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Under the current national health emergency, the federal government has relaxed federal guidelines relating to MAT take home medications to reduce exposure to COVID-19. The changes are designed and intended to reduce the risk of exposure for MAT patients, staff and the public. Under the new guidance, HUBs may provide all stable patients with 28 days of take-home doses of the patient's medication for opioid use disorder. Hubs may also provide 14 days of take-home medication for those patients who are less stable but who the Hub believes can safely handle this level of take-home medication. The federal guidance says that clinical stability and ability to safely manage medication must be determined by the clinical team and documented in the patient's medical record.

This committee heard testimony earlier this week from Bob Bick of the Howard Center that the Hub in Burlington continues to see about 200 patients a day in person. Many Hub patients across Vermont are still required to travel to a Hub daily or every other day to get a medication they rely on to survive. Many do not own cars and rely on shared rides or public transportation or travel on foot. Many have underlying health conditions (many such conditions, like hepatitis C, are more common in this population). Many have children they must bring with them. When they arrive, they are often not provided with gloves or masks, and the Hub staff often do not wear gloves or masks either. Dosing hours are limited, so many patients arrive at the same time.

I spend a lot of my time these days talking to people living with opioid use disorder and their families. What I hear is fear, and a deep sense of helplessness –of not having any way to control the systems that are putting them or their loved one at unnecessary risk of severe illness and death.

We should look for ways to further reduce the number of patients who are being forced to expose themselves and their loved ones to increased risk of contracting COVID-19 in order to continue treatment for their other life-threatening health condition, opioid use disorder. We should do this for them, for the clinic staff and the public.

One suggestion is to require that patients be provided with masks and gloves prior to entering the Hub.

Another suggestion is to create a presumption or expectation that all Hub patients be given 28 days of take-home medication, and that Hubs be required to document in the medical record:

- First, a specific, individualized factual basis for denying the maximum allowable take homes under federal guidelines (that is, require documentation of a specific, not theoretical basis for a determination that the patient is so clinically unstable or their ability to safely manage medication is so clinically compromised that they should be limited in the number of take home doses below the 28 day baseline
- Second, require the Hubs to take steps to actively address clinical instability and enhance the ability to safely manage medication in an ongoing and timely manner, and document those efforts in the clinical record
- Third, require Hubs to reassess eligibility for increased take homes frequently (at least weekly) and update the clinical record

The legislature could charge the Vermont Department of Health with implementing quality assurance measures to make sure Hub patients are only denied maximum access to take homes as a last resort and then only as briefly as possible.

The other recommendation I have relates to MAT in correctional facilities. MAT patients in correctional facilities continue to report to me that they are required to sit "elbow to elbow" in a row with other patients while they receive their MAT dose. I recommend that for the duration of the public health emergency, incarcerated patients are dosed individually, in their cells, as has often been done for other medications.

I also have some thoughts about COVID-19 as related to incarcerated individuals:

The document *COVID-19 Guidelines – Release of Incarcerated Individuals* released by DOC this week suggests that the Department does not believe it has the legal authority to release individuals due to enhanced COVID-19 risks factors including age and underlying health

conditions unless an individual is already "incapacitated by illness to the extent that they are physically incapable of presenting a public danger." The document does not appear to list age or underlying health conditions as factors the Department is currently considering in determining eligibility for release (although they may be).

I recommend that legislators consider implementing a special COVID-19 medical furlough that permits the release of individual at enhance risk of COVID-related death unless they pose a "specific, not theoretical, threat to public safety" –a phrase used by the Attorney General's recommended guidance regarding incarceration decisions during the COVID-19 emergency that should also apply in this context.

I also recommend that legislators consider giving the Department of Corrections guidance by creating a presumption of release for specific categories of incarcerated individuals, and require the Department to document an actual, not theoretical risk to public safety if release is denied in an individual case. Categories of incarcerated individuals presumed eligible for immediate release should include:

- those held for lack of residence (if DOC pays for the initial night in a motel room, my understanding is that the person would then be eligible for a continued motel stay through Economic Services while community based providers assist with longer term housing)(many incarcerated people say they could obtain housing in the community once released, but have trouble making calls and arrangements through case workers in the facility)
- those who are past their minimum sentences
- those who are within their six-month window prior to reaching their minimum sentence (or better, expand the usual six-month month window to one year or 18 months)
- those who are particularly medically vulnerable

Although the Department has been evaluating incarcerated individuals for release, that process has been taking weeks in many cases. One option would be to surge resources to urgently identify incarcerated people who can be safely released to the community. There is broad consensus that quickly reducing incarcerated populations is an important step to slow

COVID-19 and prevent mass outbreaks in the close quarters of correctional facilities that spill over into all Vermont communities. The goal should be to reduce numbers at least to the point that each incarcerated person has their own cell. Currently, many remain unnecessarily incarcerated, putting public health at risk.

Vermont Public Radio has spoken to incarcerated individuals in a number of Vermont prisons and documented an ongoing lack of consistent access to soap, paper towels, alcohol-based hand sanitizer and bleach-based cleaning products for cleaning the kitchen and other common areas as well as individual cells. It may be helpful to explore why this issue continues to persist "on the ground" in facilities despite Department efforts to address the problem.

Vermont Public Radio also documented that incarcerated individuals are also still being forced to eat in close quarters in "chow halls" often containing 50 to 100 or more people. I have heard similar reports that people are waiting in food lines close together and sitting with their cafeteria trays "two inches apart." People say they are still often being given recreation in the gym instead of outside (which most prefer as safer), and that outside recreation is often cancelled up to "half the time" at the Newport facility (and often limited to the upper yard where people have limited ability to distance). Perhaps individuals could be given the option to take some of their meals in their cells? This would help reduce large gatherings and allow more voluntary social distancing. My understanding is that taking meals in cells is often mandatory during flu outbreaks in Vermont prisons.