Regulating Methadone in Correctional Facilities and Our National Data Challenge

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An Alternative Regulatory Model for Jails and Prisons

- Yesterday's presentation from Jodi Rich underscored the problems of current methadone regulations in jails and prisons
- We found widespread challenges complying with a patchwork of state and federal rules, which are inconsistently applied.
- Best option for new regulations, described in a forthcoming White Paper with Josh Rising and Sara Whaley:[1]
  - Expand the current hospital regulations to cover people who are incarcerated.

[1] *Josh Rising, Brendan Saloner, Sara Whaley. White Paper: Access to Methadone in Correctional Facilities. Johns Hopkins School of Public Health. March 4, 2022 Draft.* https://tinyurl.com/4j27458h

The Rationale for a Hospital-Style Regulation

- Hospitals are allowed to handle methadone as they do any other controlled substance, and to dispense it to inpatients with OUD who are receiving treatment for non-OUD related causes[1]
    - *Like hospitals*, correctional facilities are institutional settings of care where patients need interim care
    - *Like hospitals*, correctional facilities are very secure and often stock and dispense controlled medications
    - *Like hospitals,* a critical task is to connect patients to continuing community care
- Jails in particular are short-stay facilities, where many existing regulations around care provision are not well-matched to available resources and acute needs of a population that churns rapidly

[1] *See Alex Walley's March 4, 2022 NASEM presentation for details of hospital regulations*

Our National Data Challenge

- Workshop presentations provide a great compilation of available service use data, but there are huge holes in our understanding of access and quality of care. Lots of basic questions cannot be answered nationally:

- *How many people want access to methadone but cannot get it?*
- *What is the national average retention in methadone and how many new patients enter treatment every year?*
- *What are the typical patterns of dosing, take-home, counseling, and UDS experienced among patients?*

- Alongside regulatory changes, we need to modernize data collection infrastructure

Elements of a Data Strategy

- Modernize NSDUH to include incarcerated people and people experiencing homelessness
- Require methadone treatment to be identified in the Treatment Episode Data Set (instead of any MOUD)
- Undertake a national longitudinal cohort study of methadone patients to identify factors related to quality of care, recovery outcomes, and retention in treatment
- Plan for data collection activities outside the OTP to extend to mobile units, correctional facilities, long-term care, pharmacies

	Available Data	What we Don't Know
Size and Characteristics of Treated Population	• NSSATS: Point-in-time count (state aggregates) • State admin data and claims: patient-level treatment records	• National data that tracks patients longitudinally, national demographics of patients at OTPs
Access Barriers and Facilitators	• Select studies on travel distance, cost, and wait times	• National, patient-centric measures on realized access and patient barriers
Quality of Care	• Select studies on retention, NSSATS facility measures on processes of care	• National measures on whether care is effective, comprehensive, patient-centered
Medical Outcomes	• Small sample studies with patient-reports, claims-based analyses for specific payers	• National trends in overdose risk among methadone patients, other self-reported markers of relapse/recovery
Non-Medical Outcomes	• Single state/county data linkage studies, small sample studies with patient reports	• National trends in recidivism, child welfare involvement, employment, housing stability