Vermont DOC Medication-Assisted Treatment (MAT) Program

Clinical Guidelines

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Treatment guidelines do not apply to all patients. Please use your clinical judgment, and always document the clinical rationale for your treatment decisions.

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MAT PROGRAM ADMISSION

All patients with Opioid Use Disorder (OUD) will be admitted to the Vermont DOC Medication-Assisted Treatment (MAT) Program, and will receive treatment for as long as medically necessary, in accordance with Vermont Act 176 and evidence-based best practices.

Continuation of MAT from the community

1. All patients with a history of OUD and in active community treatment, verified with the community provider/pharmacy, will be admitted to the MAT Program for continuation of their treatment modality (buprenorphine, methadone, naltrexone, and/or evidence-based behavioral health services for substance use disorder).

Assessment of new and current inmates seeking MAT

1. All new individuals coming into Vermont correctional facilities are assessed at entry using a validated screening tool for substance use disorders based on DSM-5 criteria. All current inmates seeking treatment for OUD can request an assessment via the established sick-call process and will be given the same validated screening tool. If the screening tool is positive for opioids, further history is collected and reviewed by a MAT medical provider. MAT medical providers diagnose OUD and determine appropriate treatment.

DIAGNOSIS OF OPIOID USE DISORDER

Diagnosis of OUD is based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). OUD is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following criteria, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. a need for markedly increased amounts of opioids to achieve intoxication or desired effect;
    b. markedly diminished effect with continued use of the same amount of an opioid.
11. Withdrawal, as manifested by either of the following:
    a. the characteristic opioid withdrawal syndrome;
    b. the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms.

"Yes" response to items 1-9: 1 point
"Yes" response to 10a and/or 10b: 1 point total for question 10
"Yes" response to 11a and/or 11b: 1 point total for question 11

Opioid Use Disorder Severity Definitions

The validated assessment tool currently being used in our system to evaluate an inmate for the presence of DSM-5 criteria is the TCU-5. The score on the TCU-5 translates to an equal score on the DSM-5. Both correspond to the following OUD severity definitions:

1. Mild Opioid Use Disorder: Presence of 2-3 symptoms (score of 2-3)
2. Moderate Opioid Use Disorder: Presence of 4-5 symptoms (score of 4-5)
3. Severe Opioid Use Disorder: Presence of 6 or more symptoms (score of 6 or more)

CLINICAL ASSESSMENT

The following information is reviewed by the MAT medical provider in making the diagnosis of opioid use disorder and determining appropriate treatment:

1. Patient meets criteria for the diagnosis of mild/moderate/severe opioid use disorder, based on DSM-5 diagnostic criteria and scoring.
2. Evidence of current or past opioid use through UDS records (i.e., positive urine toxicology screen for opiates, oxycodone, fentanyl, buprenorphine, and/or methadone).
3. Community health records supporting or verifying the diagnosis of OUD and/or treatment of OUD and/or related complications, including treatment for an opioid-related overdose.
4. Vermont Prescription Monitoring System (VPMS) and other prescription records convey a history of OUD and/or treatment.
5. Physical exam findings supporting the diagnosis of OUD, such as active opioid withdrawal or physical evidence of recent injection (e.g. Clinical Opiate Withdrawal Scale (COWS), track marks).
6. Drug-related criminal charges related to opioid use, correctional disciplinary reports related to opioid use, loss of facility jobs or removal from facility programming due to opioid use.

MAT PROGRAM TREATMENT REQUIREMENTS

Participation in the MAT Program required adherence to the following:

1. Sign the MAT Patient Agreement.
2. Sign the Informed Consent for Buprenorphine, if appropriate.
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. Engagement with the individualized treatment plan, including:
    a. Attendance at dosing and all scheduled appointments.
    b. Engagement with evidence-based behavioral health services for substance use disorder, if elected or if part of treatment plan.
    c. Provide urine drug screens when requested.
5. The MAT medication is taken as prescribed and in accordance with the medication administration procedure.

TREATMENT

All patients with a diagnosis of OUD will be offered treatment for as long as medically necessary. Treatment will consist of the following modalities:

1. Buprenorphine
2. Methadone
3. Naltrexone
4. Evidence-based behavioral health services for substance use disorder

For clinical guidance, MAT Medical Providers can refer to the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.

1. Medical providers take multiple factors into account when deciding which modality to use in a given case, including the patient's medication preference and motivation for change, the severity of opioid use, other substances used in conjunction with opioids, co-occurring psychiatric and medical conditions, prior history and response to MAT, and currently prescribed medications.

2. For moderate to severe OUD, treatment with first-line medications (buprenorphine, methadone, extended-release naltrexone) is recommended. Shared decision-making between the medical provider and patient is critical. While oral naltrexone is not superior to placebo in treatment retention or preventing illicit opioid use, it is helpful in transitioning to extended-release naltrexone, which may be offered 7 days prior to release.

3. Evidence-based behavioral health services for substance use disorder are offered in conjunction with first-line medications, but will not be required to receive first-line medications.

4. Evidence-based behavioral health services for substance use disorder alone, or in conjunction with oral naltrexone, may be indicated if a patient has a mild opioid use disorder, has a history of prior success using this modality alone, is highly motivated for treatment and has good premorbid function, or if the patient has a strong preference for psychosocial treatment despite education on the superior efficacy of the first-line medications. Shared decision-making between the medical provider and patient is critical.

Buprenorphine

1. For clinical guidance, MAT Medical Providers can refer to the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.

2. A patient must be seen face-to-face (i.e. in person or via telehealth) by a buprenorphine-waivered provider for all new buprenorphine inductions.

3. The on-call MAT Medical Providers will prescribe medications for withdrawal symptoms, if clinically appropriate, until the patient can be seen face-to-face for buprenorphine induction.

4. For patients with OUD in active treatment with buprenorphine in the community, The MAT Medical provider can continue the verified dose of buprenorphine, without a face-to-face appointment, up to the FDA-approved maximum dose of 24mg/day.
    a. The on-call buprenorphine-waivered provider can write for a covering community buprenorphine prescriptions for 30 days. After 30 days, a face-to-face visit with a buprenorphine-waivered medical provider is required to continue the prescription.

5. If a patient is on the subcutaneous injection form of buprenorphine in the community, the patient will be transitioned to sublingual buprenorphine while incarcerated.

6. The MAT Team will ensure that a Vermont Prescription Monitoring System (VPMS) query is completed and the findings documented in the medical record.

7. Patients initiated on buprenorphine during incarceration can be increased by facility medical providers up to a dose of 16mg, with the following exceptions:
    a. Authorization can be obtained from the MAT Medical Director for buprenorphine dose increases above 16mg/day, to a maximum of 24mg/day.
    b. Pregnant women on buprenorphine can have their dosage of buprenorphine increased above 16mg/day, not to exceed 24mg/day,

8. Requests for dose adjustments are initiated by the inmate by putting in a sick slip, and if non-acute, triaged by nursing to the MAT Team. The MAT Team will work with the inmate to fill out a Treatment Adjustment Form, which will be submitted to the waivered medical provider of record for evaluation and medication orders.

9. Per the MAT Care Coordination Policy (attached), re-entry coordination services will work to ensure the patient is able to continue treatment with buprenorphine upon release.

Methadone

1. For clinical guidance, MAT Medical Providers can refer to the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.

2. Patients with a verified methadone prescription at a Hub will be continued on their documented dose during their incarceration, as clinically appropriate.
    a. The patient's home Hub that originally generated the prescription will always be the prescriptive authority.
    b. If the inmate's home Hub is not proximal to the facility they are lodged in, guest dosing with the nearest Hub will be arranged.
    c. If the patient is moved to another facility:

i. Notify the home Hub so that they may facilitate new guest dosing documentation
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.

3. The MAT Program will obtain all pertinent records from the Home Hub, including the patient agreement and consent to treat.

4. The facility MAT medical provider will review and approve continuation of methadone dosing.
    a. If there are concerns about continuing methadone dosing (impaired state of an inmate, a UDS with benzodiazepines), the methadone dose will be held and the Hub Medical Director will be contacted for instructions.
    b. The MAT Medical Director will be notified.

5. Inmates for whom initiation with methadone is a medical necessity, as determined by the MAT Medical Director and the patient, the MAT Program will coordinate with a regional Hub for an evaluation.
    a. Reasons for Hub Referral for Treatment with Methadone:
        i. Persistent illicit opioid use while on buprenorphine 16mg SL daily.
        ii. Persistent opioid cravings despite being on buprenorphine 16mg SL daily.
        iii. Adverse reaction to buprenorphine, (e.g. vomiting, headache, edema, anaphylaxis, etc.).
        iv. History of persistent illicit opioid use while on buprenorphine, and/or prior treatment success with methadone.
        v. History of IV use of buprenorphine
        vi. History of diverting buprenorphine
        vii. History of OUD and co-occurring chronic pain, with failure to stabilize both with buprenorphine.
        viii. History of worsening of psychiatric co-morbidities with buprenorphine

6. Methadone dose adjustments are done by the home Hub. If an inmate on methadone has problems with their dose, they will submit a sick slip, the home Hub will be contacted, and pertinent requested information will be provided to them. An in-person, video, or telephone appointment will be facilitated if needed. Requested information may include:
    a. A pre-dose COWS assessment
    b. A new urine drug screen
    c. Details for the request for dose adjustment.

7. In response to a dose adjustment request, the expectation is that the correctional facility and patient receive clear documentation from the home Hub with their plan of action. As per Vermont law, any changes in medication must be caused into the record and also be provided orally and in writing to the inmate.

8. Per the MAT Care Coordination Policy (attached), re-entry coordination services will work to assure the patient is able to continue dosing at a community Hub upon release.

Naltrexone

1. For clinical guidance, MAT Medical Providers can refer to the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.

2. If a patient is on extended-release naltrexone in the community, the patient will be transitioned to oral naltrexone while incarcerated.

3. The patient may elect to transition to a naltrexone 380mg intramuscular injection 7 days prior to release, after LFTs have been checked.

4. Per the MAT Care Coordination Policy (attached), re-entry coordination services will work to ensure the patient is able to continue treatment with naltrexone upon release.

URINE DRUG SCREENING

Urine Drug Screening (UDS) is a required component of the Vermont DOC MAT Program.

1. All persons coming into correctional facilities will receive a UDS upon arrival in booking.
    a. If a patient reports no history of substance use, a UDS will still be done.
    b. If patient refuses an observed UDS upon arrival in booking, a refusal must be signed.

2. The MAT Team will conduct monthly random urine toxicology of no less than ten percent (10%) of the inmate population receiving MAT Medications.

3. Patients who have a positive UDS will be scheduled for UDS once per 30 days, for 90 days, or as clinically indicated. Refusal of a UDS will be considered a positive screen.

4. The UDS report will be forwarded to the Health Service Administrator with a copy sent to the MAT Medical Provider of record.

5. To protect patient confidentiality, the results of UDS along with patient-identifying information will not be shared with DOC. The MAT Program 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.

6. Patients who are on MAT who wish to continue it on release to the community will need to have a UDS completed within thirty days of release to adhere with Hub requirements.

7. 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.

TREATMENT CHALLENGES

If barriers to effective treatment arise, the MAT Team will meet with the patient for an evaluation, including a Functional Analysis (FA) and Cost-Benefit Analysis (CBA), which will be submitted to a MAT Medical Provider for review:

Unexpected Urine Drug Screen (UDS) result

1. The MAT Team will meet with the patient to document the reason for the unexpected UDS result, and complete an FA and CBA. The MAT Team will submit a Treatment Adjustment Form to the MAT Medical Provider, who may modify the individualized treatment plan.

Missed medical and dosing appointments

1. The MAT Team will meet with the patient to document the reason for the absence, and complete an FA and CBA. The MAT Team will submit a Treatment Adjustment Form. The MAT Medical Provider may modify the individualized treatment plan, particularly if there is a pattern of absences.

Suspected Diversion and Possession charges

1. Buprenorphine diversion reports from the MAT medline:
    a. The MAT Team will meet with the patient to complete an FA and CBA, discuss and document treatment implications, and submit a Treatment Adjustment Form.
    b. The MAT Medical Provider may modify the individual treatment plan. Medications for withdrawal symptoms will be offered with any dose reduction.
    c. In the event of multiple buprenorphine diversions (2 or more), the MAT Medical Provider will consult with the MAT Medical Director for referral to a higher level of care (the Hub) for treatment with methadone, or offering treatment with naltrexone.

2. Buprenorphine possession reports outside of the MAT medline:
    a. Possession charges convey instability. The MAT Team will meet with the patient for an FA and CBA, and discuss and document treatment implications.
    b. The MAT Medical Provider will be contacted to optimize the individual treatment plan. The medication may need to be changed if the behavior persists.

3. Methadone diversions from the MAT medline, and methadone possession charges:
    a. The MAT Team will meet with the patient for an FA and CBA, discuss and document treatment implications, and submit a Treatment Adjustment Form to the MAT Medical Director.
    b. The MAT Team submits the DR report, FA and CBA to the home Hub Medical Director. The MAT Team facilitates an in-person, video, or telephone appointment between the patient and the home Hub Medical Provider.
    c. If the Hub elects to taper the patient from methadone, they will provide the taper schedule and medications. Medications for withdrawal symptoms will be offered by the MAT Program. Treatment with naltrexone will be offered. Criteria for re-induction with methadone prior to release will be discussed with the Hub.

Threatening or aggressive behavior

1. The MAT Team will work with the patient to de-escalate the situation.
2. The MAT Team will work with the aggrieved staff and patient to make a plan to repair the harm (do an FA and CBA, develop a plan to mitigate a future lapse in behavior, write a letter of apology, etc.).
3. To maintain safe and uninterrupted MAT Program services, security will be contacted to determine whether adjustments to security procedures are needed.
4. The MAT Medical Director and the DOC Director of Addiction Services and Mental Health will be notified.

Impairment

1. If there is concern for patient impairment, an urgent assessment is necessary. A nurse will evaluate the patient at the location of their impaired state, if safely able to do so. Alternatively, the patient is brought to Health Services. The nurse will screen for objective signs of impairment using the Impairment Assessment Tool, which is completed in the medical record.
    a. The examining nurse will immediately convey the results to the facility MAT Medical Provider, or alternatively the on-call MAT provider, for instructions. The plan will be documented in the medical record.
    b. The home Hub will be notified of any incident involving a methadone patient in their care, prior to administration of the next dose of methadone. The plan will be documented in the medical record, and the MAT Medical Director notified.
    c. The MAT Team will meet with patient for an FA, CBA, and to discuss treatment/recovery implications. The MAT Medical Provider may optimize the individual treatment plan.

VOLUNTARY TAPERS

1. The MAT Team will meet with the patient to document the reason for the taper request, and to complete an FA and CBA.
2. The MAT Team will document that patient education has been provided conveying that the relapse rate is greater than 90% when stopping a first-line medication for OUD.
3. Buprenorphine tapers should be done as slow as possible (2mg/week or slower), though taper rates will be tailored to the patient and the specific clinical circumstances, with shared decision-making.
4. Methadone tapers are done in coordination with the home Hub.
5. The patient will be offered treatment with clonidine, hydroxyzine, loperamide, acetaminophen, and ibuprofen with any potential dose reductions

PREGNANT PATIENTS

The standard of care for pregnant patients with OUD is to provide buprenorphine or methadone as part of treatment. The treatment of pregnant women with OUD will be done in close consultation with the Comprehensive Obstetrics and Gynecology Services (COGS) Clinic at UVMMC. Pregnant women metabolize buprenorphine and methadone more quickly, particularly during the last several months of pregnancy, and this may affect the dose the patient requires.

1. In efforts to minimize adverse outcomes to the fetus, pregnant patients with OUD not currently in treatment will be prioritized for induction with an opioid agonist or partial agonist, in close consultation with the COGS Clinic.

2. Pregnancy is a particularly risky time to consider tapering from methadone or buprenorphine, or to switch between these medications, as it may result in miscarriage. When a pregnant patient desires to do so, it will be done in close consultation with the COGS Clinic and Hub, if appropriate, and the patient will need to sign documentation that the taper is against medical advice.

3. Patients will be regularly monitored for signs of dose inadequacy via regular facility medical provider visits, COGS clinic appointments, and the established sick call process.
    a. The dosage of buprenorphine for pregnant may be increased above 16mg, not to exceed 24mg, at the recommendation of the COGS Clinic, or with approval from the MAT Medical Director. After delivery, the aim is to gradually and compassionately adjust the buprenorphine dose back to the pre-pregnancy dose.

    b. When symptoms of methadone dose inadequacy are reported, care will be coordinated with the home Hub. After delivery, close communication with the

home Hub is needed to gradually and compassionately adjust the methadone dose back to the pre-pregnancy dose, as deemed appropriate by the home Hub.

4. When a pregnant patient diverts their MAT medication from the medline:
    a. Buprenorphine:
        i. The MAT Team will meet with the patient for an FA and CBA, discuss treatment/recovery implications, and submit a Treatment Adjustment Form.
        ii. The MAT Medical Provider may modify the individual treatment plan. Reducing the dose of buprenorphine may be contraindicated due to risk to the unborn fetus.
        iii. The MAT Medical Director will be notified.
    b. Methadone:
        i. The MAT Team will meet with the patient for an FA and CBA, discuss treatment/recovery implications, and submit a Treatment Adjustment Form to the MAT Medical Director.
        ii. The MAT Team submits the DR report, FA and CBA to the home Hub Medical Director. The MAT Team facilitates an in-person, video, or telephone appointment between the patient and the home Hub Medical Provider.