Report to
The Vermont Legislature

Vermont Department of Corrections
Peer Review of the Medication-Assisted Treatment Policy and Procedures and Clinical Guidelines
Interim Report

In Accordance with Act 72
An act relating to making appropriations for the support of the government

Submitted to: Joint Legislative Justice Oversight Committee

Submitted by: Mike Touchette
Commissioner

Prepared by: Annie Ramniceanu, LCMHC, LADC
DOC Director of Addiction and Mental Health Systems

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Introduction

Act 72 of 2019 (H.542), "An act related to making appropriations for the support of the government," (otherwise known as the Big Bill – Fiscal Year 2020 Appropriations Act), requires the Department of Corrections (DOC) to provide, on or before November 15, 2019, an interim report to the Joint Legislative Justice Oversight Committee regarding the Department's Peer Review of the medication-assisted treatment (MAT) policy and procedure and clinical guidelines. No. 72 (2019), § E.338.3. This interim report will provide the background of MAT provision in Vermont correctional facilities, the definition of peer review in this context, the peer review selection process, method and participants, and a summary of the significant comments and recommendations. Also provided are the supporting documents: Act 176, the Vermont Correctional MAT policies and procedures and clinical guidelines, the summary of the peer reviewer comments by reviewer and by section of the documents (Policy and Procedure/Clinical Guidelines).

Background

On May 25, 2018, Governor Phil Scott signed into law Act 176, "An act relating to the provision of medication-assisted treatment for inmates." The legislation supports the use of MAT as a medically necessary component of treatment for Vermont inmates diagnosed with an opioid use disorder.

Act 176 establishes several key definitions pertaining to the treatment of opioid use disorders for all Vermonters. For all Vermonters, MAT is defined as the use of U.S. Federal Drug Administration-approved medications in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. "Medical necessity" means healthcare services that are appropriate in terms of type, frequency, level, setting and duration to the individual's diagnosis or condition and informed by generally accepted medical or scientific evidence, consistent with generally accepted practice parameters. The definition also states that such services will be informed by the unique needs of each individual and presenting situation and will include a determination that a service is needed to achieve proper growth and development and to prevent the worsening of a health condition.

That being said, the majority of Act 176 provides the Vermont Department of Corrections broad practice guidelines for the delivery of MAT in correctional facilities. The guidelines are as follows:

- To screen inmates for substance use disorders within 24 hours of admission to a correctional facility as part of the initial and ongoing substance use screening and assessment process.

- To provide an inmate, who upon admission to a correctional facility, and who has a verified prescription, including buprenorphine, methadone or other medication prescribed in the course of medication-assisted treatment to be continued on that medication and to be provided that medication by the Department pending an evaluation by a licensed physician, a licensed physician assistant or a licensed advance practice nurse.

    - And if in the clinical judgment of the licensed physician, physician assistant or advanced practice registered nurse, it is not medically necessary to continue the medication at that time, the provider may defer provision of that medication. If the provider makes the clinical judgment to discontinue a medication, the provider shall cause the reason to

be entered into the inmates' medical record, specifically stating the reason for the discontinuance.

- To ensure that inmates receiving medication-assisted treatment prior to entering a correctional facility continue to receive medication prescribed in the course of medication-assisted treatment for as long as medically necessary.

- To ensure that if, at any time, an inmate screens positive as having an opioid use disorder and a qualified provider authorized to prescribe buprenorphine deems that buprenorphine medication-assisted treatment is medically necessary, and the inmate elects to do so, the inmate will be authorized to receive the medication for as long as medically necessary.

- To ensure that an inmate who commences buprenorphine while in a correctional facility may transfer to methadone if methadone is deemed medically necessary by a provider authorized to prescribe methadone; if the inmate elects to do so as recommended by a provider authorized to prescribe methadone.

- To ensure that as part of re-entry planning, an inmate's medication-assisted treatment will commence prior to release if medication-assisted treatment is determined to be medically necessary and the inmate elects to do so.

- To ensure that if medication-assisted treatment is indicated and despite best efforts induction is not possible prior to release, that comprehensive care coordination with a community-based provider will occur.

- To ensure that counseling or behavioral therapies shall be available in conjunction with the use of medication for medication-assisted treatment as provided for in the Department of Health's "Rule Governing Medication-Assisted Therapy for Opioid Dependence for: Office based Opioid Treatment Providers Prescribing Buprenorphine; and Opioid Treatment Providers."

In order to comply with these requirements, the DOC directed and provided oversight to the DOC Health Contractor, Centurion Vermont, to create and implement Medication-Assisted Treatment (MAT) Policies & Procedures and Clinical Guidelines. It should be noted that the Centurion MAT Medical Director is also a Vermont HUB Director and that he and the DOC sought guidance from in and out-of-state qualified medical providers. Once the MAT Policy and Procedures and Clinical Guidelines underwent a final local review and were adopted, the DOC initiated a peer review process to get feedback from an even broader set of national and regional independent qualified experts.

Definition of Peer Review

Peer review is generally defined as an evaluation of work by one or more people who are experts in the work being reviewed and have similar competencies as the producers of the work. The overall goal of a peer review is to encourage authors of a work to meet the highest accepted standards of their discipline, and as a result of the review, their work becomes an accepted and trusted standard. The DOC hopes that through the process of peer review, the Vermont MAT Policies and Procedures and Clinical Guidelines will represent the highest standard of medication-assisted treatment within a correctional

environment, add to the national body of work concerning correctional addiction medicine treatment, and make the DOC's treatment of opioid use disorders, via its medication-assisted treatment program, more transparent.

Peer Reviewer Solicitation and Selection Method

From March through July 2019, the DOC elicited the names of potential peer reviewers from the Vermont Health Department; nationally known experts in the field of addiction medicine and correctional health; jurisdictions who had or were in the process of adopting medication-assisted treatment in a correctional setting; the American Medical Association; the National Institute of Corrections Mental Health/Medical Directors listserv; and recognized leaders in the treatment of opioid use disorders with medication-assisted treatment in Vermont. The Department spoke to potential reviewers by phone, in person, and by email, and inquired whether any of their colleagues would be appropriate to join the peer review process. It should be noted that there were inherent limitations to the solicitation process because few correctional systems treat opioid use disorder with all three federally approved medication-assisted treatments. Additionally, it should be noted that there were no financial incentives provided to reviewers and that they provided their comments voluntarily and out of professional good will.

All potential reviewers were provided the same version of Vermont's correctional MAT Policy and Procedure and Clinical Guidelines and a standard template to provide comments and advised that they could submit their comments to the DOC Director of Addiction and Mental Health Systems via any method that worked for them. . One reviewer provided comment by phone and in that instance, both the DOC Director of Addiction and Mental Health Systems and the Centurion MAT Medical Director participated in the call. The DOC Director of Addiction and Mental Health Systems created a written electronic transcription of the call.

Collating and Organizing Reviewer Comments Method

The qualified national experts who either offered to conduct a peer review or who were asked to do so included:

Out of State:

1. Dr. Carmen Alvarez, PHD, RN, CRNP, CNM. Dr. Alvarez's research focuses on the development and implementation of health promotion and risk reduction interventions primarily for underserved ethnic-minority women with a history of trauma—specifically adverse childhood experiences (ACEs) and intimate partner violence (IPV). Dr. Alvarez's research goals are to identify and better understand intervening variables in the relationship between ACEs/IPV and poor health to inform culturally tailored interventions for this population. Her most recent work— "Improving Psychosocial Well-Being among Immigrant Latina Survivors of ACEs"—is supported by the RWJF Harold Amos Medical Faculty Development Program. Her BSN and MSN are from Emory University and her PhD is from the University of Michigan. https://nursing.jhu.edu/faculty_research/faculty/faculty-directory/carmen-alvarez

2. NIC Medical and Mental Health Directors https://nicic.gov/ were also asked via a listserv email to provide peer review and one state offered:

Dr. Herb Kaldany, DO. Dr. Kaldany is the Statewide Psychiatry Director at New Jersey Department of Corrections. He received his medical degree from Rowan University School of Osteopathic Medicine and has been in practice for more than 20 years. He is currently the Statewide Medical Director of the New Jersey Department of Corrections. https://nj1015.com/nj-prison-staff-getting-trained-to-help-drug-addicted-inmates/ ; https://www.njtvonline.org/news/video/mid-state-correctional-facility-provides-treatment-for-inmates-with-addiction/https://www.linkedin.com/in/herbert-kaldany-013ba118

3. Dr. Jon Lepley, DO. Dr. Lepley developed the Philadelphia MAT Prison Program. Dr. Lepley is Board Certified in Family Medicine and holds additional qualifications in Addiction Medicine and Correctional Medicine. https://www.philly.com/philly/health/addiction/philadelphia-womens-prison-tries-bold-experiment-to-save-lives-give-inmates-a-treatment-opioid-20180802.html https://www.eagleville.org/jon-lepley-named-eagleville-hospitals-director-of-medicine/ https://whyy.org/articles/philly-jails-expand-use-of-medication-to-ease-withdrawal-to-inmates-with-opioid-addiction/

4. Dr. Jennifer Clarke, MD. Dr. Clarke, the Rhode Island DOC Medical Director, participated in several phone calls with DOC and Centurion MAT Medical Director during the development of the Policies and Procedures and Clinical Guidelines. She declined participating in the Peer Review because she has already provided input during the policy development phase. http://www.doc.ri.gov/rehabilitative/health/index.php

5. Dr. Johnathon Giftos, MD. Dr. Giftos is the Clinical Director of Substance Use Treatment for NYC Health + Hospitals, Division of Correctional Health Services at Rikers Island, where he oversees diversion, harm reduction, treatment and reentry services for incarcerated patients with substance use disorders. He is also the medical director of the opioid treatment program (OTP) for the NYC jail system, in which he also provides clinical care -- including the provision of methadone and buprenorphine maintenance treatment -- to incarcerated patients with opioid use disorders. He advises cities and states around the country on the provision of substance use treatment -- including methadone and buprenorphine -- in correctional settings, and he has partnered with Physicians for Human Rights to advocate for evidence-based treatment for patients with cases before drug courts. Dr. Giftos provided input during the development of the MAT Policies and Procedures and Clinical Guidelines and therefore did not participate in the Peer Review. http://www.einstein.yu.edu/faculty/15053/jonathan-giftos/

6. Dr. Jaimie Meyer, MD, MS, FACP. Dr. Meyer is an Assistant Professor in Infectious Diseases at Yale School of Medicine and a Clinical Assistant Professor at Yale School of Nursing. She completed her clinical training and maintains board certifications in Internal Medicine, Infectious Diseases, and Addiction Medicine, along with DEA certification to prescribe and implant buprenorphine. Her clinical work and research focus on HIV prevention and treatment among women with, and at-risk of, HIV in criminal justice and community settings, especially as it is intertwined with and complicated by substance use disorders and intimate partner violence. She has served as an expert consultant on women in prison and jail settings for the UN Office on Drugs and Crime, the Federal Bureau of Prisons, the U.S. Commission on Civil Rights, and the Connecticut Department of Corrections. https://medicine.yale.edu/intmed/infdis/people/jaimie_meyer.profile

7. Lynn Madden, MPA, PhD. (Her review was provided within the review provided by Dr. Meyer): Since 2006, she has served as Chief Executive Officer of the APT Foundation, a non-profit agency founded in 1970 by members of the Yale University Department of Psychiatry to promote health and recovery for those who live with substance use disorders and/or mental illness. Her professional interests focus on identifying treatment gaps in substance abuse/mental health treatment and improving access to those services. Prior to leading the APT Foundation, she served as a startup administrator involved in planning and program implementation for the non-profit Acadia Hospital in Bangor, Maine, a 100-bed psychiatric and substance abuse treatment hospital and its sister provider corporation. She was responsible for planning, implementation and ongoing operation of psychiatric service groups including five inpatient services units, ambulatory services, partial hospital services and outpatient treatment programs as well as a substance abuse services continuum including emergency shelter, transitional housing, inpatient detoxification, methadone treatment, and intensive outpatient services. https://aptfoundation.org/about-us/bios/

8. Dr. Faye Taxman, PhD. Dr. Taxman is a Professor in the Criminology, Law and Society Program at George Mason University. Dr. Taxman is recognized for her work in the development of the seamless systems of care models that link the criminal justice with other service delivery systems, reengineering probation and parole supervision services, and organizational change models. She conducted a multi-level organizational survey of the correctional and drug treatment systems to examine the utilization of evidence-based practice in correctional and drug treatment settings and the factors that affect the adoption of science-based processes and interventions. She performed several studies that examine the efficacy of various models of technology transfer and processes to integrate treatment and supervision. In one study, she explores the use of contingency management and incentive systems for drug-involved offenders.

   Her work covers the breadth of the correctional system from jails and prisons to community corrections and adult and juvenile offenders. She has had three R01 from the National Institute on Drug Abuse and one cooperative agreement. She has also received funding from the National Institute of Justice, National Institute of Corrections and Bureau of Justice Assistance for her work. She has active “laboratories” with her 18-year agreement with the Maryland Department of Public Safety and Correctional Services and four-year agreement with the Virginia Department of Corrections. She is the senior author of "Tools of the Trade: A Guide to Incorporating Science into Practice," a publication of the National Institute on Corrections which provides a guidebook to implementation of science-based concepts into practice. She is on the Editorial Boards of the *Journal of Experimental Criminology* and *Journal of Offender Rehabilitation*. She has published articles in *Journal of Quantitative Criminology*, *Journal of Research in Crime and Delinquency*, *Journal of Substance Abuse Treatment*, *Journal of Drug Issues, Alcohol and Drug Dependence*, and *Evaluation and Program Planning*. She received the University of Cincinnati award from the American Probation and Parole Association in 2002 for her contributions to the field. She is a Fellow of the Academy of Experimental Criminology and a member of the Correctional Services Accreditation Panel (CSAP) of England. In 2008, the American Society of Criminology’s Division of Sentencing and Corrections recognized her as Senior Scholar. She has a Ph.D. from Rutgers University-School of Criminal Justice and a B.A., from University of Tulsa. https://www.gmuace.org/about_ace-team_director.html

9. Donna Strugar- Fritsch, BSN, MPA, CCHP. Donna has been with Health Management Associates (HMA) for 16 years and has advised prisons, jails, policy makers, and correctional health vendors in correctional health care operations, best practices, and emerging trends. She has consulted with the state prison systems and with medium-sized and large jails all over the country on all aspects of inmate health care. She is an expert in jail medication procurement, administration, and safeguarding practices with practices to mitigate diversion of controlled substances and other medications in correctional settings. Donna is deeply familiar with the challenge's jails face in providing health care services to inmates and with the opportunity's jails have to provide more effective mental health and substance abuse services to justice involved populations. She is also experienced with design and operation of diversion and pre-entry programming, especially related to persons receiving treatment for addictions.

   Donna is currently directing a project to expand the use of MAT for opioid addiction in jails and drug courts in 29 California county jails. This innovative project is helping teams from counties and their jails to directly address the needs of detainees with opioid and other addictions. It involves coaching the joint efforts of courts, public defenders, prosecutors, county SUD treatment agencies, sheriff staff, and jail health care providers to provide continuity in addiction treatment as persons with OUD enter and leave the criminal justice system. Teams are also exploring the role of the jail as a site to initiate OUD treatment.

   Donna has worked directly with Los Angeles County jail to design a state-of-the-art, evidence-based SUD assessment and treatment program that will include continuation and induction of all forms of MAT. This involved organizing site visits in which a delegation of county and foundation officials toured and interviewed clinical and administrative leaders about the opioid treatment programs at Rikers Island, the Rhode Island Department of Corrections, and Cook County Jail.

   Donna is a registered nurse with a master's degree in Public Administration and is a Certified Correctional Health Professional under the National Commission on Correctional Health Care. https://www.healthmanagement.com/our-team/staff-directory/name/donna-strugar-fritsch/

10. American Medical Association (AMA) https://www.ama-assn.org/ members were also asked to participate. The DOC presented at the AMA Annual Conference in January 2019 on MAT in corrections. The DOC coordinated with Daniel Blaney-Koen, JD who is the AMA Senior Legislative Attorney to identify a panel of 4-55 national experts to provide review, but regrettably was unable to do so.

Vermont Medical experts:

1. Dr. Sanchit Maruti, MD, MS, and team (Jackson, MD., Goedde, MD., Mahler, LADC, LCMHC). The team works at the University of Vermont Department of Psychiatry Addiction Treatment Program.
   https://vtdigger.org/2017/09/21/uvm-medical-center-team-train-prescribers-medication-assisted-treatment/
   http://www.med.uvm.edu/psychiatry/faculty-staff

2. Dr. John Brooklyn, MD. Dr. Brooklyn is Board Certified in Family Medicine and Addiction Medicine. He has worked at the Burlington Community Health Center since 1993 and previously served as Medical Director. He has been a strong advocate for integrating people with substance use disorders into medical homes and conceived of the nationally recognized Hub and Spoke model to seamlessly treat opioid use disorders. He is on the UVM Medical Center Family Medicine and Psychiatry faculty as an Assistant Clinical Professor and has been involved with the research of heroin, tobacco and cocaine use treatments there since 1992. His work helped lead to the approval of buprenorphine for opioid users. He is a national mentor for opioid use and substance use disorder treatment and a trainer for students, residents and faculty members throughout the United States. His interests remain in primary care, preventative care, the interface of behavior and health, the promotion of healthy lifestyles, treatment of substance use disorders, mindfulness, and motivational interviewing.
   https://www.chcb.org/locations-providers/good-health-internal-medicine/
   https://www.sevendaysvt.com/vermont/dr-yes-vermonts-addiction-expert-john-brooklyn-is-in-demand/Content?oid=11969243

3. Dr. Christopher Lukonis, PhD, MD. Dr. Lukonis is the Addiction Medicine/ Behavioral Health Director at Gifford Health Care and is board certified: by the American Board of Addiction medicine (ABAM); American Board of Psychiatry and Neurology; American Society of Addiction Medicine. https://giffordhealthcare.org/provider/christopher-lukonis-ms-phd-md/

4. Dr. Nels Kloster, MD. Dr. Kloster is an Addiction Medicine Specialist in Bennington, VT and has been practicing for 14 years. He graduated from University of Vermont / College of Medicine in 2001 and specializes in addiction medicine and adult psychiatry. Dr. Kloster is the Medical Director for the methadone clinic in Brattleboro and the Serenity House residential treatment center in Wallingford. https://www.ucsvt.org/ucs-svhc-and-the-hawthorne-recovery-center-collaboration-offers-program-to-address-opioid-addiction/

Summary Findings: Clinical Guidelines.

- One reviewer wanted to ensure that the DOC's decision to treat or not to treat was not solely based on the presence or absence of a drug screen.
  - *The DOC agrees with the reviewer. It is important to note that the DOC MAT Program approach is to take a comprehensive but individual view of each patient when making medical decisions.*

- One reviewer was concerned about how the appropriate level of care at the time of release (Hub vs Spoke) was decided.
  - *The DOC agrees that its patients, solely by virtue of having been incarcerated, should not automatically be bound for a Hub. To the best of its abilities and with its limited resources, the DOC is referring each patient to the community level of care (Hub vs Spoke) that reflects the needs of the patient.*

- One reviewer recommended that fentanyl testing needs to be a standard part of the medical urine drug testing procedure in Vermont correctional facilities (as opposed to security-based urine drug testing).
    - *This is not current practice and is an area for further consideration.*

- One reviewer recommended that the timing of initial assessment for OUD, intake, and medication initiation be written into a protocol.
    - *While the initial OUD screening by law is to start within 24 hours and screening is part of the initial health care screening and assessment, the DOC agrees that practice could be further supported by a written policy and procedure. Currently timelines are supported and monitored by existing standards of care, current statute and contract Pay 4 Performance measures. The DOC will work with Healthcare Contractor to develop.*

- One reviewer commented that evidence-based behavioral services for substance use disorders need to be widely available and accessible.
    - *The DOC agrees and Healthcare Contractor is developing and maintaining a system of individual and group counseling, brief behavioral interventions. The DOC has developed and continues to expand individual and group peer support. Additionally, for those who meet the criteria and elect to participate, substance use disorder and cognitive restructuring is also available through DOC Program Services division.*

- One reviewer commented that our pregnant patients with OUD are seen in the University of Vermont Medical Center's Comprehensive Obstetrics and Gynecology Services (COGS) program and that a policy for management of pregnant women should be created.
    - *The DOC agrees and will work with Healthcare Contractor to develop.*

- One reviewer brought up the broad topic of how patients who have diverted are managed.
    - *Healthcare Contractor has a policy and procedure and continues to evaluate the medical responses/medical determination policies and procedures in response to incidents of diversion. If an inmate's MAT has been discontinued based on medical necessity, as per policy and procedure and clinical guidelines, they are re-inducted prior to release if medically necessary.*

Conclusion

The peer review process provided beneficial guidance to the DOC. The feedback will be added to the DOC's existing internal medication-assisted treatment policies and procedures/clinical guidelines and review processes. Most of the feedback is attainable and realistic and a revision of the MAT Policies and Procedures and Clinical Guidelines is currently underway. There were no big surprises of omission or major issues to address; additionally, several of the responses

included positive feedback such as “well done,” in general reviewers commended the Vermont DOC and provided encouragement and appreciation for leading the nation and “going first.” In closing, the process not only informed the specific task at hand—peer review—it also helped the DOC develop closer collegial contact with the reviewers which will be helpful for future consultation.

Attachments:

VCMAT Policy and Procedures and Clinical Guidelines

Matrix of Comments on VCMAT Policies and Procedures and Clinical Guidelines

Centurion™

Centurion of Vermont Clinical Guidelines
Medication Assisted Treatment (MAT)

Treatment guidelines do not apply to all patients. Use your clinical judgment. When these guidelines do not apply, document the clinical rationale for your treatment decision.

STANDARD:

All patients who will continue community-based treatment or be initiated for treatment of opioid use disorder with methadone, buprenorphine, or naltrexone, including the support of behavioral health counseling, during the course of correctional confinement are to be admitted to the Vermont Corrections-Based Medication-Assisted Treatment program (VCMAT).

Screening at Intake:

- Individuals with a documented history of opioid use disorder and in current/recent treatment in the community can be admitted directly to VCMAT for continuation of their treatment modalities.
- All other individuals entering the correctional system or current inmates seeking medication assisted treatment will be assessed by a qualified healthcare professional for evidence of a substance use disorder using a validated screening tool for the diagnosis of substance use disorders based on DSM-5 criteria.
- A urine drug screen for evidence of substance use will be ordered. Requests for evaluations, by those already in custody, should be done through the established sick call process.

Evaluation:

- Patients that screen positive for the evidence of a substance use disorder through use of a standardized tool, will receive further comprehensive assessment by a qualified healthcare professional, to determine history and severity of drug use.
- During the comprehensive assessment, patients will be asked to sign a release of information to verify all community based treatment of substance use disorders.
- Patients requesting VCMAT services, who screen positive for an opioid use disorder during screening, will receive a physical evaluation by a medical provider.
- The following information may be considered in making the diagnosis of *Opioid Use Disorder (OUD)*:
  - Outcomes of validated assessment tool(s).
  - Evidence of current or history of opioid use through urine drug screens.
  - Community health records verifying diagnosis and/or treatment of OUD.
  - Evidence of emergency treatment for opioid overdose.
  - Review of Vermont Prescription Monitoring System (VMPS).
  - Physical exam findings (Clinical Opiate Withdrawal Scale (COWS) assessment, pupil diameter, diaphoresis, tremor, track marks)

VCMAT Treatment Requirements

Participation in the VCMAT program requires adherence to the following requirements:

- Sign the VCMAT Patient Agreement
- Patient signature of a medication informed consent for the indicated medication modality, when a medication is part of the treatment plan.
- Adherence with the individualized treatment plan, including:
  - Attendance at all scheduled appointments.
  - Engagement with behavioral health services and case management-related services.
  - Submission of urine drug screens as ordered.
  - The medication modality must be taken as prescribed, and the patient adheres to the DOC medication administration protocol.
- Engages respectfully with health service staff, ensuring a safe treatment environment.

VCMAT Treatment Modalities

All patients with a confirmed diagnosis of opioid use disorder will have access to treatment for the duration of their correctional confinement. Treatment will consist of one or more of the following treatment modalities:

- Buprenorphine
- Methadone
- Naltrexone
- Behavioral health services

VCMAT initiation of each medical modality is as follows:

Buprenorphine:

1. Informed consent to treat with buprenorphine, and a signed VCMAT Patient Agreement.
2. Prior to buprenorphine initiation, patients in federal custody, out of state compact agreements, ICE, or facing incarceration outside of Vermont state must sign an acknowledgement to accept the risk of being moved out of state while receiving MAT, which may result in treatment disruption or termination.
3. A healthcare staff will ensure that a Vermont Prescription Monitoring System (VPMS) query is completed and the findings documented in the medical record.
4. To avoid precipitating withdrawal, prior to buprenorphine initiation, healthcare staff will obtain confirmation from the patient that the last use of opioids was:
   - At least 12 hours since last short-acting opioid use (heroin, fentanyl, oxycodone, codeine, hydrocodone, morphine, hydromorphone).
   - At least 48 hours since last use of methadone.
   - At least 24 since last use of any other extended-release opioid.

5. Upon buprenorphine initiation, community re-entry coordination services for discharge planning begins, including a signed Release of Information for the patient's hub of choice.
6. Induction orders are based on the VCMAT buprenorphine induction algorithm to a maximum of 8mg/day.
7. Additional buprenorphine dose titrations to treat acute withdrawals not adequately treated by the induction algorithm can be ordered by any waivered provider, or any non-waivered provider in consultation with the VCMAT On Call Provider or MAT Medical Director.
8. Further non-acute dose adjustments above 8mg are done in accordance with the VCMAT Treatment Adjustment section in this Clinical Guideline.
9. Upon release, patients on buprenorphine will be transitioned to a dose-equivalent buprenorphine-naloxone dual product, and will be provided with a prescription if necessary until the patient is able to dose at a community Hub.

Methadone:

By law the only entities allowed to dispense methadone to outpatients with opioid use disorder (OUD) are Opioid Treatment Programs (OTPs, or "Hubs). The expectation from the Drug Enforcement Agency (DEA) is that patients with opioid use disorder in the correctional system, if continued on methadone, must receive methadone from a hub. At this time, no correctional facility within Vermont has Hub status. The DEA allows correctional facilities to administer methadone to a patient for a maximum of three days to relieve acute withdrawal symptoms while arrangements for methadone guest dosing at a Hub are being made.

1. Patients on a confirmed dose methadone for the treatment of an opioid use disorder in the community will be continued on their documented dose of methadone during incarceration as prescribed by the home hub and as clinically appropriate.
2. All methadone patients must sign the VCMAT Patient Agreement and a Consent to Treat with Methadone.
3. Patients in federal custody, out of state compact agreements, ICE, or facing incarceration outside of Vermont state must sign an acknowledgement to accept the risk of being moved out of state while receiving MAT, which may result in treatment disruption or termination.
4. When necessary, VCMAT will order methadone bridge dosing for up to three days to treat acute withdrawal symptoms experienced by patients while arrangements are being made to have methadone supplied by the patient's home Hub.
    - Confirm with the home Hub that the patient is in their active care and on methadone, and the Hub's intent to arrange guest dosing. If the home Hub is unwilling to arrange guest dosing for the patient, methadone bridge dosing cannot be offered (the patient may still be a candidate for treatment with buprenorphine or naltrexone). If the home Hub intends to arrange guest

dosing, the patient is eligible for treatment of acute withdrawal symptoms with bridge dosing of methadone provided by VCMAT.

- Confirm with the home Hub the date of the last dose, and the amount of methadone given.

- The medical provider reviews the medical history, meds, allergies, family history of cardiac or ECG problems, a new UDS, COWS assessment, and for any signs of impairment, along with the dosing information from the home Hub, and the Hub's intention to facilitate guest dosing.

- The patient will sign an Informed Consent to Dose with Methadone, along with the VCMAT Agreement.

- The provider will order methadone dosing as follows:

    i. Last full dose 1-2 days ago:
        1. UDS negative for bzd and no concerns for impairment: Full dose until guest dosing arranged, max 3 days.
        2. UDS positive for bzd or concerns for impairment: Half dose until guest dosing arranged, max 3 days.

    ii. Last full dose 3-4 days ago:
        1. UDS negative for bzd and no concerns for impairment: half dose for one day, then full dose until guest dosing arranged, total dosing for max of 3 days.
        2. UDS positive for bzd or concerns for impairment: half dose until guest dosing arranged, max 3 days.

    iii. Last full dose 5-14 days ago:
        1. UDS negative for bzd and no concerns for impairment: half dose for one day, then increase dose by 10mg/day until full dose is reached, total dosing for max of 3 days.
        2. UDS positive for bzd or concerns for impairment: half dose until guest dosing arranged, max 3 days.

    iv. Last full dose more than 14 days ago:
        1. Contact MAT Medical Director for guidance.

- Bridge dose administration: Crush and disperse methadone tablets in 120 mL of Gatorade, then administer; add liquid to cup and administer remaining mixture.

- Patient must be monitored for 60 minutes.

- The patient can be dosed with VCMAT methadone stock for a maximum of 3 days. Patient must receive further methadone doses from guest-dosing Hub, or be given medications to alleviate symptoms of withdrawal.

- If a patient moves to a different correctional facility:

i. Notify home Hub
ii. Ensure that Hub-dispensed methadone bottles move with the patient
iii. Patient may continue to guest dose at prior guest dosing hub until new guest dosing paperwork is processed.
iv. Can bridge dose with methadone at new facility for up to three days while new guest dosing arrangements are being made.

5. Methadone dose adjustments are performed by the home Hub in communication with a facility provider.

6. Re-entry coordination services will work to assure the patient is able to continue dosing at a community Hub upon release.

Naltrexone:

1. Informed consent to treat with naltrexone, and a signed VCMAT agreement.
2. To avoid precipitating withdrawal, prior to naltrexone initiation, healthcare staff will confirm with the patient that there has been no opioid use over the past 7 days. A negative urine drug screen on the day of naltrexone initiation for all opioids must be obtained.
3. If continuing from community, start oral naltrexone 50mg/day 28 days after last injection of naltrexone. If initiating on naltrexone, start on 25mg daily for three days, then 50mg daily.
4. Transition to naltrexone 380mg intramuscular injection 7 days prior to release.
5. Re-entry coordination services will work to ensure the patient is able to continue treatment with naltrexone upon release.

Drug Screening

Urine Drug Screening is a required component of the VCMAT program.

1. Nursing staff will perform monthly Urine Drug Screenings (UDS) of at least twenty percent (20%) of the inmate population receiving MAT Medications.

2. Nursing staff will randomly select the required number of inmates (divided between different units),

    a. Identified patients will be escorted to a dry cell in or near the health services unit, or a location identified by DOC and agreed upon by medical, to await a witnessed specimen collection. Patients will not be allowed to return to the housing unit until a specimen has been collected to check for compliance. Patients will be provided with water as needed to facilitate a specimen collection.

3. A Urine Drug Screen (UDS) report will be completed by nursing to include:
    a. Name of nurse completing compliance check

b. Name of observing security staff
c. Name of inmate and patient ID or DOB, verified by nursing staff
d. Designation of "Compliant" or "Non-compliant" for each patient named
e. Date and time of compliance check
f. Action taken for non-compliance, if applicable

4. Patients who test positive will be scheduled for UDS 1x per 30 days, for 90 days. Refusal of a UDS will be considered a positive screen.

5. The report will be forwarded to the Health Service Administrator with a copy sent to the VCMAT Medical Director or designee.

6. Patients who are found to be non-adherent with the VCMAT program, by evidence of a positive UDS, shall receive immediate education and counseling by nursing staff, followed by scheduled case management assessment with a VCMAT provider. Two positive drug screens will result in provider education and counseling, and review of the patient VCMAT individualized plan for consideration of modification.

7. Patients with evidence of multiple drug screens may be placed on an alternative treatment program. Patients may be re-referred for MAT consideration after ninety-days of compliance with the alternate treatment plan, by self-request or by referral of the VCMAT case manager.

8. To protect patient confidentiality, the results of urine drug screens along with patient-identifying information will not be shared with DOC. The VCMAT Medical Director, or designee, may share evidence of general substance use data with DOC, excluding patient-identifying information, to help monitor facility substance use patterns and help ensure a safe environment.

9. Patients with a scheduled CIC, who have not had a UDS completed over the last ninety-days, either random or scheduled, will have a UDS completed as part of the CIC visit.

VCMAT Treatment Non-Adherence

All patients admitted to VCMAT agree to adhere to the following requirements:

a. Sign the VCMAT Patient Agreement
b. Patient signature of a medication informed consent for the indicated medication modality, when a medication is part of the treatment plan.
c. Adherence with the individualized treatment plan, including:
    i. Attendance at all scheduled appointments.
    ii. Engagement with behavioral health services and case management-related services.
    iii. Submission of urine drug screens as ordered.
    iv. The medication modality must be taken as prescribed, and the patient adheres to the DOC medication administration protocol.
d. Engages respectfully with health service staff, ensuring a safe treatment environment.

Non-adherence with these requirements is handled as follows:

2. Creating an unsafe treatment environment:

a. Patients who exhibit threatening or aggressive behaviors contributing to an unsafe treatment environment will be referred to behavioral health for an immediate risk assessment. Prior to continuation of VCMAT related services, the patient must be stabilized and the behavioral episode resolved.
b. In the event that participation in VCMAT is halted based on unsafe behaviors by the patient, VCMAT will make every effort to provide the patient with a humane and medically appropriate taper with buprenorphine and adjunctive non-opioid medications, if safely able to do so.
c. Patients who are identified as diverting MAT medications, and upon review are discontinued from prescribed MAT medications, will be placed on an alternative treatment plan for opioid use disorder treatment. This plan will be documented in the medical record.
d. VCMAT patients discharged based on safety concerns, who stabilize at a later period during their correctional confinement, may be referred back by a behavioral health professional or medical provider, who has assessed the clinical appropriateness for treatment re-engagement.
e. In the event that participation in MAT is discontinued for unsafe behaviors that do not stabilize, VCMAT will attempt to re-induct the patient on buprenorphine seven days prior to release.
f. All VCMAT patients with behavioral concerns, whether on a MAT medication at release or not, will be assisted in connecting with a community HUB to continue treatment, if desired by the patient.

3. **Non-adherence with scheduled appointments**

a. Missed appointments will result in the patient meeting with a VCMAT treatment team member to determine a reason for the absence and identifying a solution to avoid future occurrences.

b. Consideration of modification to the patient's individualized treatment plan, up to and including discharge from VCMAT for a documented pattern of non-compliance with scheduled appointments, may be considered.

4. **Non-adherence with ordered drug screens.**
   a. A positive drug screen for substances other than prescribed medications will be evaluated by the VCMAT treatment team and result in the following:
      i. Consideration of adjustment to the individualized treatment plan.
      ii. A member of the VCMAT treatment team will meet with the patient to discuss the positive drug screen and potential changes in treatment.
      iii. A positive drug screen will not automatically result in dismissal from VCMAT.
      iv. A positive drug screen for benzodiazepines or other sedating substances may result in MAT medication adjustments, for the safety of the patient.
   b. A drug screen that is refused or tampered with by the patient will be presumed positive for benzodiazepines or other sedating substance.
   c. Refusal or tampering with ordered drug screens by a patient may lead to the development of an alternative treatment plan.
   d. A drug screen that is negative for the patient's MAT medication may lead to modification of the patient's individualized treatment plan, up to and including an alternate treatment plan that includes discontinuation from MAT medications.

5. **Non-adherence with DOC medication administration protocols**
   a. Patients attempting to divert MAT medications, during direct observation medication administration will result in the following:
      i. The patient will meet with a MAT team member to determine the reason for the diversion.
      ii. The VCMAT Medical Director will be notified.
      iii. Evaluation and adjustment of the individualized treatment plan will be considered, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
      iv. In the event that the MAT medication was discontinued, the VCMAT Medical Director will determine whether the patient may be re-inducted during the present incarceration, be offered induction 7 days prior to release, or remain in the alternative treatment program. The determination will be documented in the medical record.

Treatment Adjustment

Adjustments to a patient's individualized MAT treatment plan may be needed, including dose changes, integration of behavioral health or mental services, or medical services.

Examples:

- Patient would like to begin tapering their dose
- Patient requests a dose increase
- patient is still exhibiting cravings / withdrawal / continued illicit drug use
- Patient is exhibiting behavioral concerns

- Patient is non-compliant with treatment plan.

1. A MAT treatment evaluation can be requested by:
   - The patient
   - Medical staff / behavioral and mental health staff / nursing
   - VDOC administrative and designated staff members

2. Buprenorphine dose adjustments can be performed by:
   - A buprenorphine-waivered medical provider at the CIC appointment, or as needed.
   - A non-waivered medical provider at the CIC appointment, or as needed, in consultation with the VCMAT on-call provider or MAT Medical Director.
   - Via the Treatment Adjustment Form filled out by nursing, which goes to the MAT Medical Director's queue.

3. Buprenorphine doses can be adjusted by medical providers to a maximum of 16mg once daily, or with the MAT Medical Director's approval in certain circumstances, to 24mg/day.

4. Buprenorphine tapers are done by 2mg/week, though taper rates will be tailored to the patient and the specific clinical circumstances.

5. Methadone dose adjustments are performed by the home Hub in communication with a facility provider. If a methadone patient needs a dose adjustment (due to impairment or being on a sub-therapeutic dose, for example), the patient must be seen by a medical provider. If a medical provider determines that a methadone dose adjustment is needed, the home Hub is contacted with the following information:
   - A pre-dose COWS assessment
   - A new urine drug screen
   - The reason for the request for dose adjustment, which includes the provider's assessment.

6. Other treatment evaluations, such as behavioral concerns or treatment non-adherence, are submitted to the MAT Medical Director via the Treatment Adjustment Form.

Impairment

1. If there is concern for patient impairment, an urgent dose adjustment may be necessary. To screen for objective signs of impairment, the impairment assessment tool will be filled out on Correctek. An impairment assessment can be requested by:
   i. The patient
   ii. Medical staff / behavioral staff / nursing
   iii. All facility staff with the opportunity to observe the patient

2. Referrals for assessment of impairment will be considered urgent and the assessment must be completed as soon as possible.

3. The impairment assessment is performed by nursing or a facility medical provider.

4. If a patient is found to have a positive impairment assessment, a buprenorphine-waivered provider or the VCMAT on-call provider must be contacted immediately for dose adjustment.

5. If a patient on methadone is found to have a positive impairment assessment, the next dose of methadone will be held and the home Hub will be contacted for orders.

Buprenorphine or Methadone Discontinuation

Buprenorphine:

1. Discontinuations not related to diversion:
    a. Buprenorphine tapers should be done by 2mg/week, though taper rates will be tailored to the patient and the specific clinical circumstances.
2. Discontinuations related to diversion:
    a. After convicted for diversion of buprenorphine from the medline, the patients will be given a questionnaire (How many times have you been convicted of diversion (verified by nursing)? Why did you divert? Given that you diverted, why should we allow you to remain in the program? What assurances can you give use that you will not divert again?).
    b. First diversion: Modification of the patient's individualized treatment plan, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
        i. The patient may be given a warning and will be referred to counseling for the diversion, and must meet all components of the individualized treatment plan. In this example it would be made clear to the patient that further instances of diversion will not be tolerated.
        ii. If a patient is to have their buprenorphine discontinued after the first diversion, a buprenorphine taper is not given since there is no way to know how much buprenorphine the patient has actually been taking. The patient will be treated compassionately with clonidine, hydroxyzine, and lomotil.
    c. Second diversion: The patient will have their buprenorphine discontinued (a buprenorphine taper is not possible since there is no way to know how much buprenorphine the patient has actually been taking). The patient will be treated compassionately with clonidine, hydroxyzine, and lomotil.
    d. The patient may reapply for treatment with buprenorphine after three months. The decision to reinitiate treatment will depend on documented engagement of the patient with substance abuse counseling and other requirements set forth in the treatment plan.
    e. Third diversion: The patient will have their buprenorphine discontinued (a taper is not possible since there is no way to know how much buprenorphine the patient has actually been taking). The patient will be treated compassionately with clonidine, hydroxyzine, and lomotil.
    f. Readmission to the program after the third diversion will be made by the VCMAT Medical Director on a case by case basis.
    g. All patients who have diverted are eligible for re-initiation on buprenorphine 7

days prior to release.

Methadone:

1. Discontinuations not related to diversion:
    a. Must be done in coordination with the home Hub.
2. Discontinuations related to diversion:
    a. Hold methadone dosing, coordinate with the home Hub.

Alternative Treatment Plans (ATP): Patients diagnosed with an OUD will not be removed from VCMAT, however they may be provided with an ATP that does not include medication administration. Patients who do not receive medication for an OUD will be tracked by a case manager and referred for behavioral health interventions. Patients may be considered for re-induction pending release (7 days prior to release) by the medical provider overseeing the ATP. The VCMAT Medical Director will monitor ATP MAT patients needing consideration of reintroducing MAT medications. This plan will be documented in the medical record.

Peri-operative management of the opioid-dependent patient

Post-operative pain management of patients on buprenorphine and methadone poses a challenge for several reasons:

1. Opioid- Induced Hyperalgesia: Patients on maintenance therapy for opioid use disorder with buprenorphine and methadone undergo changes in pain perception, leading to increased pain sensitivity. A procedure done under local anesthesia may be well-tolerated by a patient not on maintenance therapy, while the same procedure would cause more significant pain issues in a patient on maintenance therapy.
2. Cross-tolerance: The presence of buprenorphine or methadone impedes the ability of more potent opioids with better analgesic effects from attaching to the opioid receptor. This leads to more difficult pain control, and explains the higher doses of opioid analgesics that are necessary to adequately treat the pain of patients on maintenance therapy.
3. Concern from the provider that providing opioid analgesics will lead to illicit drug use.
4. Concern from the provider that the increased pain reports may be an attempt to obtain more opioids.

Peri-operative Management of Buprenorphine:

- Perioperative pain management is at the discretion of the practitioner performing the procedure, and it should be part of the conversation/consent process for the procedure so that the patient knows what to expect. If a patient needs to have their buprenorphine held at the provider's request pre-operatively, the patient needs to be informed of this and give consent, before doses are temporarily held.
- Non-opioid medications such as local anesthetics (lidocaine or bupivacaine), NSAIDs (e.g. ketorolac, ibuprofen, meloxicam), and acetaminophen among others do not act via the opioid receptors and will therefore not be impeded by buprenorphine. Generously utilizing these non-opioid medications are key to

managing pain in patients with opioid use disorder.

- To overcome blockade, buprenorphine is sometimes halted pre-operatively, or if a patient is kept on buprenorphine, much higher doses of the full opioid receptor binders are necessary to overcome buprenorphine blockade.
- Inadequately treating pain in patients with opioid use disorder is more likely to cause a relapse than adequate analgesia.
- Acute pain with objective findings requires adequate analgesia, with the determination to use opioid or non-opioid agents being at the discretion of the practitioner performing the procedure.
- The patient's dose of buprenorphine may be split to every 12 hours or every 8 hours to maximize the analgesics of buprenorphine for the patient experiencing post-operative pain.
- The MAT Medical Director can be contacted for consultation

Peri-operative Management of Methadone:

- Perioperative pain management is at the discretion of the practitioner performing the procedure, and post-operative pain management should be part of the conversation/consent process for the procedure so that the patient knows what to expect.
- Doses of methadone are not typically held.
- Non-opioid medications such as local anesthetics (lidocaine or bupivacaine), NSAIDs (e.g. ketorolac, ibuprofen, meloxicam), and acetaminophen among others do not act via the opioid receptors and will therefore not be impeded by buprenorphine. Generously utilizing these non-opioid medications are key to managing pain in patients with opioid use disorder.
- Because of the cross-tolerance of patients of methadone to other opioids, providers should be aware that higher doses of opioid analgesics may be required to achieve adequate pain relief.
- Inadequately treating pain in patients with opioid use disorder is more likely to cause a relapse than adequate analgesia.
- Acute pain with objective findings requires adequate analgesia, with the determination to use opioid or non-opioid agents being at the discretion of the practitioner performing the procedure.
- The MAT Medical Director can be contacted for consultation.

Peri-operative Management of Naltrexone:

- Oral naltrexone must be discontinued 3 days prior to procedure. Intramuscular naltrexone lasts 28 days and must be switched to oral naltrexone, which must be discontinued 3 days prior to procedure.
- Discontinuation of naltrexone prior to an elective surgery presents a particularly vulnerable time for relapse for a patient with opioid use disorder.
- Peri-operative pain management is at the discretion of the practitioner performing the procedure. Discussion about naltrexone and pain management should be part of the conversation/consent process for the procedure so that the patient knows what to expect.
- Non-opioid medications such as local anesthetics (lidocaine or bupivacaine), NSAIDs (e.g. ketorolac, ibuprofen, meloxicam), and acetaminophen among others do not act via the opioid receptors and will therefore not be impeded by naltrexone. Generously utilizing these non-opioid medications are key to

managing pain in patients with opioid use disorder.

- Because of the antagonistic effects of naltrexone, providers should be aware that higher doses of opioid analgesics given in a monitored setting may be required to achieve adequate pain relief.
- Acute pain with objective findings requires adequate analgesia, with the determination to use opioid or non-opioid agents being at the discretion of the practitioner performing the procedure.
- The MAT Medical Director can be contacted for consultation.

Attachments:
Clinical Opioid Withdrawal Scale (COWS)
Texas Christian University Screen 5 (TCU-5)
Texas Christian University Opioid Supplement Screen
VCMAT Buprenorphine Induction Algorithm
VCMAT Treatment Adjustment Form
Impairment Assessment Tool

References:

- **21 CFR 1306.07(b)**,
https://www.deadiversion.usdoj.gov/pubs/manuals/narcotic/appendixa/treatment.htm#inmatentp

Alford et al. Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy. Ann Intern Med. 2006 January 17; 144(2) 127-134.

Clinical Opiate Withdrawal Scale (COWS) Assessment
For each item, mark the number that best describes the patient's signs or symptom.
Patient should be at rest prior to evaluation.

Resting pulse rate _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120 **Score:** _____	**Gastrointestinal upset** *Over last half hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting **Score:** _____
Sweating *Over past half hour not accounted for by room temperature or inmate activity* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face	**Tremor** *Observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching

4 Sweat streaming off face **Score:** _____	**Score:** _____
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds **Score:** _____	**Yawning** *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute **Score:** _____
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only rim of the iris is visible **Score:** _____	**Anxiety or irritability** 0 None 1 Inmate reports increasing irritability or anxiousness 2 Inmate obviously irritable or anxious 4 Inmate so irritable or anxious that participation in the assessment is difficult **Score:** _____
Bone or joint aches *If patient was having pain previously, only additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Inmate reports severe diffuse aching joints/muscles 4 Inmate is rubbing joints or muscles and is unable to sit because of discomfort **Score:** _____	**Gooseflesh skin** 0 Skin is smooth 3 Piloerection* of skin can be felt or hairs standing up on arms 5 Prominent piloerection *Piloerection is gooseflesh or goose bumps **Score:** _____
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks **Score:** _____	☐ **Total COWS Score** The total score is the sum of both columns. Note score on flow sheet **> 36 = Severe:** Notify physician or designee immediately **25 - 36 = Moderately Severe:** Notify physician or designee immediately. **13 - 24 = Moderate:** Notify physician or designee immediately. **5 - 12 = Mild:** Notify physician or designee for orders **< 5 =** Notify physician or designee of initial evaluation

Please double-click below to see the TCU Drug Screen 5 and Opioid Supplement.

Client ID#	Today's Date	Facility ID#	Zip Code	Administration

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

		Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

O None
O Alcohol
O Cannaboids – Marijuana *(weed)*
O Cannaboids – Hashish *(hash)*
O Synthetic Marijuana *(K2/Spice)*
O Opioids – Heroin *(smack)*
O Opioids – Opium *(tar)*
O Stimulants – Powder Cocaine *(coke)*
O Stimulants – Crack Cocaine *(rock)*
O Stimulants – Amphetamines *(speed)*
O Stimulants – Methamphetamine *(meth)*
O Synthetic Cathinones *(Bath Salts)*
O Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
O Dissociative Drugs – Ketamine/PCP *(Special K)*
O Hallucinogens – LSD/Mushrooms *(acid)*
O Inhalants – Solvents *(paint thinner)*
O Prescription Medications – Depressants
O Prescription Medications – Stimulants
O Prescription Medications – Opioid Pain Relievers
O Other (specify) _____

VCMAT Buprenorphine Induction Algorithm

Our goal is to ensure that buprenorphine induction is carried out in a manner that emphasizes patient safety and clinical effectiveness. The induction period will be over 14 days and to a maximum dose of 8mg SL daily. A patient may request a dose reduction at any time (including outside of the induction period) for complaints of sedation/impairment/side-effects.

Day	**Indication (must meet 2 of 3 indications)**	**STOP if**:	**Max dose**
1	COW > 4	COW is 0 An impairment assessment was clinically indicated today and is POSITIVE An impairment assessment was done over past 24 hours. Obtain UDS if not already done and notify MAT Medical Director	Buprenorphine 2mg SL, under the tongue for 10 minutes. Saliva must be kept in the mouth for 10 minutes for buprenorphine to be fully absorbed.
3	COW > 3 Intensive opioid craving Patient reports continued illicit opioid use. Patient felt effect.	An impairment assessment was clinically indicated today and is POSITIVE An impairment assessment was done over past 24 hours. Hold dose, obtain UDS if not already done, and notify MAT Medical Director	If less than 2 indications met, continue prior day dose. If 2 of 3 indication met, and no concerns, increase daily dose by 2mg SL. Max dose buprenorphine 4mg SL daily.
5	COW > 3 Intensive opioid craving Patient reports continued illicit opioid use. Patient felt effect.	An impairment assessment was clinically indicated today and is POSITIVE An impairment assessment was done over past 24	If less than 2 indications met, continue prior day dose. If 2 of 3 indication met, and no concerns, increase daily dose by 2mg

Day	**Indication (must meet 2 of 3 indications)**	**STOP if**:	**Max dose**
		hours. Hold dose, obtain UDS if not already done, and notify MAT Medical Director	SL. Max dose buprenorphine 6mg SL daily.
7	COW > 3 Intensive opioid craving Patient reports continued illicit opioid use.	An impairment assessment was clinically indicated today and is POSITIVE An impairment assessment was done over past 24 hours. Hold dose, obtain UDS if not already done, and notify MAT Medical Director	If less than 2 indications met, continue prior day dose. If 2 of 3 indication met, and no concerns, increase daily dose by 2mg SL. Max dose buprenorphine 8mg SL daily. If at 8mg, stop assessments.
14	COW > 3 Intensive opioid craving Patient reports continued illicit opioid use.	An impairment assessment was clinically indicated today and is POSITIVE An impairment assessment was done over the past week. Hold dose, obtain UDS if not already done, and notify MAT Medical Director	If less than 2 indications met, continue prior day dose. If 2 of 3 indication met, and no concerns, increase daily dose by 2mg SL. Max dose buprenorphine 8mg SL daily. Stop assessments.

Patient Name: _____ Patient DOB: _____

Date: _____

Current Buprenorphine Dose:_____mg

Date of admission to MAT:_____

Why is a MAT Treatment Evaluation requested?

_____

_____

Continued use of illicit drugs?: YES NO
If yes, please describe:

Drug	Amount used and route	Frequency in last week	Date of last use

Any patient/staff reports of sedation or impairment on current dose? YES NO

If yes, describe:

_____

Drug Screens:	Side effects/toxicity:
Date:_____Results:_____ _____ Date:_____Results:_____ _____ Date:_____Results:_____	Sedation: yes / no Description: _____ Constipation: yes / no Description:_____ Sweating: yes / no Description: _____ Other: yes / no Description: _____

Medical/psych history:

_____

Any known active patient med/behavioral issues:

_____

New stressors:

_____

Medications:

_____

Allergies:
_____

For dose adjustment requests only:
Symptoms 3-4 hrs after medicating:_____
Progression of symptoms and timeline:_____
_____
Sx 24 hrs after medicating (if reporting withdrawal, do pre-dose COW):_____

Compliance with counseling/ monthly check-ins/treatment plan:
_____

Nursing impression: _____
_____

For behavioral concerns only:
Current behavioral interventions on treatment plan:
_____
_____

Compliance with behavioral interventions on treatment plan:
_____

MAT Team assessment/recommendation:
_____

***For non-compliance with treatment plan*:**
Nature of non-compliance:
_____

Nursing impression: _____
_____

Staff filling out form: _____

MAT Medical Director assessment/plan:
_____

Impairment Assessment Tool

Patient Name: _____ PID: _____

Date of assessment: _____

Medication Utilized and current dose: _____ Date dose began:___

Reason for sedation/impairment concerns
(describe):_____
_____

Reports of any illicit drug use (describe):
_____

History of benzodiazepine use:
_____

Point of Care Urine Drug Screen Results:

BZD	+	-
MTD	+	-
BUP	+	-
OPI	+	-

OXY	+	-
COC	+	-
AMPH	+	-

Presentation:	_____ _____ _____
Mental Status:	Oriented___ Disoriented___ Time___ Place___ Person___ Alert___ Drowsy___ Lethargic___ Inattentive___ Forgetful___ Stuporous___ Cooperative___ Combative___
Mood / Emotional Status:	Normal ___ Angry ___ Elation___ Calm___ Friendly___ Evasive___ Fearful___ Anxious___ Irritable___ Withdrawn___ Euphoric___ Hostile___
Speech:	Spontaneous___ Sudden Silences___ Slow and deliberate___ Rapid___ Content clear___ Content not clear___ Logical progression___ Slurring___
Eyes:	Nystagmus___ Poor eye contact___ Drooping eyelids___ Pupils constricted/pinpoint___ Dilated___ Equal___ Unequal___
Gait:	Heel to toe steady___ Unsteady___ Finger to nose good___ Finger to nose poor___
Vital Signs:	Temperature___ Pulse___ BP___ Respirations___ %O2_____
General Impression:	

Informed consent to treat with Buprenorphine	Inmate Name: [*1]	Inmate Number: [*2]
	DOB: [*3]	Institution: [*4]
MEDICATION: Buprenorphine		**DOSAGE RANGE: 2mg – 16mg**

Buprenorphine is an FDA-approved medication for treatment of opioid use disorder (addiction). Buprenorphine is a partial stimulator (agonist) of the opioid receptor. The binding of buprenorphine to the opioid receptor reduces cravings and withdrawal symptoms, and decreases the ability of other opioid drugs from binding the opioid receptor. Similar to other opioids, Buprenorphine can result in physical dependence.

Side effects of buprenorphine include dizziness, headaches, blurred vision, nausea, vomiting, diarrhea, constipation, anxiety, chills, sweats, urinary retention, restless legs, increased heart rate and insomnia.

The form of buprenorphine that you will be taking in corrections is not combined with naloxone, and patients are at increased risk of harm if not taken as prescribed. Buprenorphine must be held under the tongue until completely dissolved. When taking buprenorphine, please do not talk or swallow any saliva while melting, for a full 10 minutes. If you need more time to melt, please draw the attention of a staff-member to indicate that more time is needed. If buprenorphine is swallowed before 10 minutes have passed, or you swallow intact fragments of buprenorphine instead of being allowed to be absorbed by the tissue under the tongue, the stomach will destroy the swallowed buprenorphine and you will not feel full effect from the dose.

The buprenorphine you will receive will be in crushed form. Research shows that the amount of buprenorphine absorbed sublingually into your body is not affected by whether buprenorphine is administered as an intact tablet or in a crushed form.

After the buprenorphine melting period, a mouth check will be performed. You should be prepared to attend the medication line for an extended period, as compared to a typical medication administration line.

Combining buprenorphine with other substances, especially those which can cause sedation such as benzodiazepines (Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) or alcohol, can be dangerous. A number of deaths have been reported among persons mixing buprenorphine with sedating substances. The strong binding affinity and partial stimulation of buprenorphine to the opioid receptor can cause withdrawal if you take it when other opioids are still in your system. Attempts to override this by taking more opioids could result in an opioid overdose.

At the time of release from corrections, your dose of buprenorphine will be converted to a prescription for a buprenorphine-naloxone product, and may be called into a pharmacy for you, if needed. Please be aware that the naloxone component of this product is not significantly absorbed by your body if taken sublingually.

There are other medical treatments for opioid addiction, including methadone and naltrexone. Medications for opioid use disorder are used in combination with psychosocial treatments such as counseling, mutual help groups, and self-management apps, websites and books.

Withdrawal symptoms from buprenorphine are generally less intense than with heroin or methadone, and can be minimized by tapering gradually over several weeks to months. Do not stop taking this medication without discussing it with health services. You have the right to stop taking this medication any time by notifying health services orally or in writing. If you decide to stop taking the medication, it will not affect your ability to receive other health care.

I understand that by signing this form I am agreeing to be treated with this medication. Medical staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a signed copy of this form will be given to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____

Name/Title Stamp

I have been advised to take Methadone, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____

Name/Title Stamp

Informed consent to treat with Methadone	Inmate [*1] Name:	Inmate Number [*2]
	DOB: [*3]	Institution: [*4]

MEDICATION: Methadone **DOSAGE RANGE: N/A**

PURPOSE AND BENEFITS: Methadone is a medication used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opioids.

SIDE EFFECTS/RISKS OF THIS TREATMENT: Shortness of breath, difficulty breathing, respiratory depression, feeling lightheaded, hives/rash, swelling of face, lips, tongue or throat, chest pain, palpitations, confusion, ataxia, sedation, constipation, urinary retention, leg swelling, abnormal heart rhythm, death.

Combining methadone with other substances, especially those which can cause sedation such as benzodiazepines (Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) or alcohol, can be dangerous and potentially fatal. Because methadone can cause a dangerous heart rhythm, taking methadone with other medications that cause changes in the heart rhythm increases the risk to patients for a fatal heart rhythm and death.

RISKS OF REFUSING THIS TREATMENT include, but are not limited to: Opioid withdrawal, return to illicit opioid use, which increases your risk of overdose and death.

LENGTH OF CARE: You were prescribed methadone in the community for opioid use disorder by an Opioid Treatment Program (OTP, known as a "Hub" in Vermont). The Hub has agreed to approve and dispense your dose of methadone while you are in corrections. If you are far away from the Hub you usually attend for treatment, your Hub has made arrangements for you to receive your dose of methadone via a Hub in proximity to the correctional facility where you are now. These doses are picked up regularly by DOC and brought to the correctional facility where you reside, and administered by Health Services staff. Your prescribing doctor at the home Hub, in coordination with Health Services, may adjust the dosage during treatment. If you have concerns about your dose, please notify Health Services.

NOTIFICATION: Do not stop taking this medication without discussing it a medical provider. You have the right to stop taking this medication at any time by notifying Health Services orally or in writing. Health Services will coordinate the discontinuation of the methadone with your Hub. If you decide to stop taking the medication, it will not affect your ability to receive other health care. If you are pregnant, we advise you to continue taking methadone until after delivery.

I understand that by signing this form I am agreeing to be treated with this medication. Mental health staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a signed copy of this form will be given to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____
Name/Title Stamp

I have been advised to take Methadone, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____

Name/Title Stamp

Informed consent to treat with Naltrexone	Inmate [*1] Name:	Inmate Number [*2]
	DOB: [*3]	Institution: [*4]

MEDICATION: Naltrexone

DOSAGE RANGE: 25-50mg (oral) 380mg (IM)

PURPOSE AND BENEFITS: Naltrexone is an FDA approved medication for treatment of opioid use disorder that binds the opioid receptor and blocks opioids from binding to the receptor. Naltrexone helps in decreasing cravings for opioids and for alcohol.

SIDE EFFECTS/RISKS OF THIS TREATMENT: Naltrexone can cause opioid withdrawal if this medication is taken too soon after opioid use. The medication should be started 7-10 days after opioids have last been consumed. Naltrexone may cause headaches, nausea, vomiting, depressed mood, anxiety, vision changes, fatigue, and suicidal thoughts. Naltrexone should not be taken if you have significant liver damage or liver failure.

RISKS OF REFUSING THIS TREATMENT include, but are not limited to: Continuation or worsening of your condition.

LENGTH OF CARE: This medication may be taken for as long as necessary.

NOTIFICATION: Do not stop taking this medication without discussing it with your doctor. You have the right to stop taking this medication any time by notifying the doctor or mental health staff orally or in writing. If you decide to stop taking the medication, it will not affect your ability to receive other health care. Notify your physician if there is a possibility that you are pregnant or if you experience abnormal movements.

I understand that by signing this form I am agreeing to be treated with this medication. Mental health staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a signed copy of this form will be given to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____
Name/Title Stamp

I have been advised to take Naltrexone, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____
Name/Title Stamp

Nursing Protocol for Medication Assisted Treatment (MAT) of Opioid Use Disorders Policy

Title: Protocols for Medication-Assisted Treatment (MAT) of Opioid Use Disorders

Purpose: Written guidelines to outline steps to be taken in the assessment, induction, administration, and documentation of MAT treatments within Vermont correctional facilities.

NEW INTAKE

***NOT* currently on MAT:**

1. Patient comes into facility and completes Healthcare Receiving Screening- 'NEW' 'Encounter' 'Centurion Receiving Screening'

2. ALL patients answer TCU 5 drug assessment screen during intake:
   - IF patient scores more than 'NEVER' on TCU questions *13E, 13F, 13R or 13T*
   - Then the TCU Opioid Supplement is completed

3. Patient is placed on detox protocol if clinically indicated and first detox score is acquired. 'NEW' 'Order' 'COWS'/ 'CIWA'. (Nursing must complete a new phone call when any new orders are received, 'NEW' 'Encounter' Phone call-SBAR').

4. Nurse conducts a Urine Drug Screen and enters results into Correctek using 'NEW' 'Order' 'UDS'.

5. Nurse contacts medical provider with:
   - TCU score
   - UDS results
   - First detox score

6. Phone call encounter is completed with provider instructions. 'NEW' 'Encounter' Phone call-SBAR'.
   - If provider orders Buprenorphine:
     I. MAT Initiation template is completed- 'NEW' 'Encounter' 'MAT Initiation'
     II. MAT Induction protocol completed for Days 1, 3, 5,7, & 14 - 'NEW' 'Encounter' 'MAT Induction'
   - If provider does NOT order Buprenorphine:
     I. Patient continues with detox protocol

***MAT continuation from the community*:**

1. Patient comes into facility and completes Healthcare Receiving Screening. 'NEW' 'Encounter' 'Centurion Receiving Screening'

2. ALL patients answer TCU 5 drug assessment screen during intake:
   - IF patient scores more than 'NEVER' on TCU questions *13E, 13F, 13R or 13T*
   - Then the TCU Opioid Supplement is completed

3. Nurse conducts a Urine Drug Screen. 'NEW' 'Order' 'UDS'.
4. Nurse contacts patient HUB/Pharmacy for MAT dosing information (*See Attached HUB Contact Information)
5. Med count is completed. 'NEW' 'UDR' 'Med Count'
6. MAT Worksheet completed. 'NEW' 'UDR' 'MAT Worksheet'
7. Nurse contacts medical provider with TCU score, UDS results and medication dosing information
8. Phone call encounter is completed with provider instructions 'NEW' 'Encounter' Phone call-SBAR'
9. MAT Initiation template is completed. 'NEW' 'Encounter' 'MAT Initiation'
10. Orders submitted as prescribed by provider

Admitted Patients

Self-request for MAT assessment:

1. Patient submits sick-call form requesting MAT assessment
2. Nursing completes MAT Medical Need Determination template. 'NEW' Encounter' MAT Medical Need-NEW'
3. UDS completed. 'NEW' 'Order' 'UDS'
4. MAT Determination sent to MAT Medical Director for Review. Sends automatically when 'Completed' is selected in the template.
5. MAT Medical Director reviews and makes Determination
6. Nurse reviews provider's determination. Go to 'Start' menu, Nursing Department, then 'MAT Determination for Nursing Review' (this will create a report showing all of the MAT Determinations completed by MD.)
7. When provider determines MAT is to be started:

    - If provider orders **Buprenorphine**:
        I. MAT Initiation template is completed- 'NEW' 'Encounter' 'MAT Initiation'

II. MAT Induction protocol completed for Days 1, 3, 5,7, & 14 - 'NEW' 'Encounter' 'MAT Induction'
III. MAT Initiation template completed. 'NEW' 'Encounter' 'MAT Initiation'
IV. Orders submitted
V. Patient begins dosing

- If provider orders **Naltrexone**:
  I. MAT Initiation template completed. 'NEW' 'Encounter' 'MAT Initiation'
  II. Orders submitted
  III. Patient begins dosing

Impairment Assessment

1. If patient appears impaired at any time, nursing to complete Impairment Assessment Tool (IAT). 'NEW' 'Encounter' 'MAT Impairment Assessment Tool'

2. MAT Medical Director reviews IAT and notifies nursing of new orders if indicated by phone call.

3. Nurse completed phone call encounter. 'NEW' 'Encounter' Phone call-SBAR'

Treatment Adjustments

1. Patient submits sick-call form requesting MAT Dose adjustment

2. Nursing submits MAT Treatment Adjustment order. 'NEW' 'Order' "MAT Tx Adjustment'

3. Nursing completes 'MAT Treatment Adjustment' template with patient. 'NEW' 'Encounter' 'MAT Treatment Adjustment'

4. MAT Medical Director reviews template and makes determination

5. MAT Medical Director contacts nursing with determination and further orders, nurse completes phone call encounter. 'NEW' 'Encounter' Phone call-SBAR'. Nursing alerts patient of determination

Methadone Patients

1. Patients on a confirmed dose methadone for the treatment of an opioid use disorder in the community will be continued on their documented dose of methadone during incarceration as prescribed by the home HUB and as clinically appropriate

2. All methadone patients must sign the VCMAT agreement.

3. **Patients in federal custody, out of state compact agreements, ICE, or facing incarceration outside of Vermont state must sign an acknowledgement to accept the risk of being moved out of state while receiving MAT, which may result in treatment disruption or termination.**

4. When necessary, VCMAT will order methadone bridge dosing for up to three days to treat acute withdrawal symptoms experienced by patients while arrangements are being made to have methadone supplied by the patient's home HUB.
    - Confirm with the home HUB that the patient is in their active care and on methadone, and the HUB's intent to arrange guest dosing. If the home HUB is unwilling to arrange guest dosing for the patient, methadone bridge dosing cannot be offered (the patient may still be a candidate for treatment with buprenorphine or naltrexone). If the home HUB intends to arrange guest dosing, the patient is eligible for treatment of acute withdrawal symptoms with bridge dosing of methadone provided by VCMAT.
    - Confirm with the home HUB the date of the last dose, and the amount of methadone given.

    - The medical provider reviews the medical history, meds, allergies, family history of cardiac or ECG problems, a new UDS, COWS assessment, and for any signs of impairment, along with the dosing information from the home HUB, and the Hub's intention to facilitate guest dosing.

    - The patient will sign an Informed Consent to Bridge Dose with Methadone, along with the VCMAT Agreement.

    - Bridge dose administration: Crush and disperse methadone tablets in 120 mL of Gatorade, then administer; add liquid to cup and administer remaining mixture.

    - Patient must be monitored for 20 minutes.

    - The patient can be dosed with VCMAT methadone stock for a maximum of 3 days. Patient must receive further methadone doses from guest-dosing HUB, or be given medications to alleviate symptoms of withdrawal.

    - If a patient moves to a different correctional facility:
        i. Notify home HUB
        ii. Ensure that HUB-dispensed methadone bottles move with the patient

        iii. Patient may continue to guest dose at prior guest dosing HUB until new guest dosing paperwork is processed.
        iv. Can bridge dose with methadone at new facility for up to three days while new guest dosing arrangements are being made.

5. Methadone dose adjustments are performed by the home HUB in communication with a Centurion provider.

6. Re-entry coordination services will work to assure the patient is able to continue dosing at a community HUB upon release.

Arranging for guest dosing at the nearest HUB:

1. Obtain a signed release of information from the patient to communicate with the home HUB.

2. Contact home hub nursing via phone **during HUB dosing hours**
    a. Confirm the home HUB's plan to continue caring for the patient and their intent to arrange guest dosing for the patient.
        i. If plan is confirmed, verify medication, dose, AND date and amount of last dose.
    b. Provide **home HUB nursing** with the following:
        i. Urine Drug Screen
        ii. COWS assessment. (also provide BAC and impairment assessment if done),
        iii. The name of preferred guest dosing HUB,
        iv. Number of methadone bottles requested per week/month.
    c. Nearest guest dosing HUBs:
        i. CRCF: Chittenden Clinic
        ii. NWRCF: BAART St. Albans
        iii. NSCF: BAART Newport
        iv. NECC: BAART St. Johnsbury
        v. SSCF: BAART Berlin
        vi. MVRCF: West Ridge Center

3. Notify **guest dosing HUB** with the following:
    a. Patient's correctional facility
    b. Patient home HUB
    c. Methadone dose, guest dosing need, and number of bottles requested.

4. Admit patient to VCMAT

Nursing Protocol for Medication Assisted Treatment (MAT) of Opioid Use Disorders Policy

HUB Contact Information

Clinic	Telephone	Intake & Office Info
Community Health Center *Burlington* Suboxone	802-864-6309	Mon-Fri: 8am –5pm Must call to schedule
Chittenden Clinic Suboxone & Methadone	802-488 -6450	Must complete phone referral Call and select option #1 Open 7 days a week
Pain clinic St. *Albans* Suboxone	802-524-8809	Mon-Fri: 8am –5pm Must call to schedule
Treatment Associates *Morrisville* Suboxone	802-851-8219	Mon-Fri: 8am –5pm Must call to schedule
Central Vermont Addiction Medicine-Suboxone and Methadone	802-223-2003	Walk in Monday-Friday 7a.m.-8 a.m. Will see counselor
Treatment Associates *Montpelier* Suboxone	802-225-8355	Walk in Tuesday and Thursday 1 p.m. to 2:30 p.m.
BAART *St. Johnsbury* Methadone and Suboxone	802-748-6166	Mon-Fri: 6 am –2 pm Must call to schedule
BAART *Newport* Methadone and Suboxone	802-334-0110	Mon-Fri: 6 am –2 pm Must call to schedule
BAART *St. Albans* Methadone and Suboxone	802-370-3545	Mon-Fri: 6 am –2 pm Must call to schedule
BAART *Berlin* Methadone and Suboxone	802-223-2003	Mon-Fri: 6 am –2 pm Must call to schedule
Brattleboro Retreat *Brattleboro* Suboxone	802-258-3707	For intake: Call and select option #4 Open 7 days a week

Vermont Corrections

Medication Assisted Treatment (VCMAT)

Patient Agreement

3/18/19

Understanding the Vermont Corrections Medication-Assisted Treatment (VCMAT) Program

By signing this form, you allow VCMAT, the DOC, the Vermont Department of Health, your designated community-based treatment provider(s), the Chief Medical Examiner, and others to send and receive limited portions of your protected health information, including but not limited to information protected by a federal law called, 42 CFR Part 2 which protects patient confidentiality regarding substance use diagnosis and treatment. This sharing of information is needed for care coordination purposes on your behalf, to ensure that VCMAT is providing you with safe, effective care during your time in corrections, and to ensure that your care continues when you are released to the community.

This Agreement has been developed for all VCMAT-engaged patients. All VCMAT services offered, regardless of facility, is based on patient consent and a medical provider determination that MAT treatment for an opioid use disorder is medically necessary. The medical provider will make the final determination in regards to what qualifies as medical necessity, based on the VCMAT clinical guidelines for MAT. All patients are assessed individually, but will follow general criteria that includes, but may not be limited to:

- Any patient may submit a *Healthcare Request Form* to be considered for screening for an opioid use disorder.
- Patients placed on a Clinical Opioid Withdrawal Scale (COWS) protocol may be offered buprenorphine to control withdrawal symptoms. A diagnostic screening for an opioid use disorder may be administered, and the results of the screening and other important clinical information may be used by a medical provider to determine medical necessity for you to be initiated into the VCMAT program.
- Patients who are confirmed to have been previously engaged in community based MAT, who upon assessment will be continued, may have their dose adjusted to meet State and Federal dosing guidelines and VCMAT clinical guidelines.
- MAT will be provided for as long as medically necessary, as determined by the medical provider, and as outlined by VCMAT clinical guidelines. Patients may be tapered, discontinued, or offered alternative treatments, as clinically appropriate.
- Patients discontinued from MAT while in DOC custody may be considered for re-initiation of their MAT medication prior to release.

The DOC is required to verify that MAT services are safe and effective. By consenting to treatment you are permitting VCMAT, the DOC, Vermont Department of Health, the Chief Medical Examiner, the Department of Vermont Health Access, the Department of Public Safety, SIREN, your designated community-based treatment provider(s), and others as deemed appropriate to send and receive any information which is needed for care coordination as well as quality assurance purposes, as permitted under federal and/or Vermont State law.

By consenting to treatment, you are accepting the following responsibilities:

- You agree to review and sign an informed consent for the MAT medication modality being utilized, if a medication is part of the treatment plan.
- You agree to sign a release of information so that a VCMAT staff member may coordinate your care while in DOC custody and upon release to the community.
- You agree to take an active role in your treatment and recovery while in DOC custody, and adhere to your individualized treatment plan, including:
    - Attendance at all scheduled appointments
    - Engagement with counseling and case management-related services.
    - You agree to provide random and scheduled urine drug screens (UDS) as requested.
    - You will take your MAT medication as prescribed.
- You agree to engage respectfully with Health Services staff, ensuring a safe treatment environment.
- You agree to adhere to the DOC medication administration protocol

The following are considered behaviors of non-adherence and act as barriers to effective treatment and may result in the development of an alternate treatment plan:

- Exhibiting threatening or aggressive behaviors contributing to an unsafe treatment environment.
- Non-adherence with scheduled medical, counseling, or case management appointments.
- Non-adherence with requested drug screens.
- Not taking your MAT medication as prescribed, or non-adherence with DOC medication administration protocols.

I understand that treatment non-adherence may lead to the following:

- Modification of my individualized treatment plan, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
- Discontinuations from MAT medications not related to diversion, if deemed necessary by the medical provider, will be done in a medically compassionate manner using opioid and adjunctive non-opioid medications.
- Discontinuation from MAT medications related to diversion, if deemed necessary by the medical provider, will be done in a medically compassionate manner using non-opioid medications.

Patient's Acknowledgement of Understanding

Patient Initials	
	I hereby authorize and give voluntary consent to the VCMAT Medical Director and/or any appropriately authorized designees he/she may select to administer or prescribe the drug methadone, buprenorphine, naltrexone, or other US Federal Drug Administration-approved medication as an element in the treatment of an opioid use disorder (OUD).
	Procedures to treat OUDs have been explained to me and I understand that treatment will involve taking prescribed medications, with the goal of managing symptoms of dependence. It has been explained that methadone and buprenorphine are narcotic drugs which can be harmful if taken without medical supervision, or in ways other than prescribed.
	I understand that these medications are potentially addictive medications. Alternative methods of treatment, the possible risks and side effect of medication, and the possibilities of complications have been explained to me.
	The goal of medication assisted-treatment is total rehabilitation, which includes the absence of illicit drug use (including illicitly-obtained buprenorphine and/or methadone, among other substances). Eventual withdrawal from the use of all drugs is an appropriate treatment goal, however, for some patients, medication-assisted treatment shall continue for as long as it is determined to be medically necessary, and for as long as I consent to treatment.
	I understand that periodic medical re-assessments shall occur to consider appropriate care, including the potential for increase, decrease, and discontinuation of medication-assisted treatment for OUD.
	I understand that I may discontinue participation with medication assisted therapy at any time, however, this should be done in consultation with a medical provider with appropriate care and supervision for detoxification.
	I agree that I will inform all medical professionals, who may treat me for any medical problem, that I am enrolled in an OUD treatment program.
	I have been educated on the potential risks associated with the use of other drugs and/or medications in conjunction with MAT medications.
	I understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me.
	I understand that these alternate procedures shall be used when in the VCMAT Medical Director's or designee's professional judgment, it is considered advisable.

	My signature below indicates that I also understand that a limited portion of my protected health information, including information protected by 42 CFR Part 2, may be disclosed by and received from VCMAT, the Vermont Department of Corrections, Vermont Department of Health, and other entities as described above.
	I have had an opportunity to ask questions regarding this document and they have been answered to my satisfaction.
	I am consenting to medication-assisted treatment while in DOC custody and when I re-enter the community, and I understand that failing to comply with this agreement may result in a taper/discontinuation of MAT medications.

_____

Patient Signature Date

_____

Healthcare Staff Signature Date

Health Services	**POLICY: Medication-Assisted Treatment Program** **Table of Contents**	
		Date of Draft: 2.8.19, 2.10.19 **Revised: 2.26.19, 3.8.19, 3.16.19, 3.18.19**

Vermont Corrections Medication-Assisted Treatment (VCMAT)
Table of Contents

Policies

Attachments

Health Services	**POLICY: Medication-Assisted Treatment Program** **Background and Policy Statement**	
	NO. A	**Date of Draft: 2.2.19, 2.8.19, 2.10.19** **Revised: 2.26.19, 3.8.19, 3.16.19, 3.18.19**

REFERENCES:
Vermont Legislative Act 176, *S.166* **(**Act 176)

Binswanger, Ingrid A Et al. Release from prison--a high risk of death for former inmates. New England journal of medicine vol. 356,2 (2007): 157-65.

National Sheriffs' Association (NSA) and the National Commission on Correctional Health Care (NCCHC). Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field. Published October 2018.

Substance Abuse Center for Behavioral Health Statistics and Quality. Results from the 2016 National Survey on Drug Use and Health: Detailed Tables.

SAMHSA. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm. Published September 7, 2017. Accessed March 7, 2018.

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Spotlight on Opioids. Washington, DC: HHS, September 2018.

ATTACHMENTS:
Centurion Healthcare Information for Release

A. BACKGROUND:
The Surgeon General of the United States has stated that opioid use disorder is a treatable brain disease, not a moral failure or character flaw, and that a cultural shift is needed of how we think about and treat patients with substance use disorders.

The National Commission on Correctional Health Care and the National Sheriffs' Association have stated their unequivocal support for use of evidence-based treatment for opioid use disorder within jails. A 2015 study from SAMHSA showed that about half of state and federal prisoners meet criteria for substance use disorder, and the Bureau of Justice Statistics estimates that two-thirds of people in jail meet criteria for drug dependence or abuse.

Patients with opioid use disorder who have engaged in criminal activity and are placed in the correctional system have significant risk factors for morbidity and mortality, and have a high rate of recidivism. From a public health perspective and from the standpoint of costs to society, these high-risk patients are in immediate need of stabilization of their disease. Upon release from correctional custody, patient with opioid use disorder are 129 times more likely to die of an opioid related overdose as compared to the community. Based on the empirical evidence, the criminal justice system must adopt medication assisted treatment that includes the use of gold

standard medications such as buprenorphine, methadone, and naltrexone to successfully treat patients with opioid use disorder.

B. STANDARD:

The Vermont Corrections Medication-Assisted Treatment (VCMAT) Program mission is to provide high-quality Medication–Assisted Treatment (MAT) for all patients in Vermont correctional facilities who request treatment for opioid use disorder and meet the guidelines to receive treatment, for as long as medically necessary, in accordance with Vermont Act 176 and evidence-based best practices. All patients with a confirmed diagnosis of opioid use disorder will have access to treatment during their correctional confinement. Treatment will consist of one or more of the following modalities:

a. Buprenorphine
b. Methadone
c. Naltrexone.
d. Behavioral health services.

Upon release, all VCMAT patients will be provided with a reentry plan that includes coordination with a MAT community based provider for continuation of treatment services. Patients will be provided with a prescription of buprenorphine upon release, as needed, to allow time to register with the identified MAT community based provider.

Health Services	**POLICY: Medication-Assisted Treatment Program Admission Criteria**	
	NO. B	**Date of Draft: 2.2.19, 2.8.19, 2.10.19 Revised: 3.8.19, 3.16.19, 3.18.19**

ATTACHMENTS:
TCU Screen 5
TCU Opioid Supplement Screen
Clinical Opiate Withdrawal Scale (COWS) Assessment

STANDARD: The Vermont Corrections Medication-Assisted Treatment (VCMAT) Program is to provide high-quality Medication Assisted Treatment (MAT) for all patients who meet established treatment guidelines, for as long as medically necessary, in accordance with Vermont Act 176 and evidence-based best practices.

ADHERENCE INDICATORS: The following will be utilized to admit patients to VCMAT:

1. All individuals entering the correctional system or current inmates seeking medication assisted treatment will be assessed by a qualified healthcare professional for evidence of a substance use disorder using a validated screening tool for the diagnosis of substance use disorders based on DSM-5 criteria. Additionally a urine drug screening for evidence of substance use will be ordered. Requests for evaluations, by those already in custody, should be done through the established inmate healthcare request form process.

2. Patients that screen positive for the evidence of a substance use disorder will receive further comprehensive assessment by a qualified healthcare professional to determine history and severity of drug use through a standardized tool.

3. During therecieving screening process, patients will be asked to sign a release of information to verify all community based treatment of substance use disorders, including treatment for over-dose.

4. Patients requesting VCMAT services, who screen positive for an opioid use disorder during screening, will receive a clinical review by aQualified Healthcare Provider. The following information may be reviewed in making the diagnosis of opioid use disorder:
   a. Patient meets criteria for the diagnosis of an opioid use disorder based on a validated assessment tool.
   b. Evidence of current or history of opioid use through urine drug screens (i.e., positive screen for opiates, oxycodone, fentanyl, buprenorphine, and/or methadone).
   c. Community health records verifying diagnosis and/or treatment of opioid use disorder, including emergency treatment for overdose.
   d. Vermont Prescription Monitoring System (VPMS) and other records convey history of opioid use disorder and/or treatment

e. Physical exam findings support diagnosis of opioid use disorder (Clinical Opiate Withdrawal Scale (COWS) assessment, pupil diameter, diaphoresis, tremor, track marks).

Based on the medical provider's assessment and clinical judgment, diagnosis of an opioid use disorder will be added to the individualized treatment plan, including Chronic Care and MAT treatment planning froms for admission to VCMAT services.

5. Based on the medical provider's assessment, patients who meet criteria for a substance use disorder, other than opioid use disorder, will be referred to the Behavioral Health department for assessment of services. Should the medical provider believe alternative medical treatment is clinically indicated, an order will be written and the patient scheduled for follow-up services.

6. When a patient has stopped taking the MAT prescription by request and later decides that s/he would like to be back on the prescription, the patient must be seen by a buprenorphine-waivered MAT Provider or a non-waivered provider who consults with the MAT On-call provider. The determination will be documented in the medical record.

7. When a patient is re-incarcerated:

   a. Verification of continued community MAT engagement will be made. Once verified MAT medications will be continued in compliance with medication continuation protocols.
   b. If a patient has not continued community MAT engagement, they will be reassessed for continuation of care through the established intake assessment protocols.

Health Services	**POLICY: Medication-Assisted Treatment Program** **Program Treatment Requirements**	
	NO. C	**Date of Draft: 2.2.19, 2.8.19, 2.10.19** **Revised: 2.26.19, 3.8.19, 3.16.19, 3.18.19**

ATTACHMENTS:
Treatment Adjustment form

STANDARD: All patients who will continue community based treatment or be initiated for treatment of opioid use disorder with methadone, buprenorphine, or naltrexone, including the support of behavioral health counseling, during the course of correctional confinement are to be admitted to the Vermont Corrections Medication-Assisted Treatment (VCMAT) Program.

Participation in the VCMAT requires adherence to the following requirements:

1. Patient signature of the VCMAT consent for treatment form.
2. Patient signature of a medication informed consent for the indicated medication modality, when a medication is part of the treatment plan.
3. Participant in the VCMAT program, the patient has an Opioid Use Disorder (OUD), a chronic illness. Patients with an OUD chronic illness are to be seen by a provider for a chronic care visit every 90 days.
4. Adherence with the VCMAT individualized treatment plan, to include:
   A. Attendance at all scheduled appointments
   B. Engagement with all counseling and case management related services
   C. Submission of urine for a urine drug screen as ordered
   D. Medication adherence as prescribed
5. Engage respectfully with Health Services staff, ensuring a safe treatment environment.
6. Adhere to DOC medication administration protocol.
7. Treatment non-adherence is addressed in policy NO. H VCMAT Treatment Non-Adherence.

Health Services	**POLICY: Medication-Assisted Treatment Policy** **Impairment Policy**	
	NO. D	**Date of Draft: 2.3.19, 2.10.19** **Revised: 2.26.19, 3.8.19, 3.16.19, 3.18.19**

ATTACHMENTS:
Impairment Assessment Tool

STANDARD:
If there is concern about the impairment of a VCMAT patient, a referral for assessment is to be made to the Health Services department. An impairment assessment may be requested by all facility staff with the opportunity to observe the patient, or by self-request of the patient.

1. Referrals for assessment of impairment will be considered urgent and the assessment completed as soon as possible.

2. Security staff will escort the patient to the Health Services department to be screened for objective signs of impairment using the impairment assessment tool. This assessment will be documented in the medical record.

3. The impairment assessment will be performed by a nursing staff member and if positive, referred to the facility medical provider for review of the treatment plan and follow up orders as clinically indicated. This review will be documented in the medical record.

4. When assessment results are positive for impairment, the dose of buprenorphine will be held and the VCMAT on-call provider will be immediately contacted for follow-up orders.

Health Services	**POLICY: Medication-Assisted Treatment Policy** **Treatment Non-Adherence**	
	NO. E	**Date of Draft: 2.2.19, 2.8.19, 2.10.19, 2.18.19** **Revised: 2.26.19, 3.8.19, 3.16.19, 3.18.19**

ATTACHMENTS:
VCMAT Patient Agreement form

STANDARD:
Adherence to policy No. C VCMAT Treatment Requirements, supports the effectiveness of treatment for an opioid use disorder. When barriers to effective treatment exists, based on non-adherence with program requirements, modification of the patient's individualized treatment plan, to include discontinuation from MAT medications, will be considered.

The following are considered behaviors of non-adherence and are barriers to effective treatment:

1. **Creating an unsafe treatment environment:**
   a. Patients who exhibit threatening or aggressive behaviors contributing to an unsafe treatment environment will be referred to behavioral health for an immediate risk assessment. Prior to continuation of VCMAT related services, the patient must be stabilized and the behavioral episode resolved.
   b. In the event that participation in VCMAT is halted based on unsafe behaviors by the patient, VCMAT will provide the patient with a humane and medically appropriate taper with buprenorphine and adjunctive non-opioid medications, when safely able to do so.
   c. Patients who are identified as diverting MAT medications, and upon review are discontinued from prescribed MAT medications, will be placed on an alternative treatment plan for opioid use disorder treatment. This plan will be documented in the medical record.
   d. VCMAT patients discharged based on safety concerns, who stabilize at a later period during their correctional confinement, may be referred back by a behavioral health professional or medical provider, who has assessed the clinical appropriateness for treatment re-engagement.
   e. In the event that participation in MAT is discontinued for unsafe behaviors that do not stabilize, VCMAT will attempt to re-induct the patient on buprenorphine seven-days prior to release.
   f. All VCMAT patients with behavioral concerns, whether on a MAT medication at release or not, will be assisted in connecting with a community HUB to continue treatment, if desired by the patient.

2. **Non-adherence with scheduled appointments**
   a. Missed appointments will result in the patient meeting with a VCMAT treatment team member to determine a reason for the absence and identifying a solution to avoid future occurrences. This will be documented in the patient's medical record. Consideration of modification to the individualized treatment plan, up to and including discontinuation from MAT medications for a documented pattern of non-adherence with scheduled appointments, may be considered.

3. **Non-adherence with ordered drug screens.**
   a. A positive drug screen for substances other than prescribed medications will be evaluated by the VCMAT treatment team and result in the following:
      - Consideration of adjustment to the individualized treatment plan.

- A member of the VCMAT treatment team will meet with the patient to discuss the positive drug screen and potential changes in treatment.
- A positive drug screen will not automatically result in dismissal from VCMAT.
- A positive drug screen for benzodiazepines or other sedating substances may result in MAT medication adjustments, for the safety of the patient.

b. A drug screen that is refused or tampered with by the patient will be presumed positive for benzodiazepines or other sedating substance.
c. Refusal or tampering with ordered drug screens by a patient may lead to the development of an alternative treatment plan.
d. A drug screen that is negative for the patient's MAT medication will lead to modification of the patient's individualized treatment plan, up to and including an alternate treatment plan that includes discontinuation from MAT medications.

5. **Non-adherence with DOC medication administration protocols**
   a. Patients attempting to divert MAT medications, during direct observation medication administration will result in the following:
      - The patient will meet with a VCMAT team member to determine the reason for diversion
      - The VCMAT Medical Director will be notified.
      - Evaluation and adjustment of the individualized treatment plan will be considered, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
      - Patients who have their MAT medication discontinued due to diversion will be treated compassionately with non-opioid medications.
      - Patients on an alternate treatment plan may reapply for MAT treatment after ninety-days of adherence to the alternate treatment plan. Patients may request reconsideration through a healthcare request form or be referred by their VCMAT case manager.
      - The VCMAT Medical Director will determine whether the patient may be re-inducted during the present incarceration, be offered induction 7 days prior to release, or remain in the alternative treatment program. The determination will be documented in the medical record.

Health Services	**POLICY: Medication-Assisted Treatment Policy** **Care Coordination**	
	NO. F	**Date of Draft: 2.3.19, 2.8.19, 2.10.19** **Revised: 2.26.19, 3.8.19, 3.16.19, 3.18.19**

ATTACHMENTS:
HUB Transfer of Care
Centurion Healthcare release form

STANDARD:
Follow-up care planning begins at admission into VCMAT. All VCMAT patients will be offered community based MAT follow-up services that are accessible and available upon release.

1. Collecting documentation for Care Coordination begins when the patient is inducted onto a MAT medication. The following documents are completed for each medical record labeled MAT initiation.
    a. Release of Information
    b. Patient's requested HUB upon release
    c. Patient consent for treatment
    d. The MAT Medical Determination form, including all completed assessments and the final MAT determination
    e. Anticipated release date

2. When Health Services is informed of a patients release date, communication from the VCMAT care coordinator to the identified HUB begins.

3. Patients will be given a re-entry information packet with community follow-up contact information upon admission. This will include what the patient is to do if released without receiving their reentry plan documentation.

4. The Care Coordinator or designee will enter all the care coordination release information in the patient's discharge summary found in the medical record.

5. When a patient is released from incarceration, there will be a standardized referral packet that will be sent to the community HUB or provider for the transfer of care:
    a. When the Health Services department is notified by DOC of a patient's anticipated release date the coordination to transfer care to the community begins.
    b. VCMAT care coordination staff will complete the referral process by submitting the HUB transfer of care request and required documentation for a patient being released to the community. When necessary the Care Coordinator will complete additional HUB referral information, as requested. Information provided to the HUB and/or community provider will include:
        - The most recent urine drug screen and lab results
        - Patient's medical and mental health history, medications, and treatment plans
        - The last physical assessment completed
        - Recent COWS scores
        - MAT medical determination

- Notice of the most recent MAT prescription and dose
- VCMAT discharge identifying the selected community HUB and scheduled appointment date/time

c. The community HUB accepting the transfer of care will confirm the request by returning the transfer of care form, with the HUB medical director signature, indicating acceptance of the patient upon release. Confirmation will be faxed to the Health Services department.

d. If the HUB appointment or community provider appointment cannot be scheduled on the day of release, the patient will be provided a prescription for buprenorphine, sufficient to continue MAT until the scheduled HUB appointment; typically, this will not exceed a four-day order.

Health Services	**POLICY: Medication-Assisted Treatment Policy** **Urine Drug Screening**	
	NO. G	**Date of Draft: 2.3.19, 2.8.19, 2/10/19** **Revised: 2.26.19, 3.16.19, 3.18.19**

ATTACHMENTS:
None

STANDARD:
Completeing Urine Drug Screens is a required component of the VCMAT program.

1. Nursing staff will perform monthly Urine Drug Screenings (UDS) of at least twenty percent (20%) of the inmate population receiving MAT Medications.

2. Nursing staff will randomly select the required number of inmates (divided between different units),

    a. Identified patients will be escorted to a dry cell in or near the health services unit, or a location identified by DOC and agreed upon by medical, to await a witnessed specimen collection. Patients will not be allowed to return to the housing unit until a specimen has been collected to check for compliance. Patients will be provided with water as needed to facilitate a specimen collection.

3. A UDS report will be completed by nursing to include:
    a. Name of nurse completing compliance check
    b. Name of observing security staff
    c. Name of inmate and patient ID or DOB, verified by nursing staff
    d. Designation of “Compliant” or “Non-compliant” for each patient named
    e. Date and time of compliance check
    f. Action taken for non-compliance, if applicable

4. Patients who test positive will be scheduled for UDS screens 1x per 30 days, for 90 days. Refusal of a UDS will be considered a positive screen.

5. The report will be forwarded to the Health Service Administrator with a copy sent to the VCMAT Medical Director or designee.

6. Patients who are found to be non-adherent with the VCMAT program, by evidence of a positive UDS screen, shall receive immediate education and counseling by nursing staff, followed by scheduled case management assessment with a VCMAT provider. Two positive UDS screens will result in provider education and counseling, and review of the patient VCMAT individualized plan for consideration of modification.

7. Patients with evidence of repeat or multiple positive UDS screens may be placed on an alternative treatment program. Patients may be re-referred for MAT consideration after ninety-days of compliance with the alternate treatment plan, by self-request or by referral of the VCMAT case manager.

8. To protect patient confidentiality, the results of urine drug screens along with patient-identifying information will not be shared with DOC. The VCMAT Medical Director, or designee, may share evidence of general substance use data with DOC, excluding patient-identifying information, to help monitor facility substance use patterns and help ensure a safe environment.

9. Upon release patients who are on MAT will need to have UDS completed within the last thirty-days to comply with HUB requirements.

10. Patients with a scheduled CIC, who have not had a UDS completed over the last thirty-days, either random or scheduled, will have a UDS completed as part of the CIC visit.

centurion

(Attachment A)

HEALTHCARE INFORMATION WHEN PATIENT IS RELEASED

NAME: _____ ID#: _____ DOB: _____

RELEASED FROM: _____ DATE OF RELEASE: _____

Acute Healthcare Problems: _____

_____

Chronic Healthcare Problems: _____

_____

_____

Mental Health Needs: _____

_____

_____

Date of Last Physical Examination: _____ Date/Results of Last PPD: _____

Current Medication ☐ Yes ☐ No

Medication/Dosage	Instructions	Last Taken	# of Pills Provided	Prescription Provided	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Pending Appointments

Date_____ Time_____ Clinic_____

Date_____ Time_____ Clinic_____

Other Follow-up Recommended:_____

_____

Address and Contact Number of Mental Health Clinic: _____

_____

Release of Information: Your doctor, clinic, or other healthcare provider can request copies of your health records by sending an appropriate signed waiver for Release of Information to the Healthcare Records Department

(Facility Name): _____

(Facility Address)_____

(Facility Contact Number): _____

I have received instructions on how to take the medication I am being provided I have had the opportunity to have my questions answered about medication side-effects and other information about my healthcare. I understand that the medications are not packaged in child-proof containers and it is my responsibility to keep the medications away from children.

_____ _____

Patient Signature Date/Time Healthcare Staff Date/Time

(Attachment B)

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

		Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	○	○
2.	Did you try to control or cut down on your drug use but were unable to do it?	○	○
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4.	Did you have a strong desire or urge to use drugs?	○	○
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	○	○
6.	Did you continue using drugs even when it led to social or interpersonal problems?	○	○
7.	Did you spend less time at work, school, or with friends because of your drug use?	○	○
8.	Did you use drugs that put you or others in physical danger?	○	○
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	○	○
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	○	○
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	○	○
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	○	○
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	○	○

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

○ None
○ Alcohol
○ Cannaboids – Marijuana *(weed)*
○ Cannaboids – Hashish *(hash)*
○ Synthetic Marijuana *(K2/Spice)*
○ Opioids – Heroin *(smack)*
○ Opioids – Opium *(tar)*
○ Stimulants – Powder Cocaine *(coke)*
○ Stimulants – Crack Cocaine *(rock)*
○ Stimulants – Amphetamines *(speed)*
○ Stimulants – Methamphetamine *(meth)*
○ Synthetic Cathinones *(Bath Salts)*
○ Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
○ Dissociative Drugs – Ketamine/PCP *(Special K)*
○ Hallucinogens – LSD/Mushrooms *(acid)*
○ Inhalants – Solvents *(paint thinner)*
○ Prescription Medications – Depressants
○ Prescription Medications – Stimulants
○ Prescription Medications – Opioid Pain Relievers
○ Other (specify) _____

13. How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
a. Alcohol	○	○	○	○	○
b. Cannaboids – Marijuana *(weed)*	○	○	○	○	○
c. Cannaboids – Hashish *(hash)*	○	○	○	○	○
d. Synthetic Marijuana *(K2/Spice)*	○	○	○	○	○
e. Opioids – Heroin *(smack)*	○	○	○	○	○
f. Opioids – Opium *(tar)*	○	○	○	○	○
g. Stimulants – Powder cocaine *(coke)*	○	○	○	○	○
h. Stimulants – Crack Cocaine *(rock)*	○	○	○	○	○
i. Stimulants – Amphetamines *(speed)*	○	○	○	○	○
j. Stimulants – Methamphetamine *(meth)*	○	○	○	○	○
k. Synthetic Cathinones *(Bath Salts)*	○	○	○	○	○
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	○	○	○	○	○
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	○	○	○	○	○
n. Hallucinogens – LSD/Mushrooms *(acid)*	○	○	○	○	○
o. Inhalants – Solvents *(paint thinner)*	○	○	○	○	○
p. Prescription Medications – Depressants	○	○	○	○	○
q. Prescription Medications – Stimulants	○	○	○	○	○
r. Prescription Medications – Opioid Pain Relievers	○	○	○	○	○
s. Other (specify) _____	○	○	○	○	○

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

○ *Never* ○ *1 time* ○ *2 times* ○ *3 times* ○ *4 or more times*

15. How serious do you think your drug problems are?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

○ *Never* ○ *Only a few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

17. How important is it for you to get drug treatment now?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

TCU Drug Screen 5 (v.Aug17)

(Attachment C)

TCU DRUG SCREEN 5 – Opioid Supplement

***If the response to TCU Drug Screen 5, page 2, Q13e, Q13f, or Q13r regarding opioid use is more than "Never," then complete the following questions.**

In the LAST 12 MONTHS –

1. **What types of opioids have you used?**

   a. Heroin ..... ○ *No* ○ *Yes*
   b. Oxycodone (Oxycontin, Percodan, Percocet) ..... ○ *No* ○ *Yes*
   c. Hydrocodone (Vicodin, Lortab, Lorcet, Norco, Zohydro) ..... ○ *No* ○ *Yes*
   d. Morphine (Kadian, Avinza, MS Contin) ..... ○ *No* ○ *Yes*
   e. Fentanyl (Duragesic, Fentora) ..... ○ *No* ○ *Yes*
   f. Hydromorphone (Dilaudid, Exalgo) ..... ○ *No* ○ *Yes*
   g. Methadone (Dolophine) ..... ○ *No* ○ *Yes*
   h. Oxymorphone (Opana) ..... ○ *No* ○ *Yes*
   i. Codeine (Tylenol/cough syrup with codeine) ..... ○ *No* ○ *Yes*

2. **How many times did you inject an opioid?**

   ○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

3. **How many times did you take an opioid in another way (e.g., ground pills and sniffed it, put a film in your mouth)?**

   ○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

4. **How many times did you take an opioid prescribed for you?**

   ○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

5. **How many times did you take an opioid prescribed for someone else?**

   ○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

6. **From whom did you get the opioids you took?**

   a. Medical doctor/pharmacy? ..... ○ *No* ○ *Yes*
   b. Family member? ..... ○ *No* ○ *Yes*
   c. Friend? ..... ○ *No* ○ *Yes*
   d. Someone else (e.g., "on the street")? ..... ○ *No* ○ *Yes*

7. **Have you taken opioids for medical reasons?** ..... ○ *No* ○ *Yes**

   ***IF YES,** briefly describe the reasons:

   _____

8. Have you taken opioids for <u>non-medical reasons</u>? ..... ○ *No* ○ *Yes**

***IF YES,** briefly describe the reasons:

_____

9. Has a <u>doctor prescribed</u> opioid medications for you? ..... ○ *No* ○ *Yes**

***IF YES:**

a. did you have the most recent <u>prescription filled</u>? ..... ○ *No* ○ *Yes**

b. did you <u>take all of the medications</u> as prescribed? ..... ○ *No* ○ *Yes**

c. did you <u>give or sell any of your medications</u> to someone else? ..... ○ *No* ○ *Yes**

10. Have you taken <u>other medications or illegal drugs</u> for medical reasons (e.g., to treat pain)? ..... ○ *No* ○ *Yes**

***IF YES,** please list:

Drug/medication: _____ Reasons for taking: _____

Drug/medication: _____ Reasons for taking: _____

Drug/medication: _____ Reasons for taking: _____

11. Do you or someone close to you (e.g., family, friend) have <u>access to naloxone (Narcan)</u> to reverse an overdose? ..... ○ *No* ○ *Yes*

12. How many times have you <u>EVER overdosed</u> after taking opioids?

○ *Never* ○ *Once* ○ *Twice* ○ *3 times* ○ *4 or more times*

13. <u>In the last 12 months</u>, how many times <u>have you overdosed</u> after taking opioids?

○ *Never* ○ *Once** ○ *Twice** ○ *3 times** ○ *4 or more times**

***IF MORE THAN "NEVER," in the last 12 months:**

a. <u>What types</u> of opioids did you use?

1. Heroin ..... ○ *No* ○ *Yes*
2. Oxycodone (Oxycontin, Percodan, Percocet) ..... ○ *No* ○ *Yes*
3. Hydrocodone (Vicodin, Lortab, Lorcet, Norco, Zohydro) ..... ○ *No* ○ *Yes*
4. Morphine (Kadian, Avinza, MS Contin) ..... ○ *No* ○ *Yes*
5. Fentanyl (Duragesic, Fentora) ..... ○ *No* ○ *Yes*
6. Hydromorphone (Dilaudid, Exalgo) ..... ○ *No* ○ *Yes*
7. Methadone (Dolophine) ..... ○ *No* ○ *Yes*
8. Oxymorphone (Opana) ..... ○ *No* ○ *Yes*
9. Codeine (Tylenol/cough syrup with codeine) ..... ○ *No* ○ *Yes*

b. How many times did you go to the <u>hospital or emergency room</u> because of an overdose on opioids?

○ *Never* ○ *Once* ○ *Twice* ○ *3 times* ○ *4 or more times*

c. How many times were <u>you given naloxone (Narcan)</u> because of an overdose?

○ *Never* ○ *Once* ○ *Twice* ○ *3 times* ○ *4 or more times*

d. Have you <u>received any follow-up treatment</u> after the most recent overdose? ..... ○ *No* ○ *Yes*

14. Have you <u>received Medication Assisted Treatment (MAT) in the last 12 months</u>? ..... ○ *No* ○ *Yes*

15. Are you <u>currently receiving Medication Assisted Treatment (MAT)</u>? ..... ○ *No* ○ *Yes*

***IF YES,** what type?

a. Methadone (Dolophine or Methadone) ..... ○ *No* ○ *Yes*
b. Buprenorphine (Subutex, Suboxone) ..... ○ *No* ○ *Yes*
c. Oral naltrexone (Depade, Revia) ..... ○ *No* ○ *Yes*
d. Depot natrexone (Vivitrol) ..... ○ *No* ○ *Yes*
e. Other, specify: _____ ..... ○ *No* ○ *Yes*

16. Have you <u>obtained</u> any of these medications <u>without a prescription</u>? ..... ○ *No* ○ *Yes*

17. Have you <u>taken more</u> of these medications <u>than were prescribed</u>? ..... ○ *No* ○ *Yes*

(Attachment D)

Clinical Opiate Withdrawal Scale (COWS) Assessment
For each item, mark the number that best describes the patient's signs or symptom.
Patient should be at rest prior to evaluation.

Resting pulse rate _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120 **Score:** _____	**Gastrointestinal upset** *Over last half hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting **Score:** _____
Sweating *Over past half hour not accounted for by room temperature or inmate activity* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face 4 Sweat streaming off face **Score:** _____	**Tremor** *Observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching **Score:** _____
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds **Score:** _____	**Yawning** *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute **Score:** _____
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only rim of the iris is visible **Score:** _____	**Anxiety or irritability** 0 None 1 Inmate reports increasing irritability or anxiousness 2 Inmate obviously irritable or anxious 4 Inmate so irritable or anxious that participation in the assessment is difficult **Score:** _____
Bone or joint aches *If patient was having pain previously, only additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Inmate reports severe diffuse aching joints/muscles 4 Inmate is rubbing joints or muscles and is unable to sit because of discomfort **Score:** _____	**Gooseflesh skin** 0 Skin is smooth 3 Piloerection* of skin can be felt or hairs standing up on arms 5 Prominent piloerection *Piloerection is gooseflesh or goose bumps **Score:** _____

Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks **Score:** _____	**Total COWS Score** The total score is the sum of both columns. Note score on flow sheet **> 36 = Severe:** Notify physician or designee immediately **25 - 36 = Moderately Severe:** Notify physician or designee immediately. **13 - 24 = Moderate:** Notify physician or designee immediately. **5 - 12 = Mild:** Notify physician or designee for orders **< 5 =** Notify physician or designee of initial evaluation

(Attachment E)

VCMAT Treatment Adjustment Form

Patient Name: _____ Patient DOB: _____

Date: _____

Current Buprenorphine Dose:_____mg

Date of admission to MAT:_____

Why is a MAT Treatment Evaluation requested?

_____

_____

Continued use of illicit drugs?: YES NO
If yes, please describe:

Drug	Amount used and route	Frequency in last week	Date of last use

Any patient/staff reports of sedation or impairment on current dose? YES NO

If yes, describe: _____

Drug Screens:	Side effects/toxicity:
Date:_____Results:_____ Date:_____Results:_____ Date:_____Results:_____	Sedation: yes / no Description: _____ Constipation: yes / no Description: _____ Sweating: yes / no Description: _____ Other: yes / no Description: _____

Medical/psych history: _____

Any known active patient med/behavioral issues: _____

New stressors: _____

Medications: _____

Allergies: _____

For dose adjustment requests only:
Symptoms 3-4 hrs after medicating:_____
Progression of symptoms and timeline:_____
_____
Sx 24 hrs after medicating (if reporting withdrawal, do pre-dose COW):_____

Compliance with counseling/ monthly check-ins/treatment plan:
_____

Nursing impression: _____
_____

For behavioral concerns only:
Current behavioral interventions on treatment plan: _____
_____

Compliance with behavioral interventions on treatment plan: _____

MAT Team assessment/recommendation:
_____

***For non-compliance with treatment plan*:**
Nature of non-compliance: _____

Nursing impression: _____
_____

Staff filling out form: _____

MAT Medical Director assessment/plan: _____

(Attachment F)

Impairment Assessment Tool

Patient Name: _____ PID: _____

Date of assessment: _____

Medication Utilized and current dose: _____ Date dose began:___

Reason for sedation/impairment concerns (describe): _____

_____

Reports of any illicit drug use (describe): _____

History of benzodiazepine use: _____

Point of Care Urine Drug Screen Results:

BZD	+	-
MTD	+	-
BUP	+	-
OPI	+	-

OXY	+	-
COC	+	-
AMPH	+	-

Presentation:	_____ _____ _____
Mental Status:	Oriented___ Disoriented___ Time___ Place___ Person___ Alert___ Drowsy___ Lethargic___ Inattentive___ Forgetful___ Stuporous___ Cooperative___ Combative___
Mood / Emotional Status:	Normal ___ Angry ___ Elation___ Calm___ Friendly___ Evasive___ Fearful___ Anxious___ Irritable___ Withdrawn___ Euphoric___ Hostile___
Speech:	Spontaneous___ Sudden Silences___ Slow and deliberate___ Rapid___ Content clear___ Content not clear___ Logical progression___ Slurring___
Eyes:	Nystagmus___ Poor eye contact___ Drooping eyelids___ Pupils constricted/pinpoint___ Dilated___ Equal___ Unequal___
Gait:	Heel to toe steady___ Unsteady___ Finger to nose good___ Finger to nose poor___
Vital Signs:	Temperature___ Pulse___ BP___ Respirations___ %O2_____
General Impression:	

(Attachment G)

Vermont Corrections Medication Assisted Treatment (VCMAT)
Patient Agreement

*See separate attachment –final to be inserted upon official approval of document

Centurion of Vermont
5430 Waterbury-Stowe Road
Building 1, Ground Floor
Waterbury Center, VT 05677
Phone: 802-221-4726 Fax: 802-244-1935

Hub Transfer of Care Request for Incarcerated Patient

The purpose of this form is to request Hub dosing and admission for a patient who is being released from incarceration

☐ If box is checked, request is **urgent** as patient is pending release within 24 hours.

Requesting Agency: _____

Contact: _____ Telephone number: _____

Hub where dosing/admission is requested: _____

Contact: _____ Telephone number: _____

Patient Name: _____ Date of Birth: _____

Patient's current insurance carrier_____ Policy #_____

Date incarceration began: _____ MAT med utilized and dose: _____

If MAT med was started during incarceration, date commenced:_____

If patient was already receiving MAT prior to incarceration, dates of treatment:_____

Planned release date: _____ Requested date to begin dosing at hub: _____

All current Medications/Dosages: _____

Active Medical Problems: _____

Allergies (including documented allergy for naloxone): _____

_____ _____ _____ _____

Medical from Sending Facility Date MD from accepting Hub Date

Enclosures:
Consent to Release Information signed by patient
DSM5 diagnosis sheet
Centurion MAT Admission Assessment/progress notes
Lab results for tb, hep c, hiv if available

Form revised 10/12/2018

POLICY: Medication-Assisted Treatment Program				
COMMENT SHEET				
Section	**Comment #:**	**Page #**	**Bullet #**	**Comment**	**Response**
	Jaimie Meyer				
General	1	1	Title	Note that there is no provision for treatment of OUD in pregnancy in either the policy or clinical guideline document. Probably deserves a dedicated section noting that the goal of treatment of OUD for pregnant women is not only to improve OUD outcomes but also to prevent neonatal abstinence syndrome…so pregnant women should be prioritized for MAT.	Agree
VCMAT Treatment Modalities	2	3	9	The details of this need to be spelled out further- perhaps it is elsewhere in the document? Plan for transitional care	Agree that the care coordination / transition of care piece needs to be refined. The MAT Care Coordination Workgroup has completed ths work in a separate document. The MAT team will consider adding this document to these Policies.
Methadone	3	3	intro	Does this just mean that the Hub has to accept them? How is this operationalized (i.e. signed agreement, verbal ok)? Do the Hubs come into the DOC to dose or do they just deliver the medications? Also you might spell out somewhere in here, if true, that all MAT is to be administered as directly observed therapy	Like any citizen for whom it has been medically determined to have an OUD and whose OUD may be best treated with methadone, the Hubs will evaluate and treat with methadone, if medicllly neccessaty. . There is a chain of custody agreement that allows DOC to pick up the bottles of methadone for an incarcerated patient, and bring them into the correctional facilities for administration. Agree that the Policy should state that MAT is to be administered as directly observed therapy.
	Christopher Lukonis				
Evaluation	1	1	4	Delete: "assessment, pupil diameter, diaphoresis, tremor, track" as duplicative of COWS from "Physical exam findings (Clinical Opiate Withdrawal Scale (COWS) assessment, pupil diameter, diaphoresis, tremor, track injection marks)"	Agree
VCMAT Treatment Modalities	2	2; 7	p.2: 4th bullet pg 2; p. 7: VCMAT Tx Non Adherence Section, d.	Concern with "Engages respectfully with health service staff, ensuring a safe treatment environment." Too vague: Will someone with personality disorder not get treated?	Agree. At the same time, health services staff need to be protected from verbal abuse and other concerning behavior. If an inmate/patietn is disruptive, it does not universally mean removal from the program, but the behavior will need to be addressed.

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
Methadone	3	4	5th bullet under #4	Below, if there are concerns for impairment, the dose should be held until that is resolved.	Agree
Drug Screening	4	6	#6	Replace: "Patients who test positive" with Patients who have unexpected test results" There are two places in this bullet needing this change. Replace: Two positive drug screens with "Two unexpected UDS results."	Agree
Drug Screening	5	6	#7	Replace: "Patients with evidence of multiple drug screens" with "Patients with multiple unexpected UDS results…"	Agree
VCMAT Non-Adherence	6	7	2a	Comment: Does this mean their medication and/or counseling will be put on hold? If so, not a good idea if the goal is to try and stabilize their behavior.	Removing someone from the program due to behavioral concerns is only in extreme circumstances where staff safety is concern, and mirrors how these types of situations are handled in the community. The number of patients who have been removed from the program have been very few, and have typically been able to restart once the behavioral concern was addressed.
VCMAT Non-Adherence	7	7	2e	Comment: What will the procedure be? 7 days is too short for a patient who has lost tolerance to opioids. I would suggest at least two weeks.	We determine the re-start window (seven or fourteen days) on a case by case basis.
Treatment Adjustment	8	8	4th	Replace: "Patient is exhibiting behavioral concerns" with "Patient is exhibiting behavioral disturbance"	Agree

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
Buprenorphine or Methadone Discontinuation	9	10	In "Buprenorphine," 2a	Replace: "After convicted for diversion of" with "If found to be diverting" buprenorphine from the medline	Agree
Buprenorphine or Methadone Discontinuation	10	10	In "Buprenorphine," 2b ii	Comment: "It may be better for everyone if the provider has the option to reduce the dose and taper."	Agree. Acknowledge that at times inmate/patient may need a taper for medical reasons. In this case, agree with this reccomendation.
References	11	13	References	Comment: "Would update. For instance: http://pcssnow.org/wp-content/uploads/2015/12/Alford-Acute-Chronic-Pain-MAT-FINAL2-12-22-15.pdf"	This will be updated. The following reference has also been added: Lembke et al. Patients Maintained on Buprenorphine for Opioid Use Disorder Should Continue Buprenorpine Through the Perioperative Period. Pain Med. 2019 Mar 1; 20(3): 425-428.
Impairment Assessment Tool	12	21	In final table, left column, second-to-last row	Replace: "Gait" with "Gait/Coordination"	Agree
	John Brooklyn MD				
Standard?	1	1	line 2	add "muscle relaxants and other sedatives like gabapentin and pregabalin"	Unable to determine where this comment matches to in the Clinical Guideline. On the TCU-5?

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
?	2	6	?	"This list contains hubs and spokes" ???	Unable to determine where in the Clinical Guideline this comment matches to.
VCMAT Tx Non Adherence	3	7	2b	At end of: "In the event….. patient, add: " a medical provider will be contacted for guidance". Then start new sentence with VCMAT… Overall, the entire section on non-adherence needs to have sentences that state "a medical provider will be contacted." This is medical treatment!!	Agree
	4	8	4 and 5	non adherence policy must imply "that medical provider will be contacted" so that for any of the situations, it does not occur in a vacuum	Agree
	Nels Kloster				

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
General from Nels Kloster:	1			Overall, I think this is well done. It looks to me like there is overlap with the Clinical Guidelines and the POLICY, but I'll comment on each document, few major, mostly minor comments. Centurion Clinical Guidelines: This seems to acknowledge illicit drug use in prison, or is it instead intended to mimic outpatient treatment protocols?	Yes, we acknowledge that there is illict drug use in prison
VCMAT Treatment Modalities: Buprenorphine	2	2	4	I would organize the times in sequence. 12, then 24, then 48 hrs.	Agree
VCMAT Treatment Modalities: Methadone	3	3	4	We don't dose impaired patients at all and I strongly suggest that as the safest course. No one dies from withdrawal, but the overdose potential is raised combining opioids and benzos or alcohol.	Agree. Language will be clarified.
VCMAT Treatment Modalities: Methadone	4	4	4th bullet, iii	I wonder where you got the protocol for Last full dose 5-14 days ago. There is the potential for overdose after such a long time off of methadone. If for example someone's dose was 100 mg (national average dose) and had been w/o for 14 days, 50 mg is excessive. I would suggest for this interval calling the HUB before dosing.	Agree. When restarting a patient on methadone when that person has not dosed with methadone for a long time needs careful monitoring. The Clinical Guideline language has since been changed from the draft sent whe the MAT Peer Review Process was intiated. At this point it has been determined that stocking a 3-day supply of methadone for bridge dosing is not feasible. Agree that consultation shoud occur with the Hub.

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
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VCMAT Treatment Modalities: Methadone	5	4	second to last bullet	Monitoring for 60 minutes must impact your work flow. Why so long?	At this point, because of the DEA regulations, the MAT team (including the VT Health Department) has decided that stocking a 3-day supply of methadone for bridge dosing is not feasible due to the once in a lifetime regulation. Other procedures
Drug Screening	6	5	Add a number	I would add having the specimen within a temperature range. We use 92 - 100 degrees. This is often included on the cups.	MAT team will discuss.
VCMAT Treatment Non-Adherence	7	7	General	The format is different from p. 2. One uses symbols and the other uses letters and numbers. Impairment. I also drug screen impaired patients.	Formating will be corrected.
Buprenorphine or Methadone Discontinuation	8	10	General	I also use ibuprofen when treating compassionately.	Agree
Peri-operative Management of Buprenorphine	9	11	General	Refer to the VT MAT Practice Guidelines attachment. p.13 Management of Acute Pain gives guidance on choices of continue, partially continue, or stop buprenorphine depending on type of procedure. p. 23 gives dose equivalents in conjunction.	Agree. This section has been updated according to the following reference: Lembke et al. Patients Maintained on Buprenorphine for Opioid Use Disorder Should Continue Buprenorpine Through the Perioperative Period. Pain Med. 2019 Mar 1; 20(3): 425-428. Agree to reflect p.23 of the VT MAT practice guidelines.

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
VCMAT Treatment Modalities, Buprenorphine	10	2?	General	I might include sexual impairment and tooth decay risks (due to acidity and drying out the mouth). These are also effects of methadone. Should you include the paragraph "There are other medical treatments...." on the methadone and naltrexone consents? And should you include "Risks of Refusing Treatment" on the bup consent? At the end where the inmate signs if being unwilling, it says Methadone which I assume should say Buprenorphine.	Agree
VCMAT Treatment Modalities, Methadone	11	3?	General	Purpose and Benefits - why not the same level of detail as the first paragraph of bup consent?	The Authorization to release/receive information as oer HIPAA and 42 CFP Part 2 have changed since the MAT Peer Review Process was initiated. This has been adressed.
	Dr. Alvarez				
Methadone	1	4	4th bullet, iii	Via Annie: "if someone misses 14 days…she is not comfortable dosing at this level…commented that 100 mg would be too much.high" (sic)	Agree. Care must be taken when restarting a patient on methadone when that person has not dosed with methadone for a long time. The Clinical Guideline language has since been changed from the draft sent to Dr. Alvarez. At this point it has been determined that stocking a 3-day supply of methadone for bridge dosing is not feasible.
Peri-operative Management of Buprenorphine	2	11	4th bullet, iii	Via Annie: ""“Anesthesia Docs are behind/not up to sped with MAT and analgesics…they do not understand that someone can stay on buprenorphine and not come off…" (sic)	Agree. Some providers are more/less comfortable than others with peri-operative management of a patient on buprenorphine.
	Donna Strugar/Fritsch				
VCMAT Treatment Modalities	1	2	4th	Add to: Behavioral health services "for SUD treatment"	Agree

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
VCMAT Treatment Modalities	2	3	General	This section needs some work. I m a not sure that the Hub issue is correct – I think that any IOTP can provide dosing to incarcerated persons, but we need to check. Also, an OTP cannot legally refuse to dose a person who is incarcerated just because they are incarcerated. If this occurs, the OTP should be reported to the state licensing entity. Also, DEA offers an option for an OTP to operate a "medication unit" that is in a separate location in which stock methadone can be stored and from which methadone can be administered to OTP patients. This option has significant application for prisons and jails. We should work with the VT agency that licenses OTPs on this very important matter.	DOC is not aware of an OTP refusing to treat an incarcerated patient just because they are incarcerated.
Methadone	3	5	6	Other considerations: How will the dosing by Hub be documented in the medical record? This is essential to avoid double dosing (by bridge dose and Hub – I have seen this happen) and so that the medical record reflects all meds given. Consider having med nurse note on MAR that Hub gave dose. Logistically, there are issues in having Hub bring methadone to site at regular times. Consider using Sally Port. When there are multiple patients and they are moving around, logistics of how to most efficiently administer patient-specific doses are complicated. Wasting doses creates tons of paperwork, missed doses are dangerous. I have experience with this and can brainstorm with the DOC team about it.	Agree. At this point, due to DEA regulations the MAT team has decided that stocking a 3-day supply of methadone for bridge dosing is not feasible.
Naltrexone	4	5-6	5	The guidelines do not address treatment of pregnant women using opioids. This is extremely important. There should be a whole section on maintaining pregnant women on methadone, inducting women on buprenorphine, and maintaining women on buprenorphine. There should strict guidelines on consultation with a perinatal addiction expert to transition a pregnant woman from methadone to bupe and to manage dosing as delivery approaches and postpartum. This is a highly specialized and risky clinical situation that is NOT uncommon to prisons and jails.	Agree

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
Impairment	5	10	4	Note that "nodding off" can occur when peak blood levels of methadone are achieved and are NOT always indicative of impairment or too high of a dose. Some patients have more rapid methadone metabolism, and do better with split doses. Also dosing times can be changed to avoid this phenomenon during group treatment and such. The Hub providers have more experience with this and can be a resource. It is important to manage this situation as is can be a trigger for other patients and can create a negative situation for the patient.	Agree
Buprenorphine or Methadone Discontinuation	6	10	General	Again, be careful here that the policy reflects how other chronic conditions are addressed and that custody is appropriately involved in designing behavior plans.	Agree
Buprenorphine or Methadone Discontinuation: Buprenorphine	7	10	General	I recommend that DOC consider requiring that the patient be educated and sign something that indicates understanding of the risk of death from overdose when MAT is discontinued	Agree
Peri-operative Management of Buprenorphine	8	12	General	Great to address this. However, I think Centurion should require that a credentialed pain management specialist be consulted in this circumstance. This is a highly specialized area with significant consequence if done poorly	MAT team will discuss.
	Dr. Sanchit Maruti w/Jackson, Goedde, Mahler				
Evaluation	1	1	1st	Change: "Patients that screen positive for the evidence of a substance use disorder" to: "Patients that screen positive for a substance use substance use disorder"	Agree

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
Evaluation	2	1	4th, then 6th	Change: "Physical exam findings (Clinical Opiate Withdrawal Scale (COWS) assessment, pupil diameter, diaphoresis, tremor, track marks)" "Physical exam findings (Clinical Opiate Withdrawal Scale (COWS) assessment, track marks)"	Agree
VCMAT Treatment Requirements	3	2	General	COWS includes those things above, it's redundant (Also suggested eliminating the "V" from "VCMAT"	Agree
VCMAT Treatment Requirements	4	2	3rd bullet, add after 4th:	Medication is not diverted to any other individual	MAT team will discuss.
VCMAT Treatment Modalities: Buprenorphine	5	2	1	Is there a reason to not give the dual product, buprenorphine naloxone right from the start? This would significantly decrease the risk of diversion and misuse.	MAT Team has discussed. Can review again if needed with MAT team
VCMAT Treatment Modalities: Buprenorphine	6	2	4th, then 1st	In a supervised setting, I think 12 hours could be fine for short-acting, provided there are sufficient withdrawal symptoms (e.g. COWS 8 or more). We use this time frame for inpatients in the medical center. It's not clear to me here that COWS scoring is part of the protocol, and I would recommend adding it if not.	MAT team will discuss.
VCMAT Treatment Modalities: Naltrexone	7	5	5	Why 7 days prior to release and not the day before or day of release?	Agree
VCMAT Treatment Modalities: Drug Screening	8	5	1	Would it be possible to do a higher percentage? We hear a lot of people saying how common it is to access substances in jail. 20% chance per month is pretty low likelihood of being screened.	Will discuss with MAT team. Substance abuse patterns in correctional facilities are probably different from the community, and conventional POC drug testing only looks for conventional drugs (e.g. methadone, buprenorphine, amphetamines, benzodiazepines, cocaine, opiates). It has been rare that a patient's drug screen, other than at entry to the correctional system, comes back positive for anything other than buprenorphine. There coud be sevetal reasons for this: a) the cutoffs on our POC tests are inadequate to detect the amount of illicit substances being consumed in our facilities, and/or b) the substance abuse patterns in Vermont facilities are different and a new correctional drug panel needs to be developed. c) the major drug (s) of abuse withinthe facility is buprenorphine

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
VCMAT Treatment Non-Adherence	9	7	2. Creating an Unsafe Treating Environment, e.	I'm not sure about this provision. Seems like it means they would automatically be put back on the medication. Would need some sort of treatment agreement first it seems.	Agree
VCMAT Treatment Non-Adherence: 4.Non-adherence with ordered drug screens	10	8	4, d.	Maybe it's purposeful, but this whole section is quite vague. Gives the team a lot of leeway to decide what to do, but more specifics may lead to less stress and disagreement between team members or disagreement between provider and client when the hard decisions come up.	MAT team will discuss
VCMAT Treatment Non-Adherence: 5.Non-adherence with DOC medication administration protocols	11	8	5.a.iii	Jackson: Almost all programs terminate treatment in the case of diversion. They may want to have stronger language here. Goedde: It might be worth specifying naltrexone as a preferred option in these cases, if the indication for MAT still appears valid.	MAT team will discusss
Treatment Adjustment	12	9	3	These are good parameters.	Thank you
Buprenorphone or Methadone Discontinuation	13	10	Bupe, 2b	I would consider including switch to naltrexone as at least an option here, in preference to just stopping MAT, unless the diagnosis of opioid use disorder is no longer thought valid. Also, change: "further instances of diversion will not be tolerated" to "Further instances of diversion will result in discontinuation of MAT."	Agree
Peri-operative Management of Buprenorphine	14	11	Bupe, 2nd to last bullet	JP: And in addition to this the total daily dose being increased temporarily is an option rather than stopping buprenorphine and starting short acting full opioid agonists. GM: Increasing by up to 50% for brief periods is our standard protocol.	MAT team will discuss.
COWS Assessment	15	17	Day 1, Max Dose	JP:Most places use COWS >8 as a baseline, though decision for induction can be made case be case if score is lower. GM: I2 mg as a maximum first day dose is going to leave many people uncomfortable, especially if they aren't seen again until day 3.	Agree. 2mg was and is the right place to start for those patients who have been incarcerated for some time before Act 176 went into effect. In the case of persistent detox symptoms, our providers are contacted and can increase the dose further if medically neccessary.
	Dr. Kaldany				
	No Comments				

	POLICY: Medication-Assisted Treatment Program				
	COMMENT SHEET				
	Comment #:	**Page #**	**Bullet #**	**Comment**	**Response**
	Faye Taxman				
	No Comments				
General Comments:	1. Check all indentations and outline numbers/letters for re-formatting after editing. 2. Choose to capitalize or not: hub (standardize)				Agree
Nursing Protocol	This needs to address documentation in medical recoprd of Hub dosing of methadone. Recommend that Centurion nurse notes that med was given by Hub on the MAR. Essential to avoid double dosing during bridge dosing and to assure the record contains full account of meds taken by patient. Also needs to address nursing role in managing pregnant women with OUDs This doesn't address the forms of buprenorphine to be used or the medication line practices to minimize diversion. Should be codified.				Agree

Centurion of Vermont Clinical Guidelines
Medication Assisted Treatment (MAT)
COMMENT SHEET

Section	Comment #:	Page #	Line #	Comment	Response
				Dr. Jaimie Meyer	
A. Background	1	2	35	These categories are based on DSM IV, which has been replaced by DSM V. So clinically we talk instead now about "moderate to severe substance use disorder" rather than "dependence or abuse".	This is a paraphrase from the cited studies, hence the wording. Will change if able.
A. Background	2	3	43	Might say instead that the criminal justice system must adopt community best-practice standards for managing opioid use disorder, which includes medications (buprenorphine, methadone, naltrexone) and has demonstrated benefits for health outcomes.	Agree
B. Standard	3	3	6-7	This makes it seem as if it is "opt in"- people need to be aware of their options and actively request treatment…as opposed to OFFERING treatment to everyone with diagnosed opioid use disorder.	Agree
B. Standard	4	3	11	With a treatment plan tailored to patient need and other clinical factors	Agree
B. STANDARD, ADHERENCE INDICATORS:	5	4	17	What does this mean? Having received training or certification in addiction medicine? Can define this somewhere.	Agree. Based on our model of care in VT DOC, we would clarify that that our providers have received training to engage in office-based treatment of opioid use disorder (the x-license training, needed to prescribe buprenorphine)
B. STANDARD, ADHERENCE INDICATORS:	6	4	Section 1., line18	All Substances? Or just Opioids?	Agree. At this time our mission is to treat OUD. Will change language to opioids.
B. STANDARD, ADHERENCE INDICATORS:	7	4	Section 1, line 19	A urine drug screen will only tell you about extremely recent use of some substances, and clears at different times depending on people's kidney/liver function and the substance. The bigger question I guess is what will you do with this information? How is it helpful? If "current inmates" request MAT and have a Utox positive for substances, are there tickets or other criminal sanctions? If new intakes have negative Utoxes are they denied MAT?	For each patient, we look at the whole picture, the drug screens included. A negative drug screen does not automatically mean denial of MAT. The VCMAT case managers build relations with patients with the aim of no one being inadvertently being missed. Drug-related

Centurion of Vermont Clinical Guidelines
Medication Assisted Treatment (MAT)
COMMENT SHEET

	Comment #:	Page #	Line #	Comment	Response
B. STANDARD, ADHERENCE INDICATORS:	8	4	Section 2, line 26	Which one? (which standardized tool)	Item 4 should be rephrased to stated that a validated assessment tool will be utilized to help diagnose OUD. At this time we use the TCU
B. STANDARD, ADHERENCE INDICATORS:	9	4	Section 2, line 30	Requiring Narcan or just receiving a prescription for it (as a preventive measure)? AND Does this include ED visits?	Item 4 refers to treatment of an overdose, which is typically done with narcan. If community records convey a prescription for narcan, we will examine the record for details.. ED visits are included
B. STANDARD, ADHERENCE INDICATORS:	10	4	35	Do you need to meet all of these criteria to receive MAT? Or are these just factors that are incorporated into the ultimate decision?	The section states, "The following information may be reviewed in making the diagnosis of opioid use disorder." these are data points used to come to a decision. We are open to re-evaluating a patient's clincal appropriateness/medical neccesity for the MAT program
B. STANDARD, ADHERENCE INDICATORS:	11	5	2	Just note that most PMP systems (I'm not sure about Vermont) will only show prior scripts for buprenorphine, not methadone or naltrexone.	The Vermont PMP will show prescriptions for buprenorphine Spokes and pain clinics, and methadone from PCPs and pain clinics (which can only be prescribed for the indication for pain by non-OTPs). Any
B. STANDARD, ADHERENCE INDICATORS:	12	5	15, #5	And following standardized clinical guidelines	Agree
B. STANDARD, ADHERENCE INDICATORS:	13	5	18	What do you mean by this [assessment]?	Centurion is not clear what is meant in this comment and has sought clarification. Based on the data points from #4 of the adherence indicators, the medical provider will be able to determine if the patient has

Centurion of Vermont Clinical Guidelines
Medication Assisted Treatment (MAT)
COMMENT SHEET

	Comment #:	Page #	Line #	Comment	Response
B. STANDARD, ADHERENCE INDICATORS:	14	5	line 21-25, #6	Could be reworded for clarification like this: If a patient who is receiving MAT (in the community or in the DOC?) decides to stop doing so, they will be appropriately tapered as per clinical guidelines. If the patient later wishes to resume MAT, s/he must be seen by a qualified health professional who will assess the patient clinically and document the final decision about whether or not to resume MAT in the medical record.	Agree
B. STANDARD, ADHERENCE INDICATORS:	15	5	line 27, #7	Meaning a patient who was previously on MAT in the DOC who returned to the community and then was subsequently back in? If so would make that clear- otherwise it seems to be the same as someone who is incarcerated for the first time.	Agree
B. STANDARD, ADHERENCE INDICATORS:	16	5	line 29 #7a and b	Is there any particular time period someone needs to be engaged? Also change "care continuation" in 7b to "re-initiation"	At this time there is no time period. Obtaining Community based treatment records, whether there was a lapse in treatment or not, will aleays be attempted so that a complete assessment is conducted. Agree with change of wording
Standard	17	6	6	Change: "All patients who will continue community based treatment or be initiated for treatment of opioid use disorder" to: "All patients who (at the point of incarceration are enrolled in a community based treatment or who are appropriate for and consent to initiation of treatment of opioid use disorder"	Agree
Standard	18	6	line 18, #3	Change: "3.Participant in the VCMAT program, the patient has an Opioid Use Disorder (OUD)" to "Diagnosis of an Opioid Use Disorder (OUD),"	The intent of this item is to require that patients adhere to a CIC visit every 90 days.

Centurion of Vermont Clinical Guidelines
Medication Assisted Treatment (MAT)
COMMENT SHEET

	Comment #:	Page #	Line #	Comment	Response
Standard	19	6	line 28, #5	This can be challenging during induction or if patients are underdosed as irritability, and impulsivity are indications of withdrawal. May need to think of an alternative way to word this.	MAT workgroup will consider.
Standard	20	7	6	Physical or psychiatric or both? [re: impairment]	Both
Standard	21	7	line 20 #4	I'm not sure this blanket statement makes sense. Doesn't it matter what type of impairment? Could say instead that the on-call provider will be immediately contacted for further instructions, including whether or not the next dose of buprenorphine should be held. [re: Physical or psychiatric or both? [re: impairment "the dose of buprenorphine will be held"]	Agree with the rephrasing
Standard	22	7	20-21	[Also re: "the dose of buprenorphine will be held"]: The strategy for managing impairment may differ between buprenorphine and methadone	As above, agree with changing the phrase to, "the on-call provider will be immediately contacted for further instructions"
Standard	23	8	21, 1c.	I put this in but then I realized maybe you define diversion differently? Attempt to divert like concealing medications during directly observed therapy? Regardless, would define it clearly here.: Change: "c.Patients who are identified as diverting MAT medications " to "c.Patients who are identified as diverting MAT (defined as distributing MAT to others),"	MAT work group will consider.

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	Comment #:	Page #	Line #	Comment	Response
Standard	24	8	21	[Entire document, but particularly and starting in section STANDARDS, items 1, 2, and 3., there are many word and grammar edits by the author. i.e. Change "MAT medications" to "MAT," wherever it appears; changing "drug screening" to "Utox" or Utox screen, change "compliant" to adherent" etc. Please see document for reference.]	MAT work group will consider.
Standard: 5. Non-adherence with DOC medication administration protocols	25	9	22-23, 4th bullet	[re: treating compassionately:] This is so kind! But would be explicit about the expectations that this means providing medications to treat the symptoms of opioid withdrawal.	Agreed
Standard: 5. Non-adherence with DOC medication administration protocols	26	9	27, 6th bullet	re: "VCMAT Director will determine whether the patient may be re-inducted": What are these determinations based on? Discretion/clinical judgment or something else?	The determination will be based on the global picture for the patient. Has the patient shown any dedication towards recovery by attending groups? Release date? Prior diversions? Etc.
Standard	27	10	24	Does this mean if they are released on an alternate date before the reentry plan can be documented or if they forget their paperwork?	We will edit point #3. It means the former (released on an alternate date before the reentry plan can be documented)
Standard	28	11	2	providers in VT have expressed concern that sometimes people are released from incarceration without an ID – maybe driver's license is no longer valid, ID is not in their possession when incarcerated, etc. A photo ID is required for admission to community MAT – perhaps this packet should contain at least a temporary ID – name with photo, DOB would be accepted by most providers.	This is a great idea and is being addressed by DOC

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Standard	29	11	Item 5d.	Is this covered by the DOC or is it expected that people will be able to fill it at their community pharmacy on release and have it covered by insurance? I'm wondering what happens with insurance gaps post-release and issues with having official picture ID (to retrieve controlled substances)	Covered by medicaid or other insurer. Provision of a DOC Picture ID is in process.
Standard	30	12	Item 2a	Is there a policy somewhere about who is qualified to witness collection? Medical staff or custody staff? Gender concordant? Also, delete "to check for compliance."	MAT work group will consider. Will delete "to check for compliance"
Standard	31	12	Item #4	Change: "4.Patients who test positive will be scheduled for UDS screens 1x per 30 days, for 90 days. Refusal of a UDS will be considered a positive screen." to "Patients who have a positive Utox will be scheduled for UDS screens at least once per 30 days, for 90 days or as clinically indicated. Refusal of a UDS will be considered a positive screen."	Agree
Standard	32	12	item #6	Perhaps could note here that… A positive Utox is not an indicator for punishment but rather an opportunity to identify gaps in and improve treatment plans (for example modifying doses of MAT, increasing behavioral supports, etc.)	Agree fully with the spirit of this comment. See Policy E, #3. language can be clarified to reflect this comment.
Standard	33	13	Item #7	Alternative treatment Program: "What does this entail?"	It is a treatment plan tailored to the patient. As an example: s/he/they needs to be switched to a different medication modality, or behavioral interventions need to be increased.
Standard	34	12	Item #8	But isn't VCMAT embedded in DOC? Do you mean DOC facility administration? Or custody staff?	At the writing of these documents, all health services are provided by a Centurion, a contractor. This includes the delivery of MAT and related services.

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	Comment #:	Page #	Line #	Comment	Response
Standard	35	12	Item #10	Re: "CIC:" "Would define Sorry not familiar with this term"	CIC is a chronic illness clinic/visit with a provider for a chronic disease such as diabetes, hypertension, opioid use disorder, etc.
TCU Drug Screen	36	15	5	The current admission to a facility or intake or incarceration	It states "before being locked up", referring to prior to incarceration. I would like to ensure that this is clearly delineated for patients.
TCU Drug Screen	37	16	25	RE: "Prescription Medications"Does it distinguish somewhere if taken in different ways than prescribed or not prescribed to you?	Currently the TCU Drug Screen 5 Opioid Supplementalis used. Question 2 on that form asks about IV use. Question 3 asks about use of an opioid in other ways. Adding this question to the assessment process can be considered.
	Dr. Christopher Lukonis				
Adherence Indicators	1	5	Item 4e	Redundant with COWS	Agree
Standard	2	6	Item 5	Re: "Respectfully:" Again, not sure what this means. You can no doubt expect to be treating some people who you are not fond of, but it may be the best for them.	Agree. This langauge choice is meant to ensure that health services staff are protected from verbal abuse and other concerning behavior. If an imate/patient is disruptive, it may not not universally mean removal from the program, but the behavior will need to be addressed.

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	Comment #:	Page #	Line #	Comment	Response
Standard	3	8	1a	"See previous comments" [?]	Comment as above, though the wording in section 1a needs to be edited. Inmates/patients are not universally removed from the program for unwanted behavior. Rather, the behavior is reviewed with the MAT Medical Director who decides how the incident is managed/ behavior is addressed.
Standard	4	8	1f	Add language. To: "...will be assisted in connecting with a community HUB" ADD: "or Spoke if appropriate"	Agree
Standard: 5. Non-adherence with DOC medication administration protocols	5	9	5a, 4th bullet	Change: "Patients who have their MAT medication discontinued due to diversion will be treated compassionately with non-opioid medications." to: " Patients who have their MAT medication discontinued due to diversion will be treated compassionately with non-opioid and/or opioid medications at the discretion of medical staff."	Qualified medical providers make all determintations. The Medical Director has decided to provide non-opioid meds when discontinuing MAT meds for several reasons: (1) there have been many incidents where patients were diverting during their taper (2) it is difficult to determine how long a patient has been diverting, and then 3. what dose the medical provider would decide the inmate/patient was actually taking....ie too hard to kow if they are taking 2mg/day or their entire dose of, say , 16mg/day. All policies and procedures will be and are reviewed and ammended as per the standard of care and evidence.

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Attachments	6	10	re: HUBS	Although I appreciate that DOC favors protocols with strict guidelines, the decision to discharge a patient on Suboxone to only Hubs may have unintended negative consequences. First, it may not be possible for patients to get there for daily dosing in terms of transportation. Second, it may put patients in contact with patients in tenuous phases of recovery as compared to a regular Spoke office. Third, the requirements of daily dosing may prevent a patient from returning to gainful employment. I would suggest that the MAT team consider placement individually for patients in a person-centered manner. For example, someone incarcerated for recent drug distribution or prescription diversion may best be served in a Hub. However, someone incarcerated for non-drug charges with good structure in place upon release may be appropriate to transfer to a Spoke or Super Spoke if the accepting provider is willing to accept them.	Agree.
Standard	7	8	5d	In terms of bridge prescriptions when transferring to the Hub, such is not necessary. Hubs may accept patients for daily dosing upon transfer even before the doctor sees the patient, on buprenorphine or methadone.	Agree. As long as the Hub has received proper notification to receive authorization from the Hub Medical Director.
Standard	7	8	3d	These terms are the acceptable ones to use now. I suggest changing throughout the document. See example below too. Change language: Instead of "adherent" or "non-adherent, use "expected" or "unexpected." [Also, replace language in item #6]	MAT work group will consider.
				Dr. John Brooklyn	
Standard	1	8	general	Non adherence policy must imply "that medical provider will be contacted" for any of the situations so it is not done in a vacuum	Agree.
				Dr. Nels Kloster	
Standard	1	6	Item #3	I'd delete the sentence "Participant in the VCMAT.....illness." Doesn't match the format.	Dr. Kloster is referring to #4 in Section C. Agree that it needs to be re-worded accordingly.
Standard	2	6	Item E	Middle of STANDARD paragraph, "exist" not "exists". 2. second line "identify" not "identifying"	Agree

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	Comment #:	Page #	Line #	Comment	Response
Standard	3	9	Item F	Should there be some mention differentiating methadone and bup? You can't prescribe bup or methadone for a transferring methadone patient.	Agree
Standard	4	12	Item G	I would add temperature range again.	MAT work group will consider.
Standard	5	23	Item G	Attachment E, p.2 should be "COWS" not "COW"	Agree
Standard	6	24	Attachment F	Do you want to include BAC as part of impairment assessment?	Agree
				Dr. Alvarez	
B. Standard	1	3	line 18-21	No mention of availability Naltrexone IM upon release	Agree. This is in process with Alkermes.
B. Standard	2	6	Item 4c	What is the plan for dialysis pats who cannot produce urine?	Agree. An alternate testing strategy would be explored.
Standard	3	7	Item 4, line 20	Methadone not listed	Agree

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	Comment #:	Page #	Line #	Comment	Response
TCU Drug Screen	4	15	Attachment B	Fentanyl is not included in ite 12. (sic, per Annie)	Agree. MAT work group will consider.
TCU Drug Screen	5	16	General	Patient education should include warning about sharing straws	Agree.
TCU Drug Screen	6	19	Item #15	Do VT inmates understand/know what MAT is/means?	Agree. A MAT patient FAQ is provided to patients at entry. Facility level MAT case managers will also provide patient education about MAT
				Donna Strugar/Fritsch	
General	1	All	All	Policy needs to address the timing of assessment at intake and a standard during which the MAT will be initiated. Very important. This caused a big problem in Rhode Island's early days, as the patients were not able to get buprenorphine till about the end of the third day at which point they were in full blown withdrawal. Optimally, the MAT dose should be available for dosing no later than 24 hours of booking Also, consider a policy in which prisoners coming from jails on MAT give the DOC 5 days notice with all the clinical information, so the transfer can be planned in advance and the methadone or buprenorphine is available when prisoner arrives. Policy should also specify which forms of buprenorphine are to be used (sublingual film, sublingual tabs, buccal, etc) and the precise medication line practices to be used to minimize diversion., including the role of custody or another health care person to do the mouth checks. Perhaps this is a separate policy, but it absolutely need to be codified and addressed. There should also be a mechanism for quantifying the instances of attempted diversion of all MAT meds (and really ALL meds) that is subject to inter-disciplinary review and action on a regular basis. Essential to measure the problem and target actions to address it where it is occurring.	Agree. The MAT work group will discuss further.
B. Standard	2	4	B.d.	Evidence-based BH services for SUD	Agree

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B. Standard	3	4	line 19	These may be different providers	Yes
B. Standard	4	4	line 20	Not clear - paper prescription, or a few days/weeks worth of actual medication? Very important distinction	This question does not match up to the P& P currently being used since the initiation of the Peer Review Provcess. This has been clarified already and a prescription is called in to the inmate/patient's pharmacy of choice to bridge their dose until the patient's community appointment. At discharge they are provided the appointment date/time and a last dose letter.
Policy No. C	5	7	General	The policies do not address treatment of pregnant women using opioids. This is extremely important. There should be a whole section on maintaining pregnant women on methadone, inducting women on buprenorphine, and maintaining women on buprenorphine. There should strict guidelines on consultation with a perinatal addiction expert to transition a pregnant woman from methadone to bupe and to manage dosing as delivery approaches and postpartum. This is a highly specialized and risky clinical situation that is NOT uncommon to prisons and jails Policies should also specify patient education content on OUD, MAT options, overdose risk, "truths" about diversion of meds (i.e., buprenorphine SL is destroyed by stomach acid and has no value if regurgitated, how the naltrexone in Suboxone works, etc. Should specify who provides the training (peers are the best), when, and where.	Agree
Standard	6	10	No. E	Need to be careful here - removal from treatment should mirror what you would do if someone was diverting a psych med or an asthma med. Also, need to have a means to involve custody in determining how to handle this. Consider that terminiating treatment significantly increases risk of overdose death	MAT work group will consider.
Standard	7	14	No. G, line 17	Excellent - so glad to see this included	
Dr. Sanchit Maruti w/Jackson, Goedde, Mahler					

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	Comment #:	Page #	Line #	Comment	Response
Adherence Indicators	1	5	Item #6, lines 17-21	Language change: "When a patient has stopped taking the MAT prescription by request and later decides that s/he would like to be back on the prescription, the patient must be seen by a buprenorphine-waivered pMAT Provider or a non-waivered provider who consults with the MAT On-call provider. The determination will be documented in the medical record." to "When a patient has stopped taking the MAT prescription by request and later decides that s/he would like to resume MAT, the patient must be seen by a buprenorphine-waivered MAT Provider or a non-waivered provider who consults with the on-call MAT provider. The determination will be documented in the medical record."	Agree
Adherence Indicators	2				
Adherence Indicators	3				
	Dr. Kaldany				
	No Comments				
	Faye Taxman				
	No Comments				