**DRAFT**

**Illinois Opioid Crisis Response Advisory Council**
**Criminal Justice Populations Committee Meeting**
**October 3, 2017**
**MEETING MINUTES**

**Chair:** Sherie Arriazola

**Committee Members Present:** Leslie Balonick; Emilie N. Junge; Stacy Munroe; John Nunley; Marc Raifman; Debi Rauch; Jessica Reichert; Jennifer Vollen-Katz; **On phone:** Bruce Angleman; Andrea Davenport; Jane Gubser; Janelle Prueter; Dan Rabbitt; Elizabeth Salisbury-Afshar, MD; Antonietta Simonian; Cyrus Winnett

**DASA and AHP Representatives:** Danielle Kirby, Kristin Stainbrook, Jen Carpenter

**Welcome, Introductions and Review of Committee Goals**

- Sherie welcomed the group and provided background on the committee, reviewing recent meeting history and reviewing the three-pillar model of the state's action plan. A graphic of this model was provided as a handout. The committee's task for this meeting is to develop recommendations for implementing strategy 9; these recommendations will be presented at the council meeting scheduled for 10/16. The committee has also been tasked with developing recommendations for implementing strategy 7, but these will be developed during a smaller meeting scheduled for 10/12. Sherie invited all interested committee members to attend the 10/12 meeting, as well.

**Illinois Opioid Action Plan Strategies to be Addressed by the Committee**

- As noted above, the committee is tasked with strategies 7 and 9 but focused on strategy 9 during this meeting:
  Strategy #9: Decrease the number of overdose deaths after an at-risk individual's immediate release from a correctional or other institutional facility

***Strategy #9 Recommendations***
**Recommendation 1: Expand Naloxone Training and Distribution**

- Implement opioid overdose prevention training to all individuals who are identified as using opioids and dispense/administer Naloxone at the time of discharge from jail and prison
- Family/Friends/Community Members - It will be essential to find ways to distribute kits to families and friends of those leaving jails and clinics: videos at visitors' spaces and waiting rooms, ensuring standing orders allowing families of people with SUD to obtain kits at no cost; and supporting and expanding the distribution points created by CRA (Chicago Recovery Alliance) to include outlying areas. Until the community is saturated with knowledge and kits, we will have only reached a small potential at-risk population.
- Resources: Federal opioid-related grants

**Discussion:**

- The committee discussed the Illinois Department of Public Health's (IDPH) decision to issue a statewide standing order for naloxone and provide training and education on the use of

naloxone to anyone requesting the drug. This order eliminates the need for a prescription, considerably improving access to naloxone for organizations that do not have a prescriber on staff. Additionally, the committee agreed that that the order is a significant move forward in that it will make it easier to provide those with opioid use disorders and their family members with naloxone itself, rather than a prescription for the drug.

- Leslie noted that nationally there is a movement to support the distribution/availability of naloxone as standard lifesaving equipment. The goal of this movement is to make the drug itself as available in (non-treatment) public settings as automated external defibrillators and to make knowledge of its use as common as knowledge of first aid and CPR. This movement also supports the distribution of naloxone among family members of those with opioid use disorders.

**Recommendation 2: Expand Treatment for Opioid Addictions within Correctional Facilities**

- Increase the number of people with an SUD who receive substance use treatment in jail and prison.
- Incorporate MAT into all treatment rendered inside jail and prison and post-release. At a minimum those who come in on MAT to should be allowed to continue it and those with severe OUD on arrival could be offered induction before leaving (even if just for a few weeks).
- Educate and offer the continuum of MAT i.e. all FDA-approved medications for the treatment of opiate use disorder, to individuals inside jail and prison.
- Resources: Federal opioid-related grants

**Discussion:**

- Multiple committee members noted that, while strategy 9 immediately calls to mind lifesaving interventions at release, it demands a continuum of interventions; this continuum includes comprehensive treatment within correctional facilities.
- Multiple committee members agreed that the committee should make the overall recommendation to expand MAT options. Within this broad consensus there was some variation in perspective on whether all MAT options should be available in all settings. For example, John noted that the recent policy change making Vivitrol available within DOC facilities was very hard won (suggesting the addition of narcotic MAT options would be an even more difficult battle) and pointed out that non-narcotic treatment offers an advantage for people who have been clean for a significant period. Additionally, Leslie raised concerns about the rise of Suboxone-related crime in some areas of the country. Other committee members, however, voiced support for the widespread availability of all MAT options and noted that there is at least one model of a state corrections department successfully offering the entire spectrum of MAT (Rhode Island).
- Jessica told the group about an upcoming Illinois Criminal Justice Information Authority conference on this topic and added that representatives of the Rhode Island DOC will be present to discuss the process by which MAT was expanded in their system. The conference will take place 11/1 in Bloomington; materials on the conference were distributed to the committee.

**Recommendation 3: Ensure post-release treatment, and resources to support treatment, are available to individuals leaving jails and prisons**

- Bridge Funding -Implement funding for services rendered during the transition period that occurs in the 1-2 months post-release. This includes case management services, initial MAT

doses/injections, temporary housing, and other prevention and intervention services and supports that work to link individuals being released from jail and prison to treatment in the community.

- In alignment with this concept, innovative models such as the Supportive Release Center (SRC) for individuals coming out of Cook County Jail should be promoted, supported, and expanded as a standard model in the release process.
- The current Medicaid system does not facilitate immediate access to post-release treatment for a majority of criminal justice involved clients, these delays in care can increase the risk of death due to overdose in the weeks following release. Approaches to improving include:
    - Automate the Restriction and Reinstating Process for Medicaid benefits that occurs upon incarceration and upon release to ensure continuity of treatment. Currently, this is a manual process and is not instantaneous. Recently, HFS and IDOC have worked to "restrict" benefits when they are notified from IDOC that someone is incarcerated. Upon release, they turn benefits back to full Medicaid benefits once they receive notice from IDOC. However, sometimes the information is not updated or transferred to HFS in real-time and benefits still restricted at release. If an individual had a redetermination date approach while on the inside, they automatically lose their coverage, since they have no way of receiving or completing the paperwork while inside.
    - Provide Medicaid Application Assistance to individuals pre-release to ensure access to treatment. HB 3270 (PA 99-415) required IDOC to provide application assistance to inmates at IDOC 45 days pre-release, yet this has not been implemented. Further, it would be helpful to have this period extended to 60 days pre-release.
    - Assuming the above has been implemented, MCO enrollment should be automated to occur 30 days prior to release to permit MCOs the ability to assist in the coordination of their transition back into the community.
- In absence to changes to Medicaid processes- funding should be permitted for clients with and without Medicaid during this transition period.
- For Juvenile Justice- Continue with the services to be implemented January 1 within IDJJ (mandatory SA treatment for early release for youth with Levels 1 & 2 treatment need; continuing care appointments in community following discharge; tracking youth reporting opioid use); expand drug education materials to include additional opiate education for youth that participate in these groups as well as the youth who participate in drug treatment while in custody.
- Resources: Federal opioid-related grants; re-purposing of IDOC GRF funds from Medicaid-covered services to non-covered services or "hard-to-cover" services, i.e. services needed in the 1-2 months post-release, HITECH "90/10" Funding

**Discussion:**

- Several committee members spoke highly of the comprehensive services offered by the SRC and voiced support for expansion of this service model. Emilie noted that additional strategies need to be implemented for those who don't choose to access such services upon release. Leslie suggested using the home visit model currently in place for people being paroled: Pre-release home visits could be conducted for those in DOC custody who are identified as having an opioid use disorder (regardless of whether they are eligible for parole or not). Family members could be engaged as partners during this visit, which would include distribution of naloxone and training on its use.

- The group considered recommending pay-for-performance strategies to support peer recovery work and post-release case management. Several committee members identified barriers using a pay-for-performance model for these services, including the limitations in the current evidence base and challenges to implementing a robust pay-for-performance design in a correctional setting. As a result of this discussion Stacy and Sherie agreed that the committee could recommend support for additional research to develop the evidence base, and Leslie supported that recommendation provided the research is informed by those with practice expertise. In a related discussion, several committee members voiced support for enhancing the technological infrastructure related to data collection and data sharing.
- The committee considered recommending the removal of utilization controls for Medicaid-covered substance use services or enactment of presumptive medical necessity for individuals released from a correctional facility within the past 30 days. There was widespread agreement that delays in Medicaid access limit treatment access upon release, but some concern about removal of utilization control as a strategy for addressing this challenge. Cyrus noted that the prior authorization process is often a mechanism for collaboration/communication between the community organization and health plan providers, and noted that removal of the prior authorization process is likely prohibited by the contractual language going into effect January 1.
- Cyrus voiced support for enacting MCO enrollment 30 days pre-release as an alternative strategy for timely access to Medicaid coverage. Several committee members identified bridge funding as an interim alternative if the MCO enrollment approach can't be implemented quickly.

**Recommendation 4: Increase Opioid Addiction Screening within Correctional Facilities at both entry and release**

- Implement the new opioid screening tool developed by TCU-IBR at Reception and Classification (R&C) Centers within IDOC and at release from IDOC until everyone is seen in order to flag individuals needing MAT post release from prison.
- Resources: Federal opioid-related grants

**Discussion:**

- John indicated that screening at both admission and release is feasible as the activities could be integrated into the existing R&C processes and database.
- Debi noted the importance of implementing screening for the juvenile justice population. Janelle will look into the availability of an adolescent version of the TCU instrument.

**Recommendation 5: Eliminate the legal "loopholes" in the Good Samaritan Law that may deter individuals from calling 911**

- There is a loophole in the Good Samaritan law that allows individuals who call 911 and are using drugs with the person who dies to be charged with drug induced homicide, which runs counter to the general understanding of the 911 Good Samaritan Laws. Even if this loophole is not frequently enforced- the perception that it might be will deter individuals from calling 911.

**Discussion:**

- Emilie and Dr. Salisbury-Afshar both pointed out that the sentences under these circumstances are long, making this loophole a strong deterrent to calling 911. Emilie pointed out that it would

be important to protect others present from prosecution, in addition to the person who places the call.

- Jessica noted that her department had been asked to investigate this issue and had found that the number of people arrested under these circumstances is very small. The committee discussed this information and multiple members expressed concern that the perception of being at risk of prosecution could deter would-be 911 callers from seeking lifesaving care, regardless of the small number of people directly impacted by the loophole.