Implementing buprenorphine pharmacotherapy in a large urban jail system, Philadelphia Department of Prisons, 2018-2019

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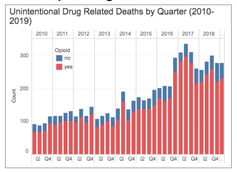
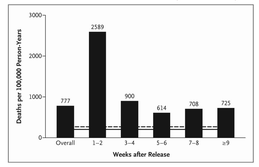
EDUCATION • POLICY • RESEARCH

BACKGROUND

- PHILADELPHIA ranked #3 in overdose mortality large U.S. cities
- Multiple studies show very high risk of overdose mortality immediately post-incarceration.
- **Philadelphia: high overdose mortality** **Elevated risk at Community Re-entry**



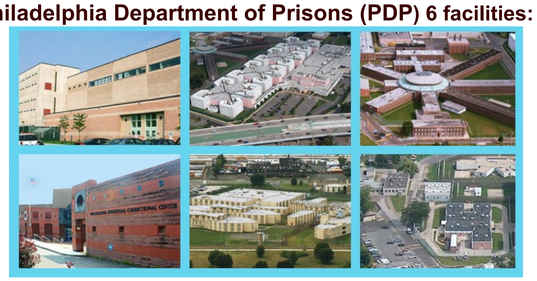
PA DOH, DBHIDS opioid dashboard2019



Binswinger et al, 2007

- Less than 1% of jails offer opioid agonist medications for OUD, although pharmacotherapy is standard of care and reduces overdose mortality as much as 50%.
- Medicaid = primary insurer for justice-involved adults in Philadelphia (2018: more than 50% entering are on MA.) Active coverage is needed for timely community treatment at re-entry; coverage is suspended when incarcerated.

Philadelphia Department of Prisons (PDP) 6 facilities:



- Alternative and Special Detention (ASD)
- Curran-Fromhold Correctional Facility (CFCF)
- Detention Center (DC)
- House of Corrections (HOC)
- Philadelphia Industrial Correctional Center (PICC)
- Riverside Correctional Facility (RCF)

- 6th largest jail system in U.S.
- Process ~25,000 inmates/year
- ~8.000/year require withdrawal management
- Daily census ~5,000, > 90% male
- Length of Stay
  - av. ~100 days (60 for women, 110 for men)
  - ~40%, in custody less than 14 days
  - ~55%, in custody less than 30 days

2017 Mayor's Opioid Task Force recommended increased access in jails to MOUD - groundwork for new program.

Corizon Health- contracted physical health provider
- Addiction Specialist Dr Jon Lepley created program & training
- Education required system-wide
  - Taught waiver training on-site: 9 staff primary care physicians
  - Need to address high level of skepticism- nurses, correctional officers (diversion, safety, etc.)
  - Outreach to community treatment providers = referral network

PDP Is *not* licensed as an OTP (Opioid Treatment Program). Has contract with community OTP: Northeast Treatment Center- provides methadone (& some buprenorphine) maintenance + group therapy to individuals already on MOUD at entry.

METHODS

Case study. Interviews, and internal data from program.

BUPRENORPHINE IMPLEMENTATION

LAUNCHED: Feb. 2018 pilot program for women (1 facility)
EXPANDED: Sept. 2018 to other 5 PDP facilities, all men

- ✓ Nurse screens all newly incarcerated (within 4 hours of intake) for opioid use disorder (OUD)
- ✓ Opioid withdrawal assessment, inc. urine drug screen
- ✓ Discusses buprenorphine initiation with those who meet criteria & flags chart
- ✓ Nurse can request 4 mg dose if needed for withdrawal symptoms w/verbal order
- ✓ Physician face to face appt- patient assessment within 24 hrs. Patient signs informed consent. RX ordered

Buprenorphine daily observed dosing
Day 1 = 4 mg/ day Day 2+ = 8 mg/ day

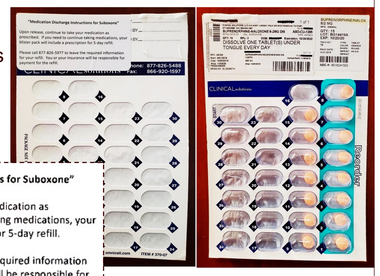
Daily Protocols for dedicated "med-line"
Nurse dispense from med cart. Patient moves to chair, waits while tablet dissolves. Patient has water to moisten mouth, drink after. Correctional officer does mouth check to confirm tablet has dissolved.

At program launch:
- Stock bottle supply + CRUSHED buprenorphine generic monotherapy tablet – in med cup

Patient Re-entry: given "bridge" RX for 5 days
+ Naloxone kit +Overdose prevention training

Formulation change (3/19):
buprenorphine/naloxone tablet, individualized blister pack w/15 doses

Re-entry: patient takes remaining doses in packs w/ "bridge" refill RX attached



Naloxone training & distribution
A video "PSA" on overdose recognition & naloxone use – played at intake/ housing units daily
Distribution of naloxone to individuals at highest risk of an overdose at time of release.

- PDP staff meet with all program participants to help them select a community outpatient treatment provider. Post-release appointment date scheduled for sentenced patients; referral to outpatient clinic for pre-sentenced.
- Option for adjunctive psychosocial treatment groups- participation not required.

OBJECTIVES

Describe the implementation of buprenorphine pharmacotherapy in the Philadelphia Department of Prisons.

Identify system and structural challenges, and policy recommendations.

RESULTS

- Medicaid re-enrollment in jail successful- MA-eligible leave w/ coverage effective no later than date of release.
- Normalized for jail staff: OUD = chronic disease that warrants treatment; Treatment is in primary care scope.
- Harm reduction approach: if participants return to opioid use, their tolerance has been sustained +buprenorphine remains in their system for days. Risk of overdose theoretically is lower.
- **Engagement in care:** during pilot approx. 40% women were filling bridge RXs.
- In 2018 ~31% of patients started on buprenorphine in PDP and discharged in 2018 received community services (from DBHIDS within 30 days)
- ~80% of eligible men participate
- 80% of participants are pre-sentence
- 50% of participants - discharged < 14 days

PILOT PROGRAM at women's jail
Feb. 5th- July 24th, 2018, women at RCF

- **25% appeared to have untreated OUD** (1,9995 women entering 2/5/18 to 7/24/18, 507 scheduled/ 454 evaluated/ 297 treated who went out of custody/ 66 declined, or not assessed suitable, or stopped after starting, or administratively withdrawn)
- **20% engaged in buprenorphine maintenance** (all women entering who received buprenorphine maintenance- entire length of incarceration.)
- **2.5% "diversion rate"**10 out of 388 caught attempting to "cheek" or divert or misuse medication (and were administratively withdrawn due to misuse.)

Structural challenges

1. **Pharmacy-** ability to fill bridge script

   Obstacles to authorization for refill RX: type of **buprenorphine formulation** (generic/brand tablet vs film) approved without a prior auth varies among (multiple) PA Medicaid plans. Also some jail prescribers lacked **Medicaid provider numbers**.

2. **Insurance/cost**

3. **PA Medicaid software system**

   a) Complexity/ uncertain MA re-activation times

   b) Unintended consequences: example- children's coverage terminated accidentally when incarcerated parent's coverage was suspended in system

4. **Community treatment & justice system communication:** lacking case management or warm handoff" capacity- referrals not always seamless. Individual's release date/ time can't be predicted reliably. Challenges with patient history/records sharing w/treatment provider.

RESULTS

Structural Challenges

5. **Data collection outcomes analysis:** requires multiple cross-system partners /complex data sharing agreements needed.

Regulatory barriers

- HHS, SAMHSA, CSAT--**DATA Waiver requirements**

  Patient limits- newly certified physician, NP or PA only can have 30 patients at a time.
  - ➢ An "emergency" request for a patient limit increase from 30 to 100 was needed after the physician w/275 patient limit left the system.

- DEA: insufficient guidance on reg's re: patient panels /capacity
- Opioid Treatment Program (OTP) requirements

CONCLUSIONS

Corrections System Policy Innovation:

Demonstrates a harm reduction approach to treatment, allowing incarcerated, pre-sentenced individuals to maintain opioid tolerance and reduce their overdose risk on re-entry.

Next steps:
Outcomes data analysis by city department of behavioral health, re: participant engagement in treatment, re-admission to jail, and fatal overdose rates.

Summary:
This first year jail buprenorphine program demonstrates successful engagement of eligible individuals, and ability to integrate OUD pharmacotherapy into large urban jail medical protocols, however regulatory barriers can be barriers to program capacity.

Policy implications: changes to federal opioid treatment regulations could reduce structural barriers.

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