Friends Research Institute
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An Implementation Process Evaluation for the *Planning Initiative to Build Bridges between Jail and Community Treatment for Opioid Use Disorder*

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All of the Bridges Team members throughout the 16 participating sites

Outline

Executive Summary

Background

The Building Bridges planning initiative focused on preparing sites to establish effective linkages between jails and community-based treatment settings in order to deliver medications for opioid use disorder (MOUD) to justice-involved people. This 9-month planning initiative was jointly funded and led by the Bureau of Justice Assistance (BJA) and Arnold Ventures. Building Bridges was designed to assist local communities by: increasing stakeholder understanding of promising practices in the use of MOUD in jails and community-based settings; developing effective partnerships between jails and community-based treatment providers; building a comprehensive plan for initiating or expanding an MOUD continuum of care model from jail to the community; and planning for continuity and coordination of MOUD during transitions into jails and reentry into communities.

A total of 16 sites across the United States were selected for participation in the Bridges planning initiative. Each site was required to include the commitment of a multidisciplinary team comprised of local stakeholders, including jail, community corrections, and community treatment leadership. Each team developed and worked towards a plan to implement at least two forms of MOUD in their jail-based setting, with continuity of medication administration in the community.

Evaluation Goals and Objectives

Friends Research Institute was funded by NIDA to conduct an evaluation of the planning initiative with the following aims:

AIM 1: Assess potential changes in stakeholder understanding of promising practices in the use of MOUD in jails and community-based settings among planning initiative team members.

AIM 2: Document the planning teams' development and refinement of comprehensive plans for initiating or expanding an MOUD continuum of care from jail to community.

AIM 3: Evaluate progress towards partnership development and MOUD coordination planning over the course of participation in the planning initiative.

Data Collection

This evaluation included qualitative and quantitative data from all participating sites, including pre-post surveys of planning team members, pre-post readiness checklists for each site, as well as qualitative interviews with team members, site visits, and notes/documentation for all in-person, web-based, and telephonic project coaching activities. Each site's action plan and tracking report were analyzed monthly to document change.

Executive Summary

Planning Initiative Outcomes

AIM 1: Assess potential changes in stakeholder understanding of promising practices in the use of MOUD in jails and community-based settings among planning initiative team members.

While team member knowledge and perceived helpfulness of MOUDs were high at baseline with limited change at the conclusion of the project, familiarity with these medications, particularly some of the newer formulations, such as depot buprenorphine, modestly improved at follow-up. Attitudes towards the adoption of evidence-based practices and endorsement regarding the benefits of providing MOUDs for justice-involved populations remained high throughout the project. Team members with clinical/treatment backgrounds tended to report being slightly more knowledgeable about most MOUDs than team members with criminal justice backgrounds, with both groups' scores similarly increasing by the end of the project. Despite the overall high levels of support for MOUDs among team members, broader organizational culture and staff preferences were not always perceived as being in alignment with these views.

Information regarding MOUDs was often delivered to the teams by their planning initiative coaches, with that information then being disseminated more broadly within their organizations. Resources specific to methadone regulations, MOUD cost issues, and template documentation were frequently requested. Increased understanding of evidence-based MOUD practices and high levels of readiness among team members culminated in considerable changes being made over the course of the planning initiative, both in the planning for and delivery of MOUDs in jails.

AIM 2: Document the planning teams' development and refinement of comprehensive plans for initiating or expanding an MOUD continuum of care from jail to community.

The strategic plans that each team developed for the implementation or expansion of MOUD treatment at the beginning of the planning initiative changed over the course of their participation, often becoming more detailed as the items were broken down into more finite goals. In some cases, teams found that the elements of their initial plans were not feasible and that alternative goals needed to be set.

Despite highly favorable ratings at baseline, at follow-up team members reported being in even more agreement that the implementation plan for the project: identified specific roles and responsibilities, clearly described tasks and timelines, included appropriate staff education, and acknowledged staff input. Among the most notable gains in necessary resources for effective MOUD treatment implementation were having a clearly defined treatment protocol and having buy-in from case management staff, but smaller improvements were also noted in medical space, funding for staff/medications, inmate educational materials, buy-in from medical and custody staff, and having an engaged implementation team. The critical role of correctional health care vendors in the development and eventual implementation of the strategic plans was noted by all teams.

AIM 3: Evaluate progress towards partnership development and MOUD coordination planning over the course of participation in the planning initiative.

The benefits of networking opportunities across teams, either during the project's two in-person meetings or via arranged site-visits, were highlighted by participants. Teams had a wide range of experience working together prior to the project, with some teams coming together for the first time to achieve this shared goal. Common facilitating factors to team partnerships and progress included regular communication and frequent (e.g., bi-weekly) meetings, as well as accountability to state and local leadership who supported their work. MOUD coordination planning discussions typically involved the necessity of tracking people and linking data across systems, which was limited in all but a few sites. Coaches often provided a universal release of information to their teams to help facilitate this process.

Executive Summary

continued

Conclusions and Implications for Practice

Flexible, Scalable Technical Assistance

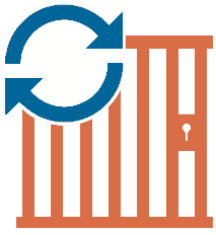
The provision of technical assistance, such as coaching, is an essential part of implementation efforts. If possible, technical assistance should include clinical and/or regulatory experts, as well as "peer-to-peer" networking opportunities to provide support and models of care delivery. Technical assistance could be provided by an agency (such as SAMHSA) or another professional organization through a "training institute" that could provide training in corrections-based MOUD treatment, help draft policy and procedural templates, and provide contact lists so that jurisdictions can learn from one another.

Health Care Funding for MOUD delivery in Jails and the Community

There may be lags in re-initiating health care coverage for patients upon release from jail. In such cases, jails can provide assistance to begin the insurance reapplication process prior to release or develop bridge programs or mobile clinics to ensure there is no lapse in patient care. Providing a better estimate of the overall treatment costs for launching and maintaining MOUD programs in jail with bridge programs in the community could be highly beneficial to jurisdictions considering starting these programs.

Linking Patient Data

The ability to track people across systems and ensure the continuity of care from jail to community is a critical and challenging implementation goal. Jurisdictions may require technical assistance to better understand how data they are currently collecting can be used to track the need and reach of MOUD services in their facilities, as well as explore ways to link that data with external health systems to assess treatment linkage success. Ultimately data will be used to track the broader public health impact of jail-based MOUD programs to help reduce overdoses and death for people leaving jail.



Short Stay Populations

With bail reform considerations adopted in many states, and being considered in many more, the percentage of people released within 72 hours of arrest is expected to grow. It can be challenging to complete a full medical assessment on this population, let alone complete induction on an MOUD, which indicates the need to coordinate rapid screening and referral capacity in the jails, as well as the need to build/enhance community capacity to promptly accept patients for treatment following arrest.

MOUD Standards of Care in Correctional Health

There is a need to strengthen standards of care for MOUD delivery and more broadly disseminate best practices in correctional health. The field is rapidly evolving due to increased need and attention, and more remains to be done in terms of providing guidance and enhancing standards for the field, especially concerning the contracting with health care vendors to deliver MOUD services.

Background

The continued, steady increase in opioid overdose deaths in the Unites States has highlighted the need to adopt a comprehensive public health approach in order to mitigate the current opioid crisis, and prevent future crises. In order to successfully address this issue, a multi-disciplinary, translational approach is necessary (Blanco, Wiley, Lloyd, Lopez, & Volkow, 2020). Two key themes in this translational approach are: (1) bridging the gap between implementation science and practice, which calls for shortening the lag between generating evidence-based interventions and their widespread adoption; and (2) Identifying the barriers to implementation. Successfully leveraging these areas requires using data to build cross-system collaborations and systems of care, in this case, collaborations between US jails and community-based treatment options. Here we describe the "Planning initiative to build bridges between jail and community-based treatment for opioid use disorder" project which sought to use implementation science to affect current treatment in jails by using medications for opioid use disorder (an evidence-based practice; EBP) to treat incarcerated people with opioid use disorder (OUD), while also connecting across systems, namely criminal justice and community-based organizations.

Jail has become a revolving door for many involved in the criminal justice system in the US, especially for those who have OUD. Historically, jails, and the criminal justice system at large, have not been a primary provider of substance use treatment, although many people who are incarcerated are imprisoned because of their drug use (Marlowe, 2002, 2009). But with the prevailing opioid epidemic in the United States, jails and institutions of incarceration are an integral place for OUD interventions (Stöver & Michels, 2010).

EBPs are important to the identification and treatment of OUD and opioid misuse. Best practices include effective client enrollment in a jail-based medication for opioid use disorder (MOUD) program; medication, dosage, and length of treatment determinations for MOUD clients; MOUD for pregnant women; other behavioral health support services in conjunction with MOUDs; client screening to address treatment continuation, withdrawal, and relapse; and engaging post-release assistance.

Planning Initiative Background

This project was part of the Bureau of Justice Assistance's (BJA) Interagency Response to the Opioid Crisis (IROC) portfolio under the Comprehensive Opioid Abuse Program, which supports innovative demonstration projects that strategically blend public health and public safety funding from multiple federal agencies and promote public-philanthropic partnerships. As such, the effort was jointly supported and led by Arnold Ventures as part of their Public Health and Criminal Justice portfolio, which support projects that aim to reduce overdose deaths as well as the social, economic, and criminal justice-related costs of the opioid epidemic.

The Building Bridges planning initiative focused on preparing for the effective linkage of jails and community-based treatment settings in order to deliver MOUD treatment continuity. Building Bridges was designed to assist local communities by:

- Increasing stakeholder understanding of promising practices in the use of MOUD in jails and community-based settings
- Developing effective partnerships between jails and community-based treatment providers
- Building a comprehensive plan for initiating or expanding an MOUD continuum of care model from jail to the community
- Planning for continuity and coordination of MOUD during transitions into jails and reentry into communities.

The ultimate goals of the planning initiative project were to enhance systems of care that could lead to:

- Reduced overdose deaths
- Reduced recidivism (re-arrest and re-incarceration)
- Increased engagement in evidence-based OUD treatment, including MOUD, by developing a continuum of care for individuals in jail through post-release treatment in the community.

MOUD IN JAILS

Currently MOUD is not a common or established practice among jails in the US, however implementation avenues are rapidly changing at the local level thanks to key community stakeholders including Sheriff's departments, jail commissioners, and local treatment programs (Klein, 2018). MOUDs, including the three Food and Drug Administration (FDA) approved medications, methadone, buprenorphine, and naltrexone, are considered central components of current standards of care for treating individuals with OUD. These medications can also be used for those with co-occurring mental illness, with physician approval. However, as of January 2018, only around 5 state departments of corrections (DOCs) offered MOUD in their drug treatment programs for incarcerated people, beyond methadone maintenance for incarcerated pregnant women (Beckman, Bliska, & Schaeffer, 2018). Out of the several thousand local and county jails that operate in the US, fewer than 200 in 30 states reported providing MOUD in 2019 (Klein, 2018). This is often limited to extended-release naltrexone delivery prior to release into the community. Jails that provide MOUDs for pregnant women (i.e., methadone) typically cease this provision immediately postpartum.

RFA DESCRIPTION

Because American correctional facilities are at the epicenter of the opioid overdose crisis, and given the increased rates of overdose following release, they were the direct target of the planning initiative. Each site was required to include the commitment of a multidisciplinary team comprised of local, diverse stakeholders drawn from health services in the local jail(s), jail custody leadership/staff, local administrators responsible for public safety, probation or parole, and the local behavioral health department who oversees substance use treatment. The funders selected sites that represented a variety of population sizes (measured by jail capacity) and geographic locations. They were also chosen based on their disproportionate impact of the opioid epidemic, coordinating capacity, and stakeholder investment. Sites were also required to work towards a plan to implement at least two forms of MOUD in both a jail-based and community-based setting, one of which must be an agonist or partial-agonist.

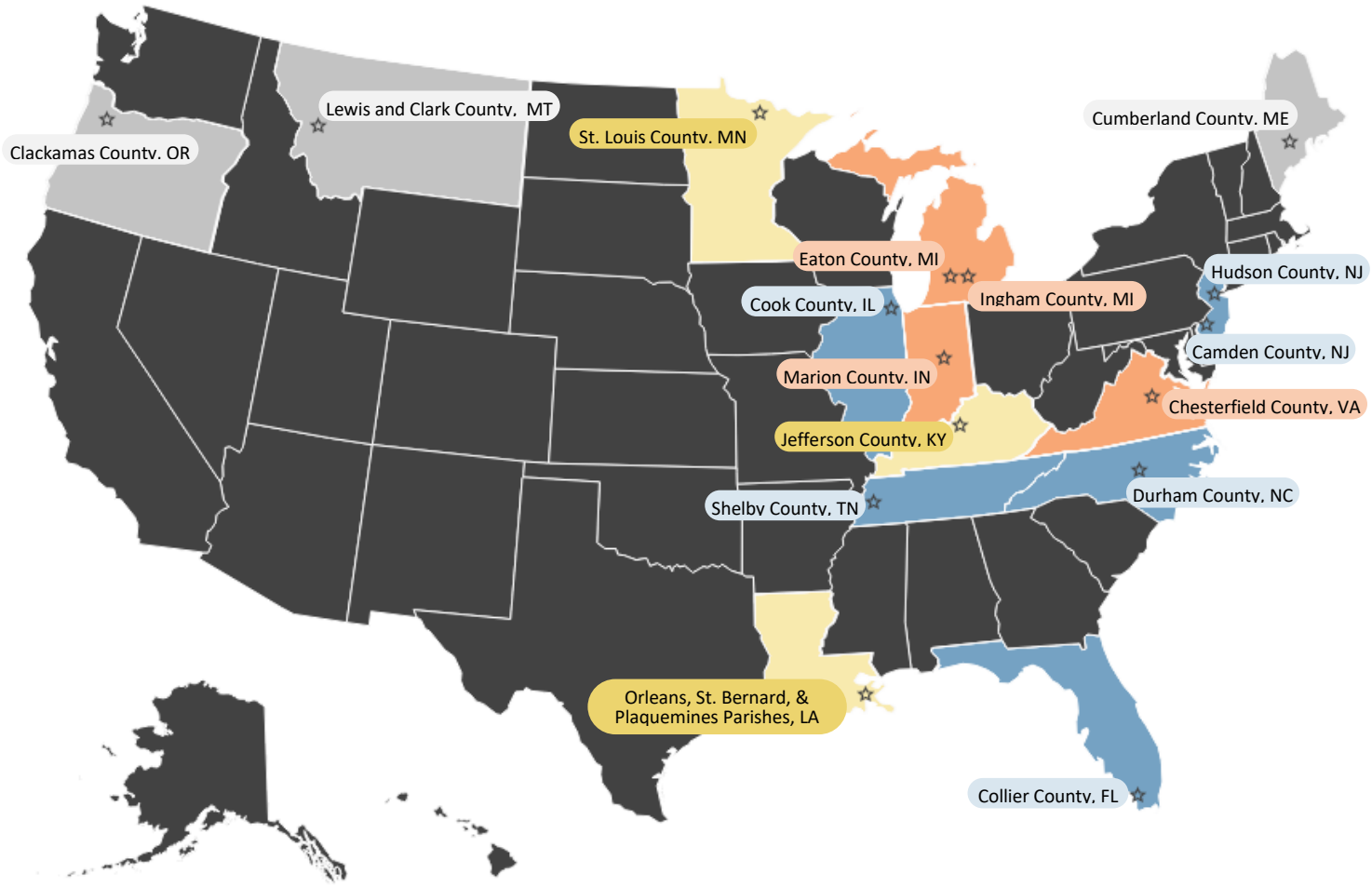
Teams and Team Members

In order to participate as a site, the Building RFA required a multi-organizational team composition, with some members required and others optional. Required team members included representatives from health services in the local jail(s), jail custody, local administrators responsible for public safety, probation or parole, and the local behavioral health department who oversees substance use treatment. Optional team members included medical coordinators, prosecutors, defense attorneys, drug court representatives, other court representatives, local MOUD providers, criminal justice coordinators, representative of the local opioid task force, etc.

Sites and Descriptions

Sixteen sites were chosen from across the United States to participate in the Bridges planning initiative. These counties varied based on general population demographics and level of preparedness to implement MOUD in their jail(s).

Participating Jurisdictions by Coach



	Lynn Dierker
	Bren Manaugh
	Margarita Pereyda
	Rich Vandenheuvel

Site Characteristics

MOUDs offered prior to participating in the planning initiative[1]

Camden County (NJ) — Population 513,657

Jail-Based: Extended-release naltrexone (XR-NTX) and buprenorphine, methadone for individuals admitted to jail while on an active treatment program in community

Community-Based Capacity: Local health center provides MOUD with XR-NTX and buprenorphine; three other community substance use treatment agencies that provide MOUDs

Chesterfield County (VA) — Population 343,599

Jail-Based: XR-NTX

Community-Based Capacity: Community Services Board offers XR-NTX, methadone, and buprenorphine via referral upon release from custody

Clackamas County (OR) — Population 412,672

Jail-Based: MOUD only available to pregnant women and medication is dispensed off-site

Community-Based Capacity: Several specialty addiction providers offer buprenorphine, XR-NTX, and methadone; two behaviorists at Clackamas County Health Centers also prescribe MOUDs

Collier County (FL) — Population 376,086

Jail-Based: XR-NTX is available to incarcerated inmates involved in drug court

Community-Based Capacity: Community behavioral health center offers buprenorphine and XR-NTX for uninsured and insured clients in the community; nonprofit addiction treatment provider offers buprenorphine and XR-NTX for insured clients; local for-profit agency provides methadone services; the community's nonprofit hospital system offers outpatient buprenorphine

Cook County (IL) — Population 5,200,000

Jail-Based: Methadone, buprenorphine, and naltrexone to inmates who are screened and deemed clinically appropriate via a pilot program; linked to behavioral health services and continued MOUD upon release

Community-Based Capacity: 12 primary care clinics (with two additional clinics launching in 2019) provide methadone, buprenorphine, and naltrexone

Cumberland County (ME) — Population 292,041

Jail-Based: MOUDs only available to pregnant women, buprenorphine and occasionally naltrexone

Community-Based Capacity: 3 opioid treatment programs offer methadone and buprenorphine; multiple other providers of buprenorphine and naltrexone

Durham County (NC) — Population 311,640

Jail-Based: None at time of application

Community-Based Capacity: MOUD offered at two locations in the community

Eaton County (MI) — Population 109,027

Jail-Based: Behavioral health therapy with elective MOUD, including buprenorphine, methadone, and naltrexone

Community-Based Capacity: Nearly all the same treatment providers and services transition with individuals from jail to the community

Hudson County (NJ) — Population 679,756

Jail-Based: Minimal MOUD to reduce risk of opioid use post-release; received funding from the State in 2017 to maximize MOUD service capabilities by implementing detox (via buprenorphine) and extended-release treatment for opioid-addicted inmates

Community-Based Capacity: 7 out of 10 community substance use treatment agencies provide MOUD services to reentrants, collectively providing methadone, buprenorphine, and XR-NTX

Ingham County (MI) — Population 290,186

Jail-Based: Methadone only if enrolled in a methadone program in the community

Community-Based Capacity: 3 MOUD clinics (one provides methadone, buprenorphine, and XR-NTX, while the other two provide only methadone); a few private practice physicians provide self-pay buprenorphine

Jefferson County (KY) — Population 760,000

Jail-Based: On-site methadone treatment for pregnant women

Community-Based Capacity: Probationers work with a social service clinician to be placed into treatment program; XR-NTX and oral naltrexone, buprenorphine, and methadone available in the community

Lewis & Clark County (MT) — Population 67,773

Jail-Based: None at the time of application

Community-Based Capacity: 2 FQHCs provide MOUDs with counseling and support groups

Marion County (IN) — Population 950,082

Jail-Based: Two primary MOUD programs partnered with jail to provide methadone for pregnant women, but no continuity of care set up post-release; XR-NTX for probation violators who are admitted to jail detox unit

Community-Based Capacity: The two MOUD programs partnered with the jail provide community care, but have limited capacity

Orleans, St. Bernard, Plaquemines Parishes (LA) — Population 400,000

Jail-Based: None at the time of application

Community-Based Capacity: Buprenorphine available at 2 pharmacies without prescription; XR-NTX at Metropolitan Human Services; buprenorphine, XR-NTX at a non-profit comprehensive treatment center; XR-NTX at 2 long-term gender-specific treatment facilities; buprenorphine and XR-NTX through individual certified physicians

Shelby County (TN) — Population 936,961

Jail-Based: Methadone maintenance treatment for pregnant women

Community-Based Capacity: Several for-profit MOUD services that offer XR-NTX; limited number of community-based MOUD services available to medically fragile, uninsured/under-insured, and low-income populations

St. Louis County (MN) — Population 200,000

Jail-Based: Buprenorphine offered to pregnant women and those already in an MOUD program at the time of booking; After 14 days individuals are weaned off the medication (due to security concerns)

Community-Based Capacity: XR-NTX and oral naltrexone, buprenorphine, and methadone available through various providers; Center for Alcohol and Drug Treatment (CADT) provides office-based buprenorphine

[1] As reported at the time of application submission

HMA Coaching

Health Management Associates (HMA), under the direction of Ms. Donna Strugar-Fritsch, BSN, MPA, CCHP, developed and oversaw the planning initiative coaching activities. Ms. Strugar-Fritsch is a nationally recognized expert in correctional healthcare and was directing a project focused on delivering MOUDs in jails and collaborative courts across 32 counties in California prior to her work on Bridges. It was this effort in California that influenced her approach to coaching content for Bridges.

COACHES AND SITE ASSIGNMENTS

The 4 HMA coaches possessed varied behavioral health and medical backgrounds with some prior experience working within corrections. Each coach was assigned at least 3 sites to consistently work with over the course of the planning initiative (Appendix A), delivering both general content and guidance across sites, as well as specific support relative to their sites' strategic plans and resources.

Steering Committee

A steering committee was assembled to provide guidance and feedback regarding: baseline and follow-up questionnaire content; interview guide development; and identification of emergent themes related to system modifications necessary for MOUD continuum of care implementation. The committee was called upon 4 times over the course of the year, with some meetings occurring via conference call and other times providing written feedback, document review, and guidance. The steering committee was comprised of five national experts in implementation science, criminal justice administration, jail-based pharmacotherapy, and survey research. The members included: Dr. Danica Kalling Knight, Texas Christian University; Dr. Hannah Knudsen, University of Kentucky; Dr. Mark McGovern, Stanford University School of Medicine; Dr. Josiah Rich, Brown University; and Sheriff Peter Koutoujian, Middlesex County, Massachusetts.

PARIHS Implementation Framework

The Promoting Action on Research Implementation in Health Services (PARIHS) framework is highly relevant for public health practitioners who are devising a knowledge translation strategy to implement research into practice (Kitson, Harvey, & McCormack, 1998). This framework is helpful in examining the interactions among three key elements for knowledge translation: evidence, context, and facilitation. Successful implementation is considered to be a function of these key elements, and each of these elements have sub-factors which can be rated from low to high, in order to evaluate implementation processes.

The main features of the PARIHS framework are:

- Evidence encompasses codified and non-codified sources of knowledge, including research evidence, practitioner experience, community preferences and experiences, and local information.
- Melding and implementing such evidence in practice involves negotiating and developing a shared understanding about the benefits, disadvantages, risks and losses of the new practice over the old.
- Some contexts are more conducive to the successful implementation of evidence into practice than others, such as organizations that have transformational leaders, elements of learning organizations and evaluation mechanisms.
- The framework emphasizes the need for appropriate facilitation to improve the likelihood of success. The needs of the organization determine the type of facilitation and the role and skill of the facilitator. Facilitators work with individuals and teams to enhance the implementation process.

Background

continued

Evaluation Study Aims

The following evaluation was funded by NIDA through a JCOIN accelerator supplement (PI Gordon; grant # R01DA043476-01A1). It was reviewed by the Western Institutional Review Board and determined to be exempt due to its quality improvement focus.

Our evaluation aims were as follows:

AIM 1: Assess potential changes in stakeholder understanding of promising practices in the use of MOUD in jails and community-based settings among planning initiative team members.

AIM 2: Document the planning teams' development and refinement of comprehensive plans for initiating or expanding an MOUD continuum of care from jail to community.

AIM 3: Evaluate progress towards partnership development and MOUD coordination planning over the course of participation in the planning initiative.

Data Collection

The following data were collected throughout the Bridges planning initiative and used for the evaluation.

Action Plans

Action plans were developed and refined by each site throughout the planning initiative. Each site formed plans to bolster their current MOUD capacity by setting implementation objectives, laying out the steps necessary to achieve these goals, identifying the agencies responsible for these steps, denoting who would be leading the particular initiative, noting other agencies or steps affected by the specific goal, and updating status on each updated action plan. Refinement and updates to action plans were central components of the teams' monthly coaching calls.

Tracking Reports

Tracking reports, developed jointly by HMA, BJA, and Arnold Ventures project leadership, were organized to succinctly layout where each site was in reaching 8 specific milestones: 1) universal evidence-based screening tool for SUD; 2) evidence-based detoxification protocol for alcohol and opioids; 3) evidence-based protocol for pregnant women with SUD; 4) ability to maintain all forms of MOUD; 5) ability to initiate at least two forms of MOUD; 6) ability to provide behavioral components of treatment; 7) pre-release planning process; and 8) access to MOUD in community within 48 hours (or sooner)/ relationship with community providers. Each site would code their progress on each goal (using the colors red, yellow, or green) as well as provide more detailed notes to document exact progress on the goal and any issues or barriers that arose in their process towards implementation of that goal.

Coaching Call Notes

An evaluation team member monitored monthly coaching calls. Notes were organized into a spreadsheet and compared with each team's strategic plan.

Team Member Survey

All active team members individually completed a baseline survey prior to the initial in-person meeting in August 2019 and a follow-up survey at the end of the planning initiative in March-April 2020. These on-line surveys included: basic demographic information; questions concerning MOUD knowledge, perceptions and attitudes (largely derived from the CJ-DATS Opinions and Attitudes about Medication Assisted Treatment scale (Friedmann et al., 2013); and a modified version of the Evidence-based Practice Attitude Scale tailored for MOUDs (Rye, Torres, Friborg, Skre, & Aarons, 2017). The Team Member Survey can be found in Appendix B.

Readiness Assessment

An implementation readiness assessment was developed based on the ORCA (Organizational Readiness to Change Assessment) Checklist, which utilizes the PARIHS implementation framework (Helfrich, Li, Sharp, & Sales, 2009). Questions are organized within the domains of MOUD evidence, context, and facilitation. These readiness assessments were completed by team members in-person jointly at the August kick-off meeting but via email submission at follow-up in March-April 2020 at the conclusion of the planning initiative. The Readiness Assessment can be found in Appendix C.

Implementation Checklist

An implementation checklist for providing medications for opioid use disorder in jails was developed for the project based on prior published literature as well as research and clinical experiences. The checklist was developed to assess the jail's: current level of OUD screening; medications provided (and to which populations); the provision of medical guidelines for dose induction, MOUD treatment, and medication tapering for

people being transferred to other facilities; procedures to prevent diversion; the tracking of patient outcomes in the community; and broader milieu factors. The 2-page checklist has 11 sections and was completed in-person by the teams during the August 2019 kick-off meeting and via email submission at follow-up in March-April 2020 at the conclusion of the planning initiative. The implementation checklist can be found in Appendix D.

Site visits

Site visits were completed by evaluation team members in February 2020. Five of the 16 sites were selected for in-person visits based on size, treatment capacity at project entry, and type of community (rural, suburban, urban). See Appendix E for all site visit materials. Teams of at least 2 members conducted each of the visits, which were coordinated through the team lead. In addition to a walk-through of the jail and its associated treatment partner clinic/facility, each day-long site visit included the following data collection activities.

FOCUS GROUPS

Focus groups included all active Bridges team members and, when possible, coincided with a scheduled team meeting. Focus group discussions sought input from a range of team members in terms of barriers and challenges encountered during the planning initiative and built off of the teams' tracking reports as a way to ground the discussion of their progress.

QUALITATIVE INTERVIEWS

The individual qualitative interviews were held in order to gather more in-depth feedback from different team members' perspectives. Themes explored included implementation challenges/barriers, future plans, healthcare vendor and jail relationships, progress/accomplishments, setting/environment contextual information, team dynamics, and views on the coaching technical assistance.

Qualitative Phone Interviews

Individual phone interviews were conducted with up to 3 team members (the jail site lead, the jail healthcare vendor, and a community treatment member) for each of the 11 sites that did not receive a site visit. Phone interviews were recorded and conducted by either Dr. Monico or Dr. Mitchell. They sought to collect similar information as was gathered in the site visits and, as was the case with the focus groups, built off of the teams' tracking reports as a way to ground the discussion of their progress. Themes explored included implementation challenges/barriers, future plans, healthcare vendor and jail relationships, progress/accomplishments, setting/environment contextual information, team dynamics, and views on the coaching technical assistance. Detailed notes were taken from all interviews and organized into a spreadsheet by theme. The phone interview guide can be viewed in Appendix F.

Coach Focus Group

A focus group was held with all 4 HMA coaches at the end of the planning initiative in March 2020 in order to discuss the successes and challenges of the facilitation process from their perspective. The session, led by Drs. Mitchell and Monico, was recorded and detailed notes were taken. The coach interview guide can be viewed in Appendix G.

Convening Notes

There were 2 in-person meetings that occurred in Alexandria, Virginia as part of the Bridges Planning initiative: the kick-off meeting August 13-14, 2019, and a follow-up meeting January 22-23, 2020. Full core team attendance was mandatory at each of the meetings. Notes were taken at all of the main and break-out sessions.

Planning Initiative Outcomes

AIM 1

Assess potential changes in stakeholder understanding of promising practices in the use of MOUD in jails and community-based settings among planning initiative team members.

TEAM SURVEY RESULTS

All active Bridges team members across the 16 participating teams were asked to complete the survey at baseline in August 2019 and at follow-up in March 2020. The baseline survey was completed by 87 of the 141 listed members who were emailed the survey link, for a response rate of 62%. The follow-up survey was completed by 94 of the 116 active team members at the time, for a response rate of 81%. A summary of demographic characteristics of respondents at both baseline and follow-up are presented in Appendix H. Summary results of individual survey items are presented in Appendix I. Means and standard deviations are given for each item at baseline and follow-up for the full sample and for sub-samples divided by respondent role type.

Neither Age nor Gender predicted any differences in baseline attitudes towards or knowledge of MOUDs. Likewise, these demographic characteristics were not associated with differences in receptivity to evidence-based practices (EBPs). Knowledge and perceived helpfulness of MOUDs tended to increase over time, however there were some exceptions. When controlling for other factors, the perceived helpfulness of buprenorphine, depot buprenorphine, oral naltrexone, and depot naltrexone did not improve. However, it is notable that familiarity with these MOUDs did significantly improve over time. Below are graphs depicting pre-post question comparisons for the two depot medications. (MAT Implementation Survey Items Table in Appendix I.)

Figure 1.

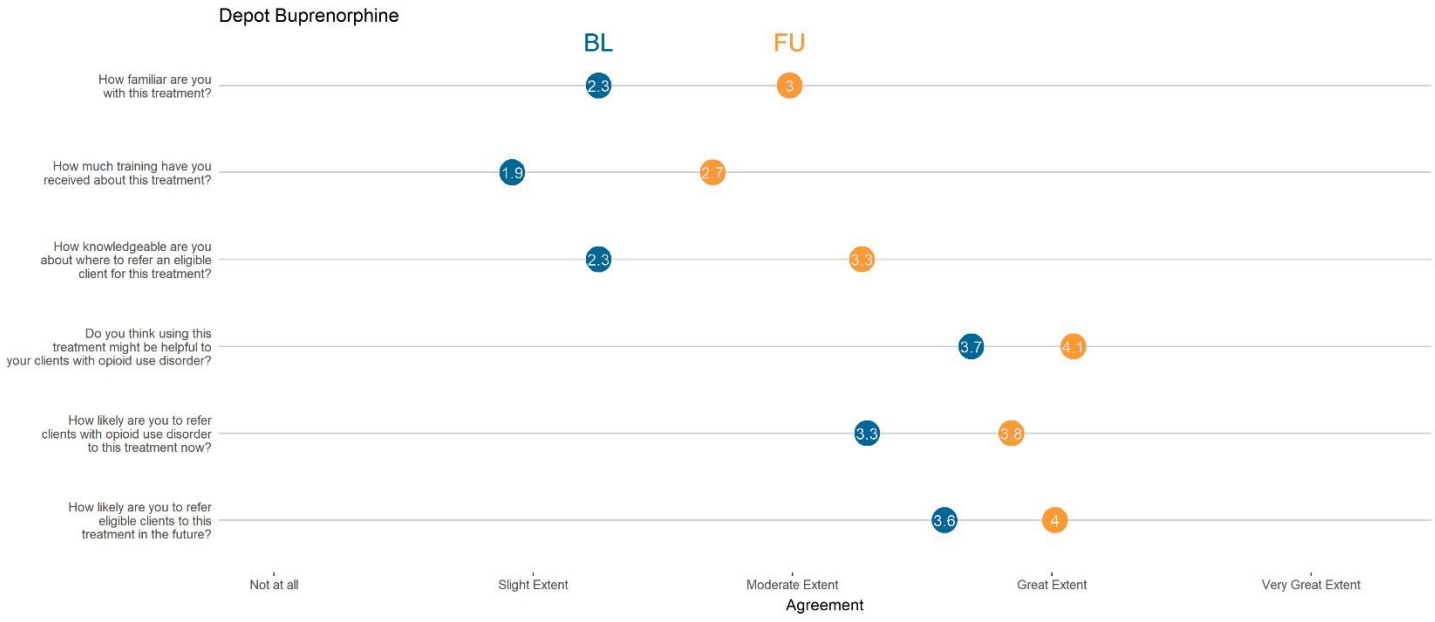
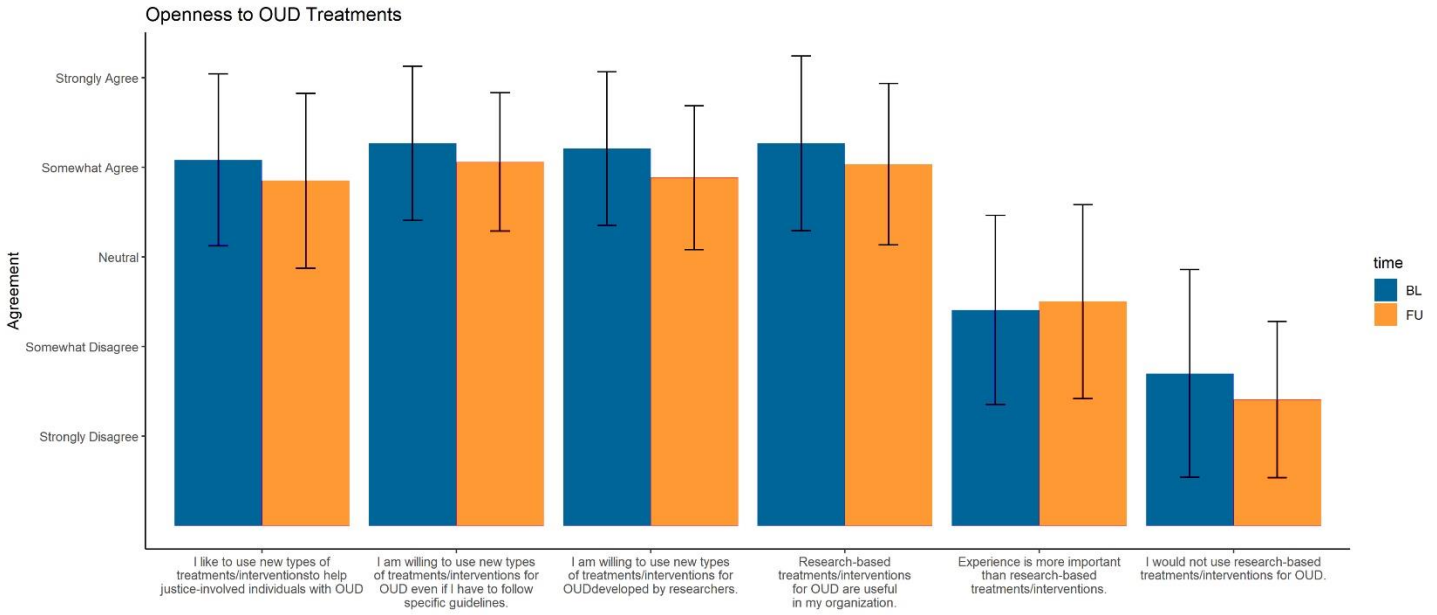


Figure 2.

Familiarity with naloxone significantly improved but not its perceived helpfulness. This might be because of the already widespread implementation of naloxone and its high baseline levels of perceived helpfulness. Participation in the initiative might have helped staff to better understand naloxone even though it already had strong support.

Surprisingly, attitudes towards the adoption of EBPs did not change over time, nor did respondents' openness to OUD treatments. However, given that counties elected to participate in an initiative to implement evidenced based practices and that individual staff members who chose to participate in the survey may be more interested in research (and therefore EBPs) this result likely reflects a very high level of openness at baseline constrained by a ceiling effect.

Figure 3.



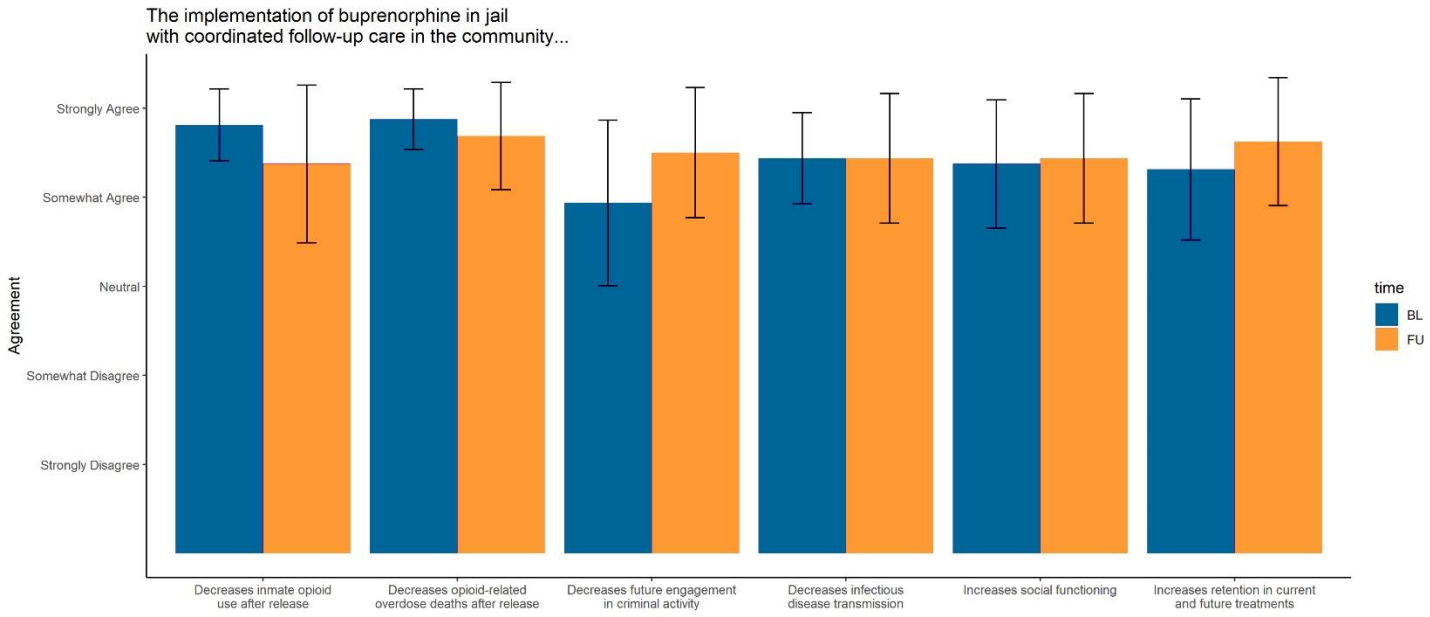
Respondent role type predicted significant differences in baseline attitudes for a number of MOUDs. Those involved with the administration of treatment (as opposed to those whose roles were primarily focused on criminal justice) had more favorable beliefs about the helpfulness of naloxone and oral buprenorphine and more knowledge about oral naltrexone, depot buprenorphine, transmucosal buprenorphine, and methadone at baseline. Although treatment providers expressed more favorable attitudes towards and more knowledge of MOUDs at baseline, there were no significant effects of respondent role and time, indicating that their change in attitudes was not significantly different from the changes in attitudes experienced by CJ representatives. Their attitudes towards EBPs did not significantly differ from those on the CJ side at baseline nor were there differences in changes towards EBPs between groups.

Most surprisingly, a state's Medicaid expansion status had no effect on baseline attitudes/knowledge nor did it affect the change in attitudes over the course of the initiative. In spite of a lack of funding, it seems participants from jurisdictions without Medicaid expansion are still familiar with and in favor of the implementation of MOUDs. While funding may be the most important barrier to overcome, this has not appeared to hamper familiarity with and favorable attitudes towards MOUDs.

READINESS ASSESSMENT RESULTS (EVIDENCE)

There was also little change in the Readiness Assessment Evidence scores for the different medications. As demonstrated in the bar chart, below, baseline scores for all medications were in the "somewhat agree" to "strongly agree" range on items addressing the benefits of starting medication in jail with continuation in the community, and they continued to be quite positive at follow-up. (Evidence Assessment Table in Appendix I.)

Figure 4.



UNDERSTANDING MOUDS IN THE BROADER JAIL SETTING

The PARIHS implementation framework categorizes a broad range of information as "evidence," including research evidence, practitioner experience, community preferences and experiences, and local information. As such, correctional and treatment staff's views of MOUDs based on prior experiences as well as their preferences were assessed in interviews and site visits. One warden interviewed expressed that seeing people properly medicated and how it positively impacts both the milieu and the trajectory of someone's life once they leave jail is powerful evidence for correctional staff, but resistance to using MOUDs must first be overcome in order to see that impact. Despite the highly favorable ratings of MOUDs by respondents on the survey and assessment instruments, broader organizational culture and staff preferences were not always perceived as being in alignment with these views. Biases against MOUDs and the

preference for abstinence-only recovery paths (e.g., the belief that MOUDs are simply "substituting one drug for another") came up as challenges encountered at numerous sites. Some teams planned to distribute "climate" surveys as part of their implementation activities in order to more fully assess staff knowledge and biases regarding different MOUDs so they could specifically address these issues and improve buy-in. Staff turn-over was also identified as an issue, indicating the importance of hiring staff open to MOUD treatment and/or training all new staff in the benefits of providing these medications.

ENHANCING MOUD KNOWLEDGE

Information regarding MOUDs was often delivered first to the teams, who then disseminated the information to people at their sites. For example, the HMS coach lead (Ms. Strugar Fritsch) and a colleague delivered one of the first presentations on the first day of the August kick-off meeting entitled "What teams need to know about OUD treatment: Medications and behavioral therapies." Her slides and materials referenced in her presentation were made available to the teams so they could be used for trainings as part of a site's implementation preparation. HMS coaches also often recommended toolkits, videos and other resources to their teams, including ones showing justice-involved people who experienced positive outcomes with MOUDs in their recovery. The profound impact of including testimonials as a source of MOUD "evidence" was often highlighted, and a person in recovery was invited to deliver a presentation on the second day of the August kick-off meeting.

Resources

In addition to the range of resources recommended by HMA and made broadly accessible to the teams on the project website (developed and managed by IIR), site-specific materials were developed by some teams. Staff training materials on MOUDs and the creation of other educational materials, such as testimonial videos, posters, and handouts, were developed and, in some cases, disseminated by the teams during the planning initiative in order to challenge misinformation and highlight accurate MOUD scientific and practice evidence so it was available to a range of stakeholders at their sites, including jail staff, correctional health staff, and inmates.

METHADONE REGULATIONS

Regulations surrounding the delivery of methadone were of considerable concern to most teams. In addition to the coaches providing resources, and several teams visiting those jurisdictions that had already developed an Opioid Treatment Program (OTP) in their jails, representatives from the DEA were invited to deliver a presentation on the second day of the January 2020 in-person meeting to clarify regulatory guidelines surrounding "guest dosing" and answer teams' questions.

CONSIDERING THE COST

Understanding promising practices in the use of MOUDs often involves cost issues related to both the cost of the medication and the necessary space and staff to deliver it in a safe manner that limits potential diversion. Financial issues were mentioned as barriers by most teams, but for teams from the three non-Medicaid expansion states it was an over-arching concern. Understanding costs for services was essential because expanding care to include new MOUDs and more people being treated within the jail often required re-contracting with correctional health vendors. Cost to the patients as well as the facility were considered by teams, since the point at which someone loses their health insurance during incarceration, and how quickly they can get it reinstated upon release, can make some medications prohibitively expensive.

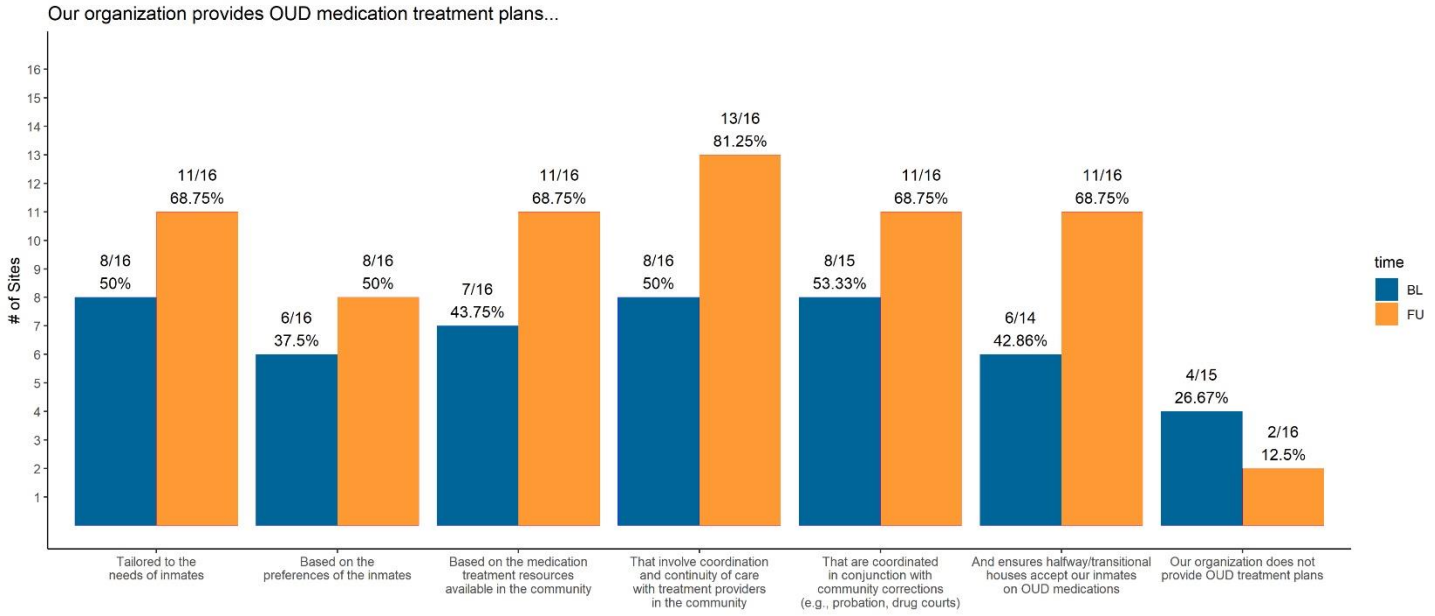
IMPLEMENTATION CHECKLIST

The increased understanding of evidence based MOUD practices and high levels of readiness among team members culminated in considerable changes being made over the course of the nine-month planning initiative, both in the planning for and delivery of MOUDs in jails. A jail-focused implementation

checklist (see Appendix D) was developed for this evaluation project and administered to each team at the kick-off meeting and again at the end of the planning initiative.

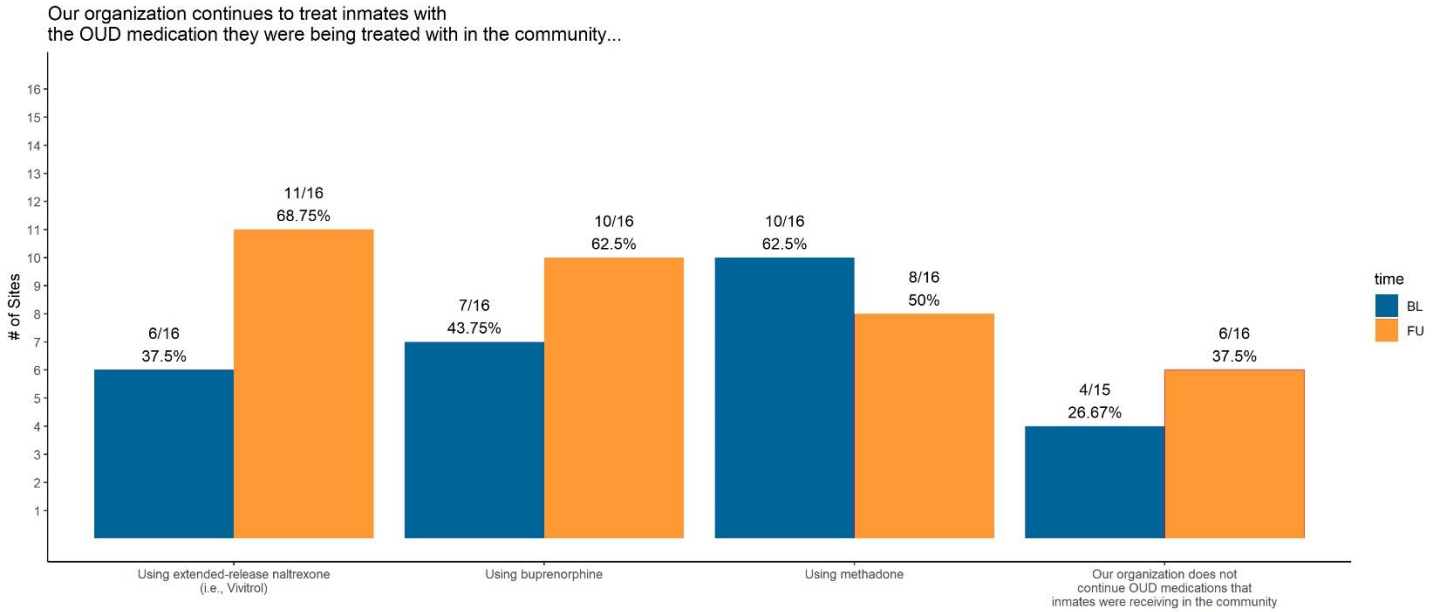
As can be seen below, gains were made at several sites in terms of providing MOUD treatment plans tailored to the needs and preferences of the inmate, coordinated with and based on the resources available in the community, and that ensured halfway/transitional houses would accept inmates on these medications.

Figure 5.



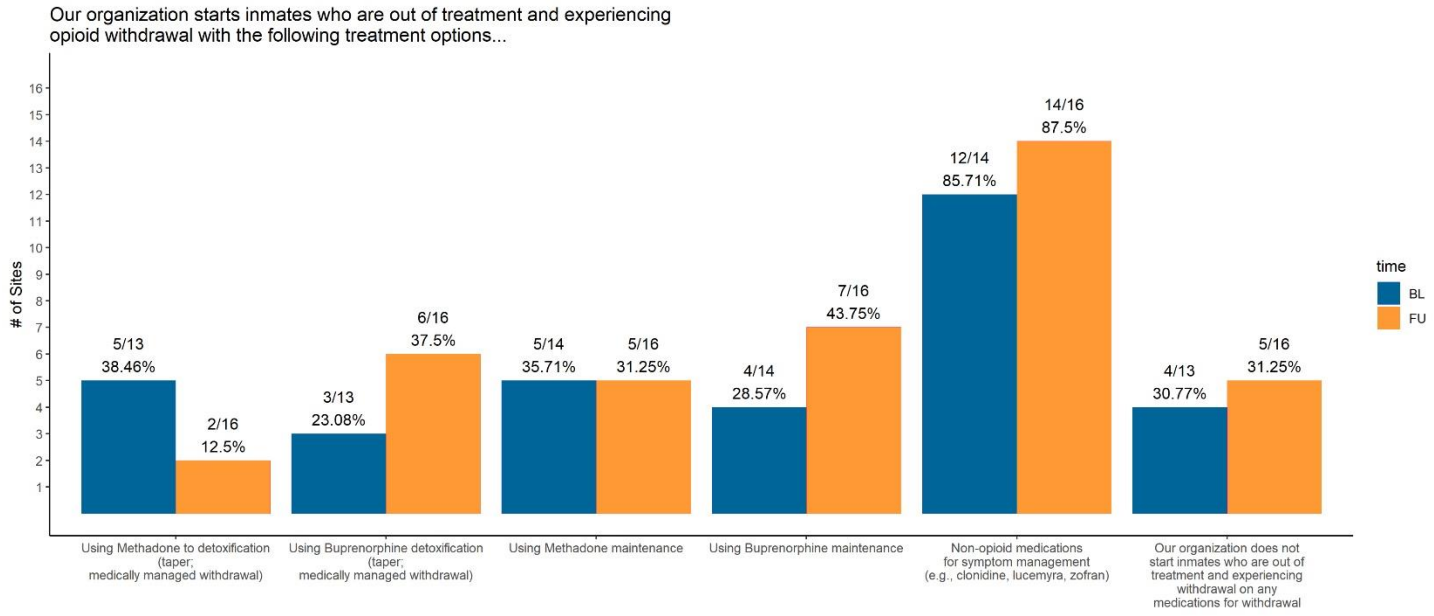
Some improvements were noted in terms of continuing Vivitrol and buprenorphine in jail for people who were receiving these medications in the community, but these improvements were not endorsed for methadone.

Figure 6.



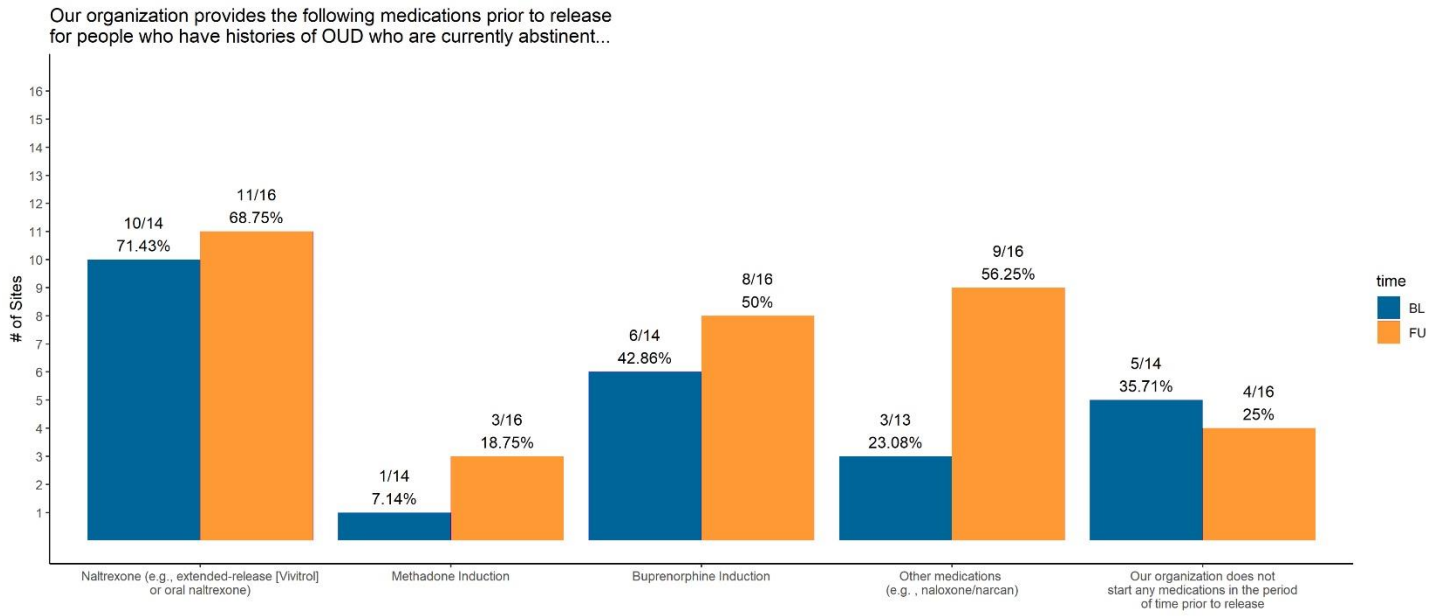
Changes were noted in terms of which medications were being used for medically managed withdrawal/detoxification tapers, with more buprenorphine and less methadone being used. Endorsement of using buprenorphine maintenance nearly doubled by follow-up while methadone maintenance remained stable.

Figure 7.



The provision of Vivitrol, methadone, buprenorphine, and naloxone for people prior to release from jail all increased at follow-up.

Figure 8.



Planning Initiative Outcomes
continued

Perhaps one area in which improvements were most notable concerned having established medical guidelines in place to safely conduct dose inductions and to treat precipitated withdrawal and opioid intoxication/overdose.

Figure 9.

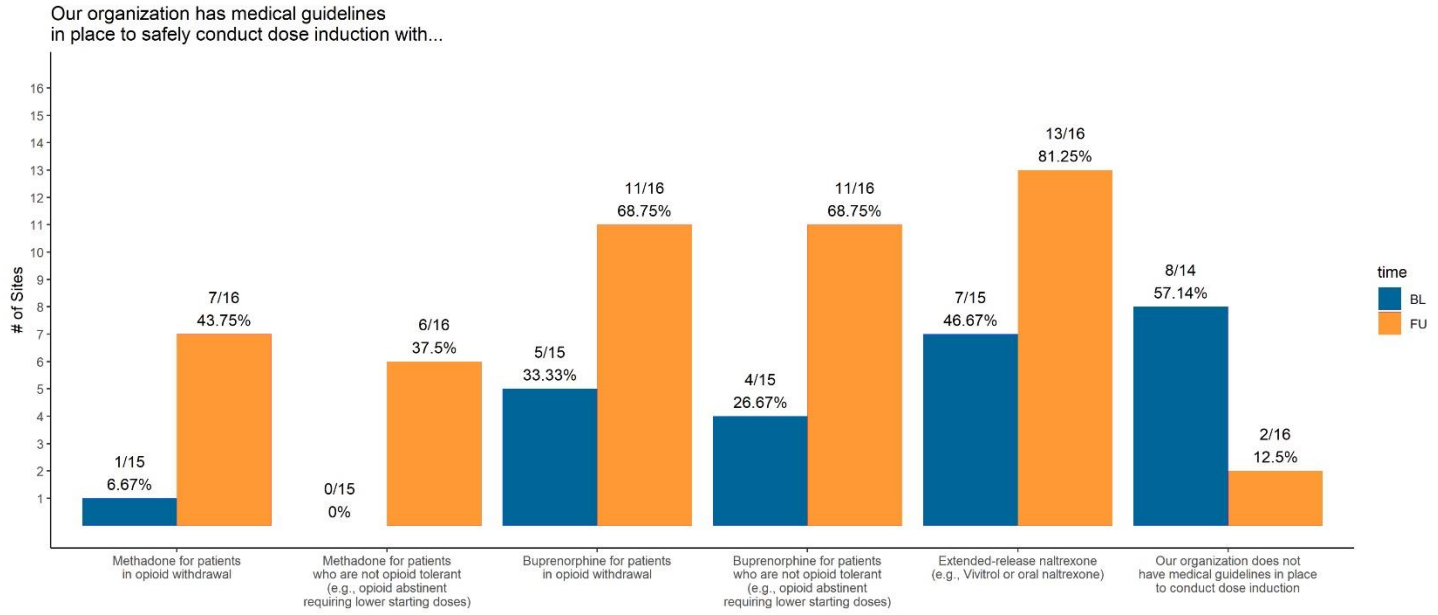
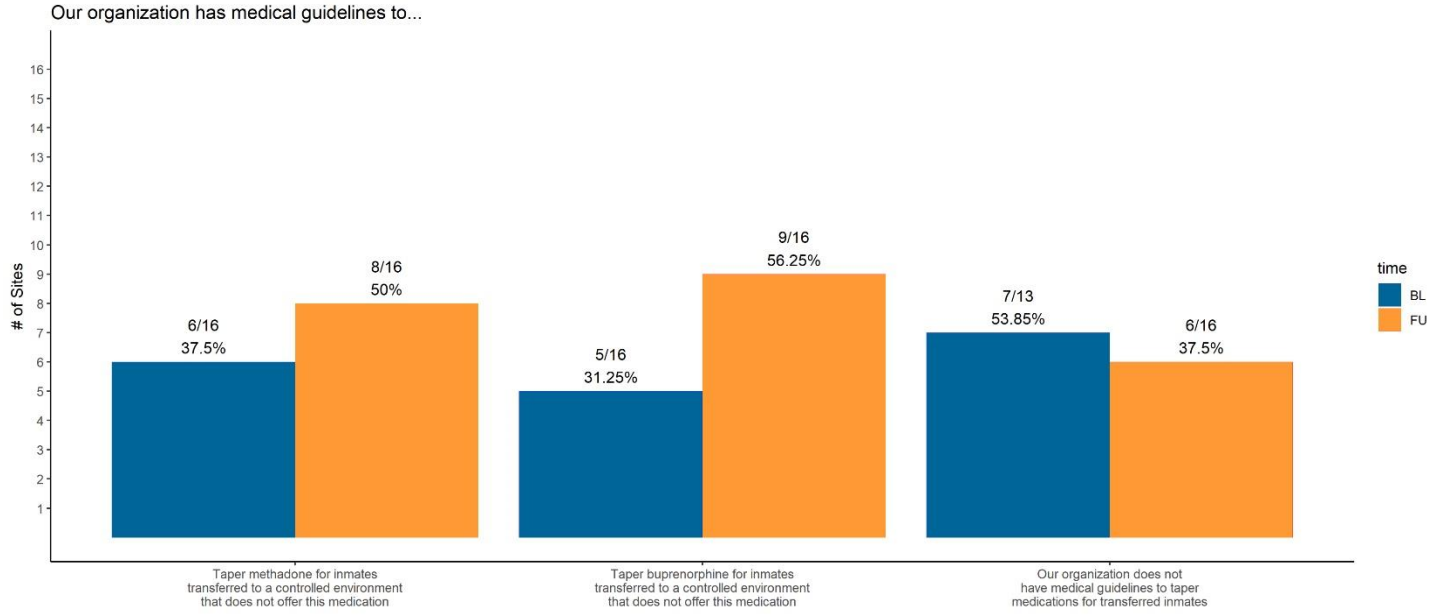
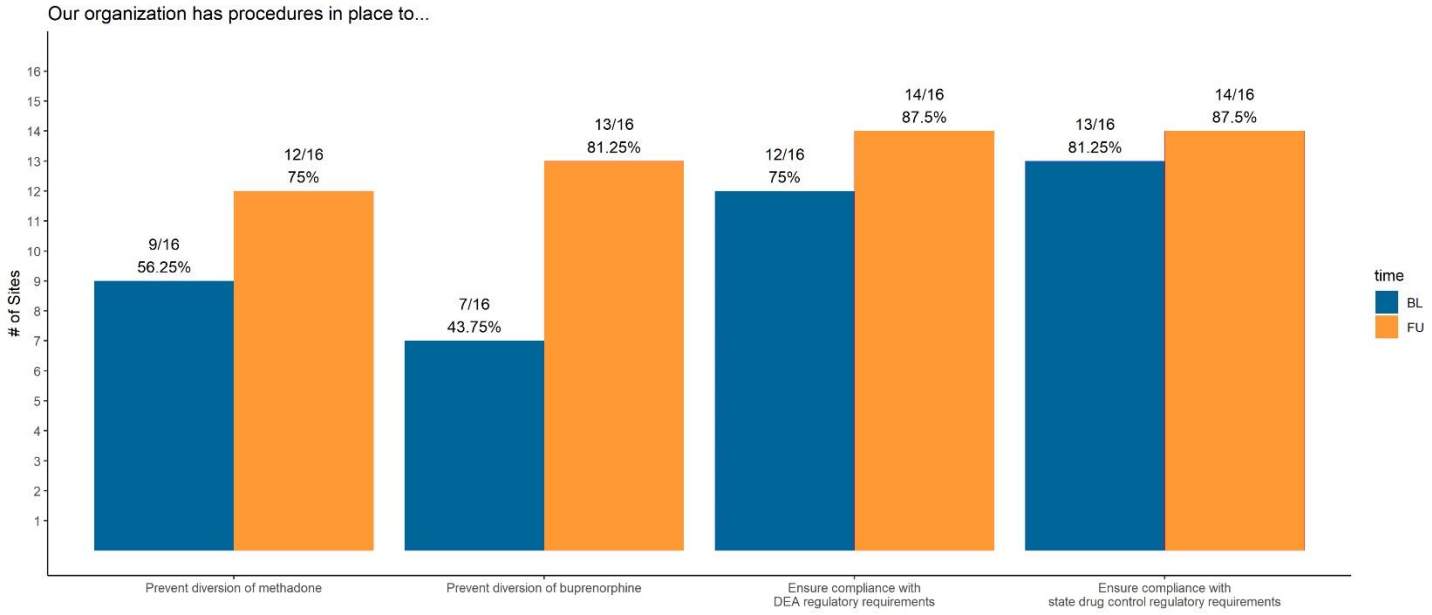


Figure 10.



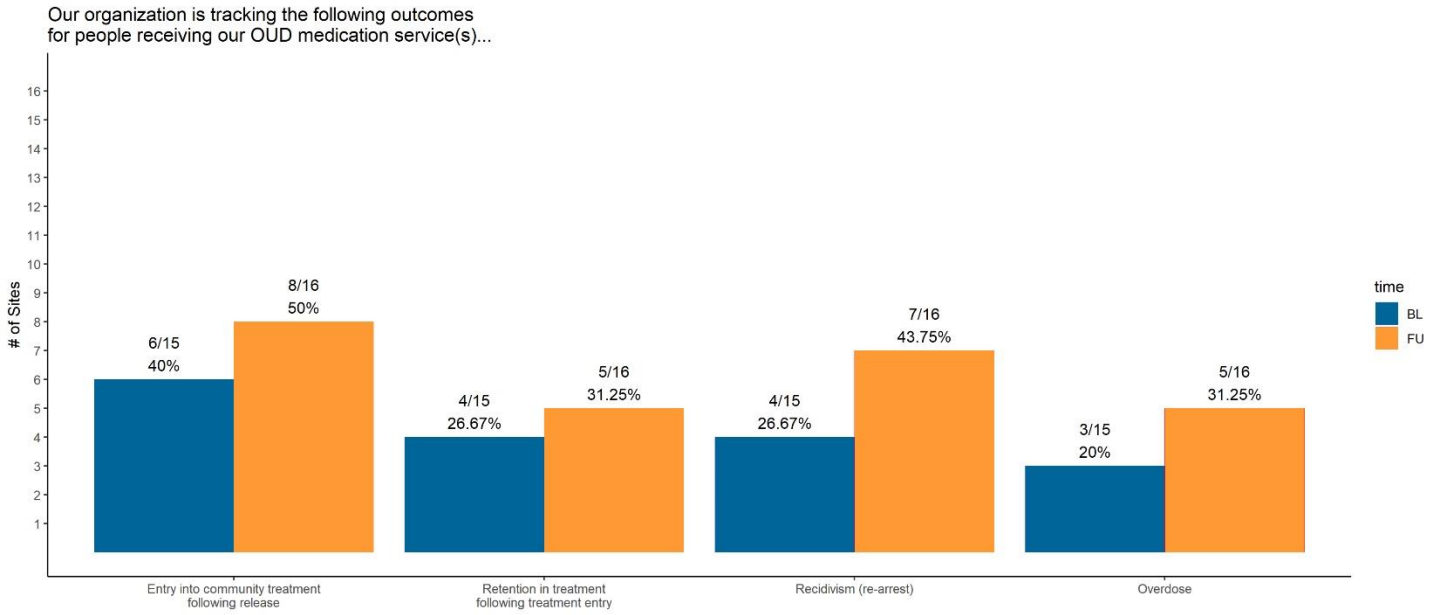
As more sites reported using buprenorphine in their facilities at follow-up, it is not surprising that more sites also endorsed having procedures in place to prevent diversion of this medication. More sites also reported having procedures to prevent methadone diversion and ensure DEA and state drug control regulatory compliance.

Figure 11.



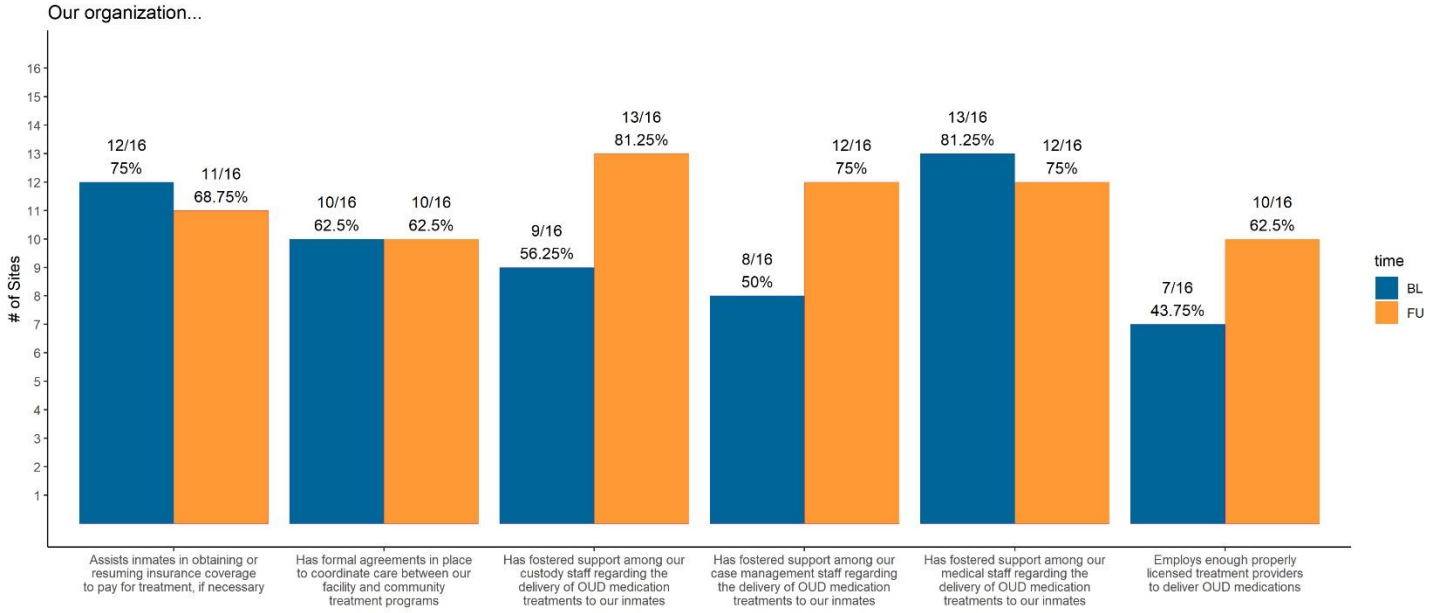
Despite being relatively low overall, at follow-up more sites endorsed being able to track outcomes for MOUD patients once they are released into the community, including whether or not someone enters their community treatment program, are retained in treatment, or overdoses. The greatest gains in data tracking capacity concerned re-arrest/recidivism.

Figure 12.



Finally, several sites reported fostering support among custody and case management staff regarding the delivery of MOUDs and reported employing enough properly licensed providers to deliver these medications.

Figure 13.



AIM 2

Document the planning teams' development and refinement of comprehensive plans for initiating or expanding an MOUD continuum of care from jail to community.

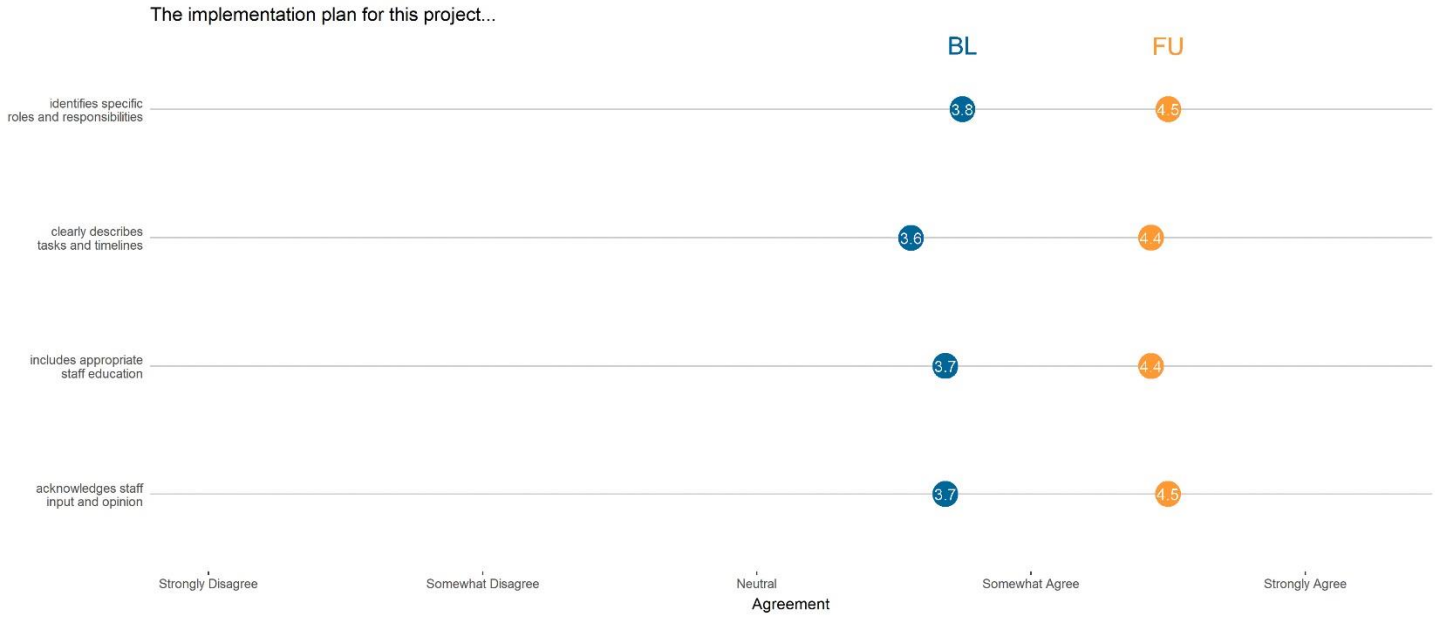
STRATEGIC PLANS

Teams developed their strategic plans for implementation or expansion of MOUD treatment in jail with coordinated care transition in the community at the beginning of the initiative. These plans changed over the course of their participation in the planning initiative, often becoming more detailed as the items were broken into more finite goals and identifying people, organizations/departments, and deadlines for achieving these goals. Other teams found that elements of their initial plans were not feasible and that alternative goals needed to be set.

READINESS ASSESSMENT RESULTS (FACILITATION)

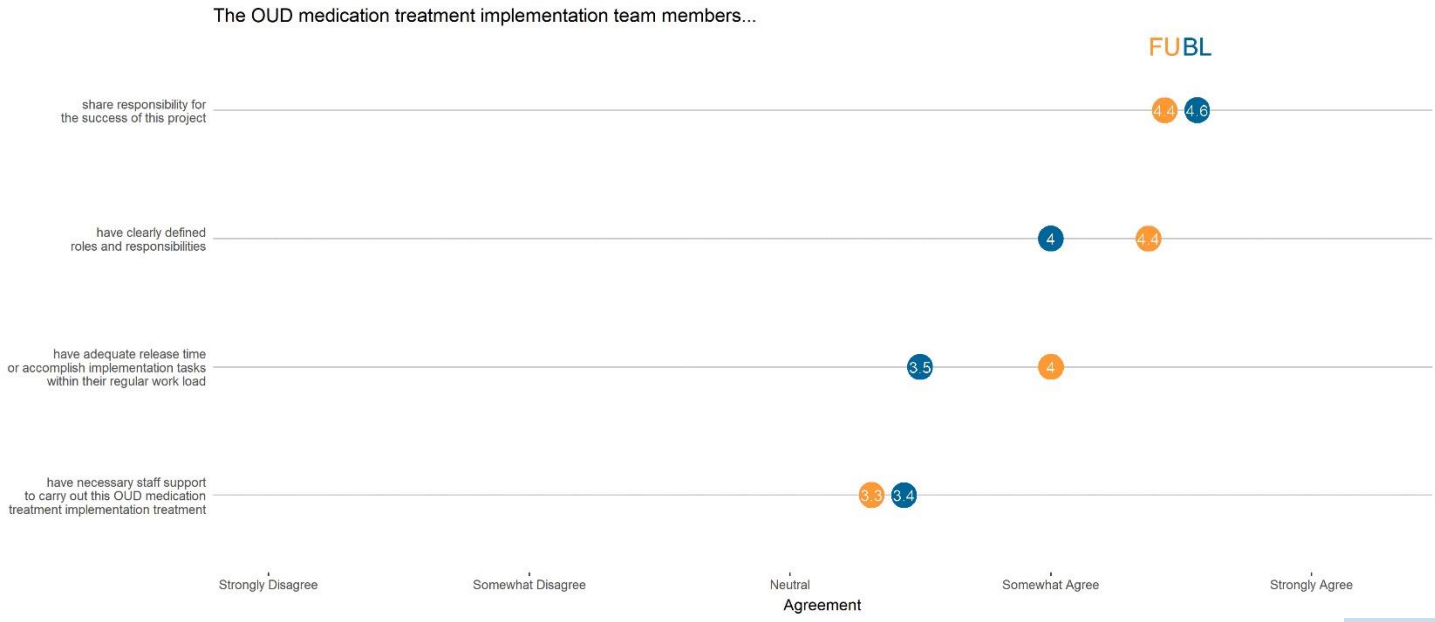
Despite highly favorable ratings at baseline, at follow-up team members endorsed being even more in agreement that the implementation plan for the project identified specific roles and responsibilities, clearly described tasks and timelines, included appropriate staff education, and acknowledged staff input. (Facilitation Assessment Table in Appendix I.)

Figure 14.



While team members continued to perceive that they shared responsibility for the success of the project and slightly increased in their views that they had clearly defined roles and adequate release time to accomplish the project's goals, their views of having necessary staff support to carry out their work on the project remained somewhat neutral.

Figure 15.



Planning Initiative Outcomes
continued

At follow-up, teams reported having more concrete ways to assess progress, gather input, and disseminate findings within their organizations.

Figure 16.

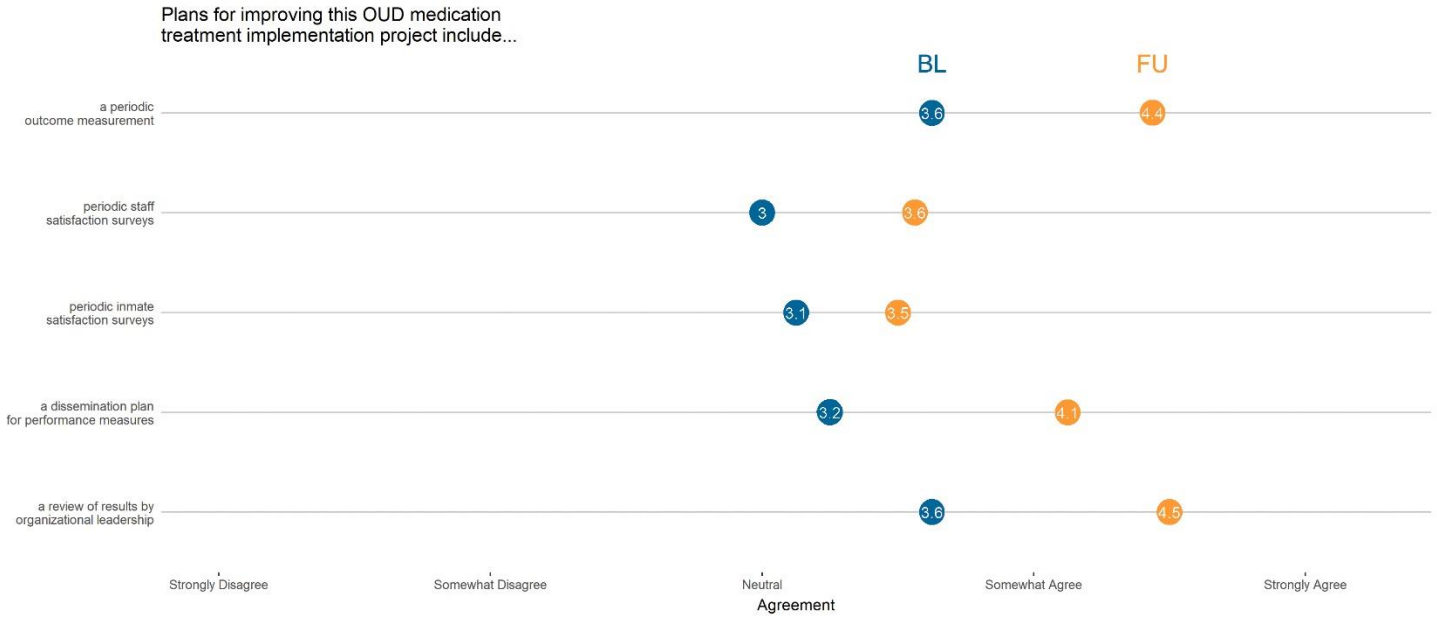
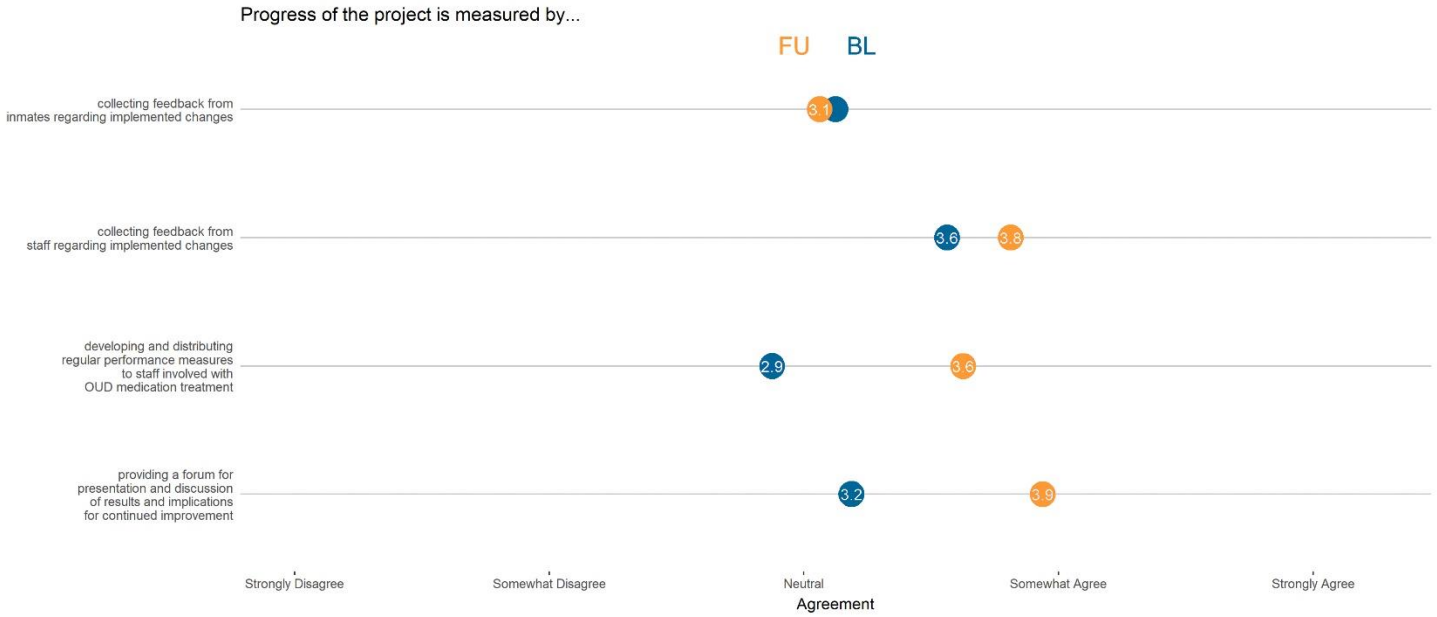
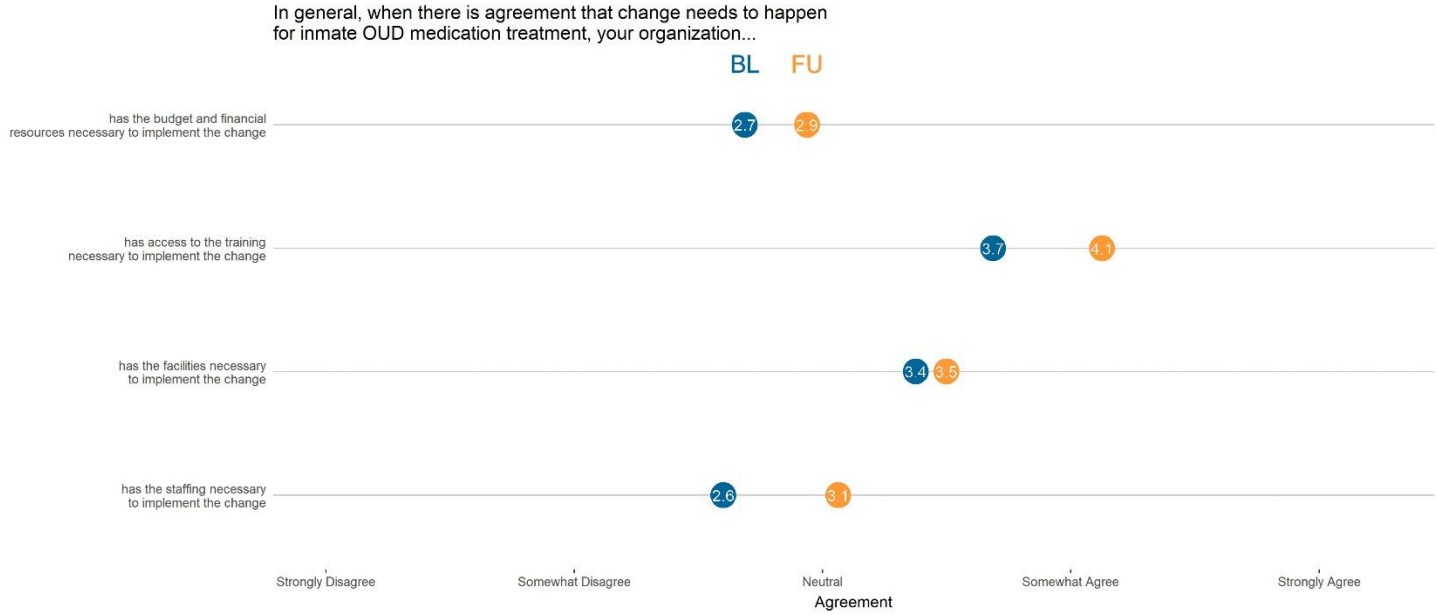


Figure 17.



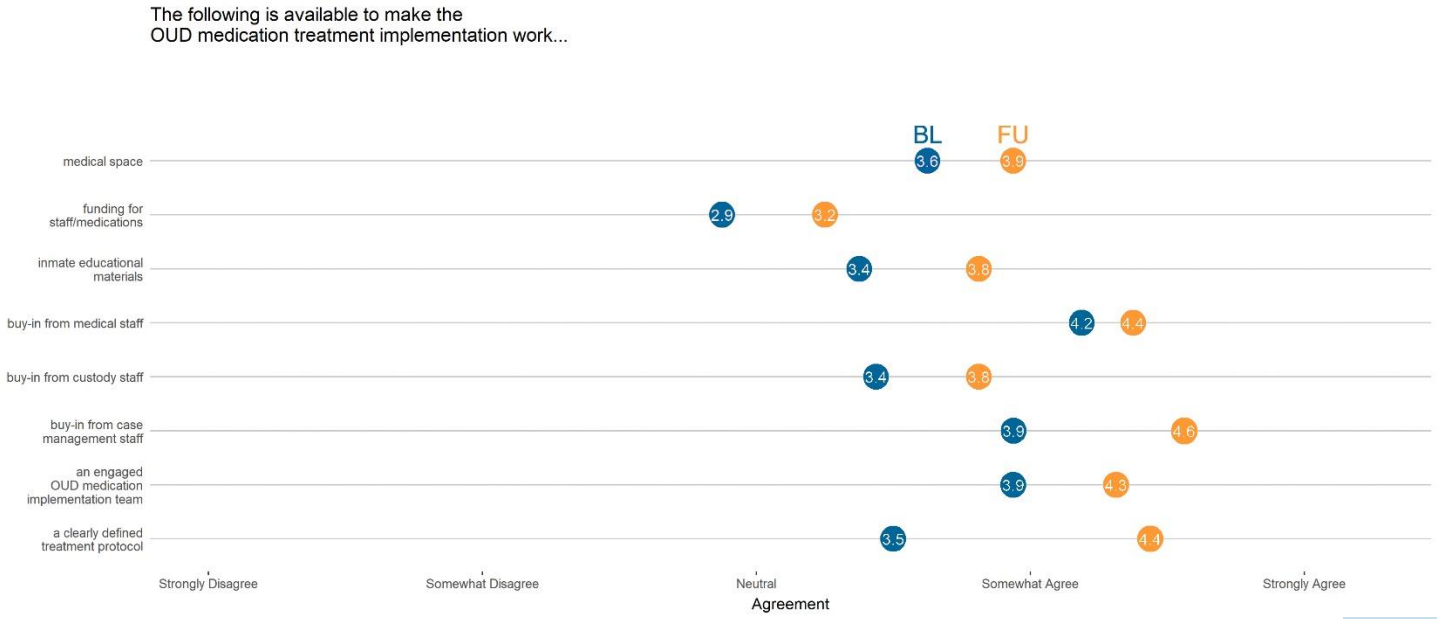
Some slight improvements were noted in terms of access to trainings and staff capacity at follow-up but budget and financial resources as well as having the facilities necessary to implement the changes were largely unaffected. This is not surprising given the relatively brief duration of the planning initiative. (Context Assessment Table in Appendix I.)

Figure 18.



The greatest gains in resources necessary to the make the OUD medication treatment implementations work were observed in having a clearly defined treatment protocol and having buy-in from case management staff, but smaller improvements were also noted in medical space, funding for staff/medications, inmate educational materials, buy-in from medical and custody staff, and having an engaged implementation team.

Figure 19.



PATIENT FLOW DIAGRAM

The following flow diagrams identify people coming into and leaving the jails in the study, the decisional points concerning MOUD treatment options, and highlight the efforts and services identified by each of the Bridges sites in their strategic plans.

Figure 20.

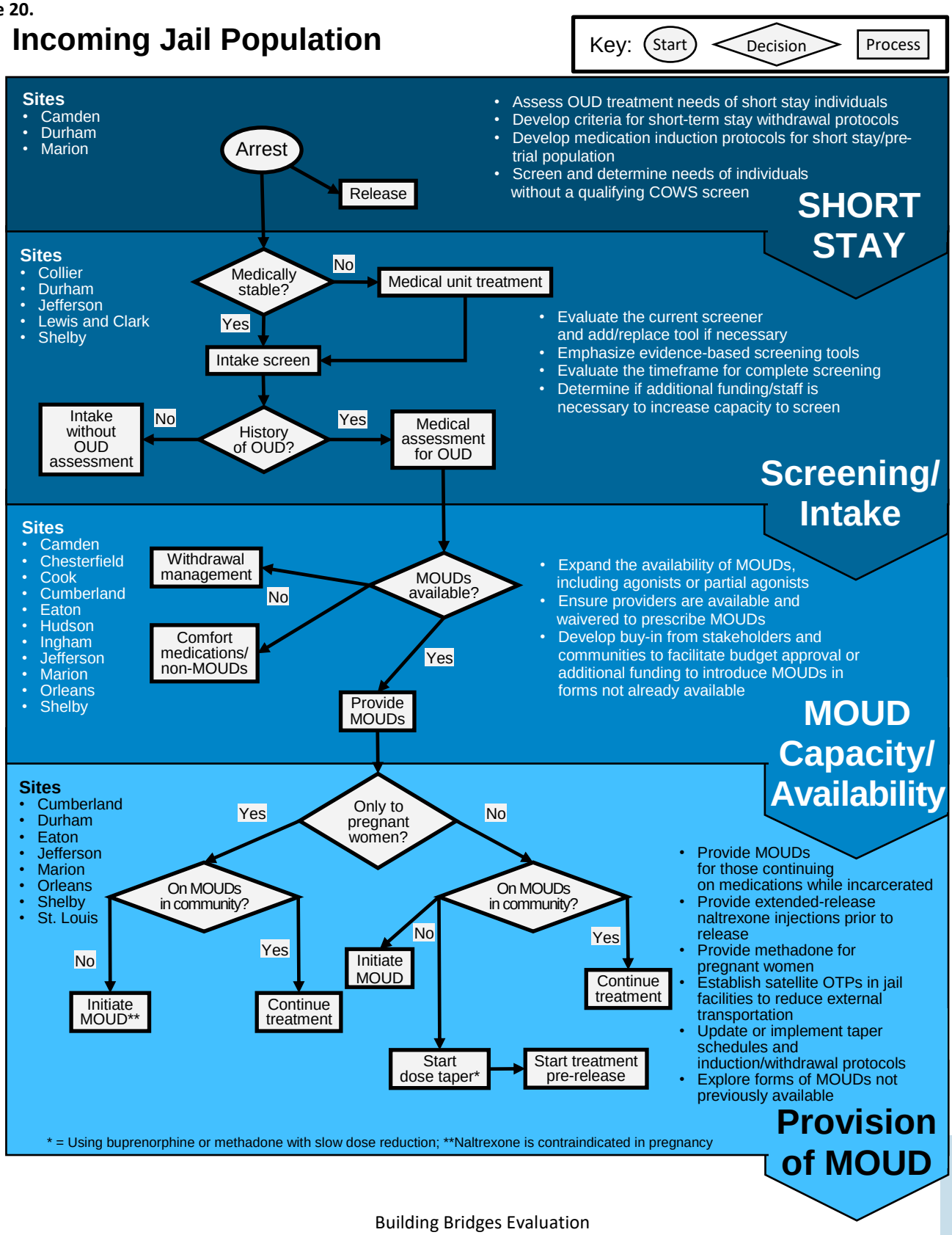
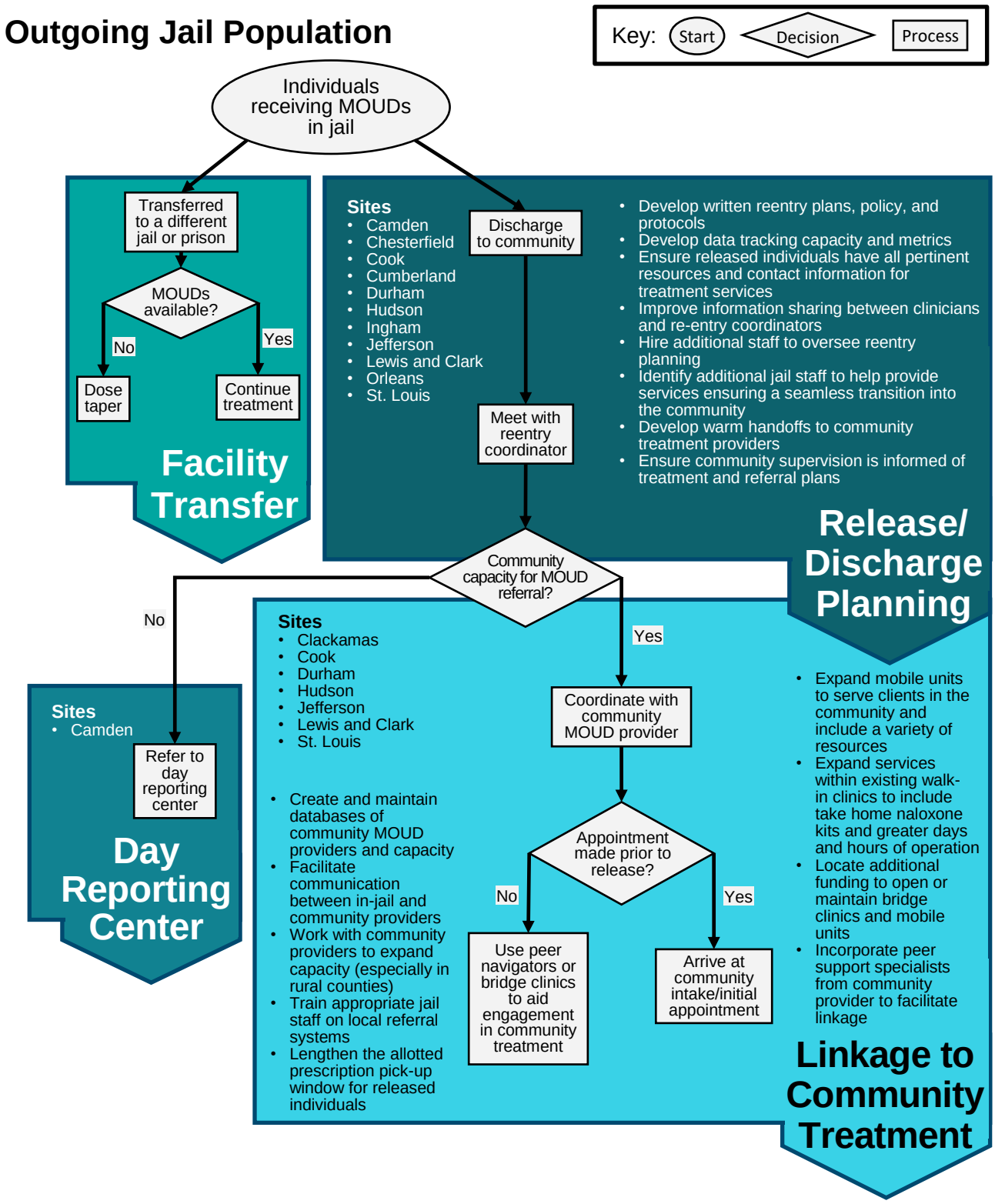


Figure 21.


Outgoing Jail Population
Key:
Start
Decision
Process
Individuals receiving MOUDs in jail
Transferred to a different jail or prison
MOUDs available?
No
Yes
Dose taper
Continue treatment
Facility Transfer
Discharge to community
Sites
Camden
Chesterfield
Cook
Cumberland
Durham
Hudson
Ingham
Jefferson
Lewis and Clark
Orleans
St. Louis
Meet with reentry coordinator
Develop written reentry plans, policy, and protocols
Develop data tracking capacity and metrics
Ensure released individuals have all pertinent resources and contact information for treatment services
Improve information sharing between clinicians and re-entry coordinators
Hire additional staff to oversee reentry planning
Identify additional jail staff to help provide services ensuring a seamless transition into the community
Develop warm handoffs to community treatment providers
Ensure community supervision is informed of treatment and referral plans
Release/ Discharge Planning
Community capacity for MOUD referral?
No
Yes
Sites
Camden
Refer to day reporting center
Day Reporting Center
Sites
Clackamas
Cook
Durham
Hudson
Jefferson
Lewis and Clark
St. Louis
Coordinate with community MOUD provider
Create and maintain databases of community MOUD providers and capacity
Facilitate communication between in-jail and community providers
Work with community providers to expand capacity (especially in rural counties)
Train appropriate jail staff on local referral systems
Lengthen the allotted prescription pick-up window for released individuals
Appointment made prior to release?
No
Yes
Use peer navigators or bridge clinics to aid engagement in community treatment
Arrive at community intake/initial appointment
Expand mobile units to serve clients in the community and include a variety of resources
Expand services within existing walk-in clinics to include take home naloxone kits and greater days and hours of operation
Locate additional funding to open or maintain bridge clinics and mobile units
Incorporate peer support specialists from community provider to facilitate linkage
Linkage to Community Treatment

EXPANDING MOUD TREATMENT CAPACITY IN JAILS

Modifying Existing Treatment Protocols/Programs

Rather than developing entirely new treatment protocols or programs, many teams looked to existing resources that could be modified in some way to accomplish their goals.

- Some teams' development and refinement of MOUD services started with efforts to better identify the need for treatment among the in-coming jail population. This was accomplished largely by adding OUD and MOUD-specific history questions to the existing jail intake medical screeners. Modifying existing protocols to incorporate more evidence-based induction and detoxification protocols was also a straight forward modification.
- Sites that did provide methadone treatment prior to participation in the Bridges planning initiative often used it only for pregnant women or a limited population, such as people already in a methadone program in the community. This was usually accomplished by transporting inmates to the OTP daily, which required significant staffing resources. Once teams adjusted their treatment protocols to include guest dosing with medications transported by the community OTPs directly to the jail (for up to a week or more of medication per participant), the potential capacity for providing this medication greatly increased.
- Switching to different buprenorphine formulations or expanding a practitioner's prescribing capacity were also noted, as was changing protocols to permit inmates to receive multiple injections of Vivitrol during incarceration, rather than just a single dose immediately prior to release.
- Modifying pre-existing abstinence-based drug treatment programs in the jail to be more inclusive and accepting of MOUDs, or creating parallel programs for people on MOUDs, was another modification considered.

Expanding Type of Medications Offered

BUPRENORPHINE.

A common first step for preparing to add buprenorphine to the jail was to ensure existing medical staff received training to become a buprenorphine waivered practitioner or to hire new practitioners who could prescribe the medication. One site interested in a newer extended-release buprenorphine formulation was negotiating with the pharmaceutical company to donate the medication for a new pilot program.

METHADONE.

Sites working towards adding methadone either sought out a community provider to do in-reach, considered asking the State Opioid Treatment Authority to classify the jail as a satellite OTP, or were exploring the process of becoming an OTP.

VIVITROL.

Another site wanted to add Vivitrol at release but planned to supplement it by providing daily oral naltrexone during incarceration to maintain them and ensure they would be ready to receive their injection at their release point. Whatever the medication being added, many reported that additional medical staff would be need to be hired.

DIVERSION CONCERNS

Increasing the number of people being medicated lead to other planned and sometimes implemented changes in operations in order to reduce the risk of medication diversion. These involved such things as changing: how people were medicated, how inmates were roomed, the expansion of health suites to accommodate care or installing additional security cameras.

MAT COORDINATORS

A few sites determined that the increased care coordination and MOUD program oversight required

of their new or expanded programs was too much to add onto any current staff members' job and needed to create a new care coordinator position. During the course of the planning initiative one site created and hired someone to fill this new position and a second site was exploring funding options before proceeding.

HEALTHCARE VENDORS

The central role of the jail health care provider cannot be understated, and distinct differences emerged in progress made and barriers encountered depending on who lead these units. In some instances, the jail's health care unit was run by the jail itself, or the local health department. In most of the sites, however, the health suite was run by an external contracted vendor. When the jails ran or had positive pre-existing relationships with the health provider, teams often made considerable progress towards implementing their strategic plans. Not all health providers or their agencies were supportive of the proposed expansion/adoption of MOUDs and revised contracts often needed to be negotiated in order to cover this expanded scope of work and its associated costs. This became an important point of negotiation for jails whose health contracts were nearing completion and up for renewal.

CONSIDERING COMMUNITY CAPACITY

The spirit of the Bridges planning initiative's focus on continuity of care was demonstrated when teams looked outward to community treatment capacity when making MOUD determinations for the jails. Whether or not a community had a sufficient number of buprenorphine waivered practitioners or OTPs was sometimes the determining factor that influenced the medications they chose to implement.

TRANSFERS TO PRISONS OR OTHER JAILS

While the focus of the planning initiative was on people receiving MOUDs in jail and being released into the community for continuing care, some sites also addressed the possible transfer of inmates started on MOUDs to prison or other jails, which may or may not provide these medications. The ability of jails to provide medication dose tapers prior to the transfer of a patient to another facility that did not offer MOUDs was contingent upon the lead-in time.

AIM 3

Evaluate progress towards partnership development and MOUD coordination planning over the course of participation in the planning initiative.

NETWORKING WITH OTHER BRIDGES TEAMS

The partnership development focus of the planning initiative was initially envisioned as occurring predominantly among team members and other organizations in their community. However, due to the size, scope, and breadth of resources and experiences across the 16 Bridges sites, partnerships developed across teams as well. According to team members interviewed, both the two in-person meetings and the networking facilitation provided by their coaches (enhanced by additional financial support offered by the funders of the Bridges planning initiative) created opportunities to network across teams. Teams learning from one another and offering models and guidance was accomplished through the 2-day meetings' structure, which provided informal opportunities to gather as well as formal break-out affinity sessions (e.g., correctional health, community supervision, etc.). Coaches encouraged teams to visit one another's sites and see other health service delivery protocols in action.

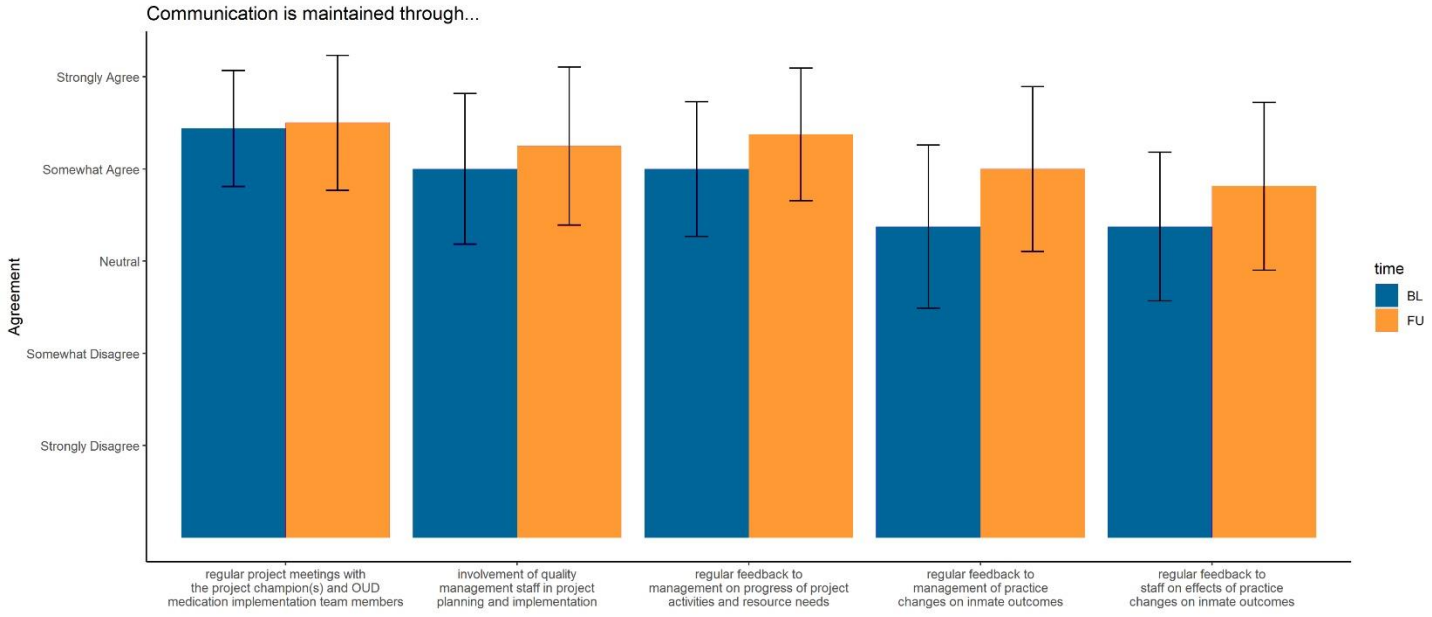
PARTNERSHIPS WITHIN TEAMS

Bridges teams had a wide range of experience working together prior to the project. Some teams were coming together for the first time to work towards a specific goal but others had pre-existing relationships and/or had worked as a team on previous projects. While having a pre-existing relationship may have enhanced a team's Bridges work, new teams were not necessarily hampered by their lack of familiarity, since they quickly came together to achieve a shared goal. Common facilitating factors to team partnerships and progress included regular communication among team members, often maintained through bi-weekly meetings. Teams said that meeting frequency helped maintain momentum and enthusiasm for the project, keeping them focused on task completion and holding them accountable to one another. Accountability to state and local leadership who supported their work also enhanced team commitment and cohesion.

READINESS ASSESSMENT RESULTS (FACILITATION)

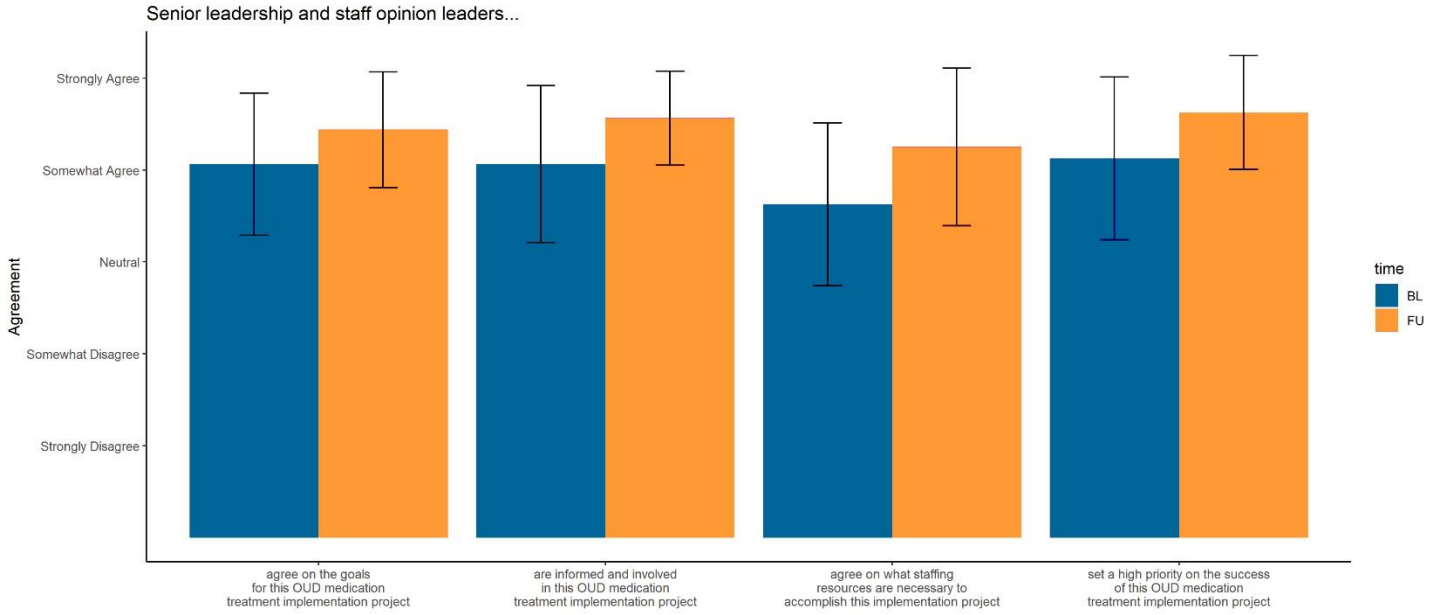
The Readiness Assessment's Facilitation questions addressing communication and leadership highlight some of the team and organizational dynamics that were present across the Bridges planning initiative teams that may have enhanced their success. As can be seen in the following chart, maintaining regular meeting schedules was a central component of the teams' communication. Providing feedback to various stakeholder groups increased over the course of the project, both as a way to share their progress and ensure buy-in remained high.

Figure 22.



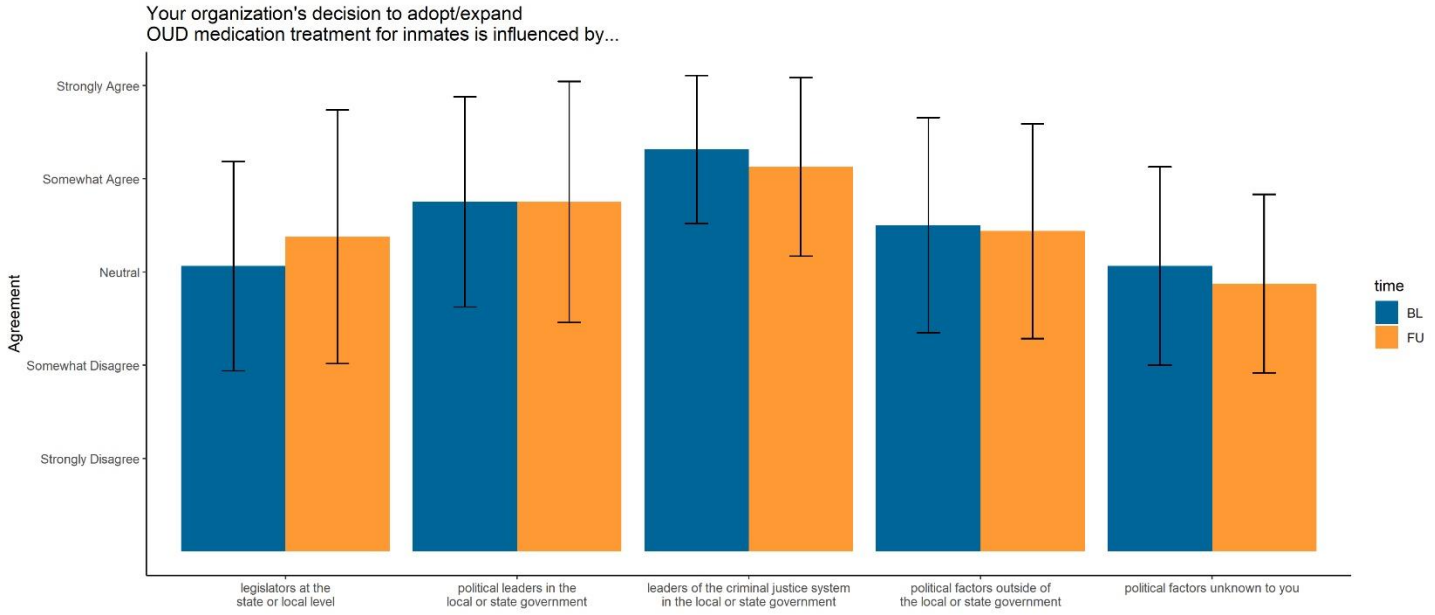
Slight perceptions of improvement were also noted in the degree to which senior leadership and staff opinion leaders were involved with and agreed on the project's goals, agreed upon staffing resources necessary to accomplish those goals, and set a high priority on achieving project success.

Figure 23.



The driving influence behind their work on expanding MOUD delivery remained unchanged over the project, with leaders in the criminal justice system in the local or state government being the greatest influence, followed by political leaders in the local or state government, larger political factors, and local or state legislation.

Figure 24.



COORDINATION OF CARE FROM JAIL INTO THE COMMUNITY (AND VICE VERSA)

- Planning the coordination of care between the jail and the community often included both a scan of existing treatment resources in the community and the expansion or creation of formal referral networks. This served to increase the range of treatment programs that jails could refer people to upon release, and established communication channels for informing programs when their participants became incarcerated. One site determined that it would be beneficial to develop an MOUD hotline, providing direct referrals to treatment that could be used throughout the community. These scans also helped the jails determine whether programs that commonly received people leaving their facility were accepting of MOUDs or could ensure people on MOUDs had access to continuing their medication.
- When the teams concluded that the community treatment capacity was insufficient for their plans, they could either modify the strategic plan or devise ways of bolstering treatment availability, such as one jail considering the development of a bridge clinic to assist people's medication continuation upon release, and another team exploring mobile treatment unit or bridge clinic options.
- Teams sometimes determined that care coordination should be enhanced by the use of care coordinators that could assist people prior to release or peer recovery specialists/coaches to help people link to and stay engaged in care once they were in the community. Significant challenges with both care coordination and true medication maintenance delivery in the jails were anticipated for "short stay" populations (e.g., those incarcerated for 72 hours or less), a population that was only expected to grow as bail reforms became more broadly adopted.

TRACKING PEOPLE AND LINKING DATA ACROSS SYSTEMS

Most teams found that there was currently limited (if any) ability to track people across systems of care and that considerable work needed to be done to either enhance the sharing of information across systems or more to more integrated systems. Coaches helped teams find a universal release of information that could be used to facilitate the sharing of information. One site's lofty, ultimate goal was to institute a universal electronic health record for their county, which would take years to develop and institute. In two instances the technical and logistical complexity of data sharing and outcome tracking lead teams to partner with local universities to help them understand and develop their data tracking capacity. Ms. Kunkel, the BJA project lead, strongly emphasized the importance of data collection and integration, both as a way to monitor implementation success and track outcomes. She led a webinar in the fall of 2019 explaining these issues and reminding sites that their ability to apply for Phase 2 Bridges funding was predicated upon them developing this capacity.

INSURANCE COVERAGE CONTINUITY

The ability to pay for MOUD treatment was an important consideration, since many people entering jail are either uninsured when they become incarcerated or lose their health insurance during their detention. If someone loses their health insurance coverage during their period of incarceration, it may take some time to get it reinstated upon release, creating costly gaps in care and barriers to MOUD continuation.

Individual Site Summaries

Due to the range of resources and experiences each site brought with them to the planning initiative, as well as the unique community context in which they were working, we highlight each site's unique accomplishments, the identified facilitating factors for their successes and challenges encountered, and each teams' future goals articulated at the end of their involvement with the Bridges planning initiative project.

CAMDEN COUNTY , NJ

Throughout the Bridges planning initiative, Camden County maintained a contract with a for-profit correctional health care provider who would be central to initiating and establishing new forms of MOUD within their facility. Much of the success of the planning initiative was dependent upon ongoing negotiations between the jail and vendor administration staff, as well as medical providers within the facility regarding which evidence-based substance use disorder treatments to provide, and how best to incorporate these treatments into existing contractual arrangements. This emerged as an important thematic area early in the evaluation period, and was inquired about in future interviews with other Bridges sites.

Facilitating Factors

The Camden County Warden was highly motivated to expand the ability of the jail facility to initiate and maintain individuals on MOUD and allow treatment options to be determined by patient choice and clinical appropriateness. Because of this administrative leadership, the Camden County team was able to successfully utilize HMA technical assistance including training tools for expanding knowledge of stakeholders and decreasing MOUD stigma, as well as coach facilitation between sites and learning from other sites, such as Cook County, regarding how to apply to become a licensed OTP.

Future Goals

Camden County intends on continuing efforts to become a licensed OTP. The Warden is also working to create a "reporting center" where individuals leaving the jail can access treatment-related services to ensure continuity of care. This is part of the broader recommendations to increase the services and care available in the community. Additionally, there continues to be a significant need for broader education about MOUD that can shift existing staff and vendor perceptions.

Major Accomplishments

Although Camden County technically offered all three forms of MOUD at the beginning of the planning initiative, there were issues with existing procedures for maintaining and inducting individuals on buprenorphine, and maintaining individuals on methadone. With regards to buprenorphine, Camden County experienced issues with provider prescribing capacity, which they were able to successfully address by expanding the DEA waiver caseload cap for existing providers, since the one year waiver regulation prevented them from this expansion until February 2020. With regards to methadone, Camden County had been transporting individuals continuing on methadone maintenance to a local OTP, but was able to identify an additional local OTP during the planning period that would complete the initial evaluation and allow Camden County to bring the medication into the jail facility for daily dispensing. Additionally, Camden County also leveraged the resources of the planning initiative to begin the process of applying to become a licensed OTP, which would alleviate both issues related to buprenorphine prescribing capacity issues and methadone maintenance and dispensing.

Challenges

The primary issue identified by Camden County regarded the stigma surrounding MOUD among key stakeholders, and the perceived resistance from the healthcare services vendor to enhance MOUD programs. Common beliefs included: MOUDs are substituting one drug for another, MOUDs are not helping individuals with OUD in the long run, and detoxification should be the primary goal. Second, there were a number of existing barriers surrounding linkage to care after release, including lack of personal identification, Medicaid re-instatement, lack of peer or patient navigation, and inconsistent initial appointments at receiving community treatment providers.

CHESTERFIELD COUNTY, VA

Prior to the start of this project, Chesterfield County offered extended-release naltrexone and oral naltrexone to individuals requesting medications at the time of their release, as well as over-the-counter medication for detoxification. Pregnant women with OUD were transferred to the local hospital for medication induction on methadone or buprenorphine. Because Chesterfield County did not begin the planning initiative with an infrastructure to provide agonist or partial agonist MOUD, the team's activities were more focused on education and preparation, than tasks related to direct MOUD delivery.

Facilitating Factors

One major facilitating factor that aided the Chesterfield County team was the pre-existing relationships between team members from previous inter-organizational projects and collaborations. Additionally, team members acknowledged not only the tremendous support they received from the highest levels of the criminal justice system administration in the state and county, but also the expectation from these individuals that team members begin to successfully navigate expanding MOUD and other treatment services. Chesterfield County also mentioned the highly informative resources provided by their coach including toolkits, MOUs, induction protocols, and videos, as well as examples from other Bridges and non-Bridges sites.

Future Goals

In addition to continued education to reduce stigma, Chesterfield County also planned to establish a contract with an external vendor to improve data management and data sharing between organizations regarding MOUD and treatment planning for incarcerated individuals moving through and exiting the criminal justice system.

Major Accomplishments

During the initiative, the Medical Director for the jail received a buprenorphine waiver and the jail employed a part-time psychiatrist. The Medical Director was also able to schedule a meeting within the jail with representatives from a manufacturer to explore initiating a pilot program for extended-release buprenorphine. One of the biggest accomplishments highlighted by the team was the identification of existing resources and capacity to expand MOUDs within the jail and larger criminal justice system. The team largely attributed this accomplishment to the regular meetings and increased communication and collaboration between stakeholders that was afforded to them as part of the planning initiative grant. Additionally, the team was also able to increase awareness surrounding MOUDs, and the possibility of increasing services to currently incarcerated individuals through the creation of educational resources, including posters in the jail, power point presentations for incarcerated individuals, videos created with the Medical Director, and cross-system maps for criminal justice staff reference.

Challenges

Chesterfield County was marked by a number of challenges that were echoed by several team members, among the most prominent was the stigma surrounding MOUD throughout the criminal justice system in the county. Stigma was also high among incarcerated individuals with OUD, many of whom already participated in the abstinence-based Heroin Addiction Recovery Program (HARP) in the jail, or belonged to other abstinence-based community treatment programs or groups. The community treatment partner also mentioned capacity challenges, given that they are a small office-based buprenorphine opioid treatment (OBOT) program, who refers individuals out to OTPs for all methadone dispensing and even some buprenorphine dispensing that is beyond their waivered capacity. The Medical Director added that the planning for buprenorphine inclusion in the jail is a large undertaking for a small medical staff who is already managing regular medical care.

CLACKAMAS COUNTY, OR

When Clackamas County began the Bridges planning initiative, the jail facility had the ability to initiate and continue individuals on extended-release naltrexone if they were taking it in the community, as well as utilize buprenorphine for detoxification and, in a limited capacity, to initiate buprenorphine. Clackamas County was also able to continue pregnant women on methadone if they were taking it in the community, but these individuals needed to be transported to an off-site OTP. Clackamas County was also in the position of navigating MOUD service changes with a contracted healthcare vendor, which added an additional stakeholder to the planning initiative team.

Facilitating Factors

The Clackamas County team identified already strong communication, coordination, and existing relationships between the jail, medical vendor staff, and parole and probation as a notable facilitating factor to their success during the Bridges initiative. However, the team also mentioned that the resources they received from the larger initiative team and their coach were essential for the development of the MAT coordinator position, keeping the motivation strong among the team, and developing a better understanding of the requirements of developing a mobile treatment unit and applying for an OTP license and credentialing.

Future Goals

Moving forward, the Clackamas County team is preparing to apply for an OTP license and credentialing. Along these lines, the jail is also interested in expanding the provision of MOUDs to include extended-release buprenorphine formulations. Finally, the team is looking into a mobile unit or bridge clinic option to assist with the ongoing issue of low community MOUD treatment capacity.

Major Accomplishments

One of the major accomplishments of the planning initiative was the creation of an MAT Coordinator position within the jail facility to assist the medical staff as the MOUD program continued to expand. Although this required creating a contract amendment with their healthcare vendor, the team was able to successfully advertise and hire for this position during the Bridges initiative. Clackamas County was also able to begin maintaining individuals on buprenorphine if they were already receiving the medication in the community, and initiate pregnant individuals on buprenorphine who were not already receiving either methadone or buprenorphine in the community.

Challenges

Providing methadone in Clackamas County was, and continues to be, a hurdle for the team. There are no methadone clinics within the county, and pregnant women currently have to be transported more than 20 miles to the nearest OTP. Releasing these individuals back into the community is a serious consideration for jail and medical staff, knowing there are a lack of local resources. These issues expand beyond methadone to all MOUDs, with limited community treatment capacity reducing their ability to link individuals to care within 48 hours of release. Even the existing relationship the jail maintains with a local residential treatment center has been difficult to navigate given their longstanding resistance to MOUDs, although they have been more accommodating of extended-release naltrexone over time, and by the end of the Bridges initiative were accepting more MOUD clients than not. Like many other teams, Clackamas County also struggles with minimal data collection and data sources. Although individuals are easy to track while incarcerated, it is very difficult for probation and parole to track MOUD individuals in the community since it is all manual and investigative.

COLLIER COUNTY, FL

At the start of the Bridges planning initiative, Collier County largely provided detoxification services for individuals with OUD, even those coming in on MOUD in the community. Pregnant women who were taking methadone in the community were continued on the medication, but were receiving doses at an off-site OTP. Some extended-release naltrexone and buprenorphine was provided, but primarily for select individuals involved in drug court. Collier County works with a contracted healthcare vendor, but extended-release naltrexone injections are provided by the community treatment provider coming into the jail. The vendor, for whom the Medical Director is a waivered prescriber, only provides buprenorphine to select individuals and does not plan to provide any other MOUDs. Identifying and maintaining funding sources were the primary challenge and barrier for Collier County.

Facilitating Factors

The Collier County team attributed much of its success to the relationships among the local organizations working on the initiative. Additionally, the Collier County Board of Commissioners had been raising awareness around the use of MOUDs in the criminal justice system prior to the Bridges initiative, but it was Bridges that finally brought the jail to move into action. The team also mentioned that there were more recovery housing options available to individuals leaving incarceration that are now accepting MOUDs since the team's outreach. Resources from the larger team initiative and coach were also helpful to the team's success including the education MOUD videos that were shown to stakeholders, learning from similar sites involved in the convenings, and getting information about peer recovery support staffing.

Future Goals

Collier County intends on introducing methadone and buprenorphine continuation for any individual who enters the facility on medication, ideally by July 2020. The healthcare vendor is also working with a local OTP who may be willing to bring methadone to the jail for dispensing to reduce security burden on jail staff. Finally, the team is looking into incorporating peer support staff into substance use and MOUD programs.

Major Accomplishments

The primary accomplishment for the Collier County team was establishing buy-in among relevant stakeholders in the criminal justice system and community, including jail staff, medical staff, judges, the Criminal Justice Mental Health and Substance Abuse (CJMHSA) planning council, the Public Safety Coordinating Council (PSCC), and a local Ad Hoc Advisory Re-integration board. The team was able to generate this buy-in through educational videos, power point presentations, informational lunches, creating strategic plans with stakeholder partners, and generating active discussions. In addition to education and information dissemination, the team was also able to add additional questions to the jail intake medical screener completed by the healthcare vendor that specifically addresses MOUD medication history and current use in the community.

Challenges

The team faced a number of challenges. The stigma surrounding MOUDs among corrections, court, and healthcare staff was considerable. Also, there were a number of challenges facing the jail facility that included short lengths of stay, unknown release dates, few available physician hours, barriers to information sharing due to the use of separate electronic record systems and challenging interagency documentation (e.g. releases of information forms acceptable to all parties), and security issues related to transporting pregnant women to the local OTP. Funding remained a significant barrier to Collier County, but the team was committed to applying for any and all state or local grants available.

COOK COUNTY, IL

At the start of the Bridges initiative, Cook County already offered all 3 FDA-approved medications for MOUD in the jail. Correctional health care in Cook County is provided by the Cook County Health Department, who are also the same system into which individuals are largely referred upon release. This is advantageous for information sharing and tracking into the community. However, although Cook County has an advanced MOUD program in the jail, the Bridges initiative was leveraged to involve the rest of the justice system beyond the healthcare providers.

Facilitating Factors

The Cook County team noted that receiving resources from their coach was particularly helpful, and they were able to use several of the videos and vignettes suggested by their coach during their trainings. The team was also fortunate to have active participation by all members, including those who were added during the planning period including judges, probation and parole officers, public defenders, and prosecutors. The structure of the Bridges planning initiative was helpful in maintaining momentum, which included creating the actions plans and scheduling bi-weekly phone conferences. The team acknowledged their coach's role in helping them to continue navigating the development of their OTP and significantly increasing the number of incarcerated individuals receiving methadone maintenance.

Future Goals

Cook County is not currently reaching everyone who wants MOUD in the jail. Ideally the team would like to continue working toward embedding MOUD into primary care across the county as a way of expanding treatment continuation in the community. They are also working towards a mobile methadone program and hope to add an additional (second) dispensing site, but that requires additional coordination and staffing. Future goals also include a real-time, update comprehensive web-based database of capacity for community based MOUD treatment, as well as programs to engage individuals released within 9 days of incarceration with MOUD and community linkage.

Major Accomplishments

A major accomplishment during the Bridges initiative surrounded trainings that increased support among corrections and criminal justice stakeholders involving medication education and the science behind them, targeting stigma and substance use disorder misconceptions. The planning team was also able to address some early policy changes within state prisons, which are now beginning to continue maintaining people on MOUDs even once they are sentenced, although this effort is still in its infancy. Cook County was also able to launch a one day a week walk-in bridge clinic program in October 2019 with the support of partners and the Bridges grant. This allows individuals who do not engage in community MOUD treatment directly upon release to use the clinic as a bridge to access care when they are ready.

Challenges

The biggest challenge for Cook County is getting DOC staff on-board with MOUD and breaking down the barriers between organizational and departmental siloes. This points to the need for a strong foundation when rolling out MOUD programs and maintaining staff trainings over time, particularly given staff turnover. There continues to be a great deal of stigma and there are times that decisions made by the court or corrections interferes with or precludes decisions that should be made by the person's treatment providers. Additionally, Illinois prisons do not have a robust program for maintaining or initiating MOUD, so individuals are often tapered off once sentenced. The Illinois prison's new policy is not to taper patients off MOUD, but this has been slow to adopt in practice.

CUMBERLAND COUNTY, ME

Prior to the start of the Bridges initiative, Cumberland County offered buprenorphine and methadone continuation for pregnant women who were receiving either medication in the community. However, these individuals who are continuing to receive methadone are transported off-site to receive dosing at a local OTP. Cumberland County did not indicate regular use or dispensing of extended-release naltrexone in the facility prior to the start of the initiative. Similar to other sites, Cumberland County also utilized a contracted vendor for correctional healthcare, which added an additional stakeholder to the team's efforts to navigate changes to their existing MOUD programs.

Facilitating Factors

The Cumberland County team identified several facilitating factors related to the structure of the Bridges initiative, including putting the relevant stakeholders together in bi-weekly meetings, the coach motivating team members with establishing goals and deadlines, and the in-person convenings allowing a free exchange of information among participating sites. Cumberland County was introduced to Eaton County during one of the convenings and they were able to learn from a site with notable successes that was of a similar size and population. Unlike other sites that noted community treatment capacity issues, the Cumberland County team remarked about the robust MOUD resources in their area and have since utilized this strength to provide in-reach to assist their healthcare vendor in MOUD improvements.

Future Goals

Moving forward, Cumberland County would like to hire an MOUD coordinator to assist jail staff in navigating issues related to the MOUD program, connecting individuals being released to ongoing care, and sustaining the relationships developed during the Bridges initiative. The team would also like to look into establishing a medical unit for dispensing methadone at the jail. Finally, the team plans to administer an inter-agency survey across systems (including jail staff, defense bar, pretrial, prosecutors, and judges) to determine the greatest educational and training need areas.

Major Accomplishments

Although Cumberland County did not focus on expanding access to any additional MOUDs during the planning initiative, the team was able to refine and improve existing programs and procedures. Among the most notable accomplishments was the expansion of take-home doses dispensed by the local OTP to the jail facility in order to limit the transportation of incarcerated individuals. The Maine State Opioid Treatment Authority (SOTA) approved up to 30 days of methadone to be dispensed in the jail as a satellite OTP for each patient, but the jail was satisfied with only allowing 5 days of take-home doses. The team was also able to establish an MOU between the sheriff's office and the City of Portland for overdose prevention and naloxone dispensing to take place prior to release, which was a joint collaboration between the healthcare vendor and jail administration.

Challenges

Throughout the initiative, Cumberland County was plagued with issues related to staffing shortages and turnover. When new staff members are hired, it can be difficult to get them on board with the MOUD programs and embedded in the process, while also ensuring a positive, sustainable working relationship between the healthcare vendor and the jail staff. Initially, the contract with their healthcare vendor did not include MOUD services, and although the jail needed to discuss expanding the contract to include MOUD, the jail also needed to work with external providers to augment MOUD services in the interim. Cumberland County also identified barriers to accessing extended-release naltrexone including pre-authorization requirements through MaineCare and community providers to continue injections due to the high expense.

DURHAM COUNTY, NC

Prior to the start of the Bridges initiative, Durham County was utilizing withdrawal protocols with MOUD detoxification (methadone and buprenorphine), as well as treating other withdrawal symptoms. Pregnant women who were already taking methadone in the community were continued on methadone during their incarceration and transported to a local OTP. Extended-release naltrexone was not being used in Durham County due to the prohibitive cost, which was a particularly significant issue considering North Carolina is not a Medicaid expansion state. Although Durham County has a long-standing abstinence-based program for treating substance use disorders within the jail, this recent focus on MOUD expansion has required a shift in paradigmatic thinking for jail staff. Durham County was also a site that was working with a contracted healthcare vendor.

Facilitating Factors

The team indicated that there were a number of facilitating factors that assisted the team in achieving their goals, including a supportive Sheriff and buy-in from major stakeholders. Additionally, the team received helpful support from their coach, such as answering any and all questions related to the project, attending their team meetings, and connecting them with additional resources that may prove helpful. The team specifically utilized a number of manuals, resources, and guides to help draft their newly-established policies and guidelines. Also, the local, major university partners have been helpful in aiding them to structure, track, and determine the best ways to analyze their data.

Future Goals

The primary future goals for the team are to implement induction procedures for buprenorphine and methadone, hire peer support staff, establish dedicated case manager and counseling staff for MOUD individuals, and increase nurse and physician time. However, to complete these goals the team is aware of the significant need to continue to seek out additional funding, as well as monitor security issues to prevent diversion.

Major Accomplishments

One of the major accomplishments for the Durham County team was the opening of a medical unit within the jail facility for the local OTP provider to directly offer doses to incarcerated individuals. The team received support for this effort from the personnel assigned to the state opioid program, and were able to successfully complete this task during the planning initiative. This expansion, coupled with a Nurse Practitioner staff member becoming waivered to prescribe buprenorphine, allowed Durham County to begin continuing individuals on methadone and buprenorphine who were being prescribed the medication in the community. Additionally, the team was also able to incorporate a validated instrument into the intake screening process, and document DSM-5 substance use disorder status into the jail's EHR. Finally, the team developed a training to combat stigma surrounding addiction and MOUD that will be mandatory for everyone in the agency from command to line staff.

Challenges

One of the major challenges facing the Durham County team from the start surrounded avenues of funding. Although the team appeared interested in extended-release naltrexone, the cost proved prohibitively expensive for the county to afford when future funding for methadone and buprenorphine is still in question. The team consistently wrestled with questions of sustainability, and how to begin considering an induction protocol without adequate resources in the community in which to refer released individuals. Staffing was also a consistent issue when considering how to expand the MOUD program, given the additional time demand involved in daily medication dosing and mitigating diversion risks.

EATON COUNTY, MI

Prior to the start of the Bridges initiative, Eaton County was initiating and maintaining individuals with OUD on all three FDA-approved MOUDs. Eaton County works with four OTPs in the local community who provide methadone dosing daily within the facility. All MOUD inductions take place within the jail, and an external community treatment organization provides the educational and support programing. Jail medical staff are employed directly by the Sheriff's office, so there is no external healthcare vendor in Eaton County.

Facilitating Factors

Eaton County team members attributed their success in increasing extended-release naltrexone injections to improved relationships with the Medicaid managed care organization, court system staff, and community mental health. The Bridges initiative allowed team members to meet regularly and maintain motivation for the project, which strengthened these necessary partnerships allowing all members to contribute to improved processes surrounding MOUD programs. Team members noted that their coach, who was very familiar with the local challenges and resources, was a wealth of information and was always available to the team. Finally, Eaton County was fortunate enough to have an existing standard release of information that covered different external treatment and health organizations.

Future Goals

Moving forward, the team plans to concentrate efforts on improving and expanding data collection and tracking systems. The team would like law enforcement to have the ability to track long-term progress of program participants and develop a performance measuring tool, which may be able to occur through an existing statewide system or Medicaid. A local university has agreed to help the county develop data tracking systems in exchange for using Eaton County as a model for other jails in Michigan that would like to implement MOUD programs.

Major Accomplishments

One of the most notable accomplishments of the Eaton County team was the expansion of extended-release naltrexone to include additional injections prior to release. Before the Bridges initiative, Eaton County jail was providing one extended-release naltrexone injection to interested individuals. However, since the team members were able to secure additional funding from the Medicaid managed care organization, they saw their first individual in custody successfully receive three injections prior to release during the planning period. Additionally, jail administration recognized the need to establish specific housing units for individuals receiving MOUD in jail, and were able to establish two separate units, one for women and one for men, in order to reduce diversion, provide peer support, and hold relevant educational programming.

Challenges

One of the most significant challenges facing the Eaton County team was a lack of post-release data collection for MOUD program participants. Team members would ideally like to institute a universal EHR system in Eaton County, but that is a much more significant undertaking than the initiative timeline would allow. Funding also continued to be an issue, and while the state of Michigan had been funding the existing MOUD program, jail administration was working closely with jail medical providers to find additional funding to support their efforts. During the initiative, the team's behavioral health partner closed, and since November 2019 the team needed to work with other resources to establish an interim plan for providing services. Finally, the jail medical department was in need of additional staffing, including a full-time RN.

HUDSON COUNTY, NJ

Prior to the start of the Bridges planning initiative, Hudson County provided incarcerated individuals access to all three FDA approved medications for OUD. Pregnant women, however, were the only ones who were referred for methadone. Incarcerated pregnant women were initiated onto methadone, if they were not already receiving an agonist treatment medication, by being transported to a local OTP for their intake and assessment, and continued being transported to this clinic once a week to receive 6 additional days of take-home dosing. Buprenorphine and extended-release naltrexone were being utilized for both initiation and continuation. Hudson County also contracted jail-based healthcare services with an external vendor.

Facilitating Factors

One of the major benefits to Hudson County's participation in the initiative was to bring greater visibility and validation for MOUD programs among criminal justice populations. The fact that all three medications for OUD were already offered in Hudson County's jail was a significant facilitating factor for progress during the initiative, since efforts related to MOUD programs were focused on scaling up existing practices to ideally allow access for all appropriate individuals. The team described the coach as being particularly helpful in assisting the members to assess the current infrastructure and identify future directions and pathways to achieve their goals.

Future Goals

Hudson County's future goals include continuing to scale up jail MOUD programs and working to develop an MOUD hotline that provides a direct referral to community treatment.

Major Accomplishments

Although extended-release naltrexone was widely used in Hudson County, the primary accomplishments of the Bridges initiative surrounded the expansion of the buprenorphine and methadone programs. During the planning period Hudson County focused on improving the dosing ability of the jail by switching to buprenorphine strips, medicating individuals individually, completing dosing checks, and supplying individuals with liquids during medication dosing – all focused on reducing diversion within the facility. The team was also able to enhance and improve communication between the jail and the healthcare vendor, which they indicated was limited prior to the Bridges initiative.

Challenges

The most notable challenges presented by the team include structural barriers to MOUD expansion within the state criminal justice system. First, New Jersey is a bail reform state, and all individuals who do not have a history of violent crimes must be released within 48 hours. This policy only takes into account the individual's criminal history in predicting recidivism or presenting a danger to the community, and does not take into account the current status of their underlying opioid use disorder. Second, residential treatment facilities in the state must provide MOUD if they collect Medicaid; however, individuals with a distribution charge who served greater than 6 months are not eligible for Medicaid and are often unable to access MOUD. Additionally, data collection is an issue for tracking patient outcomes given that the County Correctional Information, Medicaid, and Homeless Management system are all separate systems that are not linked, and only the state can run special reports from these systems. Ultimately, this siloed approach to care was an overarching barrier during the initiative and moving forward.

INGHAM COUNTY, MI

Prior to the start of the Bridges planning initiative, Ingham County only maintained incarcerated individuals on methadone if they were receiving it in the community. In these cases, Ingham County would contact the individual's provider and arrange for the community OTP to deliver the medication to the jail for dispensing. No other MOUD was provided by the jail. Ingham County does not contract jail healthcare services to a private vendor, so medical services during incarceration are provided by the county health department. When individuals leave the jail in need of continuing medical services, they are referred to a community FQHC that is also run by the county health department.

Facilitating Factors

The team identified a number of facilitating factors to their success during the Bridges initiative, including having no issues with confidentiality or releases of information because the health department provides medical care both in and out of the jail facility. If an individual is interested in receiving an MOUD, all of the necessary releases are collected during their enrollment into the medication program. Once the individual is released, they are referred to the community FQHC and all of the releases allow for the free exchange of information and continuity of care. The EHR systems in the jail facility and community FQHC are also directly linked. Additionally, the team commented that the site visits funded by BJA were particularly helpful and members took full advantage of visiting two other jail facilities to tour successful MOUD programs. The coach encouraged these site visits, as well as provided written and video resources, and helped troubleshoot emergent issues.

Future Goals

The team plans to identify the location of all pertinent data associated with incarcerated individuals on MOUDs, but this will likely be collected and tabulated by hand until more efficient processes can be developed.

Major Accomplishments

One of the most notable accomplishments for Ingham County during the planning period was the expansion of MOUD services to include buprenorphine and extended-release naltrexone. Although the team still plans to scale up the use of these medications, they made large strides in developing the capacity and infrastructure within the jail. The team was able to accomplish getting their medical providers waivered to prescribe buprenorphine, and began providing oral naltrexone during incarceration to individuals interested in receiving an extended-release naltrexone injection prior to release. The first individual to successfully continue receiving buprenorphine during incarceration occurred in February 2020. The team was also able to implement evidence-based practices to begin initiating pregnant women on methadone.

Challenges

Expansion of methadone-related services has been the most challenging to pursue during the planning initiative, and although the team completed a site visit to a jurisdiction in Massachusetts, they realize there are still many detail-oriented procedures to consider internally as they revise the program. Buprenorphine expansion was reliant on providers receiving the appropriate prescription waivers, which was a challenge early in the initiative. Funding to sustain expansion of MOUD programs was also identified as a challenge, as well as the need for greater communication between health department medical staff and the substance abuse services staff in the jail. Finally, although medical records for individuals are linked between in-jail and community services, other information related to substance use treatment is siloed.

JEFFERSON COUNTY, KY

Prior to the Bridges initiative, extended-release naltrexone was offered to individuals who were released into the community through an existing re-entry program. Methadone was offered to pregnant women to initiate while incarcerated or continue if they were receiving the medication in the community. Although the team is working to establish the proper infrastructure to provide buprenorphine, individuals do not currently have the option to receive it during incarceration. Jefferson County contracts jail medical healthcare with a private vendor.

Facilitating Factors

One of the primary facilitating factors that team members reported was the positive relationship between jail administration and the contracted healthcare vendor. Team members described this relationship as very positive, with the vendor even willing to provide extended-release naltrexone to re-entering individuals even though their contract agreement does not include providing other preventative medications, which is how some team members classify extended-release naltrexone. The team also praised the coach's efforts by stating the positive guidance they provided, as well as practical resources and troubleshooting.

Future Goals

One goal for the team moving forward is to expand Medicaid coverage to include individuals during incarceration. The team identified this as a major gap in re-entry and care coordination, and since the jail only knows if individuals continued their MOUD care into the community if they remain on community supervision, they fear many people may not be able to continue receiving MOUDs once released. The team also plans to continue collecting data that will forecast the additional cost of adding buprenorphine treatment within the jail facility, as well as expanding the methadone program to all appropriate individuals. Finally, the jail would like to apply for a waiver that would allow medical staff to treat individuals at the time of arrest for 72 hours if the local OTP is unable to drop off medication.

Major Accomplishments

During the planning period, the team was able to request that the health department, who oversees healthcare contracts, revise the existing MOU with the jail to expand access to methadone from pregnant women to all individuals who were receiving the medication in the community. Additionally, the healthcare vendor is working to revise existing corporate policies to include MOUD as a standard-of-care, and plans to use Jefferson County as a pilot site for service expansions. Further accomplishments include having three vendor providers plan to or begin receiving their waiver training to provide buprenorphine in the future, encouraging the local OTP to expand space and provider capacity to support additional methadone needs, establish an internal interdisciplinary work group to adjust management for security staff and MOUD trainings for staff members, and tracking internal trend data to determine how many individuals are entering the jail facility who would be eligible to continue receiving methadone or buprenorphine once offered.

Challenges

One challenge during the initiative and moving forward is the ongoing contract negotiations between jail administration and the contracted healthcare vendor. Although there is a positive relationship between the two stakeholders, expanding MOUD programs will require additional funding and staff. Another major challenge has been the stigma related to certain MOUDs, which is why the team ultimately decided to expand methadone services, because the jail staff has watched the positive benefits to pregnant women. Unfortunately, the diversion concerns associated with buprenorphine is a major barrier. The team agrees that more education and training will be important for all stakeholders.

LEWIS AND CLARK COUNTY, MT

Prior to the Bridges planning initiative, Lewis and Clark County only continued individuals on extended-release naltrexone if they were receiving it in the community. The jail was not offering either buprenorphine or methadone for initiation or continuation to any incarcerated individuals. Pregnant women who were receiving methadone in the community were often diverted from incarceration, but would be allowed to continue on methadone if diversion was not possible. The previous provider within the jail was opposed to MOUD, but this provider retired early in the initiative and the new provider, who was hired in February 2020, is supportive of MOUD. Jail medical healthcare is provided by jail employees, not contracted out to an external provider.

Facilitating Factors

Among the most notable facilitating factors identified by the Lewis and Clark team was the employment of medical staff through the jail directly. The jail has previously had both external contracts and county health providing medical services in the jail, but internal medical staff makes it easier for them to implement changes, kept oversight internal, and has been more cost-efficient. The team also noted that the jail has a very positive relationship with the two community FQHCs who provide MOUD, and both FQHCs are perceived as providing high-quality care. The county also has peer support specialists in the community who transport released individuals to one of the FQHCs to connect them with services immediately upon release, ensuring a seamless continuity of care. The most helpful resources provided by the coach included practical documentation, toolkits, and protocols that Lewis and Clark was able to use in their MOUD program expansion.

Future Goals

Lewis and Clark continues to work toward better data collection, and recently hired an individual to assist them. They have also applied for a grant to modify their existing jail software to track patient outcomes and track individuals into the community. The team also plans to expand their community referral network to an additional organization and have case managers coordinate which individuals to send to each. Although Lewis and Clack has not expanded their MOUDs to more incarcerated individuals, the team describes the jail as “super close” to being ready to start expansion.

Major Accomplishments

One major accomplishment the team noted during the initiative involved hiring a new provider who is supportive of MOUD, and who began working toward the waiver to prescribe buprenorphine immediately upon hire. Additionally, the team was also able to obtain grant funding early on to support the hiring of a behavioral health case manager and a peer specialist. These individuals were hired and on-boarded during the initiative. The team was also able to develop written re-entry plans, policies, and protocols, including tracking and reporting for individuals who would be receiving MOUD. The jail was also able to connect to the universal release of information in the county, which will make future MOUD referrals significantly more streamlined.

Challenges

The retirement of the primary physician in the jail during the initiative was a major hurdle for the team, but it did allow the jail to hire a new physician who was more supportive of the MOUD program development. The jail facility is also in the middle of a major renovation project, and the team needed to quickly ensure that these renovation plans included required accommodations for agonist medications, including additional security cameras. The team also continues to struggle with data collection to inform the need and associated cost with a new MOUD program, as well as stigma-related barriers in the community.

MARION COUNTY, IN

Prior to the Bridges initiative, Marion County offered methadone to pregnant women only, and these individuals needed to be transported to a community OTP to receive their medication daily. Marion County also offered extended-release naltrexone for specific individuals who were released to community supervision, violated the terms of their supervision due to their OUD, and were re-incarcerated. These individuals would be screened, and their eligibility for the extended-release naltrexone program would be determined. Marion County maintains a contract with an external healthcare vendor for jail medical services.

Facilitating Factors

One of greatest facilitating factors for the team's success was inviting jail medical staff to the second in-person Bridges convening in January 2020. During this convening, medical staff were able to have access to an expert MOUD provider who answered all of their questions and responded to their concerns. The team also benefitted from the convenings by having the ability to see how other sites navigated implementing MOUDs and how similar issues to their own were addressed. The team mentioned that the in-person initial site visit was helpful, as was their coach, who kept the team on track and provided helpful resources. Finally, the team remarked that the positive relationship between the jail and the contracted healthcare vendor was also a notable facilitating factor.

Future Goals

Moving forward Marion County is working with two additional treatment providers in the community to develop their MOUD programs to improve care coordination. The team has also started attending bi-weekly meetings with Indiana University regarding substance use treatment in jails that includes jurisdictions from around the country.

Major Accomplishments

One of the major accomplishments for Marion County during the initiative was the ability for the community OTP to regularly bring methadone into the jail facility to dispense to pregnant women being maintained on the medication. Although they plan to expand the methadone program in the future to include all individuals who are appropriate, this was a necessary first step to logistically expand the program. The team is currently debating whether the jail should apply for a license to become an OTP. Marion County has also been working to expand the extended-release naltrexone program to any incarcerated individuals who are appropriate. The team was able to get the external healthcare vendor physician to apply for and receive a waiver to prescribe buprenorphine in the future, and the nurse practitioner was in the process of receiving a waiver early in the spring of 2020. The team has obtained cost information for each MOUD, and will be able to determine the total cost of program expansion once they are able to determine the need of incoming individuals with OUD.

Challenges

One initial challenge for the team was the hesitation on behalf of the healthcare vendor to expand the existing MOUD program, and the jail accepting the vendor's caution since they are the medical experts on the team. However, this was largely dispelled after the second in-person convening. Another challenge was the absence of a release of information for substance use care to community supervision. Currently there is no way for a community supervision officer to know what medication an individual is receiving inside the jail, which limits their ability to assist individuals in reconnecting to care in the community. Marion County was also struggling with a lack of community capacity to continue individuals on MOUDs in the community.

ORLEANS, ST. BERNARD, AND PLAQUEMINES PARISHES, LA

Prior to the Bridges initiative, these Louisiana Parishes did not offer incarcerated individuals any FDA approved medications for OUD. Pregnant women who were taking methadone in the community were discontinued from the medication and placed on an oral, lower potency opioid. Individuals incarcerated in the jail who were receiving buprenorphine in the community were detoxed from the medication, and then encouraged to re-initiate buprenorphine treatment once they were released into the community. Medical providers within the jail were obligated to follow-up with an individual's buprenorphine provider to ensure that the individual resumed treatment. Medical services in these Parishes are contracted to an external healthcare vendor.

Facilitating Factors

Among the most notable facilitating factors for the Louisiana team was the extensive experience offered from the lead medical provider in the jail, who was one of the first providers in the state to use injectable formulations of buprenorphine and was responsible for overseeing all clinical services and standards of care within the facility. The team also commented on the helpfulness and utility of their coach, who was described as knowledgeable, experienced, and maintained a firm grasp of how to assist the team in identifying barriers. Further, the team mentioned that the pharmacy monitoring program allows providers an easy mechanism for medication verification.

Future Goals

Ultimately, the Louisiana team plans to implement buprenorphine, methadone, and oral naltrexone for their growing jail populations, but there are still a number of barriers that need to be addressed. The team plans to perform a basic analysis of cost using existing data related to potential volume of patients by reported medication status in the community.

Major Accomplishments

As the initiative came to a close, the team was able to develop a full plan moving forward to implement protocols for methadone, buprenorphine, and oral naltrexone within the jail, as well as the coordination of care into the community once individuals are released. All of the MOUD trainings of pertinent staff had been scheduled. As a part of these efforts, additional medical staff within the jail received buprenorphine waivers in December 2019. Additionally, a new protocol was implemented for pregnant women who are taking methadone in the community. These individuals are now transported to a local OTP provider to receive daily dosing. The team is still working closely with the community OTP provider to determine how the jail can begin offering methadone doses to incarcerated individuals so they do not need to continue daily transportation to the clinic.

Challenges

One major barrier the team identified to moving toward full MOUD implementation was the coordination of care from jail medical staff to the community. There is currently no mechanism or process for a hand-off to the community provider from the jail healthcare vendor, and although individuals tend to end up with the community provider eventually, it is generally through the on-site peer. An additional barrier the team confronted was the absence of MOUD services or medications in the contract between the local government and the jail healthcare vendor. Without the local government having a role on the team, efforts were limited until the contract with the healthcare vendor could be amended to include MOUD services and medications. Although these discussions are in process, the healthcare vendor's corporate office also needs to sign off on the additional services. Finally, extended-release naltrexone has not been approved for use in the jail because it is cost prohibitive.

SHELBY COUNTY, TN

Prior to the Bridges initiative, the only FDA-approved MOUD that Shelby County offered was through a methadone program for pregnant women. When pregnant women come into the jail, they were transported to a community OTP for methadone induction and then transported regularly for dosing. Other individuals coming into the facility with OUD were placed on detoxification management. Although Shelby County did not offer extended-release naltrexone in the jail, they planned to move forward with implementation discussions during the planning period because the team believed it would be more feasible to implement than buprenorphine. The Shelby County jail had a contract with an external vendor for providing medical services, but this contract was ending during the planning period. The team was unsure which vendor would be awarded the contract in the future.

Facilitating Factors

The Shelby County team described all of the members as highly motivated to move the jail closer to MOUD implementation during the Bridges initiative. Overall, the team identified their coach as particularly helpful in providing resources for the project, including a universal release of information that the team could use as a reference. The members expressed that the in-person convenings were a fruitful opportunity to hear from other sites about their experiences, discuss barriers they encountered, and arrange future site visits.

Future Goals

Shelby County's goals moving forward include: 1) receiving technical assistance for extended-release naltrexone implementation, 2) finalizing the intake screening tool, 3) hiring a discharge planner to assist with individuals' ability to continue receiving care in the community, and 4) continuing methadone for pregnant women after delivery to avoid withdrawal symptoms.

Major Accomplishments

One of the most notable accomplishments from the Shelby County team was the development and dissemination of a stakeholder survey to determine knowledge, attitudes, and opinions of MOUDs by staff at a variety of criminal justice agencies, including public defenders, district attorneys, judges, jail staff, and judicial commissioners. The team was pleasantly surprised by how informed they were, and how open to MOUD many of them indicated they would be. Similarly, the team also made strides in introducing the topic and importance of MOUDs to local leaders and stakeholders, to continue the culture shift toward MOUD acceptability. The team was able to implement a screening instrument to help identify individuals coming into the jail who were receiving MOUD in the community, and were working to expand this screening tool with their healthcare vendor to make it more comprehensive. Although the team was not able to make significant strides toward extended-release naltrexone implementation planning, the team had started meeting with the manufacturer about the process.

Challenges

The primary challenge Shelby County faced during the Bridges initiative was adequate resources and funding. A proposal for additional funding for MOUD was submitted in February 2020, but was moved to the health department for further consideration. The team also realized that many tasks related to the initiative were pushed to the medical staff because their input was necessary to include, but there had been some delay in moving tasks forward given competing demands on their time. With regards to extended-release naltrexone, the team had concerns about unknown release dates/times, a lack of community providers delivering this medication, its high cost and issues with individuals being able to afford injections in the community given that Tennessee is a not a Medicaid expansion state. Finally, the team maintained concerns about delays related to the potential change in contracted health vendors.

ST. LOUIS COUNTY, MO

Prior to the Bridges initiative, buprenorphine was offered to incarcerated individuals if they were receiving it in the community and also met certain other criteria. Methadone and extended-release naltrexone were not offered in St. Louis County. Pregnant women were allowed to receive a few days of emergency methadone dosing from the jail upon entry, but were ultimately transported to the emergency room for ongoing care. Generally, the jail attempted to move pregnant women with OUD into treatment or an alternative program to incarceration. The jail medical services are provided by an external, contracted vendor.

Facilitating Factors

One of the primary facilitating factors identified by the team included the immense value of the in-person convenings. The team attributed their recent ability to initiate individuals on buprenorphine to these meetings, as well as the added benefit to the team in breaking down communication barriers between the community treatment provider and the jail. Because of their fairly rapid expansion of MOUD programs and future plans, many more community providers have contacted the jail about being a community referral location for individuals leaving the facility on MOUD. The team also benefited from the experience of the lead medical provider who had recently implemented buprenorphine in a smaller county in Minnesota and was familiar with the process. Finally, the county also has a universal release of information that MOUD program participants sign when they enter the programs that allows medical providers to communicate with providers in the community.

Future Goals

The team has many goals for continued expansion and implementation including: 1) receiving additional funding for a re-entry Navigator, 2) coordinating methadone in-reach services with a local OTP, 3) utilizing grant funding for tele-health visits with peer support staff, 4) improving transportation resources for peer support to use, 5) offering oral naltrexone in the near future, and 6) developing better data collection to track outcomes that the jail can leverage for additional funding by demonstrating effectiveness of the programs.

Major Accomplishments

Among the most notable accomplishments achieved by the team is the expansion of the buprenorphine program in St. Louis County in order to be able to initiate and maintain general jail population individuals on the medication. The team attributed this success to having the opportunity for the jail's lead medical provider learn from other providers at the in-person convening about the best way to approach program expansion. Also related to the in-person convenings, the lead medical provider encouraged a number of providers in his unit to become waivered to prescribe buprenorphine. By the end of the Bridges initiative, pregnant women with OUD could be continued on methadone or buprenorphine if they were receiving either medication in the community, and could choose to initiate either medication from the jail (buprenorphine) or a local OTP (methadone).

Challenges

Due to this fairly rapid MOUD program expansion, the jail realized that they will need to hire additional medical staff to facilitate the program's growth. Team members have already approached the Sheriff with a funding proposal. The team also recognized that community education was going to be a challenge moving forward, since the county overall maintains a cultural preference for abstinence-based treatment. An additional issue the team faced was the coordination of care through re-entry. The team is working to hire an additional Navigator to facilitate a "hot hand-off" with community treatment, but recognize there are additional gaps, including insurance coverage and other necessary documentation.

Implications for Practice and Recommendations for Further Inquiry

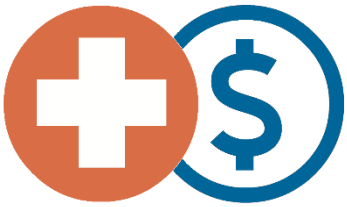
Flexible, Scalable Technical Assistance

The range of questions and issues faced by sites that participated in this effort will be faced by many jurisdictions throughout the US that wish to adopt MOUDs, and the provision of technical assistance, such as coaching, could be instrumental in their implementation efforts. The focus of the technical assistance will likely vary based on the jurisdiction's familiarity and experience with treating substance use disorders as well as their capacity for MOUD treatment in the community. Jurisdictions at earlier implementation readiness stages may require a broad overview of the issues to consider and regular meetings with coaches to monitor and guide progress. Jurisdictions looking to expand existing MOUDs, on the other hand, may need more concrete assistance, such as clinical forms, cost estimates, or workflow guidance. If possible, technical assistance should include clinical and/or regulatory experts (given the regulatory differences across states), as well as "peer-to-peer" networking opportunities to provide support and models of care delivery.

Future jurisdictions seeking to adopt MOUDs may benefit from accessing technical assistance provided by an agency (such as SAMHSA) and consulting best practices resources available through professional organizations (such as NCCHC). Technical assistance should include training in corrections-based MOUD treatment for staff and administrators, draft policy and procedural templates for jails and community treatment providers, and contact lists so that jurisdictions can learn from one another on a larger scale.

Health Care Funding for MOUD Delivery in Jails and the Community

Providing MOUDs in jail with continuation in the community is costly to the jails, who need to adjust budgets and health care contracts to account for both the medications and the additional health and correctional staff necessary to deliver care and minimize medication diversion. Additional costs may be incurred if the jail develops a bridge or mobile clinic to ensure continuity in patient care upon release. Understanding what these costs may be is a function of both the cost of services per patient, and the number of patients in need of treatment in the jail. Providing a better estimate of the overall treatment costs for launching, implementing, and sustaining these programs could be highly beneficial to jails considering initiating MOUD programs, or expanding care to include new medications, as they determine the size of the MOUD-eligible population coming into their facilities.



The "bridge" from jail to community MOUD treatment can be tricky for people to cross, even if they have health insurance prior to becoming incarcerated. There may be lags in re-initiating coverage upon release if it was suspended upon incarceration, and even more challenging if coverage was terminated during incarceration, as is done in many states. In such cases, jails can provide assistance to begin the reapplication process prior to release, however, due to the sometimes-lengthy application process and the fact that release from jail can occur with short notice, gaps are likely to be present. Greater attention to how these health care coverage barriers to treatment continuity can be minimized or eliminated is needed.

Implications for Practice and Recommendations for Further Inquiry
continued

Linking Patient Data

The ability to track people across systems, and ensure the continuity of care from jail to community, remains a goal that few Bridges sites were able to address. Some of the Bridges jails were partnering with local universities to help them better understand how the data they were already gathering could be used internally to track the need and reach of MOUD services in the facilities, as well as explore ways to link that data with external health systems in order to assess linkage success, at the very least. Sites not only envisioned using this data to determine need and reach, but also demonstrate effectiveness to skeptical stakeholders. The ultimate goal of the Bridges planning initiative was to have a broader public health impact by reducing overdoses and death for people leaving jail. Linking patient-level data across systems is central to examining this goal, and it currently remains quite limited.

Short Stay Populations

One of the most challenging groups of people that jails were concerned about treating with MOUDs are those released within 72 hours of arrest (what we referred to in our flow diagram as "short stay" populations). It can be challenging to complete a full medical assessment on this population before they are released, let alone complete induction on an MOUD. With bail reform considerations adopted in many states, and being considered in many more, this population is expected to grow. (Note that while arrest rates declined significantly nationally during the COVID-19 outbreak earlier this year, so did the censuses in many jails, as some city judges significantly reduced bail amounts or simply released prisoners without bail if they were deemed non-threatening.) The proportion of this population relative to those who remain incarcerated for weeks or months is expected to grow, which will increase the need to coordinate rapid screening and referral capacity in the jails, as well as the need to build/enhance community capacity to promptly accept patients for treatment following arrest.

MOUD Standards of Care in Correctional Health

Many of the jails participating in the Bridges planning initiative found that their contracts with the correctional health vendor was insufficient, and that re-contracting would be necessary in order to implement or expand MOUD-related treatment. Others noted that when their current contracts were up for bid the RFP would need to include the delivery of MOUDs. This speaks to the need for strengthening the standards of care in correctional health as it concerns the use of MOUDs, and making resources concerning those best practices more readily available. The field is rapidly evolving due to increased need and attention, and more remains to be done in terms of providing guidance and enhancing standards for the field.

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Appendix A: HMA Coaches

Lynn Dierker, RN is a Senior Program Director at the National Academy for State Health Policy (NASHP) focusing on health information technology. Previously, Lynn served as the director of the State-level Health Information Exchange Consensus Project. She has over 30 years of health care and health policy experience, including facilitating the launch of the Colorado Regional Health Information Organization as the first Interim Executive Director. Lynn coached the following jurisdictions: Clackamas County, Oregon; Cumberland County, Maine; and Lewis and Clark County, Montana.

Bren Manaugh, LCSW-S, CPHQ, CCTS is a licensed clinical social worker and certified clinical supervisor with more than 25-years of experience in trauma-informed care. She is an innovative strategist focusing on operations systems design and safety net funding for complex populations. Bren is a certified professional in health care quality and a specialist in organizational and systems transformation and whole person care. Bren coached the following jurisdictions: Camden County, New Jersey; Collier County, Florida*; Cook County, Illinois; Durham County, North Carolina*; Hudson County, New Jersey; and Shelby County, Tennessee*.

Margarita Pereyda, MD is a Physician Executive with expertise in strategic planning, clinical operations, health information technology, quality systems, regulatory compliance and client relations in correctional, ambulatory, hospital, and safety net environments. She is a Chief Medical Officer and Interim Chief Medical Information Officer with the Los Angeles County Department of Health Services' Correctional Health Services. Margarita coached the following jurisdictions: Jefferson County, Kentucky; Orleans, St. Bernard, Plaquemines Parishes, Louisiana; and St. Louis County, Minnesota.

Rich VandenHeuvel, MSW has a master's degree in social work and is a former behavioral health executive specializing in strategic responses to health reform. Prior to joining Health Management Associates, Rich served as the CEO for a newly formed public behavioral health managed care organization that he built from the ground up. He also has extensive experience as an executive director of a multi-county community mental health organization where he oversaw comprehensive organizational restructuring. Rich coached the following jurisdictions: Chesterfield County, Virginia; Eaton County, Michigan; Ingham County, Michigan; Marion County, Indiana.

*= Non-Medicaid Expansion state

Appendix B: MAT Implementation Survey

Demographic Information | Items with an asterisk (*) denote a required question/response.

1) Which county/parish do you represent?*

( ) Camden County, NJ	**( ) Cook County, IL**	**( ) Eaton County, MI**	**( ) Marion County, IN**
( ) Chesterfield County, VA	( ) Hudson County, NJ	( ) Ingham County, MI	( ) Orleans, St. Bernard, Plaquemines Parishes, LA
( ) Clackamas County, OR	( ) Cumberland County, ME	( ) Lewis and Clark County, MT	( ) Shelby County, TN
( ) Collier County, FL	( ) Durham County, NC	( ) Jefferson County, KY	( ) Saint Louis County, MN

2) The organization I work for is:*

( ) County or Parish run/Governmental
( ) Private/Non-Governmental
( ) Other - Specify:

3) My organization's focus is (Check all that apply):* (CJ=Criminal Justice)

[ ] Addiction Services
[ ] Behavioral Health Services
[ ] Vocational Rehabilitation
[ ] Administration
[ ] Medical Services
[ ] Social Work/Human Services
[ ] CJ: Courts/Legal
[ ] CJ: Law Enforcement
[ ] CJ: Jail/Detention
[ ] CJ: Community Supervision
[ ] Other-Specify:

4) Job Title:* _____

5) Highest Degree Status?*

( ) No High School Diploma or Equivalent
( ) High School Diploma or Equivalent
( ) Some college, but no degree
( ) Associate's Degree
( ) Bachelor's Degree
( ) Master's Degree
( ) Doctoral Degree or Equivalent
( ) Other - Specify:

6) List of Specializations or Professional Certifications: (N/A if none)*

_____

7) How long have you been working:*

In your profession/field: _____
At your current organization/agency: _____
In your current position: _____

8) What is your gender?*

( ) Female
( ) Male
( ) Prefer not to say
( ) Other – Specify:

9) What is your Race (Check all that apply)?*

[ ] White
[ ] Black/African-American
[ ] Asian
[ ] American Indian or Alaskan
[ ] Pacific Islander
[ ] Other-Specify:

10) Are you Hispanic?*

( ) Yes
( ) No

11) What is your age?* (Must be at least 18) _____

Continue to MAT Opinions/Attitudes →

Opinions & Attitudes | Items with an asterisk (*) denote a required question/response.

12) Please indicate the extent to which you agree with each item.*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
Methadone, when given as a maintenance program, reduces (blocks) the effects of opioids.	( )	( )	( )	( )	( )
Buprenorphine, when given as a maintenance program, reduces (blocks) the effects of opioids.	( )	( )	( )	( )	( )
Methadone should be available as a lifelong treatment option.	( )	( )	( )	( )	( )
Buprenorphine should be available as a lifelong treatment option.	( )	( )	( )	( )	( )
The goal of medication-assisted treatment should always be eventual detoxification and sobriety.	( )	( )	( )	( )	( )
Methadone is just substituting one addiction for another.	( )	( )	( )	( )	( )
Buprenorphine is just substituting one addiction for another.	( )	( )	( )	( )	( )
Methadone maintenance reduces users' criminal activities.	( )	( )	( )	( )	( )
Buprenorphine maintenance reduces users' criminal activities.	( )	( )	( )	( )	( )
Methadone maintenance reduces users' risk of acquiring or transmitting HIV.	( )	( )	( )	( )	( )
Buprenorphine maintenance reduces users' risk of acquiring or transmitting HIV.	( )	( )	( )	( )	( )
Methadone maintenance reduces users' risk of dying.	( )	( )	( )	( )	( )
Buprenorphine maintenance reduces users' risk of dying.	( )	( )	( )	( )	( )
Methadone maintenance increases users' chances of using illicit opioids.	( )	( )	( )	( )	( )
Buprenorphine maintenance increases users' chances of using illicit opioids.	( )	( )	( )	( )	( )
Methadone maintenance reduces users' consumption of illicit opioids.	( )	( )	( )	( )	( )
Buprenorphine maintenance reduces users' consumption of illicit opioids.	( )	( )	( )	( )	( )
Inmates do not need Methadone services after they get released because they have not used drugs while they were incarcerated.	( )	( )	( )	( )	( )
Inmates do not need Buprenorphine services after they get released because they have not used drugs while they were incarcerated.	( )	( )	( )	( )	( )

Opinions & Attitudes | Items with an asterisk (*) denote a required question/response.

13) Methadone*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
How familiar are you with this treatment?	( )	( )	( )	( )	( )
How much training have you received about this treatment?	( )	( )	( )	( )	( )
How knowledgeable are you about where to refer an eligible client for this treatment?	( )	( )	( )	( )	( )
Do you think using this treatment might be helpful to your clients with opioid use disorder?	( )	( )	( )	( )	( )
How likely are you to refer clients with opioid use disorder to this treatment now?	( )	( )	( )	( )	( )
How likely are you to refer eligible clients to this treatment in the future?	( )	( )	( )	( )	( )

14) Buprenorphine (Suboxone/Subutex)*

	1: Not at all	**2: Slight Extent**	**3: Moderate Extent**	**4: Great Extent**	**5: Very Great Extent**
How familiar are you with this treatment?	( )	( )	( )	( )	**( )**
How much training have you received about this treatment?	( )	( )	( )	( )	**( )**
How knowledgeable are you about where to refer an eligible client for this treatment?	( )	( )	( )	( )	**( )**
Do you think using this treatment might be helpful to your clients with opioid use disorder?	( )	( )	( )	( )	**( )**
How likely are you to refer clients with opioid use disorder to this treatment now?	( )	( )	( )	( )	**( )**
How likely are you to refer eligible clients to this treatment in the future?	( )	( )	( )	( )	**( )**

15) Injectable Depot Buprenorphine (Sublocade/Brixadi)*

	1: Not at all	**2: Slight Extent**	**3: Moderate Extent**	**4: Great Extent**	**5: Very Great Extent**
How familiar are you with this treatment?	( )	( )	( )	( )	**( )**
How much training have you received about this treatment?	( )	( )	( )	( )	**( )**
How knowledgeable are you about where to refer an eligible client for this treatment?	( )	( )	( )	( )	**( )**
Do you think using this treatment might be helpful to your clients with opioid use disorder?	( )	( )	( )	( )	**( )**
How likely are you to refer clients with opioid use disorder to this treatment now?	( )	( )	( )	( )	**( )**
How likely are you to refer eligible clients to this treatment in the future?	( )	( )	( )	( )	**( )**

Opinions & Attitudes | Items with an asterisk (*) denote a required question/response.

16) Naltrexone (ReVia)*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
How familiar are you with this treatment?	( )	( )	( )	( )	( )
How much training have you received about this treatment?	( )	( )	( )	( )	( )
How knowledgeable are you about where to refer an eligible client for this treatment?	( )	( )	( )	( )	( )
Do you think using this treatment might be helpful to your clients with opioid use disorder?	( )	( )	( )	( )	( )
How likely are you to refer clients with opioid use disorder to this treatment now?	( )	( )	( )	( )	( )
How likely are you to refer eligible clients to this treatment in the future?	( )	( )	( )	( )	( )

17) Injectable Depot Naltrexone (Vivitrol)*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
How familiar are you with this treatment?	( )	( )	( )	( )	( )
How much training have you received about this treatment?	( )	( )	( )	( )	( )
How knowledgeable are you about where to refer an eligible client for this treatment?	( )	( )	( )	( )	( )
Do you think using this treatment might be helpful to your clients with opioid use disorder?	( )	( )	( )	( )	( )
How likely are you to refer clients with opioid use disorder to this treatment now?	( )	( )	( )	( )	( )
How likely are you to refer eligible clients to this treatment in the future?	( )	( )	( )	( )	( )

18) Naloxone Rescue Kits (Narcan)*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
How familiar are you with this treatment?	( )	( )	( )	( )	( )
How much training have you received about this treatment?	( )	( )	( )	( )	( )
How knowledgeable are you about where to refer an eligible client for this treatment?	( )	( )	( )	( )	( )
Do you think using this treatment might be helpful to your clients with opioid use disorder?	( )	( )	( )	( )	( )
How likely are you to refer clients with opioid use disorder to this treatment now?	( )	( )	( )	( )	( )
How likely are you to refer eligible clients to this treatment in the future?	( )	( )	( )	( )	( )

Continue to MAT EBP Attitudes →

Evidence-based Practices Attitudes | Items with an asterisk (*) denote a required question/response.

19) Please indicate the extent to which you agree with each item.*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
I like to use new types of treatments/interventions to help justice-involved individuals with Opioid Use Disorder (OUD).	( )	( )	( )	( )	( )
I am willing to use new types of treatments/interventions for OUD even if I have to follow specific guidelines.	( )	( )	( )	( )	( )
I am willing to use new types of treatments/interventions for OUD developed by researchers.	( )	( )	( )	( )	( )
Research-based treatments/interventions for OUD are useful in my organization.	( )	( )	( )	( )	( )
Experience is more important than research-based treatments/interventions.	( )	( )	( )	( )	( )
I would not use research-based treatments/interventions for OUD.	( )	( )	( )	( )	( )

20) If you received training in treatments/interventions for OUD, how likely would you be to adopt if:*

	1: Not at all	2: Slight Extent	3: Moderate Extent	4: Great Extent	5: Very Great Extent
It made sense to you?	( )	( )	( )	( )	( )
It was required by your supervisor?	( )	( )	( )	( )	( )
It was required by your agency?	( )	( )	( )	( )	( )
It was required by your State?	( )	( )	( )	( )	( )
It was being used by your colleagues who were happy with it?	( )	( )	( )	( )	( )
You felt you had enough training to use it correctly?	( )	( )	( )	( )	( )
You knew it was right for the population you serve?	( )	( )	( )	( )	( )
You had a say in how you would use these treatments/interventions in your organization?	( )	( )	( )	( )	( )
It fit with your approach to working with justice-involved individuals?	( )	( )	( )	( )	( )

STOP survey here if you are not from a jail/detention setting as indicated by your response to question 3 of this survey

CONTINUE on next page if you are from a jail/detention setting as indicated by your response to question 3 of this survey

Current MAT Practices in Jails | Items with an asterisk (*) denote a required question/response.

To be completed by individuals from jail/detention-focused organizations as indicated by response to question 3 of this survey, ONLY.

21) Is any methadone treatment offered in your jail system?* ( ) Yes ( ) No

22) If yes, for whom (Check all that apply):*

[ ] Pregnant Women [ ] Maintain detainees on methadone if in community treatment at the time of arrest
[ ] Detoxification [ ] Initiate methadone treatment for detainees not in community treatment at the time of arrest

23) Methadone is not available in our jail system because (Check all that apply):*

[ ] It is not beneficial to detainees [ ] Buprenorphine is offered instead [ ] Naltrexone is offered instead
[ ] Jail favors drug-free detox [ ] Cost is prohibitive [ ] Security concerns
[ ] Administrative opposition [ ] Lack of healthcare providers [ ] Opioid addiction an uncommon problem
[ ] Administrative burdens [ ] Don't know [ ] Other - Specify:

24) Is any buprenorphine treatment offered in your jail system?* ( ) Yes ( ) No

25) If yes, for whom (Check all that apply):*

[ ] Pregnant Women [ ] Maintain detainees on buprenorphine maintenance if they were in community treatment at the time of arrest
[ ] Detoxification [ ] Initiate buprenorphine treatment for detainees who were not in community treatment at the time of arrest

26) Buprenorphine is not available in our jail system because (Check all that apply):*

[ ] It is not beneficial to detainees [ ] Methadone is offered instead [ ] Naltrexone is offered instead
[ ] Jail favors drug-free detox [ ] Cost is prohibitive [ ] Security concerns
[ ] Administrative opposition [ ] Lack of healthcare providers [ ] Opioid addiction an uncommon problem
[ ] Administrative burdens [ ] Don't know [ ] Other - Specify:

27) Is any naltrexone treatment offered for opioid use disorder relapse prevention in your jail system?*

( ) Yes ( ) No

28) Is extended release naltrexone offered?* ( ) Yes ( ) No

29) If answered yes to #28, for whom (Check all that apply):*

[ ] Continue detainees on extended release naltrexone if they were in community treatment at the time of arrest.
[ ] Initiate extended release naltrexone prior to release for individuals who were receiving naltrexone in the community at the time of arrest.
[ ] Initiate extended release naltrexone prior to release for individuals who were NOT receiving extended release naltrexone in the community at the time of arrest.

30) Naltrexone is not available in our jail system because (Check all that apply):*

[ ] It's not beneficial to detainees [ ] Methadone is offered instead [ ] Buprenorphine is offered instead
[ ] Jail favors drug-free detox [ ] Cost is prohibitive [ ] Security concerns
[ ] Administrative opposition [ ] Lack of healthcare providers [ ] Opioid addiction is an uncommon problem
[ ] Administrative burdens [ ] Don't know [ ] Other - Specify:

Thank You!

Appendix C: Readiness Assessment

DELIVERING MEDICATIONS FOR OPIOID USE DISORDER (OUD) FROM JAIL TO COMMUNITY:
ORGANIZATIONAL READINESS CHECKLIST

EVIDENCE ASSESSMENT

Please circle the number to rate the strength of your agreement with the following statements:

***FINDING* #1 = Delivering methadone to people while they are incarcerated and continuing treatment in the community upon release improves the health of individuals and promotes safety in the broader community.**

1. Based on the finding statement above, the implementation of methadone in jail with coordinated follow-up care in the community:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
Decreases inmate opioid use after release	1	2	3	4	5
Decreases opioid-related overdose deaths after release	1	2	3	4	5
Decreases future engagement in criminal activity	1	2	3	4	5
Decreases infectious disease transmission	1	2	3	4	5
Increases social functioning	1	2	3	4	5
Increases retention in current and future treatments	1	2	3	4	5

***FINDING* #2 = Delivering buprenorphine to people while they are incarcerated and continuing treatment in the community upon release improves the health of individuals and promotes safety in the broader community.**

2. Based on the finding statement above, the implementation of buprenorphine in jail with coordinated follow-up care in the community:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
Decreases inmate opioid use after release	1	2	3	4	5
Decreases opioid-related overdose deaths after release	1	2	3	4	5
Decreases future engagement in criminal activity	1	2	3	4	5
Decreases infectious disease transmission	1	2	3	4	5
Increases social functioning	1	2	3	4	5
Increases retention in current and future treatments	1	2	3	4	5

***FINDING* #3 = Delivering extended-release naltrexone to people while they are incarcerated and continuing treatment in the community upon release improves the health of individuals and promotes safety in the broader community.**

3. Based on the finding statement above, the implementation of extended-release naltrexone in jail with coordinated follow-up care in the community:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
Decreases inmate opioid use after release	1	2	3	4	5
Decreases opioid-related overdose deaths after release	1	2	3	4	5
Decreases future engagement in criminal activity	1	2	3	4	5
Decreases infectious disease transmission	1	2	3	4	5
Increases social functioning	1	2	3	4	5
Increases retention in current and future treatments	1	2	3	4	5

CONTEXT ASSESSMENT

Please circle the number to rate the strength of your agreement with the following statements:

4. Senior leadership (e.g., Warden/Jail Commander) in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
rewards staff who support innovations to improve OUD medication treatment	1	2	3	4	5
solicits opinions of staff regarding policy decisions about inmate care related to OUD medication treatment	1	2	3	4	5
actively seeks ways to improve inmate participation in OUD medication treatment	1	2	3	4	5

5. Custody staff in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
have a sense of personal responsibility for improving inmate OUD medication treatment	1	2	3	4	5
are willing to innovate and experiment to improve inmate OUD medication treatment	1	2	3	4	5
believe that improving inmate OUD medication treatment is consistent with the goals of the organization	1	2	3	4	5
are generally receptive to changes in inmate OUD medication treatment	1	2	3	4	5

6. Case management staff in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
have a sense of personal responsibility for improving inmate OUD medication treatment	1	2	3	4	5
are willing to innovate and experiment to improve inmate OUD medication treatment	1	2	3	4	5
believe that improving inmate OUD medication treatment is consistent with the goals of the organization	1	2	3	4	5
are generally receptive to changes in inmate OUD medication treatment	1	2	3	4	5

7. Medical staff in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
have a sense of personal responsibility for improving inmate OUD medication treatment	1	2	3	4	5
are willing to innovate and experiment to improve inmate OUD medication treatment	1	2	3	4	5
believe that improving inmate OUD medication treatment is consistent with the goals of the organization	1	2	3	4	5
are generally receptive to changes in inmate OUD medication treatment	1	2	3	4	5

Please circle the number to rate the strength of your agreement with the following statements:

8. Senior leadership in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
provide effective management for continuous improvement of inmate OUD medication treatment	1	2	3	4	5
clearly define areas of responsibility and authority for managers and staff in relation to inmate OUD medication treatment	1	2	3	4	5
promote communication and information sharing among different services, units, and organizations for inmate OUD medication treatment	1	2	3	4	5
provide staff with feedback on performance measures and guidelines related to inmate OUD medication treatment	1	2	3	4	5
establish clear goals for treating inmates with OUDs	1	2	3	4	5
hold staff members accountable for achieving goals related to inmate OUD medication treatment	1	2	3	4	5

9. Opinion leaders in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
believe that the current practice for inmate OUD medication treatment can be improved	1	2	3	4	5
are willing to try new protocols to treat inmates with OUD	1	2	3	4	5
work cooperatively with senior leadership to make appropriate changes to current OUD medication treatment practice patterns	1	2	3	4	5
can influence other staff to support changes in OUD medication treatment	1	2	3	4	5

10. In general, when there is agreement that change needs to happen for inmate OUD medication treatment, your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
has the budget and financial resources necessary to implement the change	1	2	3	4	5
has access to the training necessary to implement the change	1	2	3	4	5
has the facilities necessary to implement the change	1	2	3	4	5
has the staffing necessary to implement the change	1	2	3	4	5

11. Your organization's decision to adopt/expand OUD medication treatment for inmates is influenced by:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
legislators at the local or state level	1	2	3	4	5
political leaders in the local or state government	1	2	3	4	5
leaders of the criminal justice system in the local or state government	1	2	3	4	5
political factors outside of the local or state government	1	2	3	4	5
political factors unknown to you	1	2	3	4	5

FACILITATION ASSESSMENT

Please circle the number to rate the strength of your agreement with the following statements:

12. Senior leadership in your organization:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
propose to implement medication for inmates with OUD in a way that is feasible	1	2	3	4	5
provide clear goals for improvement of inmate OUD medication treatment	1	2	3	4	5
establish a project schedule with clear deliverables for OUD medication treatment implementation	1	2	3	4	5
designate an organizational champion(s) for this OUD medication treatment implementation project	1	2	3	4	5

13. The OUD medication implementation project champion:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
is committed to the success of this OUD medication treatment implementation project	1	2	3	4	5
has the authority to carry out this OUD medication treatment implementation project	1	2	3	4	5
is considered an opinion leader	1	2	3	4	5
works well with the implementation team	1	2	3	4	5
works well with custody staff	1	2	3	4	5
works well with medical staff	1	2	3	4	5

14. Senior leadership and staff opinion leaders:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
agree on the goals for this OUD medication treatment implementation project	1	2	3	4	5
are informed and involved in this OUD medication treatment implementation project	1	2	3	4	5
agree on what staffing resources are necessary to accomplish this implementation project	1	2	3	4	5
set a high priority on the success of this OUD medication treatment implementation project	1	2	3	4	5

Please circle the number to rate the strength of your agreement with the following statements:

15. The OUD medication treatment implementation team members:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
share responsibility for the success of this project	1	2	3	4	5
have clearly defined roles and responsibilities	1	2	3	4	5
have adequate release time or accomplish implementation tasks within their regular work load	1	2	3	4	5
have necessary staff support to carry out this OUD medication treatment implementation project	1	2	3	4	5

16. The implementation plan for this project:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
identifies specific roles and responsibilities	1	2	3	4	5
clearly describes tasks and timelines	1	2	3	4	5
includes appropriate staff education	1	2	3	4	5
acknowledges staff input and opinion	1	2	3	4	5

17. Communication is maintained through:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
regular project meetings with the project champion(s) and OUD medication implementation team members	1	2	3	4	5
involvement of quality management staff in project planning and implementation	1	2	3	4	5
regular feedback to management on progress of project activities and resource needs	1	2	3	4	5
regular feedback to management of practice changes on inmate outcomes	1	2	3	4	5
regular feedback to staff on effects of practice changes on inmate outcomes	1	2	3	4	5

18. Progress of the project is measured by:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
collecting feedback from inmates regarding implemented changes	1	2	3	4	5
collecting feedback from staff regarding implemented changes	1	2	3	4	5
developing and distributing regular performance measures to staff involved with OUD medication treatment	1	2	3	4	5
providing a forum for presentation and discussion of results and implications for continued improvements	1	2	3	4	5

Please circle the number to rate the strength of your agreement with the following statements:

19. The following is available to make the OUD medication treatment implementation work:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
medical space	1	2	3	4	5
funding for staff and/or medications	1	2	3	4	5
inmate educational materials	1	2	3	4	5
buy-in from medical staff	1	2	3	4	5
buy-in from custody staff	1	2	3	4	5
buy-in from case management staff	1	2	3	4	5
an engaged OUD medication implementation team	1	2	3	4	5
a clearly defined treatment protocol	1	2	3	4	5

20. Plans for improving this OUD medication treatment implementation project include:	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly agree
periodic outcome measurement	1	2	3	4	5
periodic staff satisfaction surveys	1	2	3	4	5
periodic inmate satisfaction surveys	1	2	3	4	5
a dissemination plan for performance measures	1	2	3	4	5
a review of results by organizational leadership	1	2	3	4	5

Appendix D: Implementation Checklist for Providing Medications for Opioid Use Disorder in Jails

Name of your Organization/Location: _____
For all questions, please select either "yes" or "no" as it applies to your organization for each item.

1. Our organization **screens for opioid use disorder** (OUD):	Yes	No
Using a standardized protocol	☐	☐
Only in a special population of inmates (e.g., pregnant women; people enrolled in methadone or buprenorphine treatment in the community) Please specify which populations: _____	☐	☐
In **all** inmates	☐	☐
Our organization **does not** currently screen for OUD	☐	☐

2. Our organization provides **OUD medication treatment plans**:	Yes	No
Tailored to the needs of inmates	☐	☐
Based on the preferences of the inmates	☐	☐
Based on the medication treatment resources available in the community	☐	☐
That involve coordination and continuity of care with treatment providers in the community	☐	☐
That are coordinated in conjunction with community corrections (e.g., probation, drug courts)	☐	☐
And ensures halfway/transitional houses accept our inmates on OUD medications	☐	☐
Our organization **does not** provide OUD treatment plans	☐	☐

3. Our organization **continues to treat** inmates with the OUD medication they were being treated with in the community (e.g., people in a methadone program or getting a buprenorphine prescription from a provider):	Yes	No
Using extended-release naltrexone (i.e., Vivitrol)	☐	☐
Using buprenorphine	☐	☐
Using methadone	☐	☐
Our organization **does not** continue OUD medications that inmates were receiving in the community	☐	☐

4. Our organization **starts inmates** who are out of treatment and experiencing opioid withdrawal (e.g., people using heroin or illicitly obtained prescription opioids) with the following treatment options:	Yes	No
Using Methadone to detoxification (taper; medically managed withdrawal)	☐	☐
Using Buprenorphine detoxification (taper; medically managed withdrawal)	☐	☐
Using Methadone maintenance	☐	☐
Using Buprenorphine maintenance	☐	☐
Non-opioid medications for symptom management (e.g., clonidine, lucemyra, zofran)	☐	☐
Our organization **does not** start inmates who are out of treatment and experiencing withdrawal on any medications for withdrawal	☐	☐

5. Our organization **provides the following medications** prior to release for people who have histories of OUD who are currently abstinent:	Yes	No
Naltrexone (e.g., extended-release [Vivitrol] or oral naltrexone)	☐	☐
Methadone Induction	☐	☐
Buprenorphine Induction	☐	☐
Other medications (e.g. , naloxone/narcan) Please specify which medications: _____	☐	☐
Our organization **does not** start any medications in the period of time prior to release	☐	☐

Implementation Checklist for Providing Medications for Opioid Use Disorder in Jails

continued

6. Our organization has **medical guidelines in place to safely conduct dose induction** with:	Yes	No
Methadone for patients in opioid withdrawal	☐	☐
Methadone for patients who are not opioid tolerant (e.g., opioid abstinent requiring lower starting doses)	☐	☐
Buprenorphine for patients in opioid withdrawal	☐	☐
Buprenorphine for patients who are not opioid tolerant (e.g., opioid abstinent requiring lower starting doses)	☐	☐
Extended-release naltrexone (e.g., Vivitrol or oral naltrexone)	☐	☐
Our organization **does not** have medical guidelines in place to conduct dose induction	☐	☐

7. Our organization has **medical guidelines to treat**:	Yes	No
Precipitated withdrawal from buprenorphine induction	☐	☐
Precipitated withdrawal from extended-release naltrexone induction	☐	☐
Opioid intoxication/overdose from OUD medications and from contraband opioids	☐	☐
Our organization **does not** have medical guidelines to treat precipitated withdrawal	☐	☐
Our organization **does not** have medical guidelines to treat opioid intoxication/overdose	☐	☐

8. Our organization has **medical guidelines** to:	Yes	No
Taper methadone for inmates transferred to a controlled environment that does not offer this medication	☐	☐
Taper buprenorphine for inmates transferred to a controlled environment that does not offer this medication	☐	☐
Our organization **does not** have medical guidelines to taper medications for transferred inmates	☐	☐

9. Our organization has **procedures** in place to:	Yes	No
Prevent diversion of methadone	☐	☐
Prevent diversion of buprenorphine	☐	☐
Ensure compliance with DEA regulatory requirements	☐	☐
Ensure compliance with state drug control regulatory requirements	☐	☐

10. Our organization is **tracking the following outcomes** for people receiving our OUD medication service(s):	Yes	No
Entry into community treatment following release	☐	☐
Retention in treatment following treatment entry	☐	☐
Recidivism (re-arrest)	☐	☐
Overdose	☐	☐

11. Our organization:	Yes	No
Assists inmates in obtaining or resuming insurance coverage to pay for treatment, if necessary	☐	☐
Has formal agreements in place to coordinate care between our facility and community treatment programs	☐	☐
Has fostered support among our **custody staff** regarding the delivery of OUD medication treatments to our inmates	☐	☐
Has fostered support among our **case management staff** regarding the delivery of OUD medication treatments to our inmates	☐	☐
Has fostered support among our **medical staff** regarding the delivery of OUD medication treatments to our inmates	☐	☐
Employs enough properly licensed treatment providers to deliver OUD medications	☐	☐

Appendix E: Site Visit Materials

SAMPLE SITE VISIT

Focus Group Discussion Questions

1. What previous experience(s) do you have as a group working together on other projects/initiatives?

2. Now let's take a look at your progress since last summer:
    a. How has your team made progress on the primary domain areas (refer to stoplight handout)? What factors impacted these changes or evolutions?
        i. Why did you select to focus on implementing the medications that you did?
        ii. What types of considerations does your organization make when deciding what MOUDs to offer/deliver? *Possible probes (always explore differences between types of agonists): Regulatory issues? Prior practices? Staffing? Cost? Inmate/client preferences? Judges influence? Other?*
        iii. What is your timeframe for fully implementing the goals/areas that are still in progress?
        iv. What data sources are you utilizing or planning to collect to measure progress or success?
    b. Now we would like to discuss the biggest challenges and accomplishments you identified prior to the recent in-person convening:
        i. Biggest Challenges
            1. What kinds of stigma did you encounter among system stakeholders? Was this stigma anticipated at the outset? What is being done to address it? How has it impacted your team's progress in making strides on the primary domain areas?
            2. What, specifically, are the policies and practices that were challenging to implement regarding MAT? Who is involved? What have been the biggest barriers? How has your group defined "continue treatment once released from jail"?
        ii. Biggest Achievements
            1. What are the considerable steps that have been taken toward becoming a licensed OTP? What facilitated these steps the most?
            2. How were the three positions secured that will work on discharge planning for MAT clients? What funding source allowed for this? Why did your team decide to focus on the rapid release population?

3. Technical Assistance from HMA/IIR/BJA
    a. What technical assistance did the HMA coach provide to your team?
        i. How has having a coach throughout this process influenced your progress?
        ii. What goals would you have not been able to accomplish (or make progress toward) without the assistance of the coach?
        iii. Where/how do you need the most external technical assistance (from an organization like HMA)?
    b. What were the most helpful parts/components of the planning process? Not as helpful parts/components?
        i. What resources from the coach/HMA/BJA did your team utilize during the planning process?
        ii. How much were you able to network with other jurisdiction during the planning process? In what ways have you sought out insights from others, or received inquiries?
        iii. What guidance/assistance/resources do you wish you would have had access to during the planning initiative?
    c. Has your organization attempted to address these problems/barriers before? If so, what was different this time?

Individual Interview questions

1. Please describe your role in your organization. What do you do exactly?
    a. How long have you worked in the field? How long have you worked for this specific organization? Why were you selected/did you volunteer to participate in the planning team?
    b. In general, how would you describe your organization's current views towards the use of medications to treat opioid use disorder?
        i. *Possible probes (always explore differences between types of agonists): Why do you think they have those views? Do views differ depending on who leads certain roles (e.g., Leadership? Staff/line-staff?); How do they differ/align?*
        ii. What do you think could be done to change or improve those views? Have these views changed over time? What parts of the planning initiative have targeted shifting attitudes and knowledge of MATs?

2. How does your organization handle confidentiality/ HIPPA and 42 CFR Part 2 issues when communicating with other organizations regarding justice-involved clients who have substance abuse disorders?
    a. Probes: Is there a release of information for each client? Formal MOUs between justice and treatment organizations? In-reach of clinical staff (e.g., treatment center staff are also providing care in jail)? Other?

3. Team dynamics:
    a. What organization or individual initiated the idea of applying for the Building Bridges grant? How has this organization/individual been a driving force for the team?
    b. What has been the involvement of various team members throughout the planning process?
        i. Have members joined or left the group since you began meeting? Why did this turnover occur?
        ii. Were some organizations/agencies assigned more tasks related to achieving team goals? Why?
        iii. Do you think that team members and their respective organizations had mutually beneficial gains in participating in this planning initiative?
            1. How/why/why not? How did this impact the ability to achieve your goals?

4. What is happening at your organization that may impact your team's ultimate success in implementing MOUDs (now or in the future)?
    a. What is happening at other levels that may impact your team's success?
    b. Probes: (e.g., other initiatives or projects that will be initiated in the next couple of years; other things happening at the county, state or federal level; accountability issues, etc.)

Site Visit Materials

Sample Site Visit Guide

Tracking Items	Oct	Notes	Nov		Dec		Jan
Universal Evidence-based screening tool for SUD		Use an in-house tool; have a "MAT alert" tool and process to track people through the system - need to revisit validated tool.				They don't have an active process for this right now	
Evidence-based Detox Protocol for Alcohol and Opioids Evidence-based Protocol for pregnant women with SUD						New HSA there - needs to get up to speed on their protocols. Wasn't able to speak to/confirm this on the call.	
Ability to maintain all forms of MAT		Applying for existing prescribers to increase their waiver; otherwise will have to wait for timelines. Provider capacity issues. Continuing people on Methadone by having dosing brought in from community provider.					
Ability to initiate at least two forms of MAT		Have provider capacity issues - Big challenge because of the number of people they need to serve. In Jan will be able to expand Dr. Clemons from 30 to 100. Hopefully when they get OTP that will help. Have to be probationary for a year before you get accredited – not sure of the implications for the waiver exceptions with the OTP. RE Goal to become an OTP - lead Dr. went through all the information/forms that would need to be submitted/criteria – assigned individuals to gather that information. Have another meeting scheduled in Dec once all the information is gathered. Talking with Cook County for assistance. Feel they are on track and should be able to do this/no identified barriers.				Can initiate buprenorphine and Vivitrol	
Ability to provide BH components of treatment		Received funding NJ DOC and NJ HHS – requests included line items to provide individual counseling staff and care coordinators at intake for re-entry for individuals with short Length of stays. Will award a provider – drafting RFP. Proposals will be back in early Dec – should be able to award in Dec. have started to expand their provider network.				Have current contractor that was doing groups; recently executed contract for additional individual counseling for people receiving MAT (up to 17 appointments per week) using CBT-based modality	
Pre-release planning process		Lengthen the allotted prescription pick up window. (Completed); -Adding a Suboxone “hotline” number in medical for questions post-release (completed); -Hot Hand-off process. Dependent on additional staffing which is in pipeline to be approved in County budget.		In place, building out additional elements/staffing for pre-release planning		Hiring three release navigators	
Access to MAT in community within 48 hours or sooner				Sufficient MAT providers in community; working on process/flow for consistency		Resources are in community - need to continue to work on continuity of care support protocols/staffing	
Other		Meeting with Judge Grant (completed) - strong advocate. Working on getting re-entry identification accepted. Warden Taylor brought it up with Officer of the Court/Judge. He was receptive because of the jail’s fingerprint/live identification process – so state agencies should be able to accept them. Telemedicine to expand capacity: Warden – have an area in the facility for telemedicine that’s been identified. Keep working with sites that have already implemented – having conversations – Warden and Denise are identifying providers, creating a list. Collier County – working on getting scheduling.				Cook County Site Visit re OTP licensure - 2/6; Agreement with Camden Coalition in place to develop data sharing and evaluation framework; hiring three post-release MAT navigators with State NJ funds. Looking for training materials /assistance for their clinical staff.	

Site Visit Materials

continued

Sample Planning Team Progress Handout

October 2019-January 2020

Tracking Items	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Universal Evidence-based screening tool for SUD				
Evidence-based Detox Protocol for Alcohol and Opioids				
Evidence-based Protocol for pregnant women with SUD				
Ability to maintain all forms of MAT				
Ability to initiate at least two forms of MAT				
Ability to provide BH components of treatment				
Pre-release planning process				
Access to MAT in community within 48 hours or sooner				

Complete
In progress
No movement

Appendix F: Phone Interview Guide

BRIDGES QUALITATIVE PHONE INTERVIEWS

ASK FOR PERMISSION TO RECORD INTERVIEW

Team Lead

5. Please describe your role in your organization. What do you do exactly?
    a. Why were you selected/did you volunteer to participate in the planning team?

6. We would like to start off by asking you some questions about the MOUDs your team decided to focus on implementing:
    a. What medications did the jail offer before the Bridges grant began? What medications are being offered now?
    b. Why did you select to focus on implementing the medications that you did?
    c. What types of considerations does your organization make when deciding what MOUDs to offer/deliver? *Possible probes (always explore differences between types of agonists): Regulatory issues? Prior practices? Staffing? Cost? Inmate/client preferences? Judges influence? Other?*

7. STOPLIGHT TABLE: How has your team made progress on the primary domain areas (refer to stoplight handout)? What factors impacted these changes or evolutions?
    a. What is your timeframe for fully implementing the goals/areas that are still in progress?

8. Have there been any issues with communication or coordination between the organizations/departments represented on the team?
    a. How would you describe the relationship between the jail and the healthcare vendor?
    b. How has your organization and team handled issues related to re-entry and care coordination?
    c. Confidentiality/ HIPPA and 42 CFR Part 2 issues? *Probes: Is there a release of information for each client? Formal MOUs between justice and treatment organizations? In-reach of clinical staff (e.g., treatment center staff are also providing care in jail)? Other?*
    d. How has your team addressed issues related to data collection and sources at the client level?

9. Team dynamics:
    a. What has been the involvement of various team members throughout the planning process? Did a key champion emerge during the planning process?
        i. Have members joined or left the group since you began meeting? Why did this turnover occur?
        ii. Were some organizations/agencies assigned more tasks related to achieving team goals? Why?
        iii. Do you think that team members and their respective organizations had mutually beneficial gains in participating in this planning initiative?
            1. How/why/why not? How did this impact the ability to achieve your goals?

10. Technical Assistance from HMA/IIR/BJA
    a. What technical assistance did the HMA coach provide to your team? How has the coach influenced your progress?
        i. What goals would you have not been able to accomplish (or make progress toward) without the assistance of the coach/HMA?
        ii. Where/how do you need the most external technical assistance (from an organization like HMA)?

b. What were the most helpful parts/components of the planning process? Not as helpful parts/components?
    i. What resources from the coach/HMA/BJA did your team utilize during the planning process?
    ii. How much were you able to network with other jurisdiction during the planning process? In what ways have you sought out insights from others, or received inquiries?
    iii. What guidance/assistance/resources do you wish you would have had access to during the planning initiative?
c. Has your organization attempted to address these problems/barriers before? If so, what was different this time?

11. What is happening at your organization that may impact your team's ultimate success in implementing MOUDs (now or in the future)? Other levels? *Probes: (e.g., other initiatives or projects that will be initiated in the next couple of years; other things happening at the county, state or federal level; accountability issues, etc.)*

Appendix G: HMA Coaches – Focus Group Interview Guide

Questions for HMA Coaches Focus Group
March 25, 2020 3pm EST

1) What types of resources did you primarily provide to your sites?
   a) How did they utilize those resources?
   b) Are there other resources you wish you had been able to provide?
   c) Was there consistency in the way you approached coaching your teams or did you tailor TA from the beginning of the planning initiative?

2) What were some of the team/site issues that you noticed (e.g., consistency of team composition, accountability/involvement of leadership, contractual/formal agreements in place)?
   a) Between the jail and healthcare vendor?
   b) Between the jail/healthcare vendor and re-entry/community treatment?
   c) Commitment of team members to the development of the strategic plan (ex. were some sites preoccupied with other changes in their system/organization)?

3) What were some of the issues that your sites identified that they were not able to address during this planning period?
   a) Why were they not achieved/addressed?

4) Did your role as a coach change throughout the planning period? If so, how?
   a) Did it take time for sites to understand your role as a coach?
   b) How did team leadership/site champions impact your role?
   c) How did the baseline status of MOUDs at your sites change the dynamics of the planning team or how you coached them?

5) Was the length of the planning initiative sufficient, from your perspective as a coach?

6) What kinds of feedback did you receive from the planning teams about how helpful this process was?

Appendix H: Demographic Characteristics of Respondents at Baseline and Follow-up

	Baseline *n* = 87	Follow-Up *n* = 94
Organization Type		
County or Parish run/Governmental	70 (80.5%)	72 (76.6%)
Private/Non-Governmental	9 (10.3%)	14 (14.9%)
Other	8 (9.2%)	8 (8.5%)
My Organization's Focus is… [Check all that apply; CJ = Criminal Justice]		
Addiction Services	38 (43.7%)	37 (39.4%)
Behavioral Health Services	36 (41.4%)	33 (35.1%)
Vocational Rehabilitation	8 (9.2%)	8 (8.5%)
Administration	12 (13.8%)	12 (12.8%)
Medical Services	25 (28.7%)	22 (23.4%)
Social Work/Human Services	22 (25.3%	18 (19.1%)
CJ: Courts/Legal	15 (17.2%)	25 (26.6%)
CJ: Law Enforcement	18 (20.7%)	18 (19.1%)
CJ: Jail/Detention	38 (43.7%)	46 (48.9%)
CJ: Community Supervision	21 (24.1%)	25 (26.6%)
Other	10 (11.5%)	7 (7.4%)
Highest Degree Status		
No High School Diploma	0 (0%)	1 (1.1%)
High School Diploma or Equivalent	1 (1.1%)	1 (1.1%)
Some College, but no Degree	2 (2.3%)	1 (1.1%)
Associate's Degree	5 (5.7%)	3 (3.2%)
Bachelor's Degree	23 (26.4%)	26 (27.7%)
Master's Degree	40 (46.0%)	44 (46.8%)
Doctoral Degree or Equivalent	14 (16.1%)	17 (18.1%)
Other	2 (2.3%)	1 (1.1%)
How long have you been working (years)… *Mean* (*SD*)		
In your profession/field	19.3 (9.7)	22.0 (10.6)
At your current organization/agency	11.0 (9.0)	12.5 (9.3)
In your current position	5.1 (4.7)	5.5 (4.9)
What is your Gender?		
Female	37 (42.5%)	33 (35.1%)
Male	50 (57.5%)	61 (64.9%)
What is your Race? [Check all that apply]		
White	71 (81.6%)	76 (80.9%)
Black/African-American	14 (16.1%)	15 (16.0%)
Asian	1 (1.1%)	0 (0%)
American Indian or Alaskan	0 (0%)	1 (1.1%)
Pacific Islander	1 (1.1%)	1 (1.1%)
Other	0 (0%)	1 (1.1%)
Are you Hispanic?		
Yes	4 (4.6%)	4 (4.3%)
No	83 (95.4%)	90 (95.7%)
What is your Age (years)? *Mean* (*SD*)	47.0 (9.8)	50.4 (10.6)

Appendix I: Summary Results of Individual Survey Items

MAT Implementation Survey Items

Means and Standard Deviations for individual survey items regarding Medications for Opioid Use Disorder (MOUDs) broken down by employment type

	Baseline			Follow-up		
Item	All (N=87)	CJ[1] (N=54)	Tx[1] (N=33)	All (N=82)	CJ[1] (N=52)	Tx[1] (N=30)
Methadone						
How familiar are you with this treatment?	3.31 (1.02)	3.07 (0.93)	3.70 (1.05)	3.64 (1.04)	3.45 (1.06)	3.97 (0.92)
How much training have you received about this treatment?	2.74 (1.22)	2.46 (1.14)	3.18 (1.24)	3.19 (1.18)	2.98 (1.15)	3.55 (1.18)
How knowledgeable are you about where to refer an eligible client for this treatment?	3.64 (1.2)	3.33 (1.24)	4.15 (0.94)	4.07 (1.11)	3.81 (1.13)	4.52 (0.93)
Do you think using this treatment might be helpful to your clients with opioid use disorder?	4.13 (0.87)	4.00 (0.89)	4.33 (0.82)	4.29 (0.96)	4.09 (1.05)	4.62 (0.66)
How likely are you to refer clients with opioid use disorder to this treatment now?	3.78 (1.13)	3.59 (1.16)	4.09 (1.01)	4.11 (1.17)	3.85 (1.26)	4.57 (0.82)
How likely are you to refer eligible clients to this treatment in the future?	3.98 (0.99)	3.85 (0.98)	4.18 (0.98)	4.15 (1.06)	3.90 (1.11)	4.57 (0.82)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

	Baseline			Follow-up		
Item	All (N=87)	CJ[1] (N=54)	Tx[1] (N=33)	All (N=82)	CJ[1] (N=51)	Tx[1] (N=31)
Buprenorphine						
How familiar are you with this treatment?	3.26 (1.13)	3.02 (1.04)	3.67 (1.16)	3.74 (0.99)	3.56 (0.94)	4.03 (1.02)
How much training have you received about this treatment?	2.92 (1.31)	2.63 (1.23)	3.39 (1.32)	3.47 (1.09)	3.22 (1.08)	3.88 (0.99)
How knowledgeable are you about where to refer an eligible client for this treatment?	3.48 (1.25)	3.22 (1.27)	3.91 (1.1)	4.15 (0.98)	3.94 (1.03)	4.50 (0.80)
Do you think using this treatment might be helpful to your clients with opioid use disorder?	4.30 (0.79)	4.15 (0.86)	4.55 (0.62)	4.48 (0.76)	4.32 (0.83)	4.73 (0.57)
How likely are you to refer clients with opioid use disorder to this treatment now?	4.14 (1.01)	3.96 (1.12)	4.42 (0.75)	4.45 (0.80)	4.29 (0.86)	4.71 (0.64)
How likely are you to refer eligible clients to this treatment in the future?	4.28 (0.83)	4.13 (0.89)	4.52 (0.67)	4.46 (0.77)	4.31 (0.81)	4.71 (0.64)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

(continued)

MAT Implementation Survey Items, continued

Item	Baseline All (N=87)	Baseline CJ[1] (N=54)	Baseline Tx[1] (N=33)	Follow-up All (N=77)	Follow-up CJ[1] (N=47)	Follow-up Tx[1] (N=30)
Depot Buprenorphine						
How familiar are you with this treatment?	2.25 (1.03)	2.04 (0.93)	2.61 (1.09)	2.99 (1.02)	2.87 (1.02)	3.18 (1.01)
How much training have you received about this treatment?	1.92 (1.08)	1.65 (0.99)	2.36 (1.08)	2.69 (1.18)	2.55 (1.23)	2.94 (1.06)
How knowledgeable are you about where to refer an eligible client for this treatment?	2.25 (1.27)	1.98 (1.19)	2.7 (1.29)	3.27 (1.31)	3.08 (1.31)	3.56 (1.27)
Do you think using this treatment might be helpful to your clients with opioid use disorder?	3.69 (1.09)	3.50 (1.18)	4.00 (0.87)	4.08 (1.10)	3.92 (1.21)	4.34 (0.83)
How likely are you to refer clients with opioid use disorder to this treatment now?	3.29 (1.27)	3.13 (1.26)	3.55 (1.25)	3.84 (1.18)	3.51 (1.25)	4.37 (0.85)
How likely are you to refer eligible clients to this treatment in the future?	3.59 (1.17)	3.39 (1.22)	3.91 (1.01)	4.01 (1.17)	3.79 (1.20)	4.37 (1.03)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

Item	Baseline All (N=87)	Baseline CJ[1] (N=54)	Baseline Tx[1] (N=33)	Follow-up All (N=79)	Follow-up CJ[1] (N=49)	Follow-up Tx[1] (N=30)
Naltrexone						
How familiar are you with this treatment?	2.71 (1.3)	2.46 (1.18)	3.12 (1.41)	3.21 (1.21)	3.04 (1.20)	3.48 (1.20)
How much training have you received about this treatment?	2.46 (1.28)	2.22 (1.21)	2.85 (1.33)	3.02 (1.28)	2.81 (1.30)	3.36 (1.19)
How knowledgeable are you about where to refer an eligible client for this treatment?	2.84 (1.41)	2.59 (1.37)	3.24 (1.41)	3.43 (1.28)	3.26 (1.32)	3.69 (1.18)
Do you think using this treatment might be helpful to your clients with opioid use disorder?	3.41 (1.2)	3.39 (1.23)	3.45 (1.15)	3.58 (1.22)	3.51 (1.30)	3.69 (1.09)
How likely are you to refer clients with opioid use disorder to this treatment now?	3.26 (1.3)	3.19 (1.33)	3.39 (1.25)	3.46 (1.26)	3.35 (1.33)	3.63 (1.13)
How likely are you to refer eligible clients to this treatment in the future?	3.34 (1.27)	3.28 (1.28)	3.45 (1.25)	3.54 (1.26)	3.45 (1.35)	3.70 (1.09)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

(continued)

MAT Implementation Survey Items, continued

Item	Baseline All (N=87)	Baseline CJ[1] (N=54)	Baseline Tx[1] (N=33)	Follow-up All (N=81)	Follow-up CJ[1] (N=51)	Follow-up Tx[1] (N=30)
Depot Naltrexone						
How familiar are you with this treatment?	3.24 (1.24)	3.07 (1.27)	3.52 (1.15)	3.60 (1.09)	3.50 (1.13)	3.76 (1.03)
How much training have you received about this treatment?	2.87 (1.31)	2.70 (1.35)	3.15 (1.2)	3.36 (1.20)	3.25 (1.22)	3.55 (1.15)
How knowledgeable are you about where to refer an eligible client for this treatment?	3.36 (1.34)	3.20 (1.39)	3.61 (1.22)	3.86 (1.11)	3.75 (1.14)	4.03 (1.06)
Do you think using this treatment might be helpful to your clients with opioid use disorder?	3.75 (1.11)	3.69 (1.21)	3.85 (0.94)	4.03 (1.05)	3.91 (1.07)	4.25 (0.98)
How likely are you to refer clients with opioid use disorder to this treatment now?	3.55 (1.18)	3.48 (1.28)	3.67 (0.99)	3.96 (1.09)	3.79 (1.13)	4.27 (0.98)
How likely are you to refer eligible clients to this treatment in the future?	3.68 (1.12)	3.61 (1.2)	3.79 (0.96)	3.99 (1.10)	3.82 (1.14)	4.27 (0.98)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

Item	Baseline All (N=87)	Baseline CJ[1] (N=54)	Baseline Tx[1] (N=33)	Follow-up All (N=83)	Follow-up CJ[1] (N=52)	Follow-up Tx[1] (N=31)
Naloxone						
How familiar are you with this treatment?	4.01 (0.97)	3.87 (1.03)	4.24 (0.83)	4.19 (0.92)	4.07 (0.93)	4.39 (0.86)
How much training have you received about this treatment?	3.68 (1.25)	3.5 (1.37)	3.97 (0.98)	4.01 (1.01)	3.82 (1.06)	4.33 (0.82)
How knowledgeable are you about where to refer an eligible client for this treatment?	4.01 (1.18)	3.80 (1.29)	4.36 (0.86)	4.32 (0.92)	4.19 (0.98)	4.53 (0.76)
Do you think using this treatment might be helpful to your clients with opioid use disorder?	4.36 (0.9)	4.15 (1.04)	4.7 (0.47)	4.55 (0.82)	4.50 (0.91)	4.64 (0.65)
How likely are you to refer clients with opioid use disorder to this treatment now?	4.25 (1.06)	4.00 (1.23)	4.67 (0.48)	4.49 (0.87)	4.40 (0.93)	4.65 (0.75)
How likely are you to refer eligible clients to this treatment in the future?	4.34 (0.93)	4.13 (1.06)	4.7 (0.47)	4.54 (0.83)	4.46 (0.92)	4.68 (0.65)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

(continued)

MAT Implementation Survey Items, continued

Item	Baseline All (N=86)	Baseline CJ[1] (N=54)	Baseline Tx[1] (N=32)	Follow-up All (N=86)	Follow-up CJ[1] (N=54)	Follow-up Tx[1] (N=32)
Openness to OUD Treatment Interventions						
I like to use new types of treatments/interventions to help justice-involved individuals with Opioid Use Disorder (OUD).	4.08 (0.96)	3.98 (1.02)	4.25 (0.84)	3.85 (0.98)	3.78 (1.08)	3.97 (0.78)
I am willing to use new types of treatments/interventions for OUD even if I have to follow specific guidelines.	4.27 (0.86)	4.19 (0.89)	4.41 (0.8)	4.06 (0.77)	4.00 (0.82)	4.16 (0.68)
I am willing to use new types of treatments/interventions for OUD developed by researchers.	4.21 (0.86)	4.13 (0.87)	4.34 (0.83)	3.88 (0.80)	3.85 (0.88)	3.94 (0.67)
Research-based treatments/interventions for OUD are useful in my organization.	4.27 (0.98)	4.20 (1.05)	4.38 (0.83)	4.03 (0.90)	4.09 (0.81)	3.94 (1.05)
Experience is more important than research-based treatments/interventions.	2.41 (1.06)	2.54 (1.06)	2.19 (1.03)	2.50 (1.08)	2.52 (1.14)	2.47 (0.98)
I would not use research-based treatments/interventions for OUD.	1.70 (1.16)	1.83 (1.19)	1.47 (1.08)	1.41 (0.87)	1.35 (0.73)	1.50 (1.08)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx)

(continued)

MAT Implementation Survey Items, continued

Item	Baseline All (N=87)	Baseline CJ[1] (N=54)	Baseline Tx[1] (N=33)	Follow-up All (N=89)	Follow-up CJ[1] (N=56)	Follow-up Tx[1] (N=33)
Perceptions of MOUDs						
Methadone, when given as a maintenance program, reduces (blocks) the effects of opioids.	3.56 (1.29)	3.54 (1.24)	3.61 (1.39)	3.65 (1.23)	3.55 (1.22)	3.82 (1.26)
Buprenorphine, when given as a maintenance program, reduces (blocks) the effects of opioids.	3.83 (1.11)	3.59 (1.16)	4.21 (0.93)	3.84 (1.12)	3.71 (1.14)	4.06 (1.06)
Methadone should be available as a lifelong treatment option.	3.60 (1.22)	3.31 (1.23)	4.06 (1.09)	3.70 (1.19)	3.39 (1.23)	4.21 (0.93)
Buprenorphine should be available as a lifelong treatment option.	3.71 (1.24)	3.31 (1.24)	4.36 (0.93)	3.76 (1.15)	3.54 (1.14)	4.15 (1.06)
The goal of medication-assisted treatment should always be eventual detoxification and sobriety.	2.77 (1.46)	2.96 (1.35)	2.45 (1.6)	2.79 (1.47)	3.07 (1.52)	2.30 (1.26)
Methadone is just substituting one addiction for another.	1.43 (0.86)	1.44 (0.74)	1.39 (1.03)	1.54 (1.01)	1.70 (1.14)	1.27 (0.67)
Buprenorphine is just substituting one addiction for another.	1.39 (0.83)	1.41 (0.71)	1.36 (0.99)	1.36 (0.79)	1.45 (0.85)	1.21 (0.65)
Methadone maintenance reduces users' criminal activities.	3.69 (1.08)	3.54 (1.02)	3.94 (1.14)	3.62 (1.14)	3.32 (1.25)	4.12 (0.7)
Buprenorphine maintenance reduces users' criminal activities.	3.77 (1.02)	3.56 (1.0)	4.12 (0.96)	3.64 (1.08)	3.36 (1.18)	4.12 (0.65)
Methadone maintenance reduces users' risk of acquiring or transmitting HIV.	3.79 (1.06)	3.67 (0.91)	4.00 (1.25)	3.71 (1.22)	3.50 (1.33)	4.06 (0.9)
Buprenorphine maintenance reduces users' risk of acquiring or transmitting HIV.	3.72 (1.1)	3.59 (0.96)	3.94 (1.27)	3.69 (1.22)	3.48 (1.35)	4.03 (0.88)
Methadone maintenance reduces users' risk of dying.	4.06 (0.98)	3.96 (0.99)	4.21 (0.96)	4.21 (0.87)	4.07 (0.97)	4.45 (0.62)
Buprenorphine maintenance reduces users' risk of dying.	4.16 (0.94)	3.94 (1.00)	4.52 (0.71)	4.26 (0.85)	4.11 (0.95)	4.52 (0.57)
Methadone maintenance increases users' chances of using illicit opioids.	1.99 (1.12)	2.06 (1.04)	1.88 (1.24)	2.07 (1.27)	2.05 (1.23)	2.09 (1.35)
Buprenorphine maintenance increases users' chances of using illicit opioids.	1.93 (1.08)	2.07 (1.08)	1.69 (1.06)	2.09 (1.28)	2.07 (1.25)	2.12 (1.36)
Methadone maintenance reduces users' consumption of illicit opioids.	3.76 (0.98)	3.54 (0.91)	4.12 (0.99)	3.83 (1.12)	3.61 (1.15)	4.21 (0.96)
Buprenorphine maintenance reduces users' consumption of illicit opioids.	3.82 (0.97)	3.59 (0.9)	4.18 (0.98)	3.87 (1.10)	3.66 (1.15)	4.21 (0.93)
Inmates do not need Methadone services after they get released because they have not used drugs while they were incarcerated.	1.23 (0.66)	1.20 (0.53)	1.27 (0.84)	1.30 (0.80)	1.34 (0.86)	1.24 (0.71)
Inmates do not need Buprenorphine services after they get released because they have not used drugs while they were incarcerated.	1.22 (0.64)	1.20 (0.53)	1.24 (0.79)	1.30 (0.80)	1.34 (0.86)	1.24 (0.71)

[1]CJ and Tx refer to criminal justice and treatment respondent role types respectively. Self-reported job titles were used to judge if each respondent's role was primarily concerned with the administration of criminal justice (CJ) or concerned with the provision of healthcare/treatment (Tx).

Evidence Assessment Items

Means and Standard Deviations for team leader survey Evidence Assessment items

Item	Baseline	Follow-up
The implementation of methadone in jail with coordinated follow-up care in the community...	**N=16**	**N=16**
Decreases inmate opioid use after release	4.81 (0.40)	4.25 (0.93)
Decreases opioid-related overdose deaths after release	4.81 (0.40)	4.56 (0.63)
Decreases future engagement in criminal activity	3.94 (0.93)	4.31 (0.79)
Decreases infectious disease transmission	4.50 (0.52)	4.38 (0.72)
Increases social functioning	4.38 (0.72)	4.31 (0.70)
Increases retention in current and future treatments	4.38 (0.72)	4.44 (0.73)
The implementation of buprenorphine in jail with coordinated follow-up care in the community...	**N=16**	**N=16**
Decreases inmate opioid use after release	4.81 (0.40)	4.38 (0.89)
Decreases opioid-related overdose deaths after release	4.88 (0.34)	4.69 (0.60)
Decreases future engagement in criminal activity	3.94 (0.93)	4.50 (0.73)
Decreases infectious disease transmission	4.44 (0.51)	4.44 (0.73)
Increases social functioning	4.38 (0.72)	4.44 (0.73)
Increases retention in current and future treatments	4.31 (0.79)	4.62 (0.72)
The implementation of extended-release naltrexone in jail with coordinated follow-up care in the community...	**N=16**	**N=16**
Decreases inmate opioid use after release	4.44 (0.63)	4.06 (1.12)
Decreases opioid-related overdose deaths after release	4.38 (0.81)	4.50 (0.82)
Decreases future engagement in criminal activity	3.62 (0.81)	3.88 (0.96)
Decreases infectious disease transmission	4.06 (0.85)	3.88 (0.89)
Increases social functioning	4.12 (0.72)	4.12 (0.89)
Increases retention in current and future treatments	4.00 (0.82)	4.12 (1.02)

Facilitation Assessment Items

Means and Standard Deviations for team leader survey Facilitation Assessment items

Item	Baseline (N=16)	Follow-up (N=16)
Senior leadership in your organization...		
propose to implement medication for inmates with OUD in a way that is feasible	4.31 (0.79)	4.62 (0.50)
provide clear goals for improvement of inmate OUD medication treatment	4.06 (0.77)	4.25 (0.77)
establish a project schedule with clear deliverables for OUD medication treatment implementation	3.62 (1.15)	4.25 (0.86)
designate an organizational champion(s) for this OUD medication treatment implementation project	4.38 (0.72)	4.69 (0.48)
The OUD medication implementation project champion...		
is committed to the success of this OUD medication treatment implementation project	4.94 (0.25)	4.75 (0.58)
has the authority to carry out this OUD medication treatment implementation project	4.38 (0.89)	4.44 (0.73)
is considered an opinion leader	4.50 (0.73)	4.56 (0.73)
works well with the implementation team	4.94 (0.25)	4.69 (0.60)
works well with custody staff	4.62 (0.62)	4.44 (0.89)
works well with medical staff	4.56 (0.63)	4.44 (0.89)
Senior leadership and staff opinion leaders...		
agree on the goals for this OUD medication treatment implementation project	4.06 (0.77)	4.44 (0.63)
are informed and involved in this OUD medication treatment implementation project	4.06 (0.85)	4.56 (0.51)
agree on what staffing resources are necessary to accomplish this implementation project	3.62 (0.89)	4.25 (0.86)
set a high priority on the success of this OUD medication treatment implementation project	4.12 (0.89)	4.62 (0.62)
The OUD medication treatment implementation team members...		
share responsibility for the success of this project	4.56 (0.63)	4.44 (0.63)
have clearly defined roles and responsibilities	4.00 (0.82)	4.38 (0.72)
have adequate release time or accomplish implementation tasks within their regular work load	3.50 (1.10)	4.00 (0.97)
have necessary staff support to carry out this OUD medication treatment implementation treatment	3.44 (1.03)	3.31 (1.14)
The implementation plan for this project...		
identifies specific roles and responsibilities	3.75 (1.18)	4.50 (0.52)
clearly describes tasks and timelines	3.56 (1.15)	4.44 (0.51)
includes appropriate staff education	3.69 (1.14)	4.44 (0.51)
acknowledges staff input and opinion	3.69 (1.20)	4.50 (0.63)

(continued)

Summary Results of Individual Survey Items

continued

Facilitation Assessment Items, continued

Item	Baseline (N=16)	Follow-up (N=16)
Communication is maintained through...		
regular project meetings with the project champion(s) and OUD medication implementation team members	4.44 (0.63)	4.50 (0.73)
involvement of quality management staff in project planning and implementation	4.00 (0.82)	4.25 (0.86)
regular feedback to management on progress of project activities and resource needs	4.00 (0.73)	4.38 (0.72)
regular feedback to management of practice changes on inmate outcomes	3.38 (0.89)	4.00 (0.89)
regular feedback to staff on effects of practice changes on inmate outcomes	3.38 (0.81)	3.81 (0.91)
Progress of the project is measured by...		
collecting feedback from inmates regarding implemented changes	3.12 (1.26)	3.06 (1.18)
collecting feedback from staff regarding implemented changes	3.56 (0.96)	3.81 (0.91)
developing and distributing regular performance measures to staff involved with OUD medication treatment	2.88 (1.45)	3.62 (1.15)
providing a forum for presentation and discussion of results and implications for continued improvement	3.19 (1.11)	3.94 (0.93)
The following is available to make the OUD medication treatment implementation work...		
medical space	3.62 (1.15)	3.94 (1.34)
funding for staff/medications	2.88 (1.31)	3.25 (1.39)
inmate educational materials	3.38 (1.15)	3.81 (1.22)
buy-in from medical staff	4.19 (0.75)	4.38 (0.72)
buy-in from custody staff	3.44 (0.89)	3.81 (0.98)
buy-in from case management staff	3.94 (1.12)	4.56 (0.73)
an engaged OUD medication implementation team	3.94 (1.00)	4.31 (0.79)
a clearly defined treatment protocol	3.50 (0.97)	4.44 (0.73)
Plans for improving this OUD medication treatment implementation project include...		
a periodic outcome measurement	3.62 (1.20)	4.44 (0.89)
periodic staff satisfaction surveys	3.00 (1.15)	3.56 (1.09)
periodic inmate satisfaction surveys	3.12 (1.15)	3.50 (1.26)
a dissemination plan for performance measures	3.25 (1.18)	4.12 (0.96)
a review of results by organizational leadership	3.62 (1.31)	4.50 (0.73)

Context Assessment Items

Means and Standard Deviations for team leader survey Context Assessment items

Item	Baseline	Follow-up
Senior leadership in your organization...	**N=16**	**N=16**
rewards staff who support innovations to improve OUD medication treatment	3.19 (1.28)	4.00 (0.82)
solicits opinions of staff regarding policy decisions about inmate care related to OUD medication treatment	4.00 (1.26)	4.50 (0.63)
actively seeks ways to improve inmate participation in OUD medication treatment	3.88 (1.36)	4.31 (0.79)
Custody staff in your organization...	**N=16**	**N=16**
have a sense of personal responsibility for improving inmate OUD medication treatment	3.38 (1.2)	4.31 (0.95)
are willing to innovate and experiment to improve inmate OUD medication treatment	3.38 (0.96)	4.31 (0.60)
believe that improving inmate OUD medication treatment is consistent with the goals of the organization	3.19 (1.17)	4.38 (0.81)
are generally receptive to changes in inmate OUD medication treatment	3.25 (1.00)	3.94 (0.85)
Case management staff in your organization...	**N=15**	**N=16**
have a sense of personal responsibility for improving inmate OUD medication treatment	4.07 (0.96)	4.19 (0.83)
are willing to innovate and experiment to improve inmate OUD medication treatment	4.00 (1.00)	3.94 (1.00)
believe that improving inmate OUD medication treatment is consistent with the goals of the organization	4.07 (0.96)	3.56 (1.15)
are generally receptive to changes in inmate OUD medication treatment	4.13 (0.92)	3.44 (1.21)
Medical staff in your organization...	**N=16**	**N=16**
have a sense of personal responsibility for improving inmate OUD medication treatment	4.44 (0.63)	3.56 (1.03)
are willing to innovate and experiment to improve inmate OUD medication treatment	4.31 (0.60)	3.56 (1.15)
believe that improving inmate OUD medication treatment is consistent with the goals of the organization	4.31 (0.70)	4.56 (0.73)
are generally receptive to changes in inmate OUD medication treatment	4.31 (0.70)	4.56 (0.73)
Senior leadership in your organization...	**N=16**	**N=16**
provide effective management for continuous improvement of inmate OUD medication treatment	4.12 (0.96)	4.62 (0.62)
clearly define areas of responsibility and authority for managers and staff in relation to inmate OUD medication treatment	3.88 (1.15)	4.69 (0.60)
promote communication and information sharing among different services, units, and organizations for inmate OUD medication treatment	3.81 (1.17)	4.62 (0.62)
provide staff with feedback on performance measures and guidelines related to inmate OUD medication treatment	3.38 (1.15)	4.44 (0.73)
establish clear goals for treating inmates with OUD's	3.62 (0.81)	4.62 (0.62)
hold staff members accountable for achieving goals related to inmate OUD medication treatment	3.62 (0.89)	4.44 (0.81)

(continued)

Summary Results of Individual Survey Items

continued

Context Assessment Items, continued

Item	Baseline	Follow-up
Opinion leaders in your organization...	**N=16**	**N=16**
believe that the current practice for inmate OUD medication treatment can be improved	4.44 (0.73)	4.38 (0.96)
are willing to try new protocols to treat inmates with OUD	4.44 (0.81)	4.69 (0.60)
work cooperatively with senior leadership to make appropriate changes to current OUD medication treatment practice patterns	4.25 (0.77)	4.56 (0.63)
can influence other staff to support changes in OUD medication treatment	4.44 (0.73)	4.62 (0.62)
In general, when there is agreement that change needs to happen for inmate OUD medication treatment, your organization...	**N=15**	**N=16**
has the budget and financial resources necessary to implement the change	2.69 (1.30)	2.94 (1.24)
has access to the training necessary to implement the change	3.69 (1.14)	4.12 (0.81)
has the facilities necessary to implement the change	3.38 (1.15)	3.50 (1.10)
has the staffing necessary to implement the change	2.60 (1.06)	3.06 (1.34)
Your organization's decision to adopt/expand OUD medication treatment for inmates is influenced by...	**N=16**	**N=16**
legislators at the state or local level	3.06 (1.12)	3.38 (1.36)
political leaders in the local or state government	3.75 (1.13)	3.75 (1.29)
leaders of the criminal justice system in the local or state government	4.31 (0.79)	4.12 (0.96)
political factors outside of the local or state government	3.50 (1.15)	3.44 (1.15)
political factors unknown to you	3.06 (1.06)	2.88 (0.96)

Appendix J: Site Level Characteristics

Camden County, NJ

Camden County is the eighth most populous county in New Jersey with roughly 510,000 people residing in 37 municipalities. Camden County Correctional Facility (CCCF) reports an average daily population of 836, with an average length of stay of 28 days. CCCF is one of New Jersey's largest jails, and has one of the highest reported crime rates in New Jersey. Camden County experiences high levels of substance use, drug trafficking, and drug related crime. It ranks second in substance use admissions and drug related deaths in the state. While re-entry programs are available, many community members are not aware of these initiatives and the challenges associated with returning home after incarceration. At the time of their application to the planning initiative CCCF was providing extended-release naltrexone and buprenorphine for those incarcerated and diagnosed with an OUD. Methadone was also available to those who were verified and in active treatment in the community. While MOUD was available in the community, there was still a treatment gap in which nearly one-third of individuals seeking treatment were unable to access it.

Chesterfield County, VA

Chesterfield County is part of the greater Richmond metro area in Virginia with a population of 343,599. It is the fourth most populous county in Virginia and is served by the Chesterfield County Police Department, which has one local jail operated by the Sheriff's office, and a regional jail, Riverside Regional Jail. Although overdose deaths from opioids were at a decline at the time they applied for Bridges participation, this jail system was still seeing an increase of those experiencing opioid addiction at the time of intake. Extended-release naltrexone was available for those experiencing OUD, with transfer to a community provider upon release. Although extended-release naltrexone was the only medication used during incarceration, connection to methadone and buprenorphine treatments could be accessed via referral upon release.

Clackamas County, OR

Clackamas County consists of urban, suburban, and rural settings outside of the Portland area. The county government directly services clients through community corrections, specialty behavioral health, primary care, and specialty dental services. This is through a network of Federally Qualified Health Centers (FQHCs), which allows all of these services to operate under one umbrella. At the time they applied for Bridges participation no MOUD was available in the Clackamas County jail and only pregnant women were able to access MOUD (methadone) while incarcerated, with medication provided off-site. There was also no process for connecting individuals who were being released to community treatment programs.

Collier County, FL

Collier County has a population of 376,086 people in off-season, non-tourist months. This county sees up to 1.8 million tourists a year, and county populations can reach 451,303 during peak tourist season. There are several community treatment programs that serve various local areas, but there is only one treatment center that treats uninsured clients. There is a drug court in Collier County and incarcerated individuals who qualify for drug court also qualify for MOUD, specifically extended-release naltrexone. However, because extended-release naltrexone is costly, many individuals do not receive the medication. The Collier County Jail works closely with the David Lawrence Center (DLC), which is the only treatment program that is open to the uninsured in Collier County.

Site Level Characteristics

Cook County, IL

Cook County is the most populous county in the state of Illinois with over 5 million residents. Cook County Department of Corrections (CCDOC) expands over 96 acres, or 8 city blocks, and is one of the largest single-site jails in the country. With a daily census average of approximately 6,100, over 100,000 individuals circulate through the jail every year. Cook County Health (CCH) is the safety net healthcare provider for much of the city of Chicago and suburban Cook County. CCH operates two hospitals, fifteen community-based health centers, correctional healthcare services for the county jail and juvenile detention centers, a medical home for patients with HIV/AIDS, and the Cook County Department of Public Health.

Cumberland County, ME

Cumberland County has a population of 292,500 people, which accounts for 22% of Maine's population. There are 350 people/square mile, making it the most densely populated county in Maine. Portland, Maine's largest city, is in Cumberland County. The Portland area is known as a recovery-friendly environment and had 59 sober recovery residences, as of November 2018. However, these residences will not take individuals who receiving MOUD, and rents are typically over $500/month, which effectively limits access to people who are released from jail. In 1998, Cumberland County was the first county in Maine that began operating an adult drug court. Currently, the drug court serves roughly 40 clients each year. Methadone is not available to those incarcerated in Cumberland County, since local methadone clinics do not deliver medication, and the correctional officers are unable to transport patients due to a correctional officer shortage. At the time they applied for participation in the Bridges planning initiative, only pregnant women were able to obtain MOUD during incarceration. On occasion, naltrexone could be prescribed for those incarcerated if they had a doctor with whom they were able to see for follow-up after release.

Durham County, NC

Durham County has a population of nearly 300,000 people over a land area of 108 square miles. Roughly 250-300 individuals who report current opioid use cycle through the jail system each month. Durham County jail has a capacity of 576 single cells. Durham County jail's healthcare contract is provided through the Durham County Public Health Department. The STARR (substance abuse and recidivism reduction) program provides harm reduction and overdose education to individuals with substance use disorders. This program is intended to provide structured programming to aid in modifying behaviors that lead to criminal activity, and to assist in recovery from addiction. Treatment accounts for roughly 83 hours of addiction education, group therapy, and community resources education. The Durham County Jail has strong ties with community-based MOUD treatment providers, but at the time they applied for Bridges participation, the jail did not offer any type of MOUD, but was hoping to implement delivery of buprenorphine and extended-release naltrexone.

Eaton County, MI

Eaton County is located in Michigan's Lower Peninsula, over 579 square miles. A small part of Lansing is within Eaton County, however most of the county is suburban and rural. Eaton County jail holds up to 374 inmates and has an average daily census of 250 inmates. Because major hospitals for the area lie outside of Eaton County, there is little information on true incidence of overdose and OUD related injury within the county. At the time of their Bridges application the Eaton County Sheriff's Office and Jail was providing a jail-based residential treatment program for incarcerated individuals who had been identified as having an SUD. This program initiated and maintained MOUD (naltrexone, buprenorphine, and methadone) while incarcerated and was able to transition care to community-based treatment programs.

Site Level Characteristics

Hudson County, NJ

Hudson County is the most populous county in New Jersey with almost 700,000 residents. It is also the sixth most densely populated county in the United States, hosting the state's second most populous city (Jersey City), as well as some of the nation's most densely populated cities (Union City, Guttenberg, Hoboken). After a rise in jail suicides between 2017 and 2018, MOUD implementation was ramped up, but transfer to community-based treatment programs was still problematic. At the time of their Bridges application most incarcerated people in Hudson County who had an OUD were given a long acting medication (Vivitrol) at entry, but were not continued on any medication due to budget constraints.

Ingham County, MI

Ingham County is located in south-central Michigan and is home to Lansing, the state capitol. The county is the seventh most populated county in the state with roughly 290,000 residents. Lansing and East Lansing house about 60% of the total population of Ingham County. Ingham County jail has a larger arrest rate compared to the rest of Michigan and the daily jail census hovers around 600 inmates. The average stay at the jail is 20 days. When they applied for Bridges participation MOUD was scarcely offered within Ingham County jail, with only methadone offered for those who were verified by a community treatment program at time of arrest. There were also instances where specialty court judges were able to order Vivitrol for inmates upon release, but it was rare and not a standard practice at the time.

Jefferson County, KY

Jefferson County is the largest county in the state of Kentucky with 760,000 people residing within 365 square miles. This county is both large and diverse given its expanse of area and population. In 2018 alone, Louisville Metro Department of Corrections (LMDC) placed 7,400 individuals on a detox protocol upon entering the jail after either reporting substance use or exhibiting signs of use. Of the people placed on the detox protocol, 63% report use of opiates. At the time of their Bridges application, LMDC had the Pathway Advocacy and Alliances for Community Treatment (PA2CT) Program. This program provided Vivitrol for those with OUD who were returning to the community. MOUD for pregnant women was also provided for LMDC. While initiation to MOUD was not necessarily provided to inmates, many who were released on parole or probation were able to be connected to community treatment networks that could initiate MOUDs.

Lewis and Clark County, MT

Lewis and Clark County covers 3,497 square miles in west-central Montana. The population of the county is roughly 70,000 and almost half of the population resides within the capitol city of Helena. This is the sixth most populated county in Montana (out of 56 counties). Lewis and Clark County's current detention facility was originally built with 54 beds and was modified to hold 80 beds; however, the daily census reflects over 100 inmates housed, which has led to inmates sleeping in the halls and the library. When they applied for Bridges there was construction underway to increase the bed capacity for this facility. The collection and coordination of data in Lewis and Clark County criminal justice system is difficult to track, as there are 18 separate systems and none of these systems communicate with one another. Lewis and Clark County Detention Facility did not provide MOUD at the time of their application. While there were community-based treatment centers that did provide MOUD, the jail was not yet able to partner with them. Within the jail there was a mental health therapist, mental health case manager, and a behavioral health coordinator, who were all able to connect inmates to treatment resources in the community upon release.

Site Level Characteristics

Marion County, IN

Marion County is the most populated county in Indiana, with over 930,000 residents. This county includes the state capitol, Indianapolis, which is the 16th largest city in the US. Within Indiana, as a whole, there is a shortage of MOUD providers. In Marion County, there is a lack of residential recovery treatment facilities that allow MOUD services. Many of these facilities are abstinence-based, which limits access to care. At the time of their Bridges application, within the jail there were four detox units, but none provided MOUD. Pregnant women were offered methadone treatment within the jail. The Marion County Probation Office did provide an extended-release naltrexone program in conjunction with the County's Sheriff's Office for people with OUD and who were deemed to be at high risk to reoffend and had already violated their terms of probation. Marion County also had a drug court whose goal was to divert people from Indiana Department of Corrections.

Orleans, St. Bernard, and Plaquemines Parishes, LA

The population of the tri-parish area is roughly 400,000 and includes the city of New Orleans. At the time they applied for Bridges participation they were not offering any jail-based MOUD to inmates within the County. The community did have providers that could prescribe MOUD in different capacities, including outpatient care and residential treatment. While Medicaid was expanded in this state in 2016, Louisiana Medicaid does not cover methadone, but does cover various formulations of buprenorphine.

Shelby County, TN

Shelby County is the largest county in Tennessee in terms of population and geographic area. The estimated population of Shelby County is 937, 847, with Memphis accounting for nearly 70% of the population. There are 69 unique treatment centers in Shelby County, including 24 residential, 52 outpatient, 35 dual diagnosis, 9 medical detox, and additional social detox and halfway treatment center options. At the time of their Bridges application, Shelby County jails were only able to provide a medically supervised withdrawal for OUD and offer maintenance treatment for pregnant women. No initiation to MOUD or overdose prevention prior to release was provided by Shelby County jails. The jails in the County also did not have an existing partnership with community-based treatment programs, which impeded discharge planning.

St. Louis County, MN

St. Louis County is the largest county in Minnesota with a population of 200,000. The county has three jails due to its large geographic size. At the time of their Bridges application incarcerated individuals were able to continue on MOUD if they were an active patient in a community treatment program. Additionally, pregnant women were continued and initiated on MOUD at time of booking. At all jails in the county, if someone was incarcerated for more than 14 days, inmates were typically weaned off MOUD due to security concerns. There were several community-based treatment programs that offered MOUD at varying levels, including residential and outpatient facilities. Further, there were various treatment-related courts to help those with varying degrees of criminal justice involvement, which are well-funded. While some of these court offered MOUD, not all did, and were reliant on the judge's discretion.