakers and stakeholders must work to identify and address any inhibitors to low barrier care, including funding and reimbursement, workforce development, and regulatory policies

Continuing to face issues in your county with low-barrier models of care? Reach out to your coach for additional training/technical assistance for county and community partners.

STANDARD OF CARE: “MEDICATION FIRST”

2003: Initiation and continuation of MAT was contingent upon	Outcomes: Continued use of opioids & possible death	2020: Medication is	Outcomes: Buprenorphine blocks opioid receptor & prevents overdose & death
Being face to face in clinic to look for evidence of IVDU and withdrawal symptoms	☹	Not contingent	☺
Completion of a biopsychosocial assessment	☹	Not contingent	☺
Completion of lab work	☹	Not contingent	☺
Use of no other substances and no relapses	☹	Not contingent	☺
Attending therapy	☹	Not contingent	☺

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OTHER FEDERAL GUIDANCE

DEA and HHS Joint Letter on Medications for Opioid Use Disorder (MOUD)

- DEA and HHS support the expansion of MOUD especially in rural or underserved areas. DEA is asking its registrants to ensure an adequate and uninterrupted supply of MOUD products when appropriately prescribed and asks distributors to examine any quantitative thresholds they established to ensure that individuals with OUD are able to access buprenorphine. Expanding access to MOUD is one more way to assist patients with OUD during the Opioid Public Health Emergency.

Examining the Use of Braided Funding for Substance Use Disorder Services

- This report looks at state and federal laws and policies that encourage braided funding to provide substance use disorder services, best practices for braiding funds, and pathways to sustainability for substance use disorder programs.

USING QUALITY IMPROVEMENT TO MONITOR & IMPROVE SUD TREATMENT IN CORRECTIONAL FACILITIES

11:25 am – 12:10 pm PDT
Presenters: Debbi Witham, Brittany Labarreare, and Rich VandenHeuvel

WHAT DOES THIS MEAN FOR OUR JAIL?

- What is CQI?
- Value and Foundation
- Metrics
- CQI Methods
- Breakouts and Practice

WE WANT TO HEAR FROM YOU

Please select the option that best describes the current status of CQI at your jail:

A. We have an active CQI program.
B. We have a committee that meets sporadically.
C. We started some change projects and stopped.
D. What is CQI?

CQI - A FANCY PHRASE FOR WHAT WE DO EVERY DAY

Continuous Quality Improvement (CQI), is “a planned approach to transform organizations by evaluating and improving systems to achieve better outcomes”.

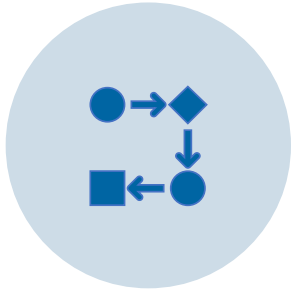
But really it is something we do in everyday life:

Daily Life	Custody	Health Care
Cooking	Critical Incident Debrief	Improve Screening Process

So, let’s hear an example from you:

CONTINUOUS QUALITY IMPROVEMENT (CQI), IS “A PLANNED APPROACH TO TRANSFORM ORGANIZATIONS BY EVALUATING AND IMPROVING SYSTEMS TO ACHIEVE BETTER OUTCOMES”.

CQI involves systematically assessing program implementation and short-term outcomes to improve service delivery and long-term outcomes.



CQI differs from traditional program evaluation approaches. It involves an iterative cycle of monitoring performance, identifying problems and potential solutions, implementing changes, and involving frontline and other staff in the improvement process.

PRINCIPLES OF CQI FOR CORRECTIONAL FACILITIES

- Celebrate success!
- Establish clear goals.
- Define measurable metrics.
- Make CQI a team sport.
- Base practices on most up-to-date evidence and tailor them to the local environment.
- Integrate appropriate CQI tools frequently.

IF YOU DON'T KNOW WHAT YOU ARE AIMING FOR, YOU DON'T KNOW IF YOU HIT IT

- National standards
- Selecting measures
  - Structure measures
  - Process measures
  - Outcome measures
- Defining success
  - Define key metrics and performance measures that demonstrate success
- Track key metrics

EXAMPLES OF GOALS AND METRICS

Not SMART	SMART	Metrics
Improve reentry connections for detainees with SUD	In 6 months, we will connect 50% of detainees receiving MOUD in the correctional facility to an appointment with an MOUD provider within 7 days of release.	Track all detainees receiving MOUD on the Excel registry; the reentry coordinator notes follow-up appointment time in the registry and calculates monthly the number of individuals with appointments within 7 days.
Distribute naloxone	In four months, 50% of all detainees with potential SUD will be released with naloxone in their property bag.	Detainees with positive screening for possible SUD at booking are flagged in jail management system (JMS), naloxone is placed in property bags, and a second flag is noted. The report of flagged detainees is analyzed monthly.

GETTING THERE – “5 WHYS”

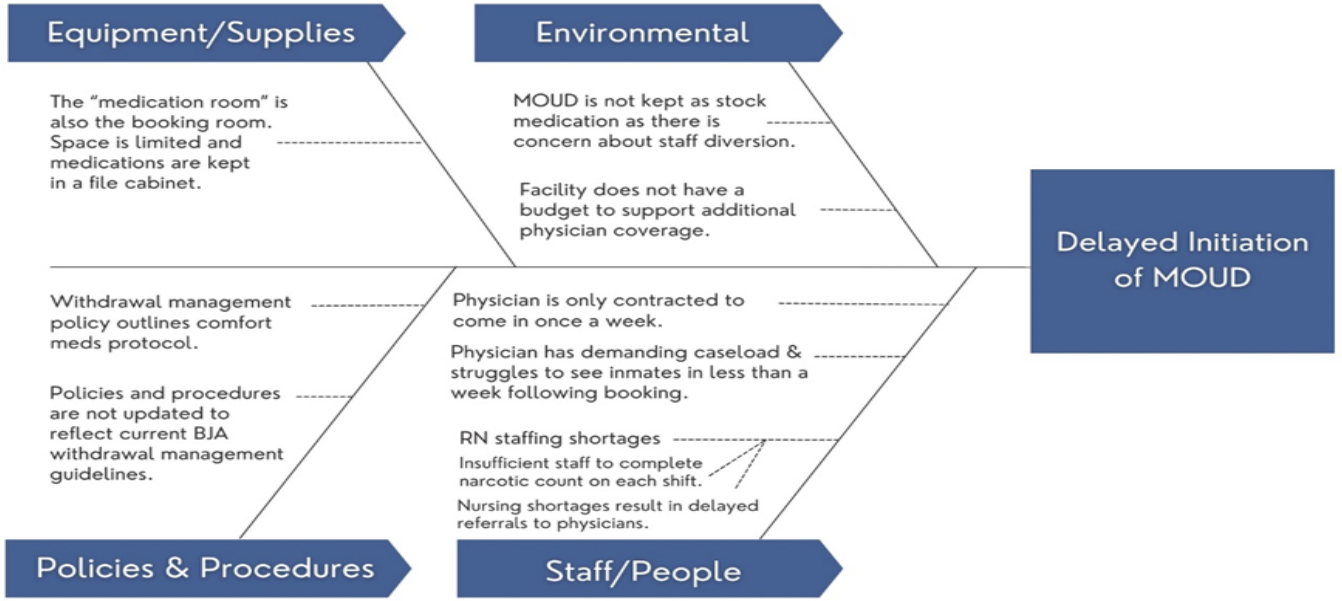
The “**5 Whys**” is a CQI technique for identifying the causes underlying a problem. It involves identifying a problem, then asking “why?” five times to get to deeper layers of what is causing the problem. The process involves the following steps (excerpted from Module 11, p. 5):

1. Work with correctional facility staff to identify the problem they want to solve or prevent.
2. Ask the question *why?* five times until the group members agree they have identified the root cause of the performance issue or problem.
3. Identify and implement solutions based on findings.

Agency for Healthcare Research and Quality. (2015). Primary Care Practice Facilitation Curriculum: Module 11 – Using Root Cause Analysis to Help Practices Understand and Improve Their Performance and Outcomes. Rockville, MD. https://www.ahrq.gov/sites/default/files/wysiwyg/ncepcr/tools/PCMH/pcpf-module-11-root-cause-analysis.pdf

GETTING THERE – ROOT CAUSE/FISHBONE DIAGRAMS

Root-cause analysis is a process that is used to identify and understand multiple causes of more complex problems and to sort these causes into categories. Completion of a root cause analysis makes these multiple potential causes visible and provides a basis for selecting elements of the process or change area that can be improved. This diagram looks like a rudimentary fish skeleton, so it is often called a “fishbone diagram.”



CQI IN ACTION: “5 WHYS”

Springfield City Jail meets regularly with their community provider who treats their inmates post release. They learn a large number of people stop MAT within 90 days after leaving the jail. Some return to use and several have had reversed overdoses.

The team use the “*5 Whys”* to learn the potential root causes:

1. Community stigma, attending a 12-step group not supportive of MAT
2. Living in recovery residences not supportive of MAT
3. Too low of a dose so cravings are not managed
4. Lack of knowledge of MAT as maintenance drugs
5. Lack of prescribers – pharmacy issues

CHATTERFALL – FIVE WHYS

The goal in your jail is to **screen everyone at booking using the TAPS and begin MOUD within 5 hours**. Custody officers have been trained and there is a tablet available in Booking.

Data analysis shows that 50% of people have been screened.

Why 1
Why 2
Why 3
Why 4
Why 5

CQI IN ACTION: SACRAMENTO COUNTY

Presenters: Tianna Hammock and Jacqueline Abdalla, MD

CQI IN ACTION: SACRAMENTO COUNTY

- Identified CQI initiative/project:
  - Moving from continuation to initiation and withdrawal management (w/ MOUD)
  - Strategy: Dedicated housing units for both initiation and withdrawal management
  - Tianna Hammock, CCHP – Health Services Administrator, Adult Correctional Health
  - Jacqueline Abdalla, MD – Assistant Medical Director, Family Medicine & Women's Health, Sacramento County Health Services

SACRAMENTO – THE (BIG) WHY

- Community (and CalAIM) Standard of Care
  - AMA and ASAM define addiction as a chronic and treatable brain disease – OUD is a chronic condition
- High numbers of acute substance withdrawal when initially incarcerated along with risks of overdose and death – fentanyl
- Class Counsel: A full MAT program that meets community standards of care and should not be delayed, as it places patients at risk

JAIL CONSTRAINTS

- High volume – high churn rate makes in house services and discharge planning difficult.
- Physical plants – not designed for health care
- Staffing shortages/high demands – long background process

	Dec	Jan	Feb
Average Daily Pop	3,113	3,088	3,100
Nurse Intakes	2,466	2,493	2,493
Range, per day	41-134	56-112	60-109
Average, per day	80	80	86

Releases by Length of Stay (LOS)
Data Period: January 2024
Report Date: February 13, 2024
Report By: DHS Primary Health / **Data Source:** SSO

Length of Stay (in Days)	Main Jail	RCCC	Total	Percentage	Total %	Cumulative %
0	581	8	589	23%	23%	23%
1	328	20	348	14%		
2	246	60	306	12%	31%	54%
3	116	10	126	5%		
4	142	30	172	7%		
5	109	10	119	5%		
6	57	9	66	3%		
7	46	8	54	2%		
8	19	5	24	1%		
9	25	7	32	1%	21%	75%
10	11	2	13	1%		
11	17	9	26	1%		
12	6	10	16	1%		
13	9	8	17	1%		
14	4	6	10	0%		
15	9	4	13	1%		
16	8	3	11	0%		
17	4	9	13	1%		
18	3	5	8	0%		
19	2	2	4	0%		
20	6	11	17	1%		
21	3	3	6	0%		
22	2	3	5	0%	5%	80%
23	1	4	5	0%		
24	2	5	7	0%		
25	2	5	7	0%		
26	2	7	9	0%		
27	5	1	6	0%		
28	4	3	7	0%		
29	4	3	7	0%		
30 – 59	78	108	186	7%		
60 – 89	41	62	103	4%	20%	100%
90 – 119	16	18	34	1%		
≥ 120	118	73	191	7%		
Total Releases	2,026	531	2,557	100%	100%	100%

PREPARATION AND ANALYSIS

- Analysis:
  - Increase demand
  - Staffing analysis
  - Medication cost analysis (beg, borrow and plead for it)
- Modify screening/intake to capture need/demand
- EHR modification to embed questions and create automatic orders from responses
- Work with custody to develop a dedicated unit/way to transmit information between systems

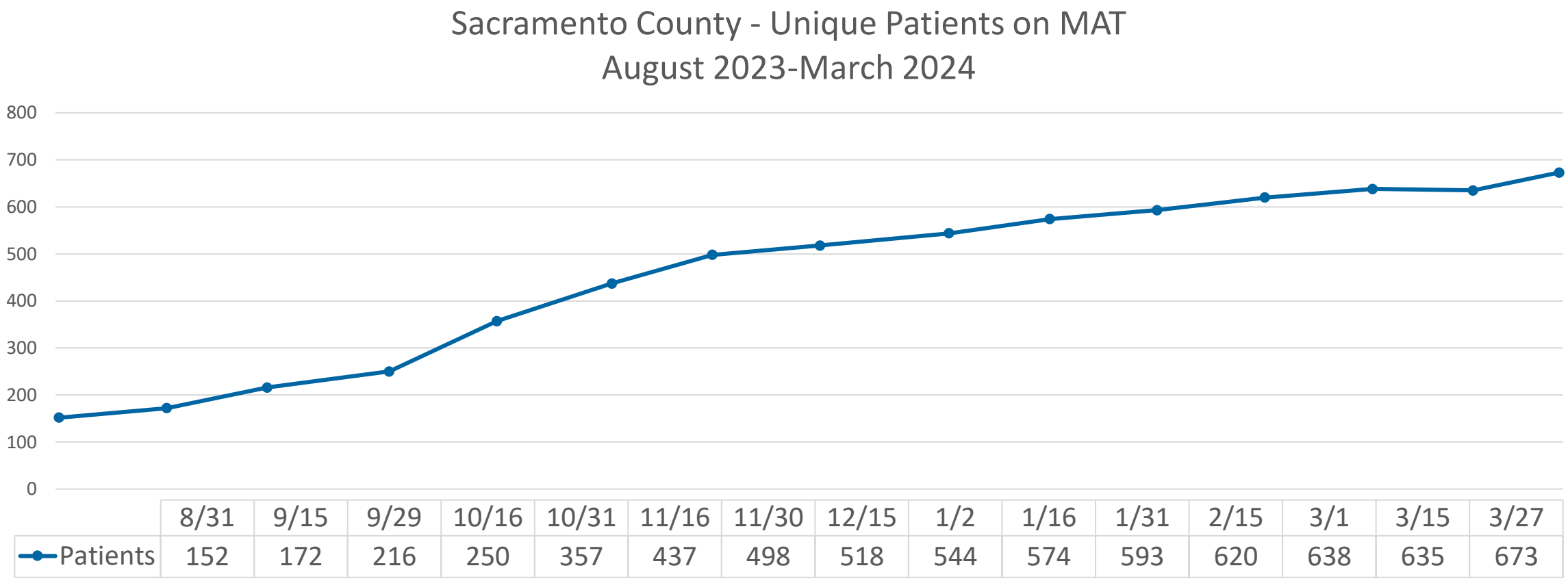
CQI IN ACTION: SOLUTIONS

- Training
  - Train nurses around intake revisions
  - Train nursing and providers on MAT overview, benefits, prescribing practices and medication administration
- P&P Updates
  - Medication administration
  - MAT/detox
  - Nurse intake
- Weekly/monthly multidisciplinary MAT meetings

CQI IN ACTION: SOLUTIONS

- The team designed improvement steps and focused improvements on smaller unique populations in a phased approach:
  - Phase I Inductions: Patients returning from ER due to overdose (>15 per month).
  - Phase II Inductions: Patients who have a history of accidental overdose identified at nurse intake.
  - Patients who have polysubstance abuse that includes opioids and benzodiazepines and/or opioids and alcohol.
  - Phase III Inductions: Patients identified at intake as having a recent history of opioid use.
  - Phase IV Inductions: Everyone else who has an OUD that meets criteria.

CQI IN ACTION: ONGOING DATA COLLECTION/ MONITORING



	8/31	9/15	9/29	10/16	10/31	11/16	11/30	12/15	1/2	1/16	1/31	2/15	3/1	3/15	3/27
Patients	152	172	216	250	357	437	498	518	544	574	593	620	638	635	673

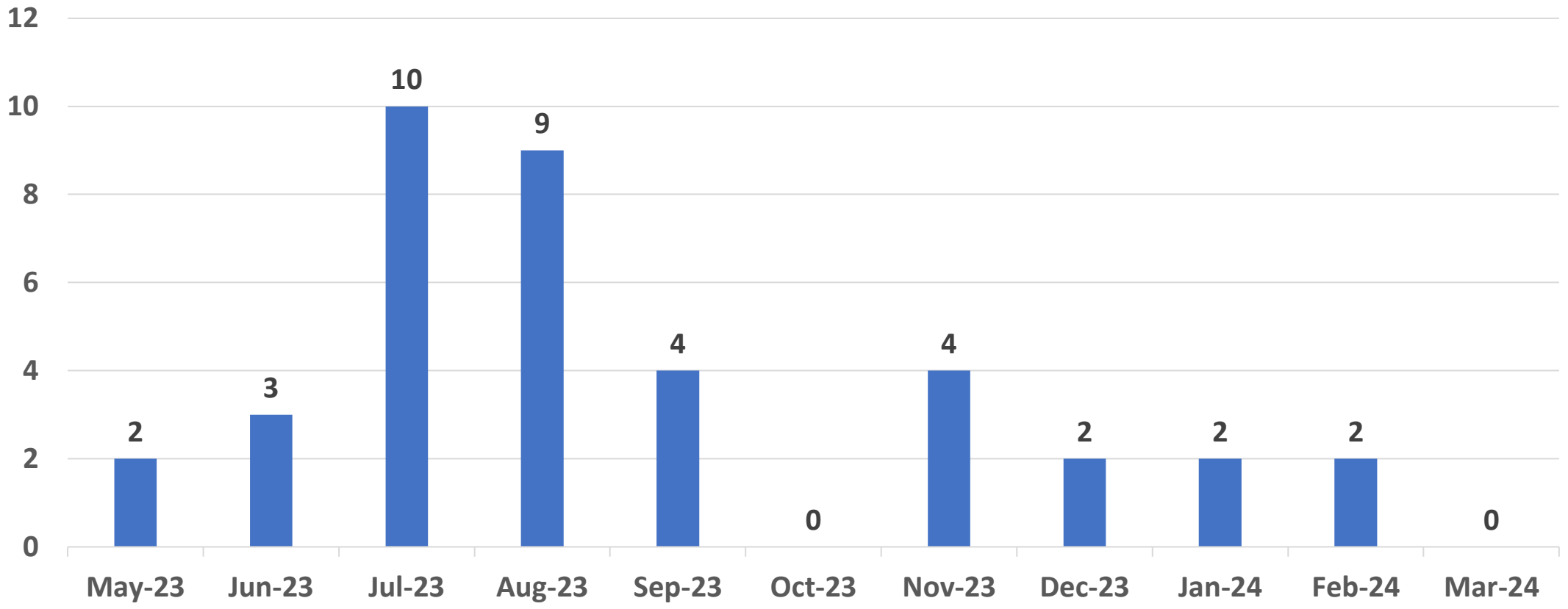
LESSONS LEARNED

- Challenges:
  - Stigma and education.
  - Staffing – providers, MAT nurses, pill call nurses, pharmacy.
  - Increased pressure on reentry coordination.
  - Increased pressure on med administration.
  - Dedicated MAT providers are needed; invested in process.

LESSONS LEARNED

- Results (so far):
  - People are being cleared off monitoring and into general population faster (using less resources).
  - Dedicated MAT providers are needed; invested in process.
  - In-custody overdoses decreasing.

ACH OVERDOSE DATA



Began officially tracking ODs on May 23, 2023, January both ODs were the same person, the same day

POLL – CQI LEARNING COMMUNITY

Learning Community would include:

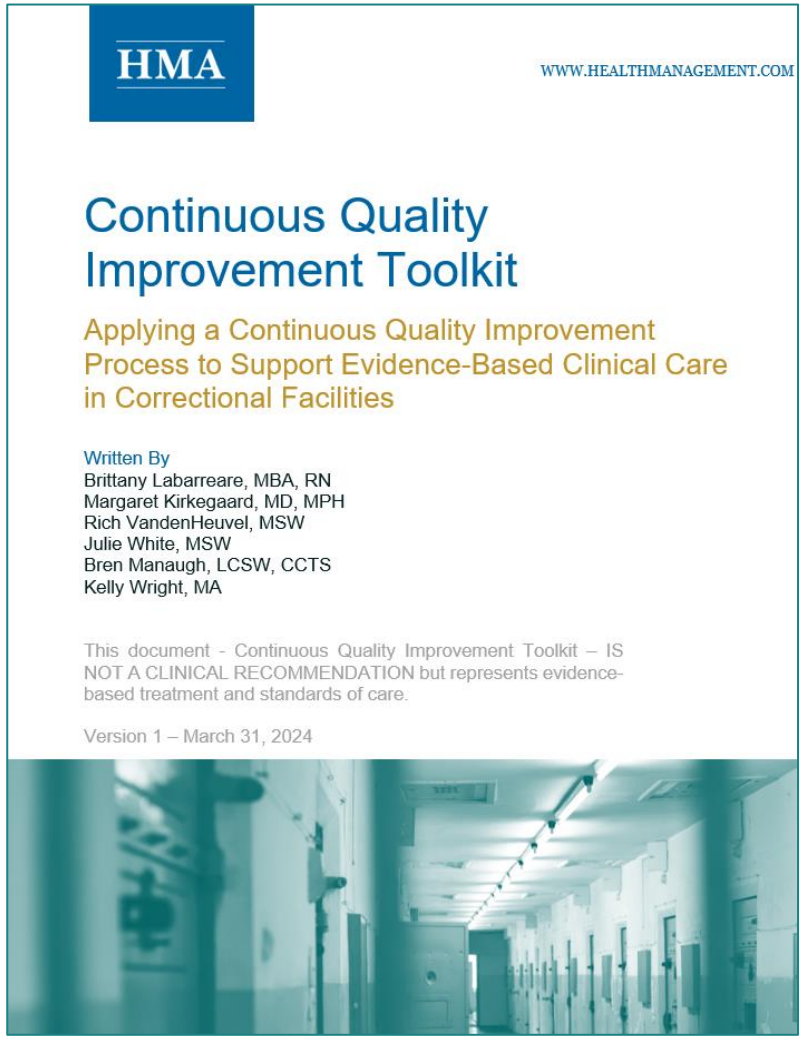
- Bi-monthly meetings
- Individualized coaching (as requested)
- Access to tools and resources

Poll: Would your county be interested in a learning community on continuous quality improvement?

- Yes
- No

NEW COACHING TOOL AVAILABLE: CQI TOOLKIT

- Please ask your coach if you would like access to this toolkit.



MAXIMIZING PARTNERSHIPS TO IDENTIFY AND SUPPORT THOSE WITH SUD AT THE JAIL "FRONT DOOR" AND REENTRY

12:20 – 12:45 pm PDT
Presenters: Marc Richman and Julie White

AGENDA

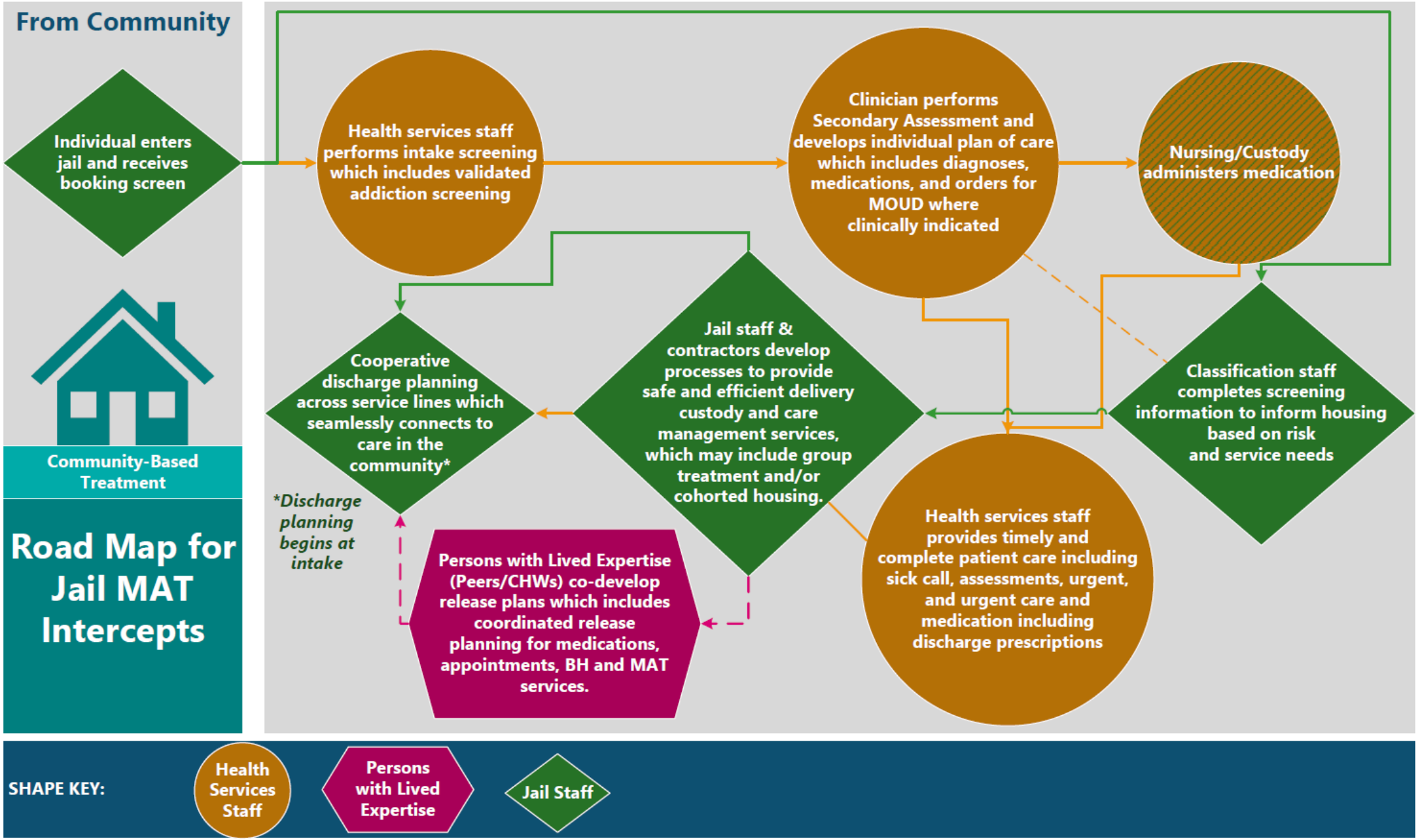
- The Importance of Early Identification
- No Wrong Door Philosophy
- An Individual's Journey Through the Justice System
- Who Are Your Partners?
- Making Partnerships Work
- Compassion Fatigue

WHY EARLY IDENTIFICATION IS CRUCIAL

- Short stays
- Stabilization
- Risk
- Prevent and manage painful withdrawal
  - Comfort meds different than treatment

NO WRONG DOOR

- Every individual's journey to recovery is unique.
- Individuals may ask for help early in their experience with justice system.
- Others may not ask for help right away (or ever).
- Is your system designed to meet individuals "where they're at" in their recovery?



PARTNERS ALONG THE JOURNEY

Pre-Booking	Booking*	Health Assessments*	During Incarceration*	Pre-Release*
Courts	Custody Intake	Medical and Behavioral Health Staff*	Health Services Staff (Medical & Behavioral Health)*	Probation
Defense Attorneys	Health Service Screen*	Standardized Tools*	Custody	Parole
	Clinical/Subjective Opiate Withdrawal Scale (COWS/SOWS) and Clinical Institute Withdrawal Assessment for Alcohol (CIWA)		Care Managers*	Community Based Organizations (CBOs)*
			Persons with Lived Expertise*	Peers*
			Education Programs	Managed Care Plans (MCPs)*

**Overlap with CalAIM requirements and components*

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MAKING PARTNERSHIPS WORK

- Release of Information
- Communication
  - Feedback loops
  - Mode of communication
  - Timeliness
  - Empowering staff
- Logistics
  - Space
  - Ability to meet with individual

Key Takeaways

- ✓ Who are you sharing with and when?
- ✓ Allowing safe space for nonjudgemental communication
- ✓ Creating time/space to communicate effectively on what you are seeing
- ✓ Being trauma-informed in approach

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MAKING PARTNERSHIPS WORK

- “We are not seeing/hearing the same thing!”
- Multidisciplinary team meetings
- Memorandums of Understanding (MOUs)
- Continuous Quality Improvement (CQI)

WHAT IS COMPASSION FATIGUE ?

Compassion satisfaction is **the pleasure and satisfying feeling that comes from helping others**. Many people enter the helping professions because they want to help - it feels good helping others. This is why we do what we do – to help people

Compassion fatigue is a broadly defined concept that can include **emotional, physical, and spiritual distress in those providing care to another.** It is associated with caregiving where others are experiencing significant emotional or physical pain and suffering**.**

CFAP, 2021

STRESS OR COMPASSION FATIGUE?

Stress

- Overcommitted
- Irritated, nervous, anxious
- Worry about/pressure of responsibilities
- Tired
- Not all stress is bad - keeps us safe & motivates us in some situations

Compassion Fatigue

- Common in helping professions
- Negative emotions felt by repeating the same actions repeatedly
- Numbness/decreased ability to empathize
- Decreased personal/prof efficacy
- All compassion fatigue is bad – may lead to burnout

MAKING YOUR MAT PROGRAM SUSTAINABLE: BEST PRACTICES TIPS FOR LEADERSHIP & IMPLEMENTATION PLANNING

12:45 – 12:55 pm PDT
Presenters: Bren Manaugh & Paul Kunkel

THINKING ABOUT SUSTAINABILITY

Think about the MAT program currently in your jail. If your **Champion – and/or 1 or 2 other key people in the effort left** – what do you think is most likely to happen with your MAT program?

A. It would continue uninterrupted.

B. We would likely have challenges with keeping it going at the same level it is now.

C. It would likely fall apart.

THINKING ABOUT SUSTAINABILITY

Think about your MAT program currently in your jail.

When your current main source of **funding for your MAT programs ends** - what do you think is most likely to happen with your MAT program?

A. It would continue uninterrupted.

B. We would likely have challenges with keeping it going at the same level it is now.

C. It would likely end.

THINKING ABOUT SUSTAINABILITY

- Tool for evaluating your current level of sustainability available from HMA
- Integrate sustainability strategy and planning into your operations and leadership NOW
- Case example: Paul and San Mateo MH efforts


Microsoft Stock Image

NEW RESOURCE | HOW SUSTAINABLE IS YOUR JAIL MOUD PROGRAM? PROGRAM SUSTAINABILITY MATRIX

HMA

How Sustainable Is Your Jail MOUD Program?

Program Sustainability Matrix

When correctional facilities make the commitment to make medications for opioid use disorder (MOUD) available to detainees, a significant amount of change and technical implementation is required, as indicated in the ***domains for MOUD implementation*** listed below. Programs can be derailed by change in leadership, new state requirements, staffing crises, or loss of grant funding. Access to MOUD is a best practice to reduce overdose death, and every jail is encouraged to solidify their program so that it can withstand any changes.

Reflect on the status of each implementation domain in your facility and consider what additional steps are needed to support the ongoing progress, success, and sustainability of your MOUD program. Possible strategies are included in some domains for consideration.

Domains for MOUD Implementation	Low Level of Sustainability	Moderate Level of Sustainability	Recommended for Sustainability
Funding	Limited or short-term funding for MOUD program; using discretionary funds in existing budget; may be using some grants funds.	Defined but short-term funding sources; using braided funding or multiple grant sources.	Dedicated funding through assigned budget allocation (i.e., eligible for reappropriation in next budget cycle); may be supplemented through grants. [*Strategy*: Use MOUD performance data to "make the case" for dedicated funding.]
Training of Health Care (HC) Staff	Some HC staff have received *ad hoc* training on topics such as substance use disorders (SUD), MOUD, stigma, and withdrawal.	Some or all HC staff have received training on SUD, MOUD, processes, stigma, and withdrawal, but it is not standardized (e.g., included in the annual training plan).	Training on SUD, MOUD, processes, stigma, and withdrawal is a specific component of ongoing HC training plan that specifies trainer responsibilities and curriculum used.
Training of Corrections Staff	Corrections staff have had some *ad hoc* training on topics such as SUD, MOUD, stigma, and withdrawal.	All corrections staff have had training on SUD, MOUD, processes, stigma, and withdrawal, but it is not standardized (e.g., part of the annual training plan).	Training on SUD, MOUD, processes, stigma, and withdrawal is specific component of ongoing corrections staff training plan that specifies trainer responsibilities and curriculum used.
Corrections Leadership	Limited leadership; jail staff implementing program with limited jail admin/sheriff support.	Clearly defined strong leadership support for MOUD program with no succession planning.	Clearly defined strong leadership support for MOUD program with succession planning. [*Strategy*: Include leadership of MOUD effort in position job description(s) and in individual performance reviews/evaluations.]
Health Care (HC) Leadership	Limited HC leadership; staff are engaged in the program, but no clear HC leader, sponsor, or champion.	Clearly defined HC leader, sponsor, and champion with no succession planning.	Clearly defined HC leader, sponsor, and champion with succession planning. [*Strategy*: Include leadership of MOUD effort in position job description(s) and in individual performance reviews/evaluation.]
Integrated Multidisciplinary Team (MDT)	HC and corrections confer on an *ad hoc* basis on issues related to MOUD; no policies and procedures that outline roles and responsibilities and integrated approach.	Have policies and procedures that outline the roles of custody and HC in addressing issues related to MOUD; no standing meeting for MDT.	Regular standing meeting for MDT to review specific cases and issues related to MOUD program as outlined in policies and procedures. [*Strategy*: Incorporate review of the jail's MOUD performance metrics.]
Documentation	MOUD program is running but not documented in policies, procedures, and standard operating procedures (SOPs).	MOUD program has some documentation in policies, procedures, and SOPs but not complete.	All elements of the MOUD program are documented in policies, procedures, and SOPs and are reviewed/updated regularly. [*Strategy*: Where feasible and meaningful to support efficient and effective processes toward MOUD program goals, incorporate relevant templates and prompts into jail management systems (JMS) and electronic health records (EHR).]

Download resource here

HMA DHCS

SUSTAINABILITY EVALUATION AND PLANNING

Key Domains for Evaluation

Funding
Training: health care and custody staff
Leadership: health care and custody
Integrated multidisciplinary team (MDT)
Data/Performance Measurement
Documentation
Board of Supervisors/County Board
Community Engagement
Management of Clinical Services
IT Infrastructure

The Evaluation Process

- Requires institutional change; managing up and down
- Buy-in and sign-off of leadership – transparent communication by leadership about the effort – current state and goal
- Actual execution of the evaluation process: Champion recommended
- Tactics
  - Are there existing meetings and/or teams where it makes sense for this to be included to inform key stakeholders? Report out status

HMA DHCS

SUSTAINABILITY EVALUATION AND PLANNING

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Action from the Evaluation Process

- Who should be involved?
  - Stakeholders of action items, e.g.
  - Training Unit – required trainings
  - HR – position descriptions, evaluations
  - Medical Director, DON/Nursing – Integrated MDT
  - Sheriff and/or Policy Director – scheduled updates to Board of Supervisors
- Phased Communication and Implementation
  - Report Outs

THINKING ABOUT SUSTAINABILITY: TAKEAWAYS

- Tool for evaluating your current level of sustainability available from HMA
- Integrate sustainability strategy and planning into your operations and leadership NOW - includes succession planning
- Once you complete the sustainability evaluation and make needed changes – repeat! (Not one and done)
- Having – and deploying - a plan helps avoid
  - Interruptions in care (care reduces overdose deaths and other incidents)
  - Stress for staff

UPCOMING LEARNING OPPORTUNITIES & WRAP UP

12:55 – 1:00 pm PDT
Presenters: Bren Manaugh

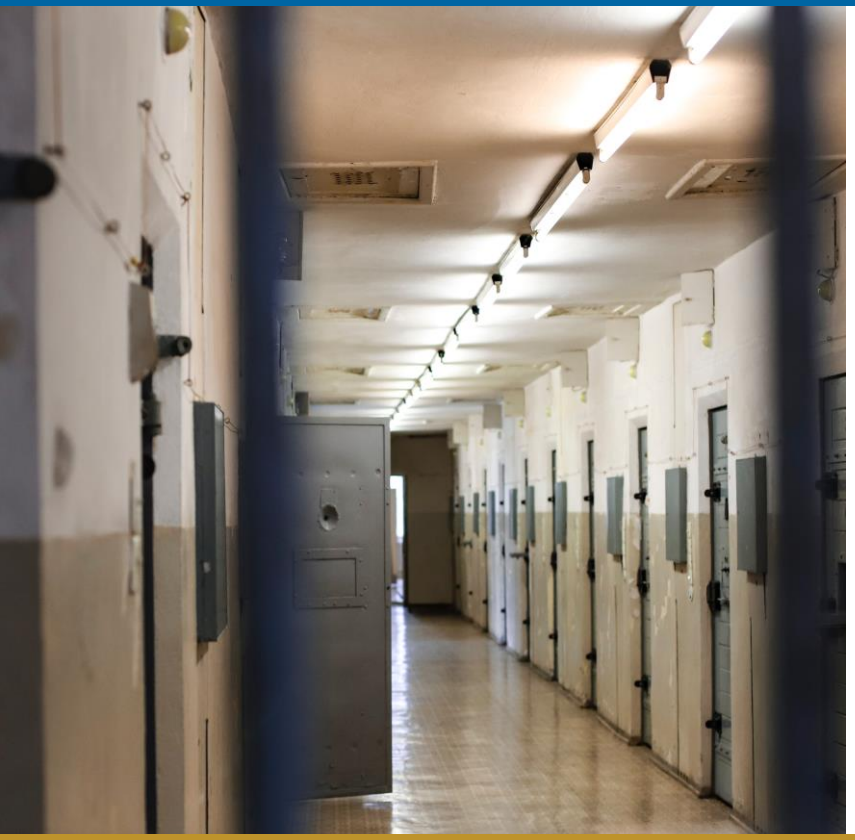
2-PART DISCUSSION GROUP | ENHANCING YOUR JAIL MAT PROGRAM THROUGH BEHAVIORAL INTERVENTIONS

- Wednesday May 29 & June 12 at 12:00 pm PDT
- HMA facilitators will provide a brief overview of behavioral interventions/therapies suitable for the jail setting and justice-involved population and discuss how to assess the “right” evidence-based intervention for patients in your facility.
- County team members will have an opportunity to discuss their own facilities’ efforts and plans and receive input from HMA SMEs and their county counterparts.

Register Here

HMA DHCS

COHORTED HOUSING DISCUSSION GROUP



- Cohorted Housing Discussion Group
  - Bi-monthly event on 4th Monday (moved in May due to MDW)
  - Next meeting: May 21 at 10:00 am PDT
  - Led by Rich VandenHeuvel and Paul Kunkel
- Counties participating: Solano, Sacramento, San Luis Obispo, Yolo, San Joaquin, San Mateo, Sutter and more

Please reach out to MATinCountyCJ@healthmanagement.com if you would like to be added to this event.

SAVE THE DATES – 2024 LEARNING COLLABORATIVES

- June Quarterly Learning Collaborative: Thursday, June 20th
- September Quarterly Learning Collaborative: Wednesday, September 25th

All events at 12:00 pm PDT

OFFICE HOURS

- Since 2021, HMA has offered two monthly office hours opportunities
- Please feel free to join whenever you have a question or just to listen in
- Email MATinCountyCJ@healthmanagement.com to be added to invites

1st Thursday of the month: All Team Members

- CalAIM SME added to these calls from HMA team for any questions

2nd Thursday of the month: Prescribers

- Anyone is welcome to join, but this will always be staffed by a prescriber.

HMA DHCS

POLLING QUESTIONS

1. Overall, today's session was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

MATinCountyCJ@healthmanagement.com